ALL REGIONS
2021

Mental Health Services for Residents of Aged Care

Psychology in Aged Care (PAC) Wellbeing Program

This program is funded through the Primary Health Networks of Brisbane North, Brisbane South, Gold Coast and North Coast NSW program.

phn BRISBANE NORTH
phn GOLD COAST
phn BRISBANE SOUTH
HEALTHY NORTH COAST
phn NORTH COAST

ChangeFutures
Heal the Past • Live in the Present • Change the Future

Acknowledgements

This report was prepared by Executive Director Julie Aganoff, Clinical Governance Manager Frankie Tarver, and Research Officer Thomas Wegener of Change Futures.

The authors would like to acknowledge the individuals involved in the development of the Outcome Measures Report including clients, practitioners and residential aged care facility staff.

In the spirit of reconciliation Change Futures acknowledges the Traditional Custodians of country throughout Australia and their connections to land, sea and community. We pay our respect to their Elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today.

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Introduction

Change Futures initially commenced providing psychological services to residents of a single facility in Brisbane in August 2015 on a pro bono basis. This continued until February 2017 when Change Futures was funded by the Brisbane North Primary Health Network to provide low intensity psychological services to residents of aged care in the Brisbane North Primary Health Network region. Change Futures was funded by St Vincent's Aged Care in seven facilities across south east Queensland from 2017 until 2019, prior to the Commonwealth funding becoming available.

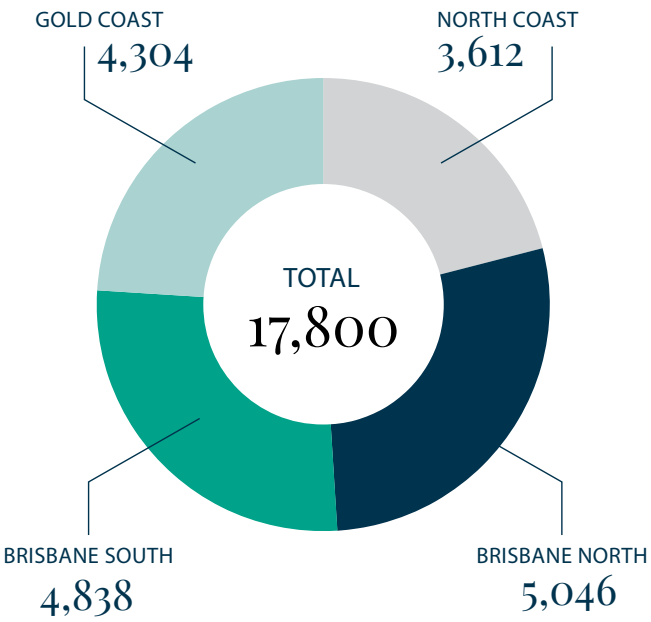
In early 2019, Change Futures was funded to provide psychological services to residents of aged care under new Commonwealth funding in Brisbane North, Gold Coast and NSW North Coast PHN regions. In 2020, Change Futures was funded to provide services to the Brisbane South Primary Health Network.

From 2015 up until 30 June 2021, Change Futures has provided 44,514 mental health services to 3,627 residents in 204 different facilities across six PHN regions (Brisbane North, Gold Coast, NSW North Coast, West Moreton, Brisbane South and Sunshine Coast). Most of this work has been funded by the Primary Health Networks in four regions, however these figures also include work undertaken for St Vincent's Aged Care.

In the 2020/2021 financial year, 17,800 sessions were delivered across the four regions as indicated in the adjacent diagram. The training of practitioners is standardised, and the same measures, interventions and procedures were used across all regions.

This report outlines the activities undertaken in Brisbane North, Brisbane South, Gold Coast, and North Coast, NSW regions; highlights the voices and experiences of the residents; and provides the results of the analysis of the outcome measures collected during sessions.

Region Sessions FY2021



PAC Program Activity Totals

2734
Residents Seen

190
Facilities Attended

2592
Referrals

5393
Reports to GPs

266
Risk Reports

465
Group Sessions

2119
Group Participants

17,800
Individual Sessions

116
Psychoeducation Sessions

668
Psychoeducation Participants

The year has been incredibly busy for practitioners despite and due to the impact of COVID-19. Many facilities have been in lockdown at various times because of the pandemic but also because of influenza, gastroenteritis and other infectious diseases.

The start of the service pre-pandemic allowed the program to become an established part of the service system in all regions, with the exception of Brisbane South which commenced in February 2020. Relationships were developed with RACFs, Older Person's Mental Health and GPs across the region.

The major issue for the service currently is demand management with referrals and requests for service outstripping funding. As a result groups were introduced across all regions, with a total of 465 groups involving 2,119 residents delivered in the last financial year. This has not been enough to meet increasing demand and from 1 July, waiting lists will be introduced.

There has been an increasing trend of risk assessments for suicidal ideation and behaviour being conducted. In this last financial year, 266 risk assessments have been reported to RACFs and GPs.

A review of the risk reports sent to GPs and facility staff over the year indicates that just over 90 per cent are for suicidality/ self harm; eight per cent for medication reviews and suspected delirium; and the remainder for worsening mental health.

Psychoeducation

Staff psychoeducation sessions were delivered on site for staff working in residential aged care. Module topics focus on specific psychological issues found when working in aged care facilities.

Each training session is designed to be practical, engaging, and relevant to those working with residents living in aged care facilities.

Staff psychoeducation sessions have been delivered in all regions in the last financial year. Specialty training in palliative care commenced in Brisbane North in April 2021.

The suite of modules offered to facilities are listed below:

669
Participants Seen

39
Facilities

12
Topics Delivered

116
Training Sessions

1 Suicide in Aged Care

(1 x 30min module)

After participating in this module staff will be able to:

- Differentiate between end-of-life readiness and suicidality, and deploy skills to identify and keep residents at risk safe.

2 Anxiety in Aged Care

(3 x 30min modules)

After participating in these modules staff will be able to:

- Explain and identify different symptoms of anxiety and how they present in aged care residents.
- Identify and describe possible triggers for anxiety in aged care residents.
- Manage anxiety in residents using do's/don'ts, specific strategies and facilitating protective factors.

3 Depression in Aged Care

(2 x 30min modules)

After participating in these modules staff will be able to:

- Explain depression, and support residents with depressive symptoms living in residential care.

4 Communication & Validation in Aged Care

(2 x 30min modules)

After participating in this module staff will be able to:

- Describe the various elements of a communication/ validation process; and become aware of personal barriers to effective communication with residents.
- Use different strategies to improve communication with residents who have specific aged-related conditions (i.e. hearing, sight, dementia, anxiety).

