Te Pou
o Te Whakaaro Nui

# TALKING THERAPIES

## FOR OLDER ADULTS

Best and promising practice guide for mental health and addiction services

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## Disclaimer

This guide has been prepared by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and Mental Health Programmes Limited (Te Pou) as a general guide and is based on current medical knowledge and practice at the time of its preparation. It is not intended to be a comprehensive training manual or systematic review of talking therapies in New Zealand. RANZCP and Te Pou will not be liable for any consequences resulting from reliance on statements made in this guide. You should seek specific specialist advice or training before taking (or failing to take) any action in relation to the matters covered in this guide.

TALKING THERAPIES FOR OLDER ADULTS

# Foreword

Service users, families and clinicians have called for greater access to evidence-based 'talking therapies' across the mental health and addiction sector. The call is for therapies that are high quality and accessible in a more consistent way across mental health and addiction services in New Zealand.

The aim of Te Pou's work in this area is to explore which therapies are currently used and what might enhance their quality, sustainability and spread across New Zealand. In 2009 Te Pou published *A Guide to Talking Therapies in New Zealand*, a user-friendly guide to talking therapies for people seeking therapy and their family members. In 2010 Te Pou is producing a series of guides that intend to better inform staff working therapeutically with specific population groups about the processes of engagement and therapies that are particularly appropriate.

The growth in New Zealand's population aged 65 years and over will accelerate in coming decades as the post-World War II baby boomers begin turning 65 from 2011. With cultural and societal changes in the 1960s and 1970s, baby boomers are more aware of the availability and effectiveness of talking therapies. This is in contrast to the current group of older adults who are more likely to receive biological treatment, such as medications, than talking therapies from mental health and addiction services. I believe we have to be prepared to meet the needs of our next cohort of older adults, and this guide serves as a platform for workforce and resource development.

My understanding and appreciation of the psychosocial issues facing older adults came from my practice in talking therapies. Talking therapies allow us to have a deeper understanding of the meaning of these issues. I encourage clinicians working with older adults to improve their skills and knowledge by training in talking therapies. The objective of this guide is to provide an overview of the promising therapies for older adults. It is not aimed to be a manual or a systematic review of talking therapies for older adults. For those who are interested in further training, resources and/or training opportunities in New Zealand are provided for each talking therapy.

Section two of this guide covers the principles of engaging and working with older people. In addition to talking therapies, I believe these principles can be applied to our everyday work with older adults and they will also be useful for those entering the workforce. Section three discusses the application of specific talking therapies and section four refers to the many resources and support services for older adults in New Zealand.

I would like to thank members of the Project Steering Group for contributing their expertise to this guide; the Royal Australian New Zealand College of Psychiatrists project team at the New Zealand National Office; and the many individuals and organisations who provided valuable feedback to our earlier drafts.

I hope this guide will generate interest in talking therapies for older adults and that they will become more readily and widely available as a way of supporting service users.

Dr Gary Cheung

Chair, Project Steering Group

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# Executive summary

This publication provides guidance on best and promising practice for talking therapies for staff working with older people in mental health and addiction services.

New Zealand's older population is growing significantly. By 2031, almost one quarter of New Zealanders will be aged 65 and over. Mental health and addiction services will continue to see increasing numbers of older adults. This is the first guide to be produced in New Zealand that specifically addresses talking therapies for older people.

This guide relies on national and international evidence from randomised controlled trials, alongside evidence from clinical experience. While research on talking therapies with older people has generally been limited, there is promising evidence of their effectiveness. Cognitive Behavioural Therapy (CBT) is the most widely researched therapy (and most widely used in New Zealand), and there is good evidence for its effectiveness with this population group.

The guide begins with a general overview of the older population in New Zealand, before moving on to profile the health and mental health of older people. The second section outlines the unique challenges facing the older age group, and gives guidelines for effectively engaging with older adults. Section three sets out the principles and applications of specific talking therapies for which there is good and promising evidence of their effectiveness. The guide finishes with a resources section which lists organisations working with older people, publications, resources and websites.

## Key messages from this guide

- The relationship between the therapist and service user is central to a good therapeutic outcome.
- Cultural competency skills are essential for staff working in a bi-cultural and multi-cultural country.
- Ageism and generational values, both on the part of the service user, the practitioner and society in general, can be major barriers to a good therapeutic outcome, and should be explored and, where appropriate, challenged.
- Despite generally limited randomised controlled trials on the efficacy of talking therapies specifically for older adults, there is evidence from clinical work that the talking therapies in this guide are beneficial.
- There is a need for more research on the effectiveness of talking therapies for older adults, and for Māori, Pacific and Asian population groups. Another important area for further research is addictions in older adults.

## Adapting talking therapies for older adults

Older people face a number of unique challenges – significant lifestyle changes, such as bereavement, retirement and loss of independence, and physical and cognitive impairments. Talking therapies may need to be adapted to take these challenges into account.

- Factors such as cognitive style (such as cohort influences and life-stage development) and cognitive change (such as dementia) must be considered in order to successfully adapt therapies for older adults.
- Involving family/whānau or other support people in therapy is essential, particularly where they have a carer role.
- There may be a need to provide education about therapy, and address issues such as stigma, ageism or shame.
- Sessions may need to be timed or paced differently, for example shorter sessions, more repetition, more sessions, follow up and booster sessions.
- Where possible, allow more time for older people, and be responsive to needs arising from mobility, sensory or other difficulties.

# Contents

# 1. Introduction

## Background

Te Pou is leading a project to enhance access to talking therapies for people who use mental health and addiction services.

In 2009, Te Pou published *A Guide to Talking Therapies in New Zealand*[1], a user-friendly guide to talking therapies for service users and family members. The guide aims to clearly describe each therapy, what mental health diagnoses it is best used for, and how people can access talking therapies.

In addition to this guide, Te Pou is also developing best (and promising) practice talking therapies guides for staff in mental health and addiction services who work therapeutically with Māori, Pacific and Asian peoples and refugee, asylum seekers and new migrants. Guides are also being developed for staff working with people overcoming addiction and adults with physical and mental health/addiction problems. These guides will be available from Te Pou's website www.tepou.co.nz.

## Purpose and target audience

This guide is intended for staff working therapeutically with older adults in mental health and addiction services. It seeks to better inform workers about effective processes and therapies that are particularly appropriate for older adults to enhance services for this growing population.

This guide provides an overview of using and adapting talking therapies for older adults, based on current clinical knowledge and practice at the time of its preparation; it is not intended to be a comprehensive training resource.

## Overview of national and international evidence

Generally, there have been limited randomised controlled clinical trials on the effectiveness of talking therapies specifically for older people in New Zealand and internationally.

Cognitive Behavioural Therapy is the most widely researched therapy through clinical trials, and has a good evidence base both for the population in general, and specifically for older adults.

The other therapies included in this guide have a good or promising evidence base for their effectiveness with adults generally. There is also promising evidence from clinical work about the effectiveness of these therapies for older adults.* There is a strong argument to give more attention to experience from clinical work, and not just because there is a lack of research-based evidence.

Older people face a number of unique challenges. They may be dealing with significant lifestyle changes such as retirement, the loss of loved ones or their independence, or facing cognitive and physical impairments. Talking therapies will invariably require some modification to work with these particular challenges, and this is where evidence from clinical experience is invaluable.

* Reference Group personal communication

# General profile of older people in New Zealand

In 2010, the projected proportion of people in New Zealand aged 65 and over is 13 per cent of the total population. By 2031, this proportion is expected to increase to 22 per cent[2]. The number of New Zealanders aged 85 years and over is projected to increase to around 322,000 by 2051[3].

## Ethnicity

Currently, around 90 per cent of older New Zealanders are solely of European ethnicity. Four per cent are Māori, 2.3 per cent are Asian, and Pacific peoples account for 1.7 per cent of the older people population[4]. The proportion of older Māori and Pacific peoples relative to the overall size of their respective ethnic populations is projected to increase significantly; as are the populations of older Asian people and other smaller ethnic groups[5].

## Geographic distribution

In 2006 around half of New Zealand's population aged 65 years and over were located in Auckland, Canterbury and Wellington[3]. While the majority of older people live in the main urban areas (areas with 30,000 or more residents), there are many older people who live in smaller urban areas, particularly when compared to the general population (22 per cent compared with 16 per cent)[4].

## Living arrangements[4]

Older people living in situations where family and community support is readily available have very different needs from those without this type of support.

While most people in the younger age groups of the older population are partnered, many women are no longer partnered by the time they reach the 75 – 84 year age group, while the majority of men (whose partners are generally younger) continue to be partnered through to their early 80s. By the time people reach their late 80s, half the men are not partnered, and almost 90 per cent of women do not have partners.

The New Zealand Family and Household Projections (2001–2021) indicate the ageing population is expected to give rise to increased numbers of people living alone, living as partners without children and living in non-private dwellings without partners or families.

However, living within a family will continue to be the most common form of living arrangement for older people, with around 62 per cent of people aged 65 years and over expected to be living in a family household. In the 85 years and older age group, living alone will continue to be the most common living arrangement (38 per cent), followed by living in a family situation (30 per cent) and living in a non-private dwelling (29 per cent).

### Income and education levels

The median income for people aged 65 and over at the time of the 2001 Census was $13,100. Although income levels are relatively low for people aged 65 and over, most report that they are able to live with what they receive[4].

Older New Zealanders have the lowest levels of tertiary qualifications of any age group in New Zealand, but an increasing number are enrolling in tertiary education programmes.

### Health literacy

Results from a 2006 adult literacy and life skills survey found that, on average, New Zealanders have poor health literacy skills. Health literacy is defined in this study by 'the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions'[6].

There has been little or no research on mental health literacy levels for older people.

## The health and mental health profile of older people in New Zealand

Mental health cannot be separated from physical health and wider determinants of health, such as socioeconomic status. This section provides an overview of the general health and mental health of older people in New Zealand, and outlines risk and protective factors. For almost all older people, a general practitioner (GP) is their usual health practitioner.

### General health profile

Most people aged 65 and over in New Zealand are fit and healthy. A minority are frail and vulnerable and require high levels of care and disability support, usually during the last few years of their lives, or have chronic illnesses or disabilities that may have been present for many years[2,4,5,7].

**Conditions and issues particularly prevalent among older people**

(these conditions account directly or indirectly for much of the morbidity in the 65 and over age group)

- Coronary heart disease (with related blood pressure and cholesterol factors).
- Stroke.
- Diabetes.
- Cancer (especially lung, colorectal, prostate and breast).
- Dementia.
- Arthritis.
- Frailty.
- Falls.
- Depression.
- Osteoporosis (leading to hip fracture).
- Pneumonia and influenza.
- Incontinence.
- Social isolation.
- Visual loss (cataract, glaucoma).
- Hearing loss.
- Chronic obstructive pulmonary disease(for example, emphysema).
- Neurological disorders (especially Parkinson's Disease).

