Pilot Study

Psychosocial Support Issues Affecting Older Patients: A Cross-sectional Paramedic Perspective

INQUIRY: The Journal of Health Care Organization, Provision, and Financing
Volume 54: 1–6

DOI: 10.1177/0046958017731963
journals.sagepub.com/home/inq
SAGE

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Abstract

This research aimed to gain an understanding of the psychosocial support needs of older patients in the out-of-hospital setting from the perspective of paramedics. Specifically, we investigate if and how paramedics are able to meet the needs of older adults, and the barriers preventing them from achieving this. This study was a cross-sectional study utilizing a sequential design with both quantitative and qualitative methodologies. All participants agreed or strongly agreed that older patients have needs beyond the physical and that they would like to do more for older patients. Paramedics discussed that psychosocial support issues are rarely in isolation and straightforward but were often coupled with broader, longer term physical health and social support issues. They would like to be able to do more for patients but feel hamstrung by lack of time, resources, and know-how.

Keywords

allied health personnel, emergency medical technicians, paramedic, psychosocial support systems, aged, older patients, cross-sectional studies

Introduction

It is well established that our population is aging and that aging is associated with declining health. Between 1996 and 2016, the proportion of Australia's population aged 65 years and above increased by 3.3% to 15.3%.[1] Increasing life expectancy rates have also seen the number of people aged 85 years and above increase by 141.2% in the last 20 years, doubling the overall numbers.[1] As people age, they are more likely to suffer from chronic conditions. By 65 years, 75% of people will have at least 1 chronic disorder, and by 85 years, this increases to 95%.[2] Multimorbidities are also more prevalent with 25% of 65-year-olds, and 50% of 85-year-olds having 3 chronic conditions.[2] The health issues associated with aging lead to an increased demand for health care services.[3,4] Paramedics, as out-of-hospital health care providers, are therefore likely to encounter many older patients.[5]

Across developed nations, emergency medical services and paramedic utilization rates are on the rise. The aging population is postulated as a contributing factor.[3] In North Carolina, USA, in 2007, patients 65 and above accounted for 38% of transports to emergency departments; this is projected to rise to 47% by 2030.[4] In Victoria, Australia, between 2011 and 2014, attendance to patients 65 and above accounted for 24% of the emergency paramedic workload.[5]

Patients often require paramedic support and clinical interventions for a wide variety of issues which can include emotional and social issues. Common psychological issues affecting older patients may include, but are not limited to, anxiety, depression, delirium, dementia, personality disorders, and substance abuse.[6] Common social and emotional issues may involve loss of autonomy, grief, fear, loneliness, financial constraints, and lack of social networks.[6,7] These psychosocial issues can also have an impact on and contribute to physical health. Psychosocial factors such as stress, anxiety, depression, social isolation, and poor relationships have been associated with an increased risk of hypertension, stroke, and cardiovascular disease.[8,9] Conversely, chronic or debilitating somatic or physical conditions such as cancer, diabetes, arthritis, cardiovascular and/or respiratory diseases, and hearing loss are associated with increased rates of loneliness and depression.[10-13] Paramedics must therefore practice holistic assessment and care of older patients and pay due attention to psychosocial issues as well as somatic conditions.

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Received 30 May 2017; revised 18 August 2017; revised manuscript accepted 18 August 2017

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The complex and multifactorial nature of psychosocial issues can make them difficult to identify. Patients typically present to primary health care practitioners with somatic complaints.[14] The presence of physical ailments can then hinder the identification of psychological difficulties as they are prioritized in the time available.[15] Mental illness, inability to cope, or loneliness can also carry a stigma which prevents some patients from raising such concerns.[14] Health care professionals may not recognize, ask about, or explore these issues with patients. This could be due to time constraints, limitations in their own skills and confidence, or lack of knowledge about available resources.[16]

Paramedics are in a unique position to interact with and assess patients in their own environment.[17] Unlike other health professionals, paramedics are able to observe living conditions which create a more holistic picture of environmental and social determinants of health. Paramedics can witness older patients living with little or no food in the house, or in unkempt and unhygienic living environments due to loss of function and/or lack of support. Such observations attest to a patient's ability to maintain daily living standards unaided. A general practitioner or emergency department physician, for example, can only ask patients whether they are "coping at home," with no guarantee of an accurate answer. Patients may deny the true nature of their situation due to fear of being institutionalized, losing independence, being embarrassed, or not having insight into the severity of their situation.[14]

Therefore, the primary aim of this research was to gain an understanding of the psychosocial needs of older patients in the out-of-hospital setting from the perspective of paramedics. Secondary aims were to investigate if and how paramedics are able to meet these needs, and what barriers prevent them from doing so.