5 Behavioural Management

(2 x 30min modules)

After participating in this module staff will be able to:

- Use a person-centered approach to manage unwanted behaviours (i.e. anxiety, distress, aggression, apathy, agitation, nocturnal disruption, vocalised disruptive behaviours, wandering) in residents more effectively.

6 Chronic Pain in Aged Care

(2 x 30min modules)

After participating in this module staff will be able to:

- Explain and appreciate the psychological and physical experience of chronic pain.
- Use practical skills to reduce distress and assist residents living with chronic pain.

7 End of Life stage

(1 x 30min module)

After participating in this module staff will be able to:

- Describe and appreciate the complexities and considerations for residents in the last psychosocial stage of life.
- Understand the influence of individual factors on the approach to end of life stage.

8 Grief in Aged Care

(1 x 30min module)

After participating in this module staff will be able to:

- Explain and identify the stages of grief, symptoms of grief and explore ways to support those grieving in residential aged care facilities.

9 Adjustment in Aged Care

(1 x 30min module)

After participating in this module staff will be able to:

- Identify and support residents experiencing difficulty adjusting to change in residential aged care facilities.

10 Self-care for staff working in Aged Care

(1 x 40min module)

After participating in this module staff will be able to:

- Explain the importance of self-care and identify personal strategies to improve quality of life, reduce burnout and compassion fatigue when working with people with life-limiting illnesses and their families

11 Palliative Care Part 1

After participating in this module staff will be able to:

- Define palliative care and describe the core values that quality palliative care is based on.
- Identify and explain the various palliative care needs of a resident.

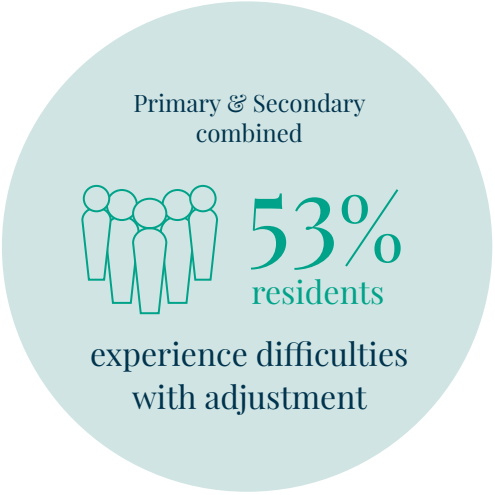
12 Palliative Care Part 2

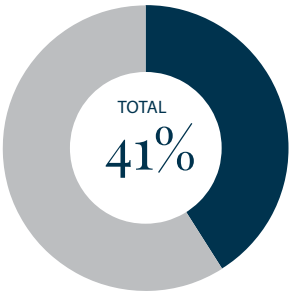
After participating in this module staff will be able to:

- Describe what person-centered care is and demonstrate how to conduct conversations accordingly.
- List and describe the 9 National Palliative Care Standards.
- Appreciate and describe the various cultural considerations when working with residents in palliative care.
- Identify symptoms of psychological distress and when it may be appropriate to communicate and refer across the multidisciplinary team to meet psychosocial needs of residents approaching end of life..

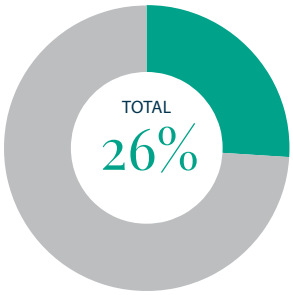
Presenting issues

The tables below outline the major issues reported by people referred to the service and as can be seen, adjustment is the most significant issue. When the primary and secondary issues are combined, 53% of residents referred experienced difficulties with adjustment. Again, combining primary and secondary issues, 41% experienced symptoms of depression, and 26% experienced symptoms of anxiety. A further 19% experienced a combination of anxiety and depressive symptoms. Around 17% experience loneliness while 11% are grieving. Clearly, the data indicates that adjustment, depression and anxiety are the most common reasons for referral.

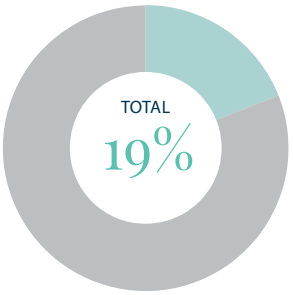




Depression



Anxiety



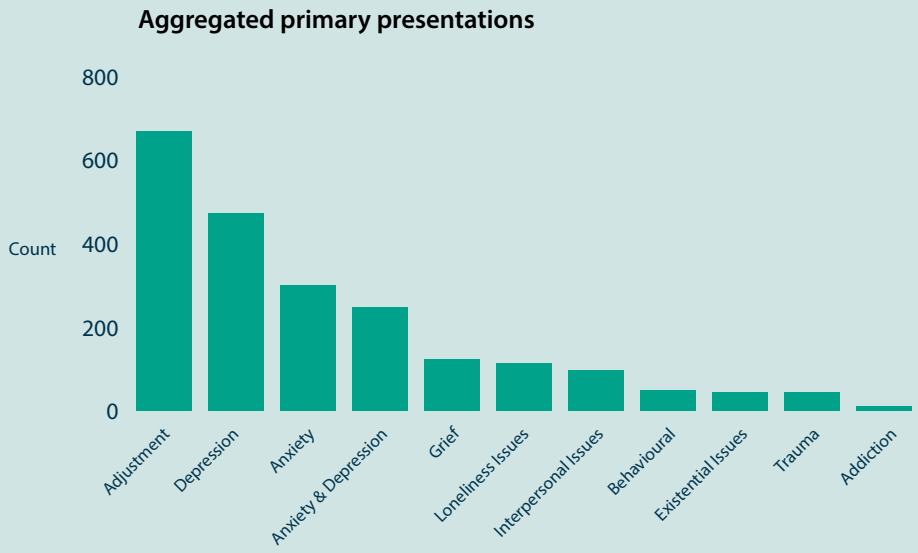
Mixed depression & anxiety

Primary & secondary presenting issues in the PAC Program

PRIMARY PRESENTING ISSUES	Proportion	SECONDARY PRESENTING ISSUES	Proportion
Adjustment	30.84%	Adjustment	22.49%
Depression	21.46%	Depression	19.09%
Anxiety	13.99%	Anxiety	11.78%
Anxiety & Depression	11.64%	Loneliness Issues	11.77%
Grief	5.71%	Anxiety & Depression	7.20%
Loneliness Issues	5.70%	Existential Issues	7.10%
Interpersonal Issues	4.40%	Interpersonal Issues	7.07%
Behavioural	2.30%	Grief	5.51%
Existential Issues	1.79%	Behavioural	4.20%
Trauma	1.73%	Trauma	3.25%
Addiction	0.45%	Addiction	0.55%