The Ministry of Health's 2006 Health of Older People survey found that compared with the 50 – 64 year age group, older people were significantly more likely to have four or more chronic conditions. Rates of moderate and severe levels of disability were also markedly higher among older people than among those aged 45 – 64 years[5].

| Summary of health risk and protective factors | |
|---|---|
| **Risk factors** | |
| • Poor nutrition.<br>• Lack of physical activity.<br>• Little or no support from family and friends.<br>• Little or no participation in community/meaningful activities.<br>• Low income/economic stress/no savings/low status occupation. | • High accommodation costs.<br>• Poor housing.<br>• Being Māori or Pacific.<br>• Being a woman.<br>• Ageism. |
| **Protective factors** | |
| • Good nutrition.<br>• Physical activity.<br>• Support from family and friends. | • Participation in community/ meaningful activities.<br>• Positive attitude and adaptability. |

Research on the living standards of older New Zealanders[5,8] found that older people most at risk of poor living standards (one determinant of poor health) were characterised by a mix of:

- low income
- a history of economic stress
- no savings
- high accommodation costs
- poor housing
- having held a low-status occupation
- being Māori or Pacific.

The Ministry of Health's 2006 survey[5] found a substantial number of older people weren't eating the recommended servings of fruit and vegetables per day, and that participation in physical activity was considerably lower in the older age groups, particularly for women. The survey also found that smoking rates were generally lower in older people, particularly for those aged 75 – 84 years. Older people were less likely to drink alcohol or to engage in potentially hazardous drinking than people aged 50 – 64 years.

Older women are at a higher risk of poor health. While women consistently have a longer life expectancy than men, they also tend to have proportionately higher rates of chronic illness and disability in later life. Older women are more likely to be widowed, live alone, have a lower income, live in social or rural isolation and/or be caring for a frail partner or elderly parents[4].

Family and friends are a key support network for older New Zealanders. They play an important role in an older person's ability to remain independent, and provide emotional and practical support.

For many older New Zealanders, living a healthy and independent life involves active participation in a range of community-based activities. Research shows regular participation in meaningful activities contributes to the overall wellbeing of older people[5,9]. These activities include socialising with others, participating in cultural groups and activities, religious and civic participation and involvement with voluntary work. Involvement in community activities also establishes and maintains social ties, which are important in later life.

Age Concern identifies a positive attitude and adaptability as protective factors for ageing well, while ageism is identified as a risk factor[9]. Ageism is discussed in more detail on page 17.

## General health of older Māori, Pacific and Asian people

Te Pou is developing best (and promising) practice guidelines for specific population groups including Māori, Pacific and Asian. For information about the health profile of these population groups, please access these reports at www.tepou.co.nz

### Some features of older Māori, Pacific and Asian people

**Māori**[5]

- Experience worse health and are more likely to be hospitalised than non-Māori.
- Have a lower life expectancy than non-Māori resulting from conditions that respond to prevention and treatment.
- Have higher rates of all heart disease and cancer mortality.
- Experience more than twice the rate of diabetes, than non-Māori.

**Pacific peoples**[5]

- Have lower life expectancy than the general population.
- Higher rates of avoidable mortality, cardiovascular disease and diabetes compared to the general population.
- Are approximately twice as likely to be obese than the national average (adults).

**Asian peoples**[5]

- Older Asian immigrants face the most difficulties in participating in New Zealand society.
- The main obstacles are English proficiency and dependence on family members to provide transport.
- Many face serious problems finding employment if their qualifications aren't recognised in New Zealand.

## General health of older people in residential care[5]

The residential care population is markedly older than the community population. People in residential care are usually there because they need a high level of care and support. Most older people in residential care require assistance with daily activities, and most have severe levels of disability (72 per cent of people aged 65 – 74 and 84 per cent of those over the age of 75).

Multiple disabilities are more prevalent for people in residential care compared to those living in the community. Stroke and cognitive impairment are common disabilities for older people in residential care. People of comparable age living in the community tend to have much lower rates of moderate or severe impairment; 15 per cent in the 65 – 74 year age group and 14 per cent of people aged 75 and over have mild disability.

The Ministry of Health's 2006 survey[5] found that older people in residential care were less active than their counterparts in private dwellings.

## Mental health profile

Growing older brings with it the inevitably of loss.

- The loss of work and income through retirement, redundancy or incapacity.
- The loss of physical and mental capacities to a lesser or greater extent.
- Older people may experience the loss of independence, particularly if they require care and/or have mobility issues.
- The loss of loved ones.
- Ultimately, older people face their mortality.

### Common mental health issues facing older people[10]

- Depression.
- Anxiety.
- The behavioural and psychological symptoms of dementia.

### Mental health issues facing some older people

- Bipolar disorder.
- Psychosis (early and late onset).
- Abuse (physical, emotional, financial or sexual) or caregiver neglect.
- Relationship issues.

### Behavioural and psychological symptoms of dementia (BPSD)

BPSD is an umbrella term for a group of symptoms and behaviours that occur in people with dementia. These are often distressing for the person and their families or carers, and challenging for health professionals.

There are many possible behavioural and psychological symptoms of dementia, including anxiety, agitation, depression, wandering, aggression, sleep disturbance, psychosis and disinhibition[10].

### Depression

Depression is not an inevitable consequence of growing old. Depression in older people is often associated with loneliness, physical illness and pain. Rates of depression are higher for older people living with chronic conditions, and for older people living in residential care. Depression in an older person may present with lowered mood and also with physical problems like sleep disturbance, loss of appetite, loss of interest, anxiety and lack of energy.

Depression may commonly be unrecognised or misdiagnosed[10]. This may stem from the difficulty in diagnosing depression due to the person's particular generational and cultural background, and personal history. Cognitive impairment can mask depression, and ageism (on the part of the service user or the practitioner) may also be a factor. Ageism is discussed on page 17. Generational and cultural factors are discussed on page 18.

## Addiction

Addiction in older people has received little attention in New Zealand. There have been some preliminary studies with older people in Christchurch, which suggest that alcohol problems in older people often go undetected or are misdiagnosed[11].

A recent international study found that 13 per cent of older men and eight per cent of older women reported at-risk drinking, while 14 per cent of older men and three per cent of older women reported binge drinking[12].

This study also revealed that alcohol misuse correlated with increased use of illicit drugs, tobacco use and the abuse of prescription medications.

### Factors associated with increased substance use

- Social isolation.
- Being male.
- Separation or divorce from partner.
- Loss of a spouse.
- Retirement.
- Depression/anxiety.
- Chronic pain.

Older women may also be at particular risk of alcohol misuse due to their relative longevity compared to men, potentially leading to more loneliness and depression[13].

## Suicide

Suicide rates for older people remain relatively high, and the risk is often overlooked in this population. Older men are particularly at risk. Older people who attempt suicide usually have a strong intent to die; they usually choose more lethal means and their attempts are more likely to be fatal. If they are physically frail, an older person is often less able to survive or recover from a physically serious suicide attempt. It is also less common for an older person to seek assistance after deliberately self-harming[14].

## Mental health profile of older Māori, Pacific and Asian people[7,15,16]

The best (and promising) practice guidelines for specific population groups developed by Te Pou (www.tepou.co.nz) will discuss the mental health profile of each group in more detail. Some general points are noted below.

Issues for Māori include:

- low socioeconomic status (which disproportionately affects Māori), as a contributing factor to mental health issues
- higher prevalence rates of mental health disorders overall than other population groups in New Zealand, with greater severity, burden and impact.

There has been limited research on the mental health of older Pacific and Asian people in New Zealand, however, common issues include:

- rapid acculturation (adaptation to an adopted country's culture)
- socio-cultural change
- low socioeconomic status
- limited English language skills
- small emotional support networks and limited participation in community life
- loneliness, isolation and anxiety.

## Mental health profile of other migrant groups and refugees

The mental health profile of these groups will be discussed in the relevant guides developed by Te Pou (www.tepou.co.nz). General considerations include:

- migrants to New Zealand come from many different countries and come to New Zealand for many different reasons, bringing a spectrum of social, educational and economic backgrounds
- a range of different protective and risk factors for mental health
- the process of migration itself can have a significant impact on psychological wellbeing
- migrants often face a range of stressors when adapting to the social and cultural frameworks of New Zealand society
- the needs of refugee and asylum seekers differ from other new migrants - often having fled from situations of trauma, conflict and human rights abuses
- language barriers, cultural differences and economic difficulties to navigate[17].

## Elder abuse and neglect

A minority of older people experience abuse and neglect; usually by other family/whānau members. The most common abuses are psychological (humiliation, harassment, controlling choices) and financial (misusing the older person's resources). Physical abuse also occurs.

Age Concern found the most common abusers are sons and daughters. Most older abusers are husbands[9], and women aged 75 to 84 living with their partner or other family/whānau are most commonly neglected.

The most common characteristics of neglected older people are:

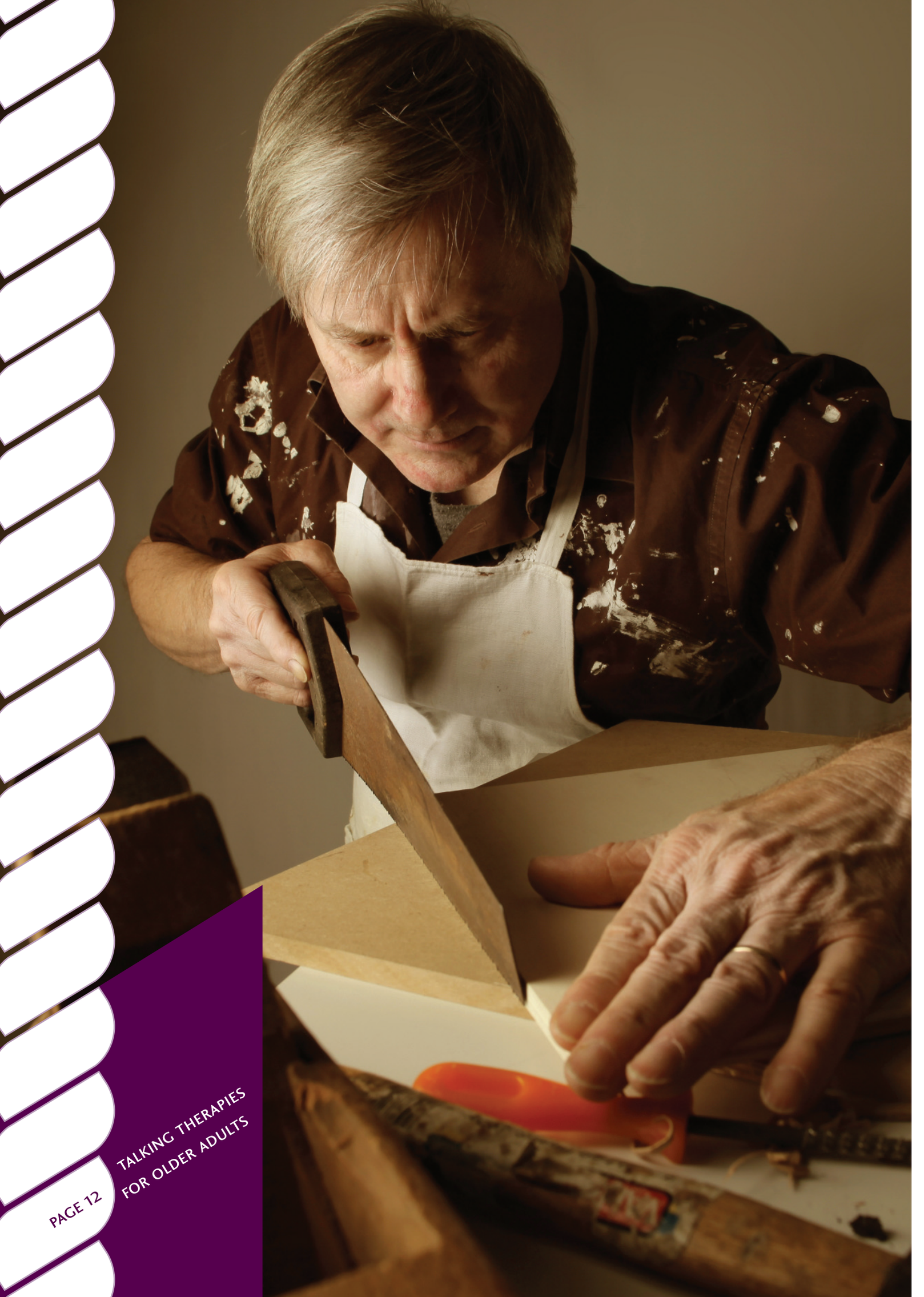
- communication difficulties
- limited social contacts and isolation
- mental or physical disabilities[9].