Methods

Design

This study was a cross-sectional study utilizing a sequential design with both quantitative and qualitative methodologies.

Participants

Participants were all qualified paramedics working for an emergency ambulance service who were delegates at the Paramedics Australasia International Conference in Adelaide, Australia, 2015. This conference was attended by 400 delegates consisting of predominantly paramedic clinicians, managers, researchers, and educators.

Instrumentation

Demographic and quantitative data were gathered via a 15-item questionnaire designed by the research team in consultation with aged care specialists. It was designed to investigate participants' experience with, and views on older patients and their psychosocial needs. It consisted of a combination of tick box and Likert scale questions (1 = strongly disagree to 4 strongly agree). The questions are listed in Tables 1 and 2. In addition to the questionnaire, qualitative data were collected via focus groups. The focus groups were conducted by the authors following consultation and agreement on procedures and practices to ensure consistency.

Table 1. Paramedic Participant Demographics (N = 14).

	Mean (SD)	Minimum-Maximum
Age	42.93 (8.86)	26-56
Self-rated experience level with older adults	7.93 (1.07)	6-10
	n (%)	
Gender		
Female	7 (50)	
Male	7 (50)	
Ambulance service location		
Victoria	8 (57)	
Other	6 (43)	
Years of experience		
<5	1 (7)	
5-9	3 (22)	
10-14	2 (14)	
15+	8 (57)	
Geriatric education		
Nil	2 (14)	
Part of unit	10 (72)	
Whole unit	2 (14)	

Procedures

The project was advertised during conference presentations, via posters, and word of mouth among conference delegates. Volunteers for the project were asked to complete the short questionnaire and participate in a 50-minute focus group discussion.

Data Analysis

The Statistical Package for the Social Sciences (SPSS), version 23.0, was used for analysis of the quantitative and demographic data. Mean and standard deviation, or median and interquartile ranges were reported as appropriate, in addition to percentages, minimums, and maximums. Qualitative focus group data were transcribed verbatim. A thematic analysis based on a 6-step approach—data familiarization, coding, identifying themes, reviewing themes, defining and naming themes, was conducted by 2 authors (LR & BW).[18] Consensus on the final themes and definitions was reached by discussion.

Table 2. Paramedic Perspective on Psychosocial Needs of Older Patients.

Question	Median (IQR)
Older patients in the out-of-hospital setting often have needs beyond the physical.	4 (4-4)
As a paramedic . . .	
I am able to recognize the psychosocial needs of older patients.	3 (3-3)
I am able to meet the psychosocial needs of older patients.	2 (2-3)
I do not have the time to meet the psychosocial needs of older patients.	3 (2-3)
I do not have the resources to meet the psychosocial needs of older patients.	3 (2-3)
I do not have the training to meet the psychosocial needs of older patients.	3 (2-4)
I would like to do more for my older patients.	4 (3-4)
I often transport older patients to hospital as there is no alternative.	3 (3-4)
I would like to receive more training in the resources available for older patients.	3 (3-4)

Note. IQR = interquartile range.

Ethics

Ethics approval was granted by Monash University Human Ethics Research Committee (MUHREC): CF15/3293 – 2015001394.

Results

Participant Demographics

All 14 participants completed both the survey and participated in the focus groups. Of the participants, 7 (50%) were female and the mean (SD) age was 42.93 (8.86) years. The majority of paramedics (8 of 14; 57%) worked for Ambulance Victoria, with the remainder spread across other national and international ambulance services. They were very experienced paramedics with 10 (71%) having 10 or more years of experience, and most (12 of 14; 86%) had completed some course work related to geriatrics as part of their training. On a Likert scale of 1 (not experienced) to 10 (very experienced), paramedics rated themselves highly, mean (SD) = 7.93 (1.07) (Table 1).

Quantitative Results

All participants (14 of 14; 100%) agreed or strongly agreed that older patients have needs beyond the physical. When asked whether they were able to meet the psychosocial needs of older patients, 10 (71%) disagreed. All paramedics (14 of 14; 100%) agreed or strongly agreed that they would like to do more for older patients (Table 2).

Qualitative Results

The focus group discussions revealed themes which have been grouped under 4 headings. Due to the anonymous nature of the questionnaires and focus groups, where direct quotes are included, participants were identified by participant number only.

Psychosocial care and support issues. Older patients often require care and support in one, or a combination, of categories: physical, psychological, social, and emotional. Examples of psychosocial issues paramedics have encountered include loneliness, anxiety, fear, grief, depression, neglect, abuse, self-care issues, care of pets, loss of confidence, and lack of social and support networks. They also indicated that these issues were rarely in isolation and straightforward, but were often coupled with broader longer term physical health and social support issues.