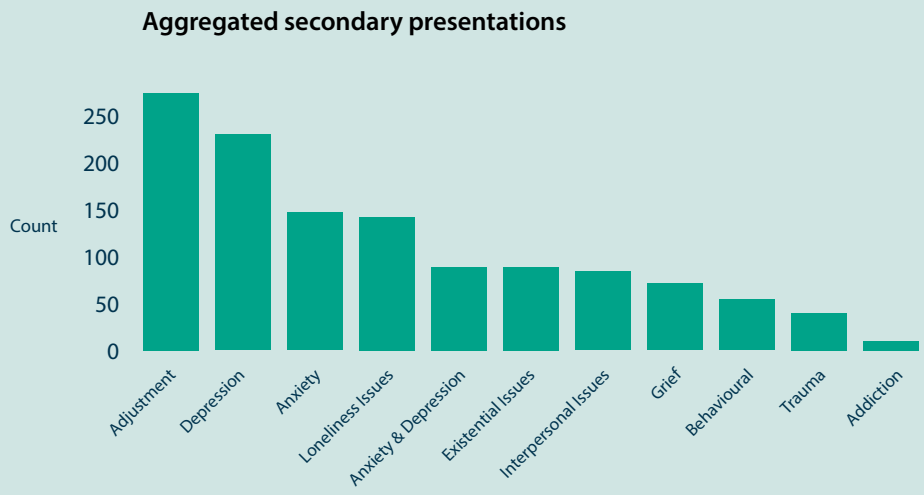
Primary presenting issues

As can be seen, the most common reason for referral to the program was difficulties with adjustment, followed by depression, anxiety, and mixed anxiety and depression.



Secondary presenting issues

For secondary issues, adjustment difficulties, depression, anxiety and loneliness issues are the most common reasons for treatment.



"I feel like I've learned how to talk about things and work through my worries. I'm not as worried anymore."

Client experience: Feedback

This feedback has been given directly by the residents to the practitioner they have been seeing.

"Over the past several weeks [since therapy commenced], I have managed to control myself and not snap at my husband."

"I never would have been able to mend my relationships without your help."

"I am so proud of myself for not having to take any anxiety medication for nearly three months now."

Client stated the service gave him a sense of peace around his end-of-life period and understanding of his situation.

"I have noticed the change in myself since you have started coming; I am able to have a conversation without breaking down. So thank you."

Client reported increased acceptance of her circumstances and lower distress around previously reported issues.

Client is feeling well adjusted and more in control of her life circumstances.

The client, who had presented with severe distress and anxiety, reported feeling at peace after the counselling session. She appreciated that she was heard and accepted.

"I wouldn't be as good as I am right now without your support. I would have continued to regress into my own little world without you."

Client has looked forward to our sessions as she expressed that it helps to maintain her emotional well being.

"I feel a lot more calm and motivated after your visit. It was hard to engage at first, but I feel like it has helped me."

Client is feeling well adjusted and more in control of her life circumstances.

"I feel like I have become more open minded to therapy and am more willing to explore things that would often be left unsaid in other relationships."

"I practice my breathing (breathwork) every day and it really has helped me to sleep better."

"Thank you for helping me adjust and sleep better."

After receiving the counselling service client reported decreased feelings of loneliness and detachment from others.

Client reported improved mood, alertness and engagement at the end of sessions.

"Thank you for your help, I now don't worry about anything, and can sleep better and feel more at peace. Before I felt that no one understood me and it was a terrible feeling not knowing who I could talk to."

Client experience: Session Rating Scale

The Session Rating Scale (SRS; Miller, Duncan & Johnson, 2002) data is aggregated (combined across PHN regions) with a total sample size of *n*=1914.

Clients are asked to rate four statements (as below) at the end of every session about their experience of the session and practitioner. This is scored (each item is rated from 0 to 10) and indicates the quality of the therapeutic alliance which in itself is a good indicator of outcomes for clients. A score of 36 and above out of 40 represents a good alliance.

The assessable items in the SRS consist of "I felt heard, understood, and respected", "We worked on and talked about what I wanted to work on and talk about", "The therapist's approach is a good fit for me", and "Overall, today's session was right for me."

SRS Aggregated: First Test Point vs Last Test Point Means

Session Rating Scale

OUTCOME MEASURE	First Test Point	Last Test Point	t-Test	Significance (2-Tailed)
SRS	M=38.13 (SD=3.26)	M=39.01 (SD=2.80)	t(1913) = -12.78	p=.001***

Table 1. Aggregated SRS score comparisons between first and last test point.

We use this assessment as a proxy for 'client satisfaction', as clients who don't score the sessions and practitioners in this range (above 35) are likely to decline further services. We know that mental health outcomes are impacted by many factors such as illness and cognitive decline. However, a strong therapeutic relationship provides significant benefits for residents. The quality of the therapeutic relationship is an important factor which contributes to positive mental health outcomes, but is also independent of them. Older adults need to be heard and respected as human beings with value, despite their situation.

Client experience: Vignettes

(All names and some details have been changed to protect the privacy of residents).

We have the privilege of working closely with people living in residential aged care. They are generally not visible to the rest of society but they all have a story. Some are shared on the following pages.

Eve (91yo) was referred by facility staff as she was self isolating and experiencing low mood, worsening dementia, and memory loss. Eve's family had also expressed concerns since she was new to the facility and was having some difficulty adjusting. Despite her memory loss, Eve has remained enthusiastic, interested, and positively engaged in our sessions. A focus of the sessions has been on improving Eve's adjustment to the facility. Establishing a more predictable routine, strengthening her social relationships, and increasing her engagement in social activities has aided this. Eve has also enjoyed spending time reminiscing on past memories of her life. Through this, Eve has shared that she was born and raised in Sweden and was the youngest of seven siblings. Eve would regularly reminisce fond memories of her parents, siblings, and her lifelong love of reading and learning. Eve was an accountant and academic. She talked about her late husband and the strength of their marriage, how they emigrated from Sweden as young adults and raised three sons. Eve continues to share a close relationship with her sons.