Neglect can be active - conscious and intentional deprivation, or passive - the result of the carer's inadequate knowledge, infirmity or disputing the value of prescribed services. Abuse and neglect can have wide ranging and long-term effects on physical and mental health.

Age Concern runs an Elder Abuse and Neglect Prevention Service. See their website for more details and to access comprehensive resources: www.ageconcern.org.nz.

**Age Concern defines neglect as:**

Elder neglect occurs when a person aged 65 or older experiences harmful physical, psychological, material/financial and/or social effects as a result of another person failing to perform behaviours which are a reasonable obligation of their relationship to the older person and are warranted by the older person's unmet needs.



# 2. Principles of engagement

## Engagement - overview

It's important to remember that while there are differences between working with younger and older adults, many principles remain the same:

- open communication
- provision of adequate information
- encouraging active collaboration in setting therapy goals and the therapeutic process.

As in any therapeutic situation, developing an effective therapeutic relationship is central to the success of therapy. Working with an older adult to build rapport and establish this relationship may require more time and effort from the health professional than when working with younger adults.

This guide assumes readers are familiar with the essential knowledge, skills and attitudes required to deliver effective mental health and addiction services as described in the Ministry of Health *Let's get real* framework. The *Let's get real* framework is explicit in stating the expectations of people who work in mental health and addiction services irrespective of their role, discipline or position in an organisation. Further information on *Let's get real* can be accessed at www.moh.govt.nz/letsgetreal

*Let's get real* presents the fundamental shared values that all staff in mental health and addiction services need to demonstrate when working with older adults.

- Respect – the person accessing the service is the focus of practice and their diversity of values must be respected.
- Human rights – the rights of people using services and their families must be upheld. These rights include, but are not limited to, the right to autonomy and self-determination and the right to be treated in a non-discriminatory way.
- Service – to deliver excellent service to all people who use services, where choice of services is available.
- Recovery – to believe and hope that every person can live a full and meaningful life in the presence or absence of their mental illness and/or addiction.
- Communities – seen as pivotal resources for effective delivery of services.
- Relationships – seek to foster positive and authentic relationships within all spheres of activity.

It is important to respect the age, experience and wisdom of an older adult, as this is often undermined during the process of therapy, in light of the current problems or disabilities the individual may be experiencing. When working with older adults the *Let's get real* framework indicates that it is important for practitioners to use age-appropriate protocols and apply an understanding of the different stages of life development.

Older adults have often experienced (or are experiencing) rapid and significant life changes. The relationship with their health professional/s may be the only consistency amid these changes[18]. A trusting therapeutic relationship can have a significant impact on the physical and mental health of older adults, improving the exchange of biomedical and psychosocial information and providing the level of care important to health outcomes.

Research has identified some issues unique to older adults. They are more likely to present with complicated medical conditions, and may leave their health professional with confusing or sometimes conflicting information. They may also fail to seek clarification about information they are given. It is important to focus on obtaining a comprehensive view of the person's problems or concerns as well as providing clearly worded, thorough explanations[19].

The community plays a vital role in the wellbeing of older adults, providing access to a range of activities, services and social opportunities. More information on support services for older adults available in the community can be found on page 45.

## Communication

Effective communication can assist adaption to the ageing process, and improve therapy outcomes. Communication must be empathic, with openness to generational and cultural differences. Attitudes to traditional therapies or medicines should also be explored.

Older adults may suffer from sensory loss (such as hearing or vision). It is essential to be aware of any particular needs an individual has, and adjust your communication style accordingly. Some older adults may feel there is a large gap between themselves and their health professional, including different ways of thinking about and explaining health problems, and they maybe concerned that the health professional will find their way of thinking unacceptable[19].

Older adults may also be reluctant to ask questions, share concerns or express opinions due to a possible perception that a client's role is to passively receive help from the expert[20]. When working with service users the *Let's get real* framework indicates that it is important for people working in mental health and addiction treatment services to effectively and inclusively ensure that service users understand their plan for recovery and facilitate access to other relevant information. People using services need to be included in all decisions about their service and treatment. Therefore it's important that older adults are encouraged to share their views regarding their health goals and perception of quality of life, and are provided the opportunity to describe their own situation and current problems. Older adults may also need to be supported to become an active partner in their own care.

### Communication tips

- Allow extra time for older adults (where possible).
- Reduce visual or auditory distractions.
- Respond to individual needs (i.e. vision or hearing loss).
- Listen actively.
- Speak clearly.
- Focus on one topic at a time.
- Summarise important points often.
- Encourage questions and self-expression.
- Provide simple written instructions.
- Regularly reflect on your own communication style.

# Adapting talking therapies for older adults

Most therapists in New Zealand adapt aspects of therapy when working with older adults.* The *Let's get real* framework highlights the importance of practitioners being skilled in developing an effective therapeutic relationship with service users, this involves the ability to work flexibly.

Adaptation may be necessary due to cognitive impairment and physical health issues. Family/whānau are likely to be more involved in the therapeutic process where an older adult has significant health and support needs, and where they are providing care. Evidence from clinical work suggests that some therapists in New Zealand use Family Therapy approaches with older people, more information on this therapy can be found on page 18.*

Age-related themes that may require a modified focus for therapy include cohort beliefs, intergenerational linkages, socio-cultural context, and the extent to which a person remains involved in personally meaningful activities/interests.

- **Cohort beliefs** are beliefs held by groups of people who were born in similar time periods, reflecting shared experiences. These can have a significant impact on the therapeutic relationship and process.
- **Intergenerational linkages** refer to the increasingly dynamic role that older adults play in families/whānau and the community, as grandparents or great grandparents. This can give rise to tensions and disagreements in intergenerational relationships, such as different concepts of family roles/ structure.
- **Sociocultural context** includes people's attitudes to their own ageing and may include negative stereotypes held by the individual about growing old.

## Cognitive changes

While some changes to cognitive functioning do occur with older age, they are not universal, and it's essential to remember that there is significant variability across individuals.* Cognitive changes can range from mild memory loss, to the behavioural and psychological symptoms associated with dementia.

If there are concerns about the older person's cognitive functioning, ensure they have comprehensive physical and neuropsychological evaluations to rule out an underlying physical condition. Depression, side effects of medication, infections, vitamin deficiencies, thyroid gland problems and brain tumours can all affect cognitive function.

You may need to adapt aspects of therapy to take into account cognitive changes.

Talking therapies for dementia are discussed on page 32.

## Physical health problems

Many older people enjoy good physical health. However, the incidence of physical illness or disability does increase with age. Health problems can limit a person's understanding, recall, ability to engage in aspects of therapy, or ability to attend sessions. Older adults may also be anxious about their physical health and any symptoms of illness.

* Reference Group personal communication

A flexible, multi-disciplinary approach can be helpful in assessing and optimising physical functioning, thereby increasing participation in and gains from therapy.

### Dependence

Dependency may become an issue in circumstances where an older adult has experienced significant bereavement or other losses, and feels isolated or lonely. The practitioner's view of the older adult's resourcefulness is critical to ensuring that therapy is seen as a useful transition in the person's life, and not another occasion for loss.

It may be helpful to emphasise from the beginning that 40 per cent of the factors that account for positive outcomes in mental health recovery are factors the person accessing the service brings – their resilience, resourcefulness, attitudes, and more tangible resources like family, friends, pets, hobbies, and interests[21].

Encourage older adults to attribute successes to their own efforts, end therapy gradually, and work together with the older adult to determine how the therapist can be replaced in the individual's support system. It may be necessary to spend some time discussing the issue of dependence in setting therapy goals[22].

## Stigma and ageism

### Stigma

The stigma associated with mental illness is an issue for all age/population groups. However, older adults are particularly vulnerable as stigma can make them less likely to acknowledge a problem and seek or accept help.

Many older adults express strongly held views about the stigma attached to mental unwellness. There is also a group effect in that those older adults born around the same time may have shared similar experiences that influence their perception of mental health problems.* Older adults may feel ashamed or embarrassed when faced with a mental health or addiction problem and down-play the impact this has on their lives. Older adults with ongoing problems may have been experiencing stigma or discrimination for many years, and have experienced a loss of self esteem as a result.

Stigma is a barrier to engagement, and may need to be addressed as part of the therapeutic process, both with the individual and their family/whānau. Remember that the current cohort of older people does not have the same understanding of mental illnesses as younger adults. The *Let's get real* framework indicates that every person working in a mental health and addiction treatment service needs to be skilled in using strategies to challenge stigma and discrimination and promote a valued place for people using services. Promoting and facilitating social inclusion can assist in reducing stigma.

Self-directed learning modules for the *Let's get real* skill of Challenging Stigma and Discrimination can be downloaded from the *Let's get real* website, www.tepou.co.nz/letsgetreal.

* Reference Group personal communication

### Ageism

Ageism refers to a person's beliefs about and attitudes towards ageing. Ageism is common in New Zealand, and may lead to older adults holding negative judgments and stereotypes about ageing that lead them to adopt patterns of behaviour consistent with those beliefs.

Ageism includes beliefs such as 'too old to change', which may prevent older adults from seeking help for their problems. This belief may also reduce their expectation about therapy outcomes.

It's important that health professionals are aware of any ageist beliefs they may hold themselves, and are able to identify and talk about ageist beliefs that emerge during the course of therapy.

Research shows that although psychological input is as effective, older people are much less likely than other groups to be offered or receive treatment owing to prejudice on the therapists part – an 'it's not worth it' attitude[23].

Older adults can also hold ageist beliefs towards their peers and towards younger people (reverse ageism). This can include an older adult questioning their therapist's empathy and skill due to an age difference. In addition, older adults may have beliefs regarding the stigma of mental health problems, especially if they associate such problems with personal failure or spiritual deficiency. Cultural factors can be particularly significant in identifying and addressing such beliefs; however, it's important that no assumptions are made and cultural expertise or input is sought as necessary.

Ageist beliefs commonly require attention in therapy. A therapeutic aim could be to highlight the arbitrary nature of age-related beliefs. It may also be useful to challenge myths about ageing by providing accurate information.

## Working with families/whānau

The appropriate involvement of families/whānau, significant others or support people is important when working with older adults, as it is for all people experiencing mental illness or addiction. The *Let's get real* framework indicates that every person working in a mental health and addiction treatment service needs to be skilled in encouraging and supporting families/whānau to participate in the recovery of service users, and ensure that families/whānau have access to information, education and support.