> . . . acute case of grief and loss. (P10)

> . . . extreme isolation where they literally have nobody, no family, no services . . . and they call us for a reasonably minor issue . . . (P2)

> . . . started as a physical condition that developed into an emotional anxiety . . . (P5)

> . . . loneliness . . . just wanted to sit down and have a cup of tea. (P1)

Addressing psychosocial issues. Paramedics spoke about what they can do for these psychosocial issues, such as transport, referral, contact services and/or family directly, handover details to other health care professionals, and provide assistance with the current minor physical issue. They also described the importance and value of the "small stuff." A caring demeanor, touch on the hand/shoulder, cup of tea, and taking time to listen can all have a great therapeutic effect. The consensus, however, was that they were rarely able to fully address a patient's psychosocial issues.

> . . . if they just need a bit more support, and then you change a few things, or get someone out to change the way something happens so she can manage on her own . . . (P4)

> . . . being nice to people, being compassionate and holding nanna's hand . . . (P2)

> . . . they are in a vulnerable state that such little caring things . . . had much more of a therapeutic effect . . . (P11)

Barriers to addressing psychosocial issues. Paramedics said they would often like to do more; however, given the often complex, multifactorial, and long-term nature of these issues, they did not have the time, knowledge, or resources necessary.

They all admitted to taking patients to hospital when it was most probably not required, due to duty of care and a lack of alternatives. They also suggested that a percentage of paramedics, particularly those with less experience, may not actually recognize these issues due to their focus on somatic conditions. Another interesting finding was the issue of compassion fatigue, with some paramedics unable to invest as much emotionally of themselves anymore. Therefore, to protect themselves, they do not delve into such issues when assessing patients.

> . . . issues are normally far bigger . . . I don't have the capacity to fix that in one sitting . . . (P3)

> . . . are focused on the acute emergency and they have not recognised that there is actually more going on . . . (P10)

> . . . I am compassion fatigued, call it burn out, call it survival . . . (P8)

Solutions. Paramedics suggested that the solutions to resolving the barriers to addressing psychosocial needs were education and resources. Paramedics need to be better educated about the psychosocial issues facing older people and the resources available to assist them. More resources and better access to them, particularly out of hours, were also highlighted. Examples discussed were extended care paramedic roles, referral services, and resource cards with relevant referral contact numbers.

> . . . organisational support . . . low acuity pathway . . . protocol . . . algorithm . . . when and how you leave people at home . . . (P6)

> . . . knowing what options you have available . . . (P10)

> . . . a matrix . . . what each hospital has in terms of services . . . what's in your local area . . . (P14)

> . . . a learning package . . . for the service. (P3)

> . . . humanise so they no longer become the old person . . . (P5)

Discussion

The results suggest that paramedics recognize there is a wide array of psychosocial issues affecting older patients. They also recognize that these issues are complex and often beyond what they can achieve within the confines of their role; however, they would like to do more and feel education and greater resources are needed.

In relation to recognition of psychosocial issues among older patients, there appear to be 3 types of paramedics: those who do, those who do not, and those who do not want to. Those who do recognize psychosocial issues tend to be more experienced and pick up on environmental cues as well as ask pertinent questions of the patient. This is because they have a greater understanding of the biopsychosocial model of care due to experience and understand the benefit of addressing broader issues beyond somatic complaints.[19] The focus group participants, who were all relatively experienced paramedics, felt that those with less experience are often so focused on the clinical findings and somatic conditions that they overlook the psychosocial cues and line of questioning.[5] As paramedics become more familiar and confident assessing and managing patients, they will be more likely to explore beyond the physical and obvious findings. There is also a suggestion that novice paramedics, who are generally in their early 20s, lack understanding, and the ability to communicate effectively with older patients.[20] Finally, providing care and compassion to patients in crisis on a daily basis can take an emotional and psychological toll on paramedics.[21] This can lead to some paramedics experiencing compassion fatigue and choosing consciously, or subconsciously, to not emotionally invest themselves into the complex psychosocial issues of patients as a self-protective mechanism.[21]

All participants agreed the psychosocial issues affecting older patients are complex in nature and are often intertwined with physical ailments. The biopsychosocial model of care attests to the fact that these facets are linked and impact each other and the patient as a whole.[19]

Social determinants of health can include socioeconomic status, physical environment, living conditions, family and social networks, lifestyle, and behavior.[22] Paramedics are uniquely placed to see people in their environment and recognize and investigate social determinants of health.[17] While it is important for paramedics to investigate and consider such social issues, they are often complex, multifactorial, and can be long term. All focus group participants agreed that they would like to do more for these problems but felt hamstrung by lack of expertise, resources, and time available on an emergency call.