Eve reported that throughout her life she has "preferred things to be more private", however, her engagement in activities like the weekly church service have eased her feelings of "emptiness" and brought her a sense of purpose. My observations suggest that Eve's personal strength, resilience, humor, wisdom, and spirituality also support her to improve. The use of reminiscence therapy, supportive counselling, relaxation techniques, and CBT across our sessions has contributed to steady improvements to Eve's psychological distress, anxiety, and depression. At times, Eve can experience increased loneliness and emptiness due to her forgetfulness of recent family visits. A strong therapeutic alliance and reassurance of her family's love and support has brought Eve comfort and lessened her feelings of loneliness. Facility staff have acknowledged that Eve's positive engagement with the service has improved her well being and adjustment to the facility. Eve's family have also expressed their gratitude for the program as it brings them reassurance that someone is there to "listen" and provide additional support for their mother's wellbeing. Eve herself has also reported that our ongoing sessions bring greater clarity to her day and she has expressed that "we always put things right".

Abby, 70yo, chose to self-refer for support with her anxiety following a recent incident with another resident. She had been a regular in the conversation groups but had never participated in individual sessions. So far, Abby has engaged very well in our sessions. Her previous engagement in our conversation group has made her more comfortable since I was already known to her. Her initial goals had been learning self-regulation and coping skills and identifying the emotions that contribute to her anxiety.

In discussing aspects of her life history, Abby disclosed that she had grown up in suburbia with a very close-knit family and a special bond with her family dog. Throughout her life, Abby has loved expressing herself creatively through music, knitting and crafts, which she still does to this day. Abby also emphasised the personal importance of maintaining harmony in her life and wanting to get along well with others.

The therapeutic interventions applied with Abby included CBT and psychoeducation around emotion regulation, cognitive restructuring, and interpersonal skills training. By the end of our sessions, Abby's symptoms had reduced significantly and she felt that she had learned good coping strategies for her anxiety. One of the main factors to Abby's improved mood has been her practice of tasks focusing on helping her to identify the emotions and thoughts contributing to her anxiety. Facility staff have also noticed the change in Abby's mood and behaviour. She has also reflected that her quality of life has improved as her anxiety has decreased. Abby is now more confident about her ability to manage her emotions and to reflect on the challenging situations she may face. At the end of our sessions, Abby quoted: "you have been very helpful with everything. I now understand a lot about relationships and know to respect myself." Abby has continued to engage in our weekly conversation group within the facility.

Wendy, 92yo, was initially referred to our service for suicidal ideation, chronic depression, difficult behaviours, and insomnia. Part of my therapeutic approach involved exploring Wendy's background and attempting to understand what was contributing to her current experiences. Wendy revealed that she experienced a sense of rejection from a very young age after growing up in foster care and having difficulty making close connections with others. Wendy has struggled with her relationships with other residents and expresses feeling easily offended. Wendy would often respond aggressively to staff and residents which led to difficult situations and fueled her depressive symptoms. Through our discussions, Wendy realised that she experiences small interactions as potential further rejection which causes her to be hostile and aggressive, and to withdraw from others.

Across our four months of therapy, Wendy has reported feeling calmer and has stopped "lashing out" at others. She has also reported eating her meals in the dining room rather than alone in her own room. Although she still faces challenges when interacting with her extended family, Wendy is better able to engage with staff and other residents. Wendy's mood has improved and she engages in more social activities than previously. She still experiences periods of depression but reports they are not as severe as before and that she is able to "come out of it" easier than before.

W has reported that the insight she has gained has helped her to make sense of her life. She has told me that the opportunity to reminisce and process the events of her life in a way that does not make her feel judged has allowed her to experience a feeling of peace. Wendy and facility staff have expressed their gratitude for the service and our ongoing support.

Mary (75yo) was referred because of her history of PTSD, anxiety, depression, and chronic pain. Additionally, in my conversations with Mary she said that her estrangement from her daughters was a significant trigger for her anxiety and depression symptoms. My initial focus with Mary was identifying her goals and building rapport through exploration of her life history and background. Her initial goals included improving her relationships with her daughters and improving her overall mood.

Mary had been adopted as a baby and grew up as an only child in Brisbane. After school she worked as a teacher before changing careers and working first within an accounting firm followed by a law firm. Her enjoyment of administrative tasks is still evident today where she has recently commenced a new role collecting data for the census. When Mary met her husband, a football player, they often enjoyed going to games together and still enjoy watching rugby union today. They have three daughters and four grandchildren. Through supportive counselling, CBT, group therapy, and interpersonal therapy, M has been able to reconcile with one of her daughters and now sees her daughter and grandchildren regularly. She reports being able to monitor her cognitive distortions and adapt them into more helpful thinking patterns which have assisted her in getting along with other residents at the facility. Recently, Mary has reported significant reductions in her symptoms of anxiety, loneliness and depression with major improvements in her quality of life. Her daughter also reported a significant improvement in their relationship and Mary's ability to communicate without judgement. Mary has expressed gratitude for the service saying "I cannot thank you enough. If it weren't for you helping me to see other perspectives, I never would have fixed my relationship with my daughter".

*In the early sessions with Andrew (81**yo**), his dementia symptoms, which included wandering and confusion, made engaging with him very challenging. The initial approach was to walk alongside him as he wandered the halls so he could understand I was a safe person and so he could be comfortable sharing space with me. After three sessions of simply walking alongside Andrew, he finally realised he could trust me. He sat down, turned to me and showed he was ready to engage. He fondly spoke of his childhood memories of growing up in a rural area with a large and close knit family. He recalled his joy of learning to play cricket with his siblings and playing regularly at school and later. During one such game, he said he took his eye off the ball when a beautiful woman caught his eye. He said it was "love at first sight" and they later married. They went on to start a family raising three girls who all loved playing cricket with their dad. His girls went on to have children of their own and Andrew treasures time spent with his grandchildren.*

Two years ago Andrew's wife filed for divorce and he said this causes him immense pain and grief. The focus of our sessions shifted to working through his feelings of distress and loss over his recent divorce as well as adjustment to living in the facility. Together we agreed to work towards the goal of improving his mood. A combination of CBT, supportive counselling, and reminiscence therapy produced a positive impact on Andrew's depressive and dementia symptoms. Andrew is incredibly thankful to be able to speak with someone about the loss that he has been carrying. He also recognises and greets me and can recall the content of our sessions, which he said he looks forward to. I am so relieved that I did not give up or wrongfully assume that dementia symptoms might preclude therapeutic benefit for Andrew.