Helping family/whānau members to understand the range of difficulties faced by older adults and the nature of their specific problems, provides valuable support to family members and can help with adherence to therapy goals or recommendations. It is important to determine how much information to provide, and the best way to provide it.

When working with families/whānau the *Let's get real* framework indicates that it is important for practitioners to share relevant information, while respecting the service user's right to privacy.

Support and information is especially critical for family caregivers, as it helps their own health and mental health, as well as improving the level of care they can offer. There are a range of support groups that can assist; information about these can be found in the Resources section on page 45.

Self-directed learning modules for the *Let's get real* skill of Working with Families/Whānau can be downloaded from the *Let's get real* website, www.tepou.co.nz/letsgetreal.

### Family therapy techniques

Therapists should consider using Family Therapy techniques or involving family/whānau members alongside other therapies when working with older adults. This may be particularly beneficial for:

- Māori and Pacific service users – where the role of the family/whānau is generally considered essential to wellbeing
- older adults with cognitive impairment and other serious health issues
- older adults who are being cared for by their family/whānau.

It is important to remember that tensions may arise when different generations within a family experience different challenges or life events at the same time, or have differing expectations about life events (such as retirement). This may lead to conflict or disappointment among family member[24]. Family circumstances should be considered when adapting therapy for an older adult.

The inclusion of other people in the therapy process can impact on the therapeutic dynamic and require more time. Care must be taken to respect the older adult's preferences.

**Confidentiality**

Confidentiality is essential to the therapeutic relationship. An older adult's right to confidentiality must be protected.

Family/whānau or other support people can be given general information about the person's condition or problem, after consultation with the service user. If they don't want the therapist to provide any information to family/whānau, then this is respected. Family/whānau can offer information to the therapist, with or without the service user's permission.

Confidentiality is not a static issue, but something to be continually negotiated, and should have the aim of promoting good long-term relationships.

## Cultural factors

The talking therapies in this guide have mostly been developed in the UK, Europe and United States. There is limited research on talking therapies specifically for Māori, Pacific, Asian and refugee/new migrant populations in New Zealand.

Culture is not limited to ethnicity; age, gender, lifestyle, spiritual beliefs and economic worth all inform culture. There can be a wide variation in beliefs and attitudes within a cultural group.

### Cultural competency

Cultural competency skills are critical for practitioners working in a multicultural society. This is the Medical Council of New Zealand's definition[25].

Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge that:

- New Zealand has a culturally diverse population
- a doctor's culture and belief systems influence his or her interactions with clients and accepts this may impact on the doctor-client relationship
- a positive outcome is achieved when a doctor and client have mutual respect and understanding.

While the Medical Council's definition of cultural competence is directed to doctors, it is a comprehensive definition that is of relevance to everyone.

## Working with Māori

Secure cultural identity is a key protective factor for building mental health resilience for Māori[26]. Māori models of health are holistic. For many Māori, the major deficiency in modern health services is a lack of spirituality.

An understanding of matauranga Māori (Māori values, knowledge, culture and worldview) is essential for the effective provision of services to Māori. The effects of history have specific influences on the mental health and wellbeing of Māori, and understanding this history is essential to providing effective services for Māori people. There are kaupapa* Māori talking therapy approaches, and these may be available in your area. Your best source of information is your local kaupapa Māori service or marae.

In general, the family/whānau is integral to the wellbeing of Māori, and older people are held in high regard. You should keep in mind that you may be negotiating treatment with the person's entire family/whānau, even if they are not present. Acknowledging the importance of whānau and accommodating their views may be essential to providing the best possible outcome for the person.

For specific information on talking therapies for Māori, please refer to Te Pou's best (and promising) practice talking therapies guide for staff working therapeutically with Māori. This guide is available on Te Pou's website www.tepou.co.nz.

Working with Māori is identified as one of the seven Real Skills that every person working in a mental health and addiction treatment service needs to demonstrate, to contribute to whānau ora for Māori. Self-directed learning modules for the *Let's get real* skill of Working with Māori can be downloaded from the *Let's get real* website, www.tepou.co.nz/letsgetreal.

## Working with Pacific service users[15]

Spirituality is an essential dimension of health for many Pacific peoples. Traditional Pacific perceptions of mental illness are frequently at variance with western clinical understanding. Western medicine's concept of chemical imbalance for example, is not readily acknowledged or understood by Pacific cultures. Conversely, western practitioners may not readily acknowledge or understand the spiritual nature of Pacific explanations of mental illness. It is important that you take the time to explore perceptions of mental illness when working with Pacific peoples.

Older Pacific people in particular may hold to the traditional understanding of mental illness as the possession of the body by an aitu (demon), or as a punishment for a past sin committed by the sufferer or their family. The family is generally seen as integral to the wellbeing of Pacific peoples, with older people held in high regard. Acknowledging the importance of other family members and accommodating their views may be essential to providing the best possible outcome for the person accessing therapy.

For specific information on talking therapies for Pacific people, please refer to Te Pou's best (and promising) guidelines for staff of mental health and addiction services who work therapeutically with Pacific peoples. This guide is available from Te Pou's website at www.tepou.co.nz.

* Kaupapa: traditional Māori ways of thinking, doing and being

*Real Skills Plus Seitapu* provides a framework of the essential and desirable knowledge, skills and attitude attributes for any person in the mental health and addiction workforce working with a Pacific person, peoples or families. This document can be downloaded from the Le Va website, www.leva.co.nz/page/14-projects+seitapu.

### Working with Asian service users[16]

International research shows that somatisation, the physical expression of psychological distress, is more common among Asian populations than Western. In New Zealand, little research has been undertaken about how socio-cultural factors influence the experience of, and explanations for, mental health and illness among Asian ethnic groups.

Mental illness is highly stigmatised in many Asian cultures. Some forms of mental illness, like schizophrenia or organic brain disorders/syndromes are conceived of as supernatural punishments for wrong-doings and may result in intense shame and stigma. Many Asian people are reluctant to use mental health care or would delay seeking care until becoming very ill.

Limited research suggests the use of both Western and traditional health practices is common among Asian migrants. Asian people often don't volunteer this information so it's important that health professionals take the lead in asking about the therapies they are using.

For specific information on talking therapies with Asian peoples please refer to Te Pou's best (and promising) guidelines for staff of mental health and addiction services working therapeutically with Asian people. This guide is available from Te Pou's website www.tepou.co.nz.

## Older adults without social supports[27]

Loneliness in older adults can cause malnutrition, weight loss, an increased incidence of ill health, anxiety, self-neglect, institutionalisation, depression and suicide. New Zealand research shows that older adults with limited social networks have poorer scores for both mental and physical health.

### Reasons for an older adult being at risk of experiencing loneliness

- Family or friends have moved away.
- Loved ones become ill or dependent, or die.
- Retirement from paid or voluntary employment.
- Decline in physical function or a disability which may prevent an older person from participating in social activities, or may lead to a loss of independence which necessitates them moving away from their community.
- Low income, which prevents participation in social activities.
- A loss of social skills over time; for example, where one partner took on the role of maintaining social networks and that partner has died.
- Ageist attitudes.
- Rural isolation.
- Living arrangements, where a partner dies and the remaining person is living alone.
- Personality traits: where a person has always had a small network of friends or has been a 'loner' throughout their life.

Age Concern New Zealand makes the following recommendations for health professionals.

- Be on the alert for loneliness and/or social isolation in older people.
- Integrate questions about loneliness into all assessments undertaken with older people; ask about both the quantity and quality of social supports available to them.
- Be aware of befriending services and how to access these.

Age Concern runs an Accredited Visiting Service (AVS), which pairs volunteer visitors to lonely or isolated older adults. See their website for more information: www.ageconcern.org.nz.

### Older adults in residential care

Moving to residential care is a significant adjustment for many older adults and their families. It can be positive, providing access to support and giving freedom from daily chores and home maintenance responsibilities. It can be a chance to meet new friends and take part in new social activities. However, it can also mean a loss of independence and autonomy. An Australian study found having a meaningful occupation following the move into residential care helped with the transition[28].

Most older adults in residential care require assistance with daily tasks and many have high levels of disability. They tend not to be as active as older adults living in the community. Rates of depression and cognitive impairment are higher for older people living in residential care.

The interpersonal dynamics of a residential care situation can also give rise to problems or issues for some older adults. It's important to consider the person's relationships with other residents and staff when making any adaptation to therapy and determining therapy goals with an older adult.

## Medication and talking therapies

Clinical experience suggests that the concurrent use of medication is not contraindicated for talking therapies.* A clinical trial of the use of medication and cognitive behavioural therapy (CBT) found that a combination of CBT and medication resulted in a greater improvement than medication alone in older people with mild to moderate depression[29].

If a person has been prescribed medication, it's important to inform them that medication and talking therapies can be used in conjunction.

Prescribing medication for mental health issues in older people is outside the scope of this guide. Some resources are listed on page 48.

* Reference Group personal communication

## *Let's get real*

All practitioners working in mental health and addiction services should be familiar with the *Let's get real* framework, which sets out the key skills practitioners need for effective engagement with people accessing services.

As indicated earlier in this guide, *Let's get real* is a framework that describes the essential knowledge, skills and attitudes required to deliver effective mental health and addiction treatment services. This is intended to complement professional competencies by having a specific focus on the essential skills and attitudes required of everyone working in mental health and addiction. *Let's get real* is recognised in the Nationwide Service Framework, phased in from late 2008.

For more information visit:
www.moh.govt.nz/letsgetreal
http://www.tepou.co.nz/page/tepou_565.php

The following table outlines some of the ways staff in mental health and addiction treatment services can demonstrate the seven Real Skills when working with older adults.

| **Real Skills for working with older adults**[30] | |
|---|---|
| Working with service users | • Building relationships with older adults and understanding later life stages and their impact on mental health.<br>• Understanding diagnostic issues for older adults, such as differences in presentation, morbidity and co-morbidities. |
| Working with Māori | • Understanding Māori models of health/illness, and the need for a holistic approach.<br>• Building knowledge of Māori models of dementia. |
| Working with family and whānau | • Forming relationships with families/whānau and working within family systems.<br>• Understanding carer support and burnout. |
| Working within communities | • Understanding how mental health and addiction services for older adults relate to other services.<br>• Knowledge of community resources and supports such as Age Concern.<br>• Working with primary care.<br>• Working with older adults from different ethnic groups. |
| Challenging stigma and prejudice | • Understanding ageism.<br>• Successful ageing including adjusting to old age and old-old age. |
| Law, policy and practice | • Ethical dilemmas such as elder abuse.<br>• Competency and capacity including the Protection of Personal and Property Rights Act 1988. |
| Professional and personal development | • Understanding service models.<br>• Understanding roles of team members. |

The Northern District Health Board Agency is currently leading a project to link *Let's get real* with competencies for mental health services for older people. For more information visit their website www.ndsa.co.nz

# Summary

## General principles guiding the use of talking therapies for older adults

- Building/establishing rapport includes education about therapy and awareness of cohort or generational influences on the therapeutic relationship.
- Involving family/whānau or other support people in the process is essential, particularly where they have a carer role. This may challenge accepted views of what constitutes a therapeutic relationship.
- It's important to pay attention to each session's pace – within and across sessions (such as shorter timeframes, more repetition, more sessions, follow up and booster sessions).
- Person-centred care is essential. The role of the therapist is to facilitate the resourcefulness of the person accessing therapy and to assist them to live well in the presence or absence of health difficulties.
- Consider factors such as cognitive style (such as cohort influences and life-stage development) and cognitive change (such as dementia). Therapy may need to be adapted accordingly.
- Consider cultural factors. You may be from a different cultural background to the person accessing therapy. Remember that beliefs and attitudes can vary widely within a cultural group.
- Ageism, both on the part of the person accessing therapy and the practitioner, is a barrier to a good therapeutic outcome. Ageist beliefs should be explored and challenged.
- Social challenges can be drastic and include changes in networks/social supports, loss of familiar roles, changes in family structure, relocation and mobility issues. These mean older adults are more vulnerable to loneliness and social isolation.
- Older adults may be uncomfortable discussing psychosocial issues, due to perceived stigma or shame. Health professionals can inadvertently create barriers through factors such as seeming to rush or not taking the time to listen.