*Bob (77**yo**) was first introduced to the service following his attempted suicide. In our conversations he revealed that his immobilisation from two previous strokes and damaged knees and hips, plus the inability to see his wife due to the Covid restrictions meant he no longer saw "any point in living". His lack of interaction with others was a significant source of Bob's low mood. Bob showed great enthusiasm and gratitude for our sessions since it provided him with a chance to share his story with another person. He spoke fondly of his proud Scottish heritage and the strict principles and "never give up" attitude that came from his background. He reflected that it was this attitude and beliefs that helped him to see a meaningful way forward through this difficult stage of life. Talking about the factors contributing to and maintaining his low mood helped Bob to put into words what he had lost and why this situation was so difficult for him. Discussing his life history further, Bob shared memories of his successful career in the construction industry. It was clear that his ability to make strong connections was an important aspect of his success. Bob believed that being able to connect to someone in a meaningful way gave him a sense of hope.*

An additional focus for our sessions was finding solutions to some of his current stressors. Bob's short term memory loss meant he would often lose his train of thought and become distracted. With time, Bob was able to experience less stress about what he could not remember and instead focused on enjoying what he could recall. Secondly, Bob found that writing down details about his life and posting them around the room helped him to feel less distressed when unable to recall these details. With time Bob has reported feeling less stressed, more confident, and less impacted by little things that would previously get him down. Bob has also reported feeling more adjusted to his immobility. Our future goal is to help Bob to engage in a reminiscence conversation group to help build his social connections within the facility.

Valerie is a 67yo female who was initially referred because of her difficulty adjusting to life in the facility and interpersonal difficulties with her partner. During initial conversations with Valerie, she shared that she was born and raised in Sydney, where she had to overcome the hardships of growing up in a single parent household after her father abandoned them when she was just six months old. Valerie also recalled that other children weren't allowed to come over to play and that she spent much of her childhood living with her grandparents. Valerie had three children in her first marriage and. Valerie has enjoyed walking and "people watching" throughout her life and she continues to do these activities in the facility.

The focus of my sessions with Valerie has been improving her mood and alleviating symptoms of distress. I have primarily utilised CBT with an emphasis on encouraging Valerie to engage in more pleasurable activities, to introduce more positive experiences for her and to help provide a sense of mastery in her day-to-day life. One of the barriers to our sessions has been Valerie's treatment for bone cancer which often leaves her feeling "exhausted", "depleted", and unable to engage in sessions. Until entering aged care Valerie also volunteered as a support person for individuals diagnosed with bone cancer. Valerie has shown a strong interest in our sessions which we will often hold on the balcony to give her a sense of privacy and calmness (Valerie is in a shared room).

Across our sessions, Valerie has reported reduced distress and depression symptoms and reports feeling more settled at the facility. She also reports that using the pool for exercise and going for walks by herself helps to increase her sense of autonomy and wellbeing. She has expressed having a sense of encouragement from the progress we have made and has expressed her appreciation of the service as she has no-one else she can talk to about these issues.

I first began working with Eve, 78yo, after she was the victim of physical aggression from another resident which left her feeling afraid and self-isolating. I have worked with Eve over a four month period and across this time I have been able to learn about her through her reminiscence. Eve grew up in rural Queensland and spent her early adult years taking care of her house and raising her two children. Eve now has nine grandchildren whom she adores and loves spending time with. Eve also reflected on some hardships in life, such as the loss of her mother and a younger sister.

My focus with Eve has been on applying CBT, relaxation strategies, and reminiscence therapy. Through this Eve has noticed a change in her thought processes which have helped her to feel more adjusted and better settled in the facility. Additionally, Eve is better able to think through her negative thoughts and can process them more "logically". She has mentioned that she tries to attend as many social activities as she can and will often talk openly and comfortably with other residents. At the end of our sessions, Eve reflected on her improved mood and feeling that she has a better understanding of the importance of her role in her family's life.

My sessions with Sue, 78yo, have focused on supporting her own adjustment to the facility, experiences with low mood, and her concerns for her husband who lives independently. She has always been open and engaged in our sessions. Sue has shared her experiences with personal and physical stressors within the facility including decreased mobility and interpersonal issues with staff. These issues stem from Sue believing she is receiving inadequate care within the facility. In our sessions, I have worked with Sue to help her identify how her negative thoughts about small things and her worries about her husband's health issues contribute to her distress and low mood.

A significant focus of our sessions has also been altering Sue's negative thoughts around physical movement. This has assisted Sue to overcome her pain barrier and has been a positive outcome for her. Sue now has more enthusiasm to engage in her physiotherapy sessions and do her exercises. The use of relaxation techniques has also improved her ability to engage in these exercises. Across our sessions Sue has voiced acceptance for the fact that the facility is the safest place for her and the best option to allow herself and her husband to care for themselves. Sue is always grateful to have sessions and has commented on how much it has assisted her to adjust and accept her declining health. Sue's husband has also provided positive feedback and has noticed an improvement in his wife's mood following sessions.

*Mary (102**yo**) found adjusting to her new life in the facility challenging. Mary is quite introverted and prefers her own company with the exception of regular outings with her son. This made it difficult*
for her to connect with other residents and contributed to her adjustment issues. She was referred for psychological support and through psychoeducation she learned about the positive impacts of social connection. The staff encouraged and supported Mary to attend the Reminiscence group along with another four to six other residents within the facility. Initially, she attended every second week, but after enjoying the group so much, Mary now attends weekly as a priority.

Family members often report back the positive impact they see within their loved ones when they attend the Reminiscence group, but also the joy they feel from seeing their parents' happiness and level of engagement when interacting in the group setting. Occasionally, family members attend the group and report hearing stories and information from their loved ones for the very first time.

Staff report that residents ring their bells less frequently, requiring less attention and assistance as their social needs are being met through these group sessions. Further there are fewer reports of loneliness and a higher level of engagement in other activities.

Each week Mary can be found sharing stories and memories with other residents within the facility Reminiscence group. She still enjoys her frequent visits from her son and has now adjusted to living in aged care.

Chris (84yo) was initially referred to the service by her general practitioner for depression. Chris has experienced a gradual decline in her physical health subsequent to a stroke some years ago that left her partially paralysed and vision loss which is now contributing to low mood and is impacting on her daily living. Chris relies on staff for assistance in completing many of her daily activities. Chris shared that after marrying and raising her family, she decided to study education and had a career as a high school teacher for many years. This was a proud accomplishment for her. Throughout her life Chris has had a passion for painting and still has many of her artworks on display in her room.