# 3. The therapies

## Overview

There are few clinical trials on the effectiveness of talking therapies specifically for older people in New Zealand and internationally. There is however, promising evidence from clinical work about the effectiveness of the therapies in this guide.*

While Cognitive behavioural therapy(CBT) has received the most research attention and has a well-established evidence base, all the therapies included in this section have good or promising evidence for their effectiveness with adults generally. The more commonly used talking therapies have received more discussion than those that are currently less commonly available.

It should be noted that the New Zealand Guidelines Group recommends older people are offered the same psychological therapies as other adults[31].

### Limitations of talking thearpies with older adults

While there are limitations to talking therapies with older adults, these will vary depending on the person and their situation.

In general, older adults may not:

- relate to a highly structured format
- cope with a high level of psychological understanding being required
- cope with longer sessions, homework, introspection, conceptualisation or self-revelation.*

### Adapting talking therapies for older adults

Talking therapies may need to be adapted to suit older adults. While each of the talking therapies discussed here are different, adapting them for older adults is guided by similar principles. This is discussed in Section Two.

Examples of the manner in which a therapy model may need to be adapted when presented to an older adult include:

- using a less overt structure and allowing the service user flexibility within each session while keeping in mind the underlying structure
- finding creative ways to teach and explore the concepts that underlie therapies with the person accessing therapy
- using a variety of learning modes such as concrete objects to represent ideas, pictures, stories and role plays
- keeping the pace of therapy slow with more repetition and rehearsal
- finding creative ways to approach required homework tasks – it is helpful if the term 'homework' is not used.*

* Reference Group personal communication

Remember, everyone is different and will require a different approach to adapting therapy. Also remember that chronological age is not a good indicator of how much adaptation is needed[32].

It may be helpful to reflect on how these core considerations for adapting talking therapies for older adults can be applied to each of the therapies discussed here.

### A note on terminology

In some research literature and depending on the country, the term 'talking therapy' is used interchangeably with 'counselling' and 'psychotherapy'.

In New Zealand, a distinction between counselling and psychotherapy is made. Psychotherapy is a generic term that refers to a number of psychotherapeutic approaches. Most of the therapies outlined in this guide are forms of psychotherapy (such as CBT, psychodynamic and psychoanalytic psychotherapy, and interpersonal psychotherapy).

The Psych Central website is a useful starting point for a more detailed history and discussion of psychotherapies in general: http://psychcentral.com.

## Cognitive behavioural therapy (CBT)

### Overview[1,33-38]

Cognitive Behavioural Therapy (CBT) is based on the premise that emotions and behaviours result primarily from cognitive processes, meaning it's possible for people to modify their cognitive processes to achieve different ways of feeling and behaving.

**CBT is effective for older people dealing with:**

- depression
- anxiety
- panic disorder
- insomnia
- pain
- medical disabilities[39].

CBT is generally a brief and time-limited intervention, with an average course requiring six to 12 one-hour sessions. Sessions are clearly structured and focused on current issues and practical solutions. CBT can be delivered in individual, couple or group form. CBT sessions use an educative approach. Through collaboration and guided discovery, the person learns to recognise their negative thinking patterns and to re-evaluate their thinking.

CBT with individuals has been widely researched. There is good evidence of its efficacy with a variety of mental health problems in older people, such as depression, anxiety disorders (including generalised anxiety disorder), panic disorder and post-traumatic stress disorder. There is also promising evidence that CBT is effective for older people with insomnia, pain and medical disabilities[35,39]. It has also been noted the effects were greater if the therapist had specialised training in working with older adults in addition to a high level of general training[32].

Bienenfeld[39] discusses a number of considerations for modifying CBT for older adults, emphasising how age and cohort do effect a person's ability to engage with CBT. He notes that while older adults retain their capacity to learn new things, they take longer to acquire information and are vulnerable to distraction[39].

**While the structure and techniques are similar across age groups, there are adaptations that may be helpful with older adults, for example:**

- consider cohort effects and take extra time to engage the service user in therapy
- adjust the pace of sessions – limit the number of new ideas or techniques introduced at any one time
- memory aids such as note books and index cards may be beneficial
- recognise and address difficulties with homework from the outset
- take time to engage the older person in the therapeutic process[22,39].

### Availability

CBT is the most widely available talking therapy in New Zealand. It is used in publicly-funded services, including mental health services for older people within DHBs. GPs and practitioners in not-for-profit organisations and private practices also offer CBT.

### Resources

- The Royal College of Psychiatrists (UK) provides a summary of CBT on their website: www.rcpsych.ac.uk.
- *Handbook of Behavioral and Cognitive Therapies with Older Adults* (2008), edited by Dolores Gallagher-Thompson, Ann Steffen and Larry W. Thompson (Springer Science).
- *Mind over Mood: change how you feel by changing the way you* think (1995) by D Greenburger and C Padesky (The Guildford Press). A well respected resource for both clinicians and people accessing therapy.

### Training

- Postgraduate level training in CBT is offered through most New Zealand universities.
- Training is also available through the New Zealand Centre for Cognitive Behaviour Therapy: www.rational.org.nz

## Group CBT

There has been less published research on providing CBT to people in groups, but there is promising evidence of its effectiveness. Group CBT with adaptations is being widely used in New Zealand's mental health services for older people.+ Across these services, group CBT has been found to be helpful for generalised anxiety and depression. Groups tend to be psycho-education based and use techniques such as relaxation training, slow breathing techniques, problem solving and helpful thinking.* Discussion with colleagues may highlight what services are locally available.

Providing therapy in groups, rather than individually, has potential advantages.

- Peoples' self-stigmatising views of mental illness, addiction and therapy may lessen by sharing their experiences with other people with similar experiences.
- Group sessions allow people the opportunity to role-play and practise new interpersonal behaviours and skills.
- The group approach may assist people in the application of these new skills[34].

+ Reference group personal communication
* Reference Group and NZPOPs - personal communication

## Computerised CBT

Computerised CBT (cCBT) has been found to help with mild depression and anxiety. Rather than seeing a therapist face-to-face, cCBT is provided through a website, CD or DVD. Some websites offer therapist support via email or telephone.

cCBT is not recommended as a stand alone therapy, unless the person accessing therapy is addressing mild issues or problems, or there is real difficulty accessing a therapist[1]. Due to its flexibility and cost-effectiveness, cCBT is likely to become more utilised in the future.

The following websites from Australia and the UK provide self-paced CBT programmes (please note they don't provide back-up therapist support via email or telephone).
www.moodgym.anu.edu.au
www.ecouch.anu.edu.au
www.livinglifetothefull.com

A pilot study investigating the potential willingness of older people with depression and/or anxiety to engage with cCBT found that older people with anxiety and/or depression may be willing to engage with cCBT[40].

However, there are some general considerations for using cCBT with older adults, including:

- the persons' access to and level of comfort with using technology
- motivation to complete the programme.

**New Zealand specific online programme**

The New Zealand Depression Initiative launched a new online self-management programme for depression in June 2010, called 'The Journal'. The programme is based on Problem Solving Therapy. The programme includes text and email reminders and has optional personalised support through the Depression Helpline. It is available through www.depression.org.nz.

## Psychodynamic and psychoanalytic psychotherapy

### Psychodynamic psychotherapy

Psychodynamic psychotherapy is based on the premise that many emotional and cognitive functions and experiences take place in the unconscious and can be modified by insight or self understanding. It uses the relationship between the person accessing therapy and the therapist to explore interpersonal issues.

**Psychodynamic psychotherapy has been found to be generally effective for:**

- depression
- anxiety
- relationship issues
- addiction issues
- grief, death and dying
- resolution of past conflicts
- resolution to lifelong patterns that could hinder life satisfaction
- life changes, aging, illness and possible dependence
- exploring denial of illness/ dementia
- improving social relationships[37,41,42].

There have been limited clinical trials on psychodynamic psychotherapy for older people. Most literature to date concentrates on its usefulness for depression in older people, where there is promising evidence of its effectiveness [32,43]. Loss is a predominant theme in therapy with older adults; actual loss such as loss of spouse, employment, independence and health, as well as the fear of future losses and loss of possibilities[32].

Psychodynamic psychotherapy is a relatively intensive therapeutic approach; people usually have one session a week and therapy can last for a few months or years,

depending on the issues the person wishes to explore.

An older adult may benefit from psychodynamic psychotherapy if they are interested in exploring the meaning of their experiences, behaviour and thoughts and want to achieve a greater sense of satisfaction in their life. Psychotherapists more often work with individuals but can work with families/whānau, or groups[32].

**Some considerations for psychodynamic and psychoanalytic psychotherapy with older adults:**

- Thoughts of a brief remaining life may accelerate psychological change.
- The older person may need the reassurance the therapist is available for the rest of their lives and it may be appropriate to indicate they may come back if necessary rather than discharging them completely.
- The realities of aging, such as mobility issues or financial constraints need to be acknowledged in therapy.
- An exploration of the relationship between mind and body may help to resolve the negative effect of physical pain and increasing disability on the person and their relationships.
- Remember that people are diverse and there may be even greater variability after a lifetime of experiences[32.]

## Psychoanalytic Psychotherapy

Psychoanalytic psychotherapy is similar to Psychodynamic psychotherapy, but is usually a more intensive course of therapy; people may have one to three sessions of therapy a week, which can last for a number of years.

Psychoanalytic psychotherapy is a broad field, incorporating a range of methodologies. A useful place to learn more is the Australian Psychoanalytical Society website www.psychoanalysis.asn.au.

## Availability

Psychodynamic and Psychoanalytic psychotherapy are not widely available through the public health service in New Zealand. Most people seeking this therapy will have to fund it themselves and, depending on the length of their course of therapy, this could amount to a significant financial investment.

Psychotherapists usually work from their own offices but some may visit people in their own homes or residential settings. The Psychotherapists Board of Aotearoa New Zealand website (www.pbanz.org.nz) has a public register of registered psychotherapists.

## Resources

- *Psychotherapy with older adults* (2004) by Bob Knight provides a good overview of psychotherapy with older adults.
- *Counselling and psychotherapy with older people: a psychodynamic approach* (2008) by Paul Terry provides an in-depth understanding of counselling and psychotherapy with older people and those who care for them.

## Training

Contact the New Zealand Association of Psychotherapists (www.nzap.org.nz) for information on training options.