In my sessions with Chris we have explored the impact of her cognitions on her wellbeing. She has expressed a sense of hopelessness and sadness about being in the facility and the idea that she will soon be unable to paint or appreciate the world around her due to her poor vision. Isolation due to recent Covid lockdowns has also contributed to a sense of loneliness and low mood for her. The main therapeutic intervention applied with Chris has been CBT with a focus on identifying and challenging her negative cognitions through cognitive restructuring. Despite her ongoing depressive symptoms caused by her poor mobility and vision, Chris engages well in our sessions. She has stated that the sessions have made her feel more hopeful about things getting better and that she is not useless. By the end of our initial five sessions, Chris reported being more optimistic about the future and our sessions. She appears motivated, open to receiving new ideas, and is appreciative of the service.

Quantitative Outcomes/ Results

Assessments used are shown in the table below and these are administered every five sessions throughout therapy to guide therapeutic approaches as well as to provide progress reports to GPs and Clinical Managers in facilities. The outcomes below are based on the results of the first and subsequent assessments.

Quantitative Outcomes/Results – Aggregated Analyses

1. Kessler Psychological Distress Scale-5 (K-5)

2. Geriatric Anxiety Scale-10 (GAS-10)

3. Patient Health Questionnaire-9 (PHQ-9)

4. Quality of Life in Alzheimer's Disease Factor 3 (QOL-AD)

5. De Jong Gierveld Loneliness Scale (DGLS)

Improved outcomes across all measures at a statistically significant level.

As shown on page 17, all measures showed statistically significant improvement over time, indicating the value of therapeutic interventions with residents.

In our earlier Outcomes Reports in 2018 and 2019, we observed that residents often showed a decline in scores from first to second test point and then significant improvement overall by the end of therapy. Our interpretation of these results was that perhaps residents were feeling safer with the practitioners by the second assessment period and were therefore more willing to share their actual feelings and thoughts.

This pattern has not been replicated in these results and we wonder if it is as a result of the service being more known and accepted by facilities and residents. It is clear that the service makes a real difference in the lives of residents and is highly valued by GPs and facility staff.

Results: First Test Point and Last Test Point

Six repeated measures t-tests were conducted to compare changes in outcome measures from a client's first test point to their last test point.

Statistically significant improvements in all measure categories were observed in aggregated client scores.

The mean score of the **Kessler Psychological Distress Scale** significantly reduced by 1.40 from first test point (M = 12.47, SD = 4.48) to last test point (M = 11.07, SD = 4.27); t(1108) = 11.46, p = <. 001. The sample size was *n* = 1109.

The **Geriatric Anxiety Scale** mean score significantly improved by 1.35 from the first test point (M = 10.74, SD = 6.43) to last test point (M = 9.39, SD = 5.92); t(936) = 7.08, p = <.001. The sample size was *n* = 937.

The **Patient Health Questionnaire** mean score significantly reduced by 0.90 from the first test point (M = 8.02, SD = 5.36) to last test point (M = 7.13, SD = 5.21); t(978) = 5.87, p = <.001. The sample size was *n* = 979.

The mean score of the **Quality of Life in Alzheimer's Disease Factor 3** increased significantly by 0.33 when comparing the first test point (M = 14.20, SD = 3.24) to last test point (M = 14.53, SD = 3.11); t(818) = -3.24, p = <.001. The sample size was *n* = 819.

Discussion

All measures showed statistically significant changes from the initial assessment to the most recent assessment. Psychological distress, depression and anxiety reduced while quality of life improved. Both social and emotional loneliness are reduced over the course of therapy as well. The charts of measures also show continuing improvement over time with improvements from first to second assessments and further improvements at the most recent assessment.

The **De Jong Gierveld Loneliness Scale (Emotional Loneliness)** mean score showed a significant decrease of 0.20 from the first test point (M = 1.90, SD = .97) to last test point (M = 1.70, SD = 1.04); t(342) = 3.99, p = <.001. The sample size was *n* = 343.

There was a significant reduction of 0.22 in the mean score on the **De Jong Gierveld Loneliness Scale (Social Loneliness)** from the first test point (M = 1.71, SD = 1.19) to last test point (M = 1.49, SD = 1.22); t(321) = 3.70, p = <.001. The sample size was *n* = 322.

Quantitative Measures: Comparing First Test Point with Last Test Point Aggregates

OUTCOME MEASURE	First Test Point	Last Test Point	t-Test	Significance (2-Tailed)
K-5	M = 12.47 (SD = 4.48)	M = 11.07 (SD = 4.27)	t(1108) = 11.46	p = <.001
GAS-10	M = 10.74 (SD = 6.43)	M = 9.39 (SD = 5.92)	t(936) = 7.08	p = <.001
PHQ-9	M = 8.02 (SD = 5.36)	M = 7.13 (SD = 5.21)	t(978) = 5.87	p = <.001
QOL-AD (factor 3)	M = 14.20 (SD = 3.24)	M = 14.53 (SD = 3.11)	t(818) = -3.24	p = <.001
DGLS(EL)	M = 1.90 (SD = .97)	M = 1.70 (SD = 1.04)	t(342) = 3.99	p = <.001
DGLS(SL)	M = 1.71 (SD = 1.19)	M = 1.49 (SD = 1.22)	t(321) = 3.70	p = <.001

Psychological Distress

K5: First Test Point vs Last Test Point Means (Aggregated)

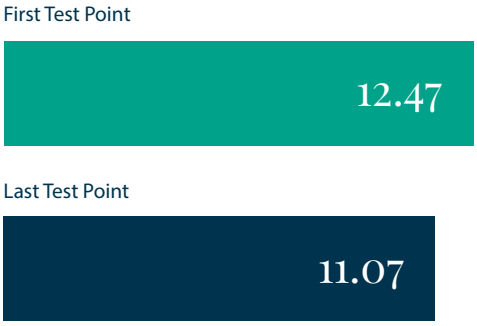


Figure 1. Sample size *n* = 1109

K5: First Test Point vs Second Test Point vs Last Test Point Means (Aggregated)

Figure 2. Sample size *n* = 629

The **Kessler Psychological Distress-5 scale (K-5)** is a subset of questions derived from the K-10 (Kessler et al., 2002), which seeks to quantify the psychological distress experienced by a resident within the previous four weeks including the day of assessment. Due to the negative reactions of clients to some of the questions in the K-10 and the issue of respondent burden, Change Futures reviewed the literature of the various Kessler scales, and chose the K-5 as the most appropriate version for this population.

With the previous four weeks in mind, the K-5 consists of five questions as follows:

- How often did you feel nervous?
- How often did you feel without hope?
- How often did you feel restless or jumpy?
- How often did you feel everything was an effort?
- How often did you feel so sad that nothing could cheer you up?