# Bibliotherapy

## Overview

Bibliotherapy is the use of self-help resources for personal growth. This can include books, journals, audio tapes, pamphlets, play scripts, journals, poems and songs and stories adapted from cinema and television. Bibliotherapy resources are increasingly available on the internet and are commonly known as e-therapy.

Bibliotherapy may be used as an adjunct to talking therapies. GPs may also 'prescribe' resources for people. Many people also find resources at their local library, bookshop or on the internet.

There is limited research on the effectiveness of bibliotherapy specifically for older people. However there is no reason to suggest that older people benefit any less from bibliotherapy than the general population. Older adults with visual, aural or cognitive impairments may require more specialised resources.

**Bibliotherapy has been found to be helpful for:**

- personal growth and change
- depression
- anxiety
- managing long-term illness
- obsessive compulsive behaviour[1].

Bibliotherapy isn't recommended as a stand alone therapy, unless the person seeking therapy is addressing mild issues, or there is real difficulty accessing a therapist. People who use self help resources without professional guidance may run the risk of misdiagnosing themselves or misapplying techniques.

## Resources

- Bibliotherapy resources are widely available but their quality varies. Therapists and GPs will usually have recommended resources.
- The following reference book helps consumers and professionals distinguish high quality, self-help resources from those of questionable value: *Authoritative Guide to Self-Help Resources in Mental Health* (2003) by Norcross et.al. (Revised edition: *The Clinician's Toolbox*).
- *Choose to be Happy* (2003) by New Zealand therapist Wayne Froggatt is a comprehensive self-help book based on CBT. It addresses a range of common personal and mental health problems, including depression, anxiety, anger management and decision making.
- *Feeling good: the new mood therapy* (1999) by David Burns is considered an excellent self-help book for depression.

# Counselling

## Overview

Counselling helps people increase their understanding of themselves and their relationships with others, to develop resourceful ways of living and to bring about change in their lives. It is generally a short-term therapy that is focused on a specific problem or issue. Counsellors are trained to provide a listening ear and may offer advice where appropriate.

Counsellors work with individuals, couples, families/whānau, or groups. Counsellors are usually trained in a number of skills and can assist with a variety of issues, some have specialist training in specific areas such as relationships, drug and alcohol addiction and sexual abuse.

### Counselling can be effective for:

- depression
- anxiety
- grief
- relationship issues
- sexual abuse
- alcohol, drug, smoking and gambling issues
- life changes
- family violence
- personal development [1, 44-46].

Counselling comes in many forms. It focuses on helping people understand their emotions, feelings and actions, and finding adaptive ways to deal with them. This could mean adopting practical action plans, developing positive thinking and adopting structured problem-solving strategies.

There has been limited research in New Zealand on counselling specifically for older people. However, a review of counselling for older people commissioned by the British Association for Counselling and Psychotherapy found good evidence that counselling is effective with older people, particularly in the treatment of anxiety, depression and in improving subjective wellbeing[46].

## Availability

Counselling is provided through public health services, not-for-profit organisations and private practice. Not all types of counselling are provided in 'mainstream' services; discussion with colleagues may identify local options. There are counsellors and health services that specialise in providing services for Māori and other population groups, depending on local population needs. Talk to the local kaupapa Māori service or marae.

We recommend counsellors who are members of the New Zealand Association of Counsellors. Search for a counsellor by region or town on their website www.nzac.org.nz.

## Training

The New Zealand Association of Counsellors provides an overview of counselling training and a comprehensive list of training providers on their website www.nzac.org.nz.

**What is dementia?**

Dementia is a neurological disorder where brain function is impaired, affecting language, memory, perception and cognition. The most common cause of dementia is Alzheimer's disease. Dementia progresses over time and is characterised by cognitive decline, psychiatric and behavioural symptoms and increasing dysfunction in daily living. Symptoms vary in different people and at different times.

Risk factors for dementia include older age, family history and cardiovascular risk factors such as high blood pressure and smoking.

# Working with dementia

## Overview

Dementia is a major cause of disability for older people in New Zealand. People with dementia have complex needs and often require long-term care. A person's management plan will depend on their symptoms and the severity of their dementia.

Dementia primarily affects people aged 65 and over. Nearly 34 per cent of New Zealanders over 90 years of age have a form of dementia. Women are more affected than men, due to their longer life span. The prevalence of dementia is expected to increase from 1 per cent of the population in 2008, to 1.5 per cent in 2026, and 2.7 per cent by 2050[47].

## Behavioural and psychological symptoms of dementia (BPSD)

BPSD is an umbrella term for a group of symptoms and behaviours that occur in people with dementia. These are often distressing for the person and their families or carers and challenging for health professionals.

There are many possible behavioural and psychological symptoms of dementia, including anxiety, agitation, depression, wandering, aggression, sleep disturbance, psychosis and disinhibition[10].

## Talking therapies for BPSD

There is some evidence that talking therapies can help with the psychological and behavioural symptoms of dementia. BPSD is often related to a person's environment or interaction with others and frequently has a number of contributing causes, all of which need to be considered when using talking therapies with this group.

The effectiveness of the following therapies is dependent on the person's level of dementia, their personal preferences, past history, and the experience and persistence of the therapist[10,47,48].

## Reminiscence Therapy[49]

There has been limited research to date on the effectiveness of Reminiscence Therapy. There is some evidence that it improves cognition, mood and general behavioural function.

Reminiscence Therapy encourages a person to recall past life events, either one-to-one with the therapist or within a group. Audiovisual aids such as photographs, sound recordings, familiar items and newspaper articles may be used to prompt memory and discussion. Family caregivers may be involved.

It is thought that stimulating a person's long-term memory may be beneficial and recognition of the past allows for the important process of life review.

## Validation therapy[50]

Validation Therapy is used in residential care settings. Validation Therapy is based on the premise that residents with dementia have an altered perception of reality and short-term memory deficits that make understanding their current reality a challenge. Therapy focuses on reinforcing the resident's own view of reality.

Research on the effectiveness of Validation Therapy is limited. Some researchers have had success managing agitation and anxiety but findings are mixed.

## Reality orientation

Reality Orientation is also used in residential care settings. It involves continuous reorientation by talking about current information (such as the date, time and location) and events during interactions. The aim is to reduce disorientation and associated agitation and anxiety.

There is some evidence that Reality Orientation improves cognition and behaviour for dementia sufferers[51].

## Cognitive Behavioural Therapy (CBT)

The National Institute of Clinical Excellence (UK) suggests that CBT for people with dementia who have depression and/or anxiety may be effective. The active participation of the person's carer/s should be considered[52].

See page 26 for more detail on CBT.

## Availability of talking therapies for dementia

The availability of Reminiscence Therapy, Validation Therapy and Reality Orientation will depend on individual residential care facilities.

## Resources

- **The Royal Australian New Zealand College of Psychiatrists (RANZCP)** has produced guidelines to encourage evidence-based practice for the treatment of elderly people in residential care with psychological and behavioural symptoms of mental disorders, the most common of which is dementia. The guidelines make recommendations for non-pharmacological interventions as well as prescribing antipsychotic medications. Please refer to the RANZCP website for the guide,
  *The Use of Antipsychotics in Residential Aged Care (2008)*,
  www.bpac.org.nz/a4d/resources/docs/RANZCP_Clinical_recommendations.pdf
- **The New Zealand Guidelines Group** has produced
  *Guidelines for the Support and Management of People with Dementia*.
  The guidelines date from 1997 but are still a useful resource.
  www.nzgg.org.nz/guidelines/0045/Guidelines_For_People_With_Dementia.pdf
- **The National Institute of Health and Clinical Excellence**, UK, has produced *Guidelines for supporting people with dementia and their carers* (2006). http://guidance.nice.org.uk/CG42/Guidance/pdf/English
- **Alzheimer's New Zealand** provides support, information, education programmes and services for people affected by dementia. Their website is a good resource: www.alzheimers.org.nz

## Talking therapies for addiction

There has been limited research on the prevalence of addiction rates for older New Zealanders. This section focuses predominantly on alcohol addiction.

Problem drinking in older people can lead to increased falls, depression, memory problems, liver disease, cardiovascular disease, cognitive changes and sleep problems. Older adults are not as resilient as younger adults and may have long periods of exposure to alcohol with the associated harmful consequences. Equally they may be relatively new 'at risk' drinkers, developing a problem only in the later years of their life[53].

Motivational Interviewing is widely used in New Zealand for addiction. This section also discusses CBT, counselling and group therapy.

### Motivational Interviewing[1,31]

Motivational Interviewing is a brief, client-centred counselling style commonly used in alcohol, drug, smoking and gambling services and increasingly in mental health and general health services in New Zealand. It works by helping people recognise and actively deal with issues, attitudes and beliefs that are preventing change. It assists a person to become committed to change, and to develop a plan for bringing about change.

Motivational Interviewing is increasingly being used to help people make health and lifestyle changes. It can be used alongside other talking therapies.

There is limited research on the efficacy of Motivational Interviewing specifically with older people in New Zealand.

The New Zealand Guidelines Group review[31] found that Motivational Interviewing:

- is a suitable intervention for addiction with all age groups, in particular with alcohol, either as a stand-alone therapy or alongside other therapies
- can be used in conjunction with CBT to enhance engagement in mental health
- is suitable for people with psychotic illnesses to enhance adherence.

### CBT with addictions

CBT with addictions involves identifying the antecedents to substance misuse, such as anger, loneliness, frustration, sadness or boredom. Studies have found that older adults respond as well as younger adults to a cognitive behaviour approach[54]. For a more detailed description of CBT, see page 26.

### Counselling

Alcohol and Other Drug Services in New Zealand provide specialist alcohol and drug counsellors. They may use a combination of counselling techniques, including Motivational Interviewing. Alcohol and drug counsellors are trained to assess the severity of substance use problems, to give advice and counselling, and make the appropriate referrals where necessary. Counselling is described in more detail on page 31.

## Group Therapy

There is some evidence that group therapy is a helpful intervention in treating alcohol disorders in older people.

Alcohol programmes designed specifically for the older age group should focus on a number of key areas.

- Age-specific group treatment that is supportive and non-confrontational and aims to build or rebuild the person's self-esteem.
- A focus on coping with depression, loneliness, and loss (such as death of a spouse or retirement). A focus on rebuilding the person's social support network.
- Using pace and content appropriate for the older person.
- Ensuring treatment is delivered by health professionals who are interested and experienced in working with older adults.
- The linkages between medical services for older people and institutional settings aids referral into and out of treatment, as well as case management[55].

## Availability

Alcohol and Other Drug (AOD) services are widely available thorough district health boards and community organisations. Depending on population need, there are specific services for Māori, and Pacific and Asian peoples. Some may provide a service specifically for older people. The talking therapies offered will vary. Most of these services are free.

The Addictions Treatment Directory has regional listings for addiction treatment and advice services in New Zealand www.addictionshelp.org.nz.

## Less widely available, evidence-based talking therapies

The following talking therapies are forms of psychotherapy largely developed since the 1960s. There have been few clinical trials on their effectiveness for older people and they are generally not widely available or widely used in New Zealand. However, there is promising evidence from clinical work about their effectiveness with older people.

Mental health practitioners with postgraduate qualifications can train in these therapies relatively quickly and as most of them are brief interventions, they are cost effective. It's likely they will become more widely available in New Zealand in future.