A resident's score between 5 to 11 is considered low to moderate risk of psychological distress, whereas a score between 12 to 25 is high to very high risk of psychological distress. As displayed in the chart above, the mean value of residents' first assessment score is categorised as high to very high risk, and by the last assessment, the resident mean score has nearly subsided into low to moderate risk.

Results from the K-5 show a significant reduction in the reported psychological stress (as measured by the K-5) of residents within the PAC Wellbeing Program from first to last test point. Residents engaged with the program had a mean score within the *high to very high* risk range at first test point. At the last test point residents had a mean score within the *low to moderate* range.

Analyses of multiple test points demonstrate more clearly the reductions in risk from high to very high at the first test point, to low to moderate at the last test point, with a trajectory of improvement over time.

Anxiety

GAS-10: First Test Point vs Last Test Point Means (Aggregated)

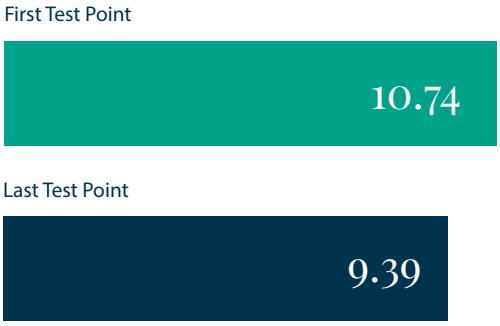


Figure 3. Sample size *n* = 937

The **Geriatric Anxiety Scale-10** (GAS-10) is a subset of statements derived from the GAS-30 (Segal et al., 2010), which seeks to quantify symptoms of anxiety and stress experienced specifically by older adults. Much like the K-5, the abridged version of the GAS-10 can be effectively administered in a timely manner, in addition to having shown strong psychometric properties in community-dwelling samples and suitability for individuals with fatigue issues. (Carlucci et al., 2021).

The assessable items, which are scored from "Not at all (0)" up to "All of the time (3)" and focus on experiences of the past week are as follows:

- I was irritable
- I felt detached or isolated from others
- I felt like I was in a daze
- I had a hard time sitting still
- I could not control my worry
- I felt restless, keyed up, or on edge
- I felt tired
- My muscles were tense
- I felt like I had no control over my life
- I felt like something terrible was going to happen to me

GAS-10 severity ratings of resident scores are categorised by the following thresholds: scores between 1 to 6 are minimal, 7 to 9 are mild, 10 to 11 are moderate, and 12+ are severe.

Residents engaged in the PAC Wellbeing Program reported a significant reduction in anxiety (as measured by the GAS-10) from first test point to last test point. Residents reported a mean score in the *moderate* range at first test point. At the last test point residents reported a mean GAS 10 score in the *mild* range.

GAS-10: First Test Point vs Second Test Point vs Last Test Point Means (Aggregated)

Figure 4. Sample size *n* = 481

Analyses of multiple test points demonstrate the reductions in symptoms of anxiety over time.

Depression

PHQ: First Test Point vs Last Test Point Means (Aggregated)

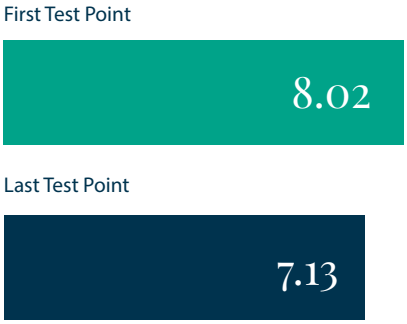


Figure 5. Sample size *n* = 979

The **Patient Health Questionnaire-9** (PHQ-9; Kroenke et al., 2001) is used to monitor the severity of depression and is sourced from the 5-module set of measures called the Patient Health Questionnaire. The scale has proven to be suitable for older adults with varied levels of cognitive functioning in primary care, home care and outpatient clinical settings.

The scale has 9 items that focus on the residents' experiences in the last 2 weeks. The items, which are scored from "Not at all (0)" up to "Nearly every day (3)" include:

– Little interest in doing things
– Feeling down, depressed, or hopeless
– Trouble falling or staying asleep, or sleeping too much
– Feeling tired or having little energy
– Poor appetite or overeating
– Feeling bad about yourself
– Trouble concentrating on things
– Moving or speaking so slowly that other people could have noticed, or being fidgety and restless
– Thoughts that you would be better off dead or of hurting yourself in some way

Severity ratings of PHQ-9 scores are as follows: 0 to 4 are none-minimal, 5 to 9 are mild, 10 to 14 are moderate, 15 to 19 are moderately severe, and 20+ are severe.

Residents in the PAC Wellbeing Program reported an average reduction in depressive symptoms (as measured by the PHQ-9) from first test point to last test point. On average, the resident's PHQ-9 scores dropped by two or more points. This was a significant reduction in the average reported depressive symptoms from first to last test point.

PHQ-9: First Test Point vs Second Test Point vs Last Test Point Means (Aggregated)

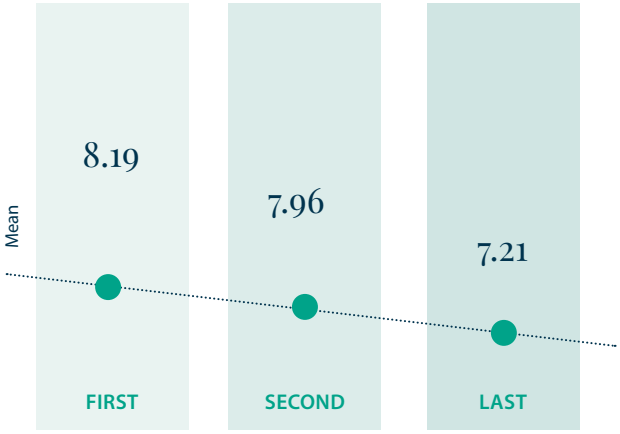


Figure 6. Sample size *n* = 523

Analyses of multiple test points demonstrate the reductions in symptoms of depression over time, from the first test point, to the second and last test points.

Quality of Life

QOL-AD: First Test Point vs Last Test Point Means (Aggregated)

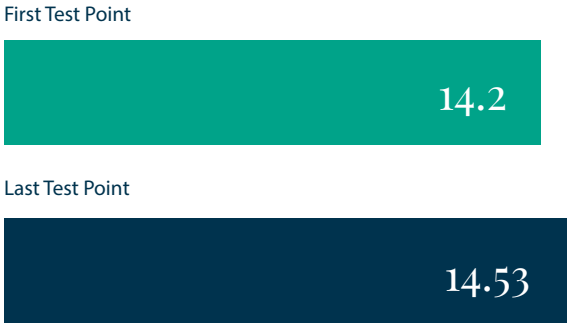


Figure 7. Sample size *n* = 819

The **Quality of Life-AD (factor 3; Logson et al., 1999)** is a scale consisting of six items designed to be administered to residents with dementia. Factor 3 measures quality of life in relation to psychological wellbeing.

The included questions consist of:

- How has your mood been lately?
- How about your memory?
- How about your family and your relationship with family members?
- How do you feel about yourself?
- How about your ability to do things for fun that you enjoy?
- How would you describe your life as a whole?

The QOL-AD focuses on life domains identified to be especially pertinent to adults with cognitive impairments. The range of possible scores measuring psychological wellbeing (factor 3) is 6 to 24, with higher scores indicating better quality of life.

The mean reported quality of life for residents in the PAC Wellbeing Program (as measured by the QOL-AD factor 3) significantly improved from first session to the last session.

QOL-AD: First Test Point vs Second Test Point vs Last Test Point Means (Aggregated)

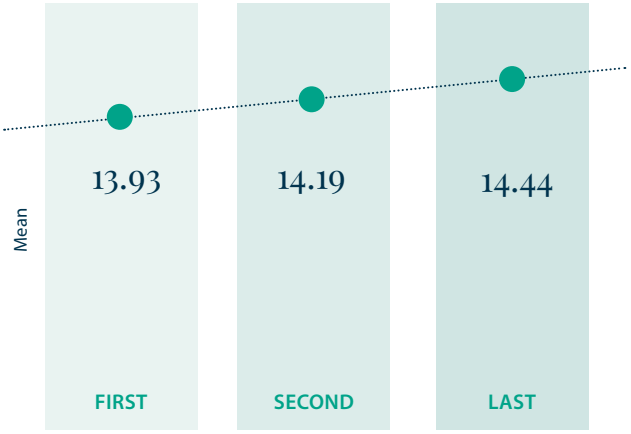


Figure 8. Sample size *n* = 410

Although improvements in scores were observed over time, the results indicate there is still much scope for further improvement in resident's quality of life.

Emotional Loneliness and Social Loneliness

DGLS(EL): First Test Point vs Last Test Point Means (Aggregated)

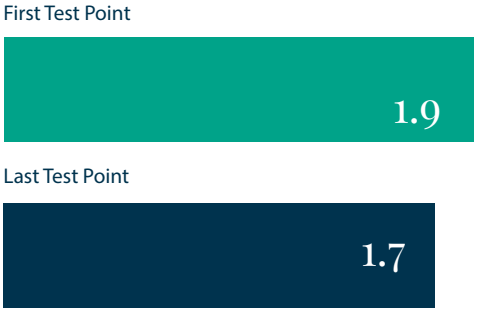


Figure 9. Sample size *n* = 343

DGLS(EL): First Test Point vs Second Test Point vs Last Test Point Means (Aggregated)

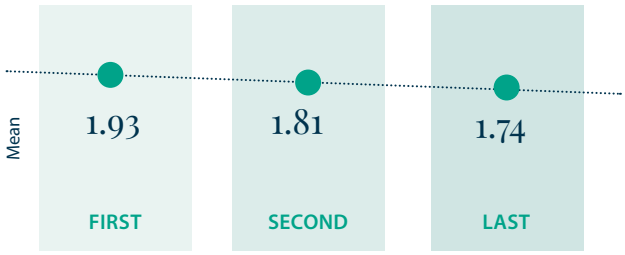


Figure 10. Sample size *n* = 138

DGLS(SL): First Test Point vs Last Test Point Means (Aggregated)

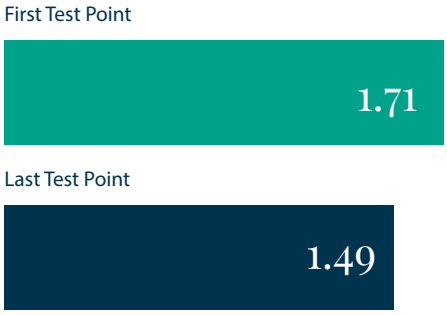


Figure 11. Sample size *n* = 322

DGLS(SL): First Test Point vs Second Test Point vs Last Test Point Means (Aggregated)

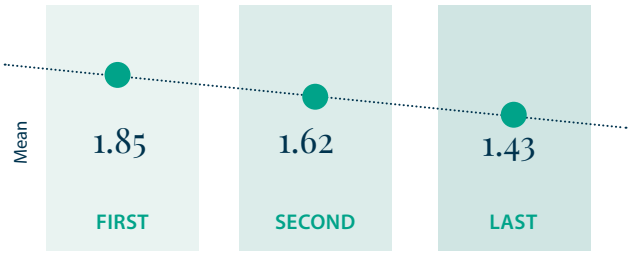


Figure 12. Sample size *n* = 127

The **De Jong Gierveld Loneliness Scale** (DGLS; De Jong, & Tilburg, 2006) is a six item scale partitioned into three items pertaining to emotional loneliness and three items pertaining to social loneliness. A low score suggests an individual has sufficient connectedness with others. Emotional loneliness can be described as a subjective experience borne from yearning an intimate bond with another person. Social loneliness is a function of lacking broader relationships with friends and confidants. Loneliness is a prominent issue facing elderly individuals, with cohorts over the age of 75 more likely to be lonely than any other age group (AIHW, 2019).

The scale consists of the following statements which are graded with the responses "Yes", "More or less", and "No".

The statements referring to emotional loneliness are:

- I experience a general sense of emptiness
- I miss having people around me
- I often feel rejected

The statements referring to social loneliness are:

- There are plenty of people I can rely on when I have problems
- There are many people I can trust completely
- There are enough people I feel close to

The two subscales of the DGLS, being emotional loneliness and social loneliness, are scored between 0 to 3, making the overall assessment scored between 0 to 6.

The De Jong Gierveld Loneliness Scale (Emotional Loneliness) mean score showed a significant decrease of 0.20 from the first test point (M = 1.90, SD = .97) to last test point (M = 1.70, SD = 1.04); t(342) = 3.99, p = <.001. The sample size was n=343.

There was a significant reduction of 0.22 in the mean score on the De Jong Gierveld Loneliness Scale (Social Loneliness) from the first test point (M = 1.71, SD = 1.19) to last test point (M = 1.49, SD = 1.22); t(321) = 3.70, p = <.001. The sample size was n=322.

Therapy is useful in reducing emotional loneliness though increasing self awareness and self understanding of barriers to connecting with others. Improvements in mood and reductions in distress can result in improved capacity for social connection in residents, and therefore increase likelihood in engaging in social activities within the facility.

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