# Interpersonal psychotherapy (IPT)

### Overview[1,56-58]

IPT was developed for the treatment of adult depression in the early 1980s and has since been modified for numerous conditions including adolescent and older adult depression, chronic depression, bulimia and bipolar disorder. It's a manual-based, time-limited (12–16 sessions) and evidence-based talking therapy. The theoretical underpinnings of IPT are attachment theory, communication theory and social theory/psychiatry.

The IPT model is consistent with the biopsychosocial model of depression and fully compatible with the concurrent use of psychotropic medication. The goal of treatment is symptoms relief. People using this therapy report that IPT offers a commonsense approach to helping them feel less depressed.*

IPT identifies and works on one of the four problem areas in a person's relationship with others. It is designed to improve communication skills and to modify expectations in relationships. The four problems areas are:

- role transition, such as retirement, downsizing, ceasing to drive and increasing medical disability
- interpersonal disputes
- grief
- interpersonal sensitivity.

IPT would suit an older adult if they feel that relationships or adjustment to role changes are the main cause of their issues, and they would like a short step-by-step course of therapy.

### IPT for cognitive impairment

The recently developed IPT for cognitive impairment (IPT-ci)[59] provides a framework for therapists working with older adults. IPT-ci builds on traditional IPT and aims to improve the coping skills of older adults. It seeks to help older adults and their caregivers manage the effects of cognitive impairment, particularly in the early phase when behaviour changes are often misunderstood, as well as plan for potential future declines in cognitive impairment.

* Reference group personal communication

The adaptation of IPT-ci includes the routine incorporation of concerned family members or caregivers into the treatment process from the outset, with flexible allowances for individual sessions with patients or caregivers. There is also an option for joint sessions to foster better understanding, communication and respect by modelling appropriate behaviours on the part of the IPT-ci therapist.*

It is recognised that caregivers themselves are also going through a role transition. They may feel compelled to take on more caregiving tasks as older people age and become more physically or cognitively impaired.

## Availability

IPT has limited availability in New Zealand due to the lack of trained IPT practitioners.

## Training

IPT can be taught to a variety of health care professionals, including social workers, mental health nurses, psychologists and other therapists. Training involves 20 hours of didactic coursework and two to three completed cases under supervision.

- Contact Dr Gary Cheung (GCheung@adhb.govt.nz) for training workshops in New Zealand.
- Postgraduate courses in IPT are offered through Otago University (Christchurch School of Medicine).

## Resources

- International Society for Interpersonal Psychotherapy: www.interpersonalpsychotherapy.org.
- Miller MD. (2009). *Clinician's guide to interpersonal psychotherapy in late-life: helping cognitively impaired or depressed elders and their caregivers* (Oxford University Press, USA).

* Reference group personal communication

# Cognitive Analytical Therapy (CAT)

## Overview

CAT is a brief, time-limited, structured and integrative model of psychological therapy. It is aimed at identifying and changing repeating patterns in a person's life which are self limiting and lead to problems coping, interpersonal difficulties or other psychological symptoms.

CAT focuses on discovering how problems have evolved and addressing the coping mechanisms a person has developed that are ineffective and contributing to maintaining their problems and/or symptoms. It is designed to give people an increased understanding of how their difficulties originated in the context of their personal history and life experiences and to increase their ability to recognise and revise these unhelpful patterns. Change is brought about by learning new coping mechanisms as well as building on their own strengths and resources.

CAT facilitates a person's capacity to self-reflect on their thoughts, feelings and behaviours, and to monitor these through homework tasks. However, as CAT emphasises the importance of relationships, in terms of both the development and maintenance of problems, therapy involves using the relationship between the therapist and person accessing therapy explicitly as a tool for change.

CAT is a collaborative and active therapy involving the person accessing therapy and therapist developing diagrammatic and written outlines of problems to help recognise, challenge and revise unhelpful patterns.

CAT has a cohesive body of theory and a growing body of research evidence for its effectiveness in treating psychological difficulties[42].*

**CAT is suitable for a wide range of presenting problems and is helpful in treating:**

- depression
- anxiety
- behavioural issues
- interpersonal difficulties
- personality disorders[42].

## CAT with older people

CAT is being used by people across the age spectrum and has particular value in working with older people, given its emphasis on shared meaning in the context of a person's life story. Later life can also be a time when past trauma and self esteem issues may surface in the context of life events and losses and CAT is a helpful framework for linking past and present.

Personality-based difficulties may present as an array of symptoms in later life and CAT has particular value in working with people presenting with self destructive or self-harming behaviours.

* Association of Cognitive Analytic Therapy; Reference Group personal communication

## Availability

CAT is widely used in Europe and other parts of the world. There is growing awareness of and interest in the model in New Zealand.

## Training

Accreditation as a CAT therapist follows completion of two years' training involving supervised practice. Currently, introductory courses are run in New Zealand.

The Centre for Psychology, Massey University (Albany campus, Auckland) runs a regular workshop series which includes CAT. Contact: psych.admin.auck@massey.ac.nz.

## Resources

A key text on CAT with older people is *Cognitive analytic therapy and later life: A new perspective on old age* by J Hepple & L Sutton. 2004. Brunner Routledge.

Association of Cognitive Analytic Therapy: www.acat.me.uk

# Acceptance and Commitment Therapy (ACT)

## Overview[60-63]*

ACT is a brief therapy that uses acceptance and mindfulness strategies, alongside commitment and behaviour change strategies. People are taught mindfulness skills to accept difficult and painful thoughts and feelings. People are assisted to better understand their values, what is important and meaningful to them, and apply this knowledge to guide and motivate them to make changes.

Instead of trying to change thinking or 'fix' things, ACT helps people identify what is really important to them in life and to develop ways to experience those 'valued' activities. This happens by doing things, not by talking about them. Other features of ACT are the emphasis on accepting what cannot be changed; paying attention to what is *actually* happening right now, rather than what a person is *thinking* about what is happening; and taking action towards values, what is most important for a person.

The literature on ACT shows promising evidence for its effectiveness with depression and anxiety but notes that more research is needed. There is limited research on the efficacy of ACT specifically for older people. There is promising evidence that ACT is helpful for older people with ongoing chronic conditions.+

## Availability

ACT is not currently widely available in New Zealand but this is likely to change as its evidence-base grows.

## Training

The Centre for Psychology, Massey University (Albany campus, Auckland) runs a regular workshop series which includes ACT. Contact: psych.admin.auck@massey.ac.nz.

## Further resources

A large number of resources and additional information can be found on the Association for Contextual Behavioral Science (US) website www.contextualpsychology.org.



* Dr Jim Hegarty; personal communication
+ Reference Group; personal communication; Dr Jim Hegarty; personal communication

# Dialectical Behaviour Therapy (DBT)

## Overview[1,64,65]

DBT is an intensive, long-term therapy used to treat serious emotional and relationship issues. It combines techniques used in CBT for changing thoughts, feelings and behaviours, with mindfulness, meditation and stress management techniques. DBT encourages people to recognise and understand different viewpoints, thereby assisting them to change how they react in difficult situations.

### DBT has proven to be effective for:

- self harming
- difficulties dealing with strong emotions
- people diagnosed with borderline personality disorder.

There has been limited research on the effectiveness of DBT for older people. There is promising evidence that DBT is effective for older people with co-morbid personality disorder and depression (alongside medication) and for chronically depressed older people alongside medication. A pilot study exploring DBT for depressed older adults found that participants receiving medication and DBT demonstrated significant improvements (pre- to post-treatment) on dependency and adaptive coping[64].

Adaptations may need to be made for DBT for older adults. It may be helpful to thoroughly explore the history of the maladaptive behaviours with the older adult, as these behaviours may have a long reinforcement history. Older adults may also need a specific focus on decision-making skills and help to overcome reliance on problem-solving strategies they have used in the past[66].

## Availability and resources

Most district health boards offer DBT. People are usually referred by a mental health service after they've had a thorough assessment of their needs.

More information can be found on the following websites.

- http://behavioraltech.org/index.cfm
- www.adhb.govt.nz/balanceprogramme
- www.tepou.co.nz/page/tepou_72.php.

# Problem Solving Therapy (PST)

## Overview[1]

PST uses a step-by-step approach to help a person with their problem solving skills. PST is based on research which shows that sometimes people dealing with issues have difficulty solving problems effectively. It is also known as Structured Problem Solving Therapy.

**PST has proven helpful for:**

- depression
- anxiety
- chronic illness
- suicidal thoughts and behaviours
- behaviour change and personal growth.

While there are limited studies on the effectiveness of PST specifically for older people, available research suggests that PST may be helpful in preventing depression following an acute stroke[67] and for the treatment of depression for older adults with Parkinson's disease and mild cognitive impairment[68]. Research also suggests that PST (delivered in primary care settings) is an effective method for treating late-life depression[69,70].

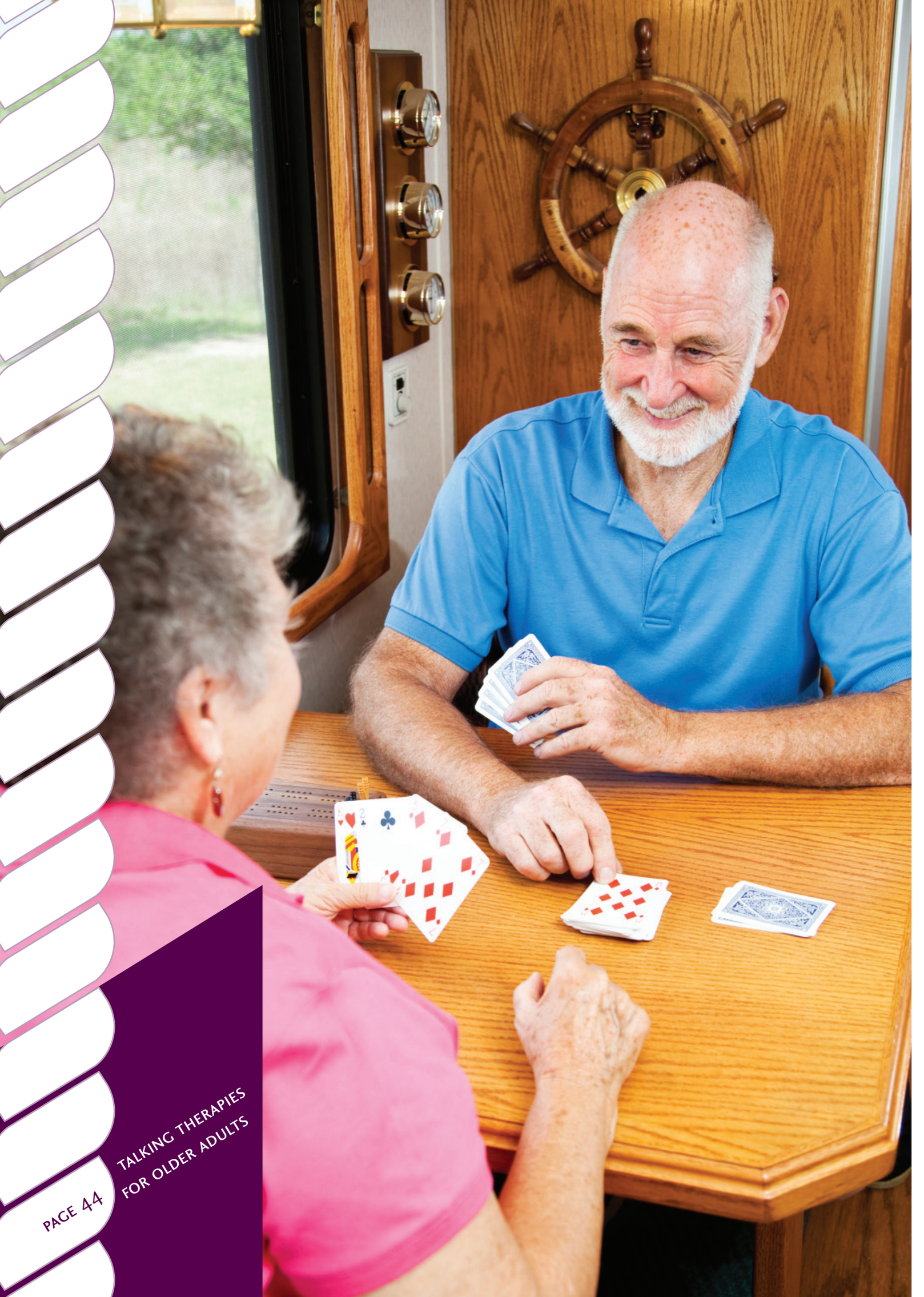
## Availability

PST is not yet widely available in New Zealand.

The New Zealand Depression Initiative is launching a new online self-management programme, which is based on Problem Solving Therapy. The programme is called 'The Journal', and is available at www.depression.org.nz.

## Training

Auckland University is currently running a trial on PST. Courses are available through the University www.problemsolvingtherapy.ac.nz.



# 4. Resources

## Support services for older adults

There are a range of support services available for older adults. A selection is listed below. Additional services and services specific to your region can be located by searching the internet, speaking with colleagues or looking in the New Zealand yellow pages.

Older adults wishing to access publicly-funded support services must have their needs assessed by a District Health Board Needs Assessment Service Coordination (NASC) agency.

The **Ministry of Health** has a full list of agencies and their respective district health boards (in alphabetical order) www.moh.govt.nz/moh.nsf/indexmh/hop-supportservicesaccess

**Health pages** has links to a range of services by region

www.healthpages.co.nz/79-Elderly-Support-Services/

**Age Concern**

www.ageconcern.org.nz

Age Concern serves the needs of older people by offering nationally contracted services, education, resources and national leadership. Contact your regional branch to enquire about the services they offer in your area. Contact details are on the website.

**Accredited Visiting Service**

Age Concern runs an Accredited Visiting Service (AVS), which pairs volunteer visitors to lonely or isolated older adults. See the Age Concern website for more information.

**Salvation Army**

www.salvationarmy.org.nz/here-to-help/seniors/

The Salvation Army offers a range of services including homecare and friendship services.

**Enliven**
Presbyterian Support Services

www.enlivenpsc.org.nz

Enliven Positive Ageing Services offers subsidised residential and community care for older adults in the North Island. This includes a range of services to help older adults maintain their independence in their own homes. Contact details for regional services can be found on the website.

**The Good Companion**

www.thegoodcompanion.co.nz

Phone: (03) 323 7177

The Good Companion assists older adults to continue living independently. They are currently based in Christchurch and Nelson. Services range from helping with daily chores and personal care, to full lifestyle management.

**New Zealand Relay**

www.nzrelay.co.nz

Freephone 0800 4 715 715

New Zealand Relay (NZRelay) is New Zealand's telecommunication service which allows people who are deaf, hearing impaired, deaf and blind, or speech impaired to make or receive phone calls. This service is available 24 hours a day, 7 days a week (Speech to Speech is a restricted days and hours service).

**St John Caring Caller**

Freephone: 0800 785 646

This is a freephone friendship service, where trained St John volunteers make a friendly phone call at an agreed frequency to chat and check on the wellbeing of the Caring Caller service user.

**Total Mobility Coordinator**

Freephone: 0800 368 267

This is a nationwide subsidised transport scheme to help eligible people with impairments continue to participate in the community.

**Grey Power**

www.greypower.co.nz

Grey Power is a lobby organisation promoting the welfare and wellbeing of people in the 50 plus age group. Grey Power's aims and objectives include advancing, supporting and protecting the welfare and wellbeing of older adults.

**SuperGold Card**

www.supergold.govt.nz

The SuperGold Card is a discounts and concessions card issued free to all eligible seniors and veterans. It gives access to discounts from a wide range of businesses nationwide and facilitates easy access to government entitlements and local authority services and concessions.

# Publications and websites

## Health and mental health

*Ageing is Living – a guide to positive living*. 2008. Age Concern New Zealand. Available from: www.ageconcern.org.nz.

*Older People's Health Chart Book 2006*. Ministry of Health: Wellington. Available from: www.moh.govt.nz.

*Older New Zealanders – 65 and beyond*. Statistics New Zealand: Wellington. Available from www.stats.govt.nz

New Zealand Psychologists for Older People (NZPOPs): www.nzpops.co.nz/index.htm

*New Zealand's 65+ Population: A statistical volume (2007)*: Statistics New Zealand: Wellington. Available from www.stats.govt.nz

*Te Rau Hinengaro: The New Zealand Mental Health Survey.* 2006. MA Oakley Browne MA, JE Wells, KM Scott (eds). Wellington: Ministry of Health. Available from www.moh.govt.nz.

*Oranga Kaumatua: perceptions of health in older Māori people.* Waldon J. 2003. Available online at: www.msd.govt.nz

*Te Orau Ora: Pacific Mental Health Profile.* 2005. Wellington: Ministry of Health. Available from www.moh.govt.nz

*Asian health in Aotearoa: An analysis of the 2002/03 New Zealand Health Survey.* Scragg R, Maitra, A. 2005. Auckland: University of Auckland. Available from www.asianhealth.govt.nz.

Mental Health Of Older People in Aotearoa, New Zealand: Needs, Issues And Psychological Approaches To Management. In Professional *Practice of Psychology in Aotearoa New Zealand*. 2007. Edited by Ian M. Evans, Julia J. Rucklidge, Michael O'Driscoll. New Zealand Psychological Society Publication

## Cultural competency

Statement on cultural competence. Medical Council Statement, 2006. Available from www.mcnz.org.nz.

Statement on best practices when providing care to Māori patients and their whānau. Medical Council Statement, 2006. Available from www.mcnz.org.nz.

*Pacific cultural competencies: a literature review.* 2008. Ministry of Health. Available from www.moh.govt.nz.

*Cultural competence: Advice to GPs to create and maintain culturally competent general practices in New Zealand.* 2007. The Royal New Zealand College of General Practitioners. Available from www.rnzcgp.org.nz/cultural-competence/.

## Medication

The Royal Australian New Zealand College of Psychiatrists has produced guidelines to encourage evidence-based practice for the treatment of elderly people in residential care with psychological and behavioural symptoms of mental disorders, the most common of which is dementia. The guidelines make recommendations for prescribing antipsychotic medications as well as non-pharmacological interventions. *The Use of Antipsychotics in Residential Aged Care (2008)*

Clinical considerations of antidepressant prescribing for older patients. (Therése Kairuz, Monica Zolezzi and Antonio Fernando. *Journal of the New Zealand Medical Association,* 16-September-2005, Vol 118. No 1222.)

Complete article available online at www.nzma.org.nz/journal/118-1222/1656/

Dilemmas in Prescribing for Elderly People: why is it difficult? *Best Practice Journal* Issue 11, 2008. Key advisor: Professor John Campbell. Complete article available online at www.bpac.org.nz/magazine/2008/february/why.asp

## Resources for specific therapies

**Cognitive Behavioural Therapy (CBT)**

The Royal College of Psychiatrists (UK) provides a good summary of CBT on their website www.rcpsych.ac.uk

*Handbook of Behavioral and Cognitive Therapies with Older Adults.* (2008) Dolores Gallagher-Thompson, Ann Steffen and Larry W. Thompson (editors). Springer Science.

**Computerised CBT**

- www.moodgym.anu.edu.au
- www.ecouch.anu.edu.au
- www.livinglifetothefull.com

**New Zealand specific online programme:** The New Zealand Depression Initiative has recently launched a new online self-management programme, called 'The Journal'. The programme is based on Problem Solving Therapy. It can be accessed through www.depression.org.nz.

**Psychodynamic and Psychoanalytic Psychotherapy**

Psychotherapy with older adults by Bob Knight (2004), provides a good overview of psychotherapy with older adults.

*Counselling and psychotherapy with older people: a psychodynamic approach,* by Paul Terry (2008) provides an in-depth understanding of counselling and psychotherapy with older people and those who care for them.

**Bibliotherapy**

*Authoritative Guide to Self-Help Resources in Mental Health,* Norcross et.al. 2003 (Revised edition: The Clinician's Toolbox). This reference book helps consumers and professionals distinguish high quality, self-help resources from those of questionable value.

*Choose to be Happy* (2003) by New Zealand therapist Wayne Froggatt is a comprehensive self-help book based on CBT. It addresses a range of common personal and mental health problems, including depression, anxiety, anger management and decision making.

*Feeling good: the new mood therapy* (1999) by David Burns is considered an excellent self-help book for depression.

**Counselling**

New Zealand Association of Counsellors www.nzac.org.nz

**Working with dementia**

The Royal Australian New Zealand College of Psychiatrists has produced guidelines to encourage evidence-based practice for the treatment of elderly people in residential care with psychological and behavioural symptoms of mental disorders, the most common of which is dementia. The guidelines make recommendations for non-pharmacological interventions as well as prescribing antipsychotic medications.

*The Use of Antipsychotics in Residential Aged Care* (2008)

The New Zealand Guidelines Group has produced *Guidelines for the Support and Management of People with Dementia*. The guidelines date from 1997 but are still a useful resource.

The National Institute of Health and Clinical Excellence, UK, has produced *Guidelines for supporting people with dementia and their carers* (2006).

Alzheimer's New Zealand provides support, information, education programmes and services for people affected by dementia. Their website is a good resource: www.alzheimers.org.nz

**Working with addictions**

The Addictions Treatment Directory has regional listings for addiction treatment and advice services in New Zealand www.addictionshelp.org.nz.

**Interpersonal Psychotherapy (IPT)**

International Society for Interpersonal Psychotherapy
www.interpersonalpsychotherapy.org.

*Clinician's guide to interpersonal psychotherapy in late-life: helping cognitively impaired or depressed elders and their caregivers*, by MD Miller. 2009. Oxford University Press, USA.

**Cognitive Analytic Therapy (CAT)**

*Cognitive analytic therapy and later life: A new perspective on old age*, by J Hepple & L Sutton. 2004. Brunner Routledge.

Association of Cognitive Analytic Therapy: www.acat.me.uk.

**Acceptance and Commitment Therapy (ACT)**

Association for Contextual Behavioral Science (US)

www.contextualpsychology.org/acbs

**Problem Solving Therapy**

Auckland University is currently running a trial on PST
www.problemsolvingtherapy.ac.nz.

The New Zealand Depression Initiative is launching a new online self-management programme, which is based on Problem Solving Therapy. The programme is called 'The Journal', and is available at www.depression.org.nz.

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