Perhaps where paramedics can have greater impact in a shorter time frame is on the psychological and emotional factors affecting the patient's physical condition. Compassionate care and reassurance can reduce stress and anxiety and have a positive effect on physiological parameters such as heart rate, respiratory rate, and pain.[23-26] The focus group participants discussed that small things such as touch, tone of voice, posture, listening, showing empathy, and providing a confident knowledgeable approach can all greatly impact the patient's condition and overall well-being. Conversely, providing definitive treatment for physical symptoms can alleviate or lessen psychological symptoms such as fear and anxiety.[27] Paramedics practicing holistic care can therefore provide better quality of care than those solely focused on the biomedical model of care.[28]

Paramedics are aware of the barriers to addressing some psychosocial issues and have considered solutions to address such barriers. One such solution was greater education not only in the undergraduate setting but also for qualified paramedics through professional development. They were highly

supportive of initiatives that "humanize" older people, which help novice paramedics see older patients as "people" rather than ailments. You will often hear paramedics and other health care professionals handover a patient with a statement similar to this: "This is a 72yo male with chest pain" rather than "This is Mr Francis. He is 72yo and is currently suffering from chest pain. He is also very anxious and distressed due to losing his wife to cancer earlier this year." A name, and one extra sentence, humanizes this patient leading to greater exploration and care regarding his emotional, psychological, and social needs, in addition to the physical. Participants suggested education including aged care placements, community placements and volunteering; any opportunity for students to have more interaction with older patients. The literature also supports that educational interventions involving direct contact with real, independently living older people are the most effective way to improve student attitudes and behavior toward older people.[29]

In addition to education of paramedics, the participants also suggested more resources need to be made available to be able to address these issues. Several Australian and international ambulance services employ extended care or community paramedics who are able to provide greater in community assessment, treatment, referral, and support.[30] These roles allow paramedics greater time and scope of practice to manage patients in their homes as opposed to transporting to hospital. Referral services which provide a more suitable alternative to paramedic attendance or transport are also expanding.[31]

A final suggestion was the development of a resource card for paramedics who are often unaware of what other services are available. Support services have been shown to help older adults remain in their own environment and maintain a higher quality of life for longer.[32] Resource cards could include contacts for local services that provide geriatric assessments, home help, meals on wheels, etc. Depending on the situation, paramedics could contact the services on the patient's behalf or leave relevant details with the patient or family for them to contact. Patients with psychosocial issues not requiring transport to hospital could therefore be cared for and supported in their own environment.

Limitations

This study was limited by the participants all being relatively experienced and sharing similar views, while less experienced paramedics could have varying views. In addition there was potential selection bias with paramedics attending the conference likely to be more professionally aware, reflective, and up to date with contemporary issues.

Conclusion

Paramedics are in a unique position to observe and assess patients in their normal environments and gather firsthand information about determinants of the patient's health. Paying due attention to the biopsychosocial issues assists paramedics to assess and treat patients holistically and provide the best quality of care. More education is required to increase paramedic awareness of psychosocial issues and the impact these have on chronic health conditions and emotional well-being. Awareness of resources and support services available to older patients would also be valuable to paramedics to avoid unnecessarily transporting some patients to hospital.

Acknowledgments

The authors acknowledge and thank the paramedic participants for their time and candor.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

References

1. Australian Bureau of Statistics. Population by age and sex, Australia, states and territories. http://www.abs.gov.au/ausstats/abs@.nsf/0/1CD2B1952AFC5E7ACA257298000F2E76?OpenDocument. Published December 2016. Accessed January 6, 2017.
2. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet*. 2012;380(9836):37-43. doi:10.1016/S0140-6736(12)60240-2.
3. Lowthian JA, Cameron PA, Stoelwinder JU, et al. Increasing utilisation of emergency ambulances. *Aust Health Rev*. 2011;35(1):63-69. doi:10.1071/AH09866.
4. Platts-Mills TF, Leacock B, Cabañas JG, Shofer FS, McLean SA. Emergency medical services use by the elderly: analysis of a statewide database. *Prehosp Emerg Care*. 2010;14(3):329-333. doi:10.3109/10903127.2010.481759.
5. Ross L, Jennings PA, Smith K, Williams B. Paramedic attendance to older patients in Australia, and the prevalence and implications of psychosocial issues. *Prehosp Emerg Care*. 2016;21(1):32-38. doi:10.1080/10903127.2016.1204037.
6. Werth JL Jr, Gordon JR, Johnson RR Jr. Psychosocial issues near the end of life. *Aging Ment Health*. 2002;6(4):402-412. doi:10.1080/1360786021000007027.
7. Brady M. Pre-hospital psychosocial care: changing attitudes. *J Paramed Pract*. 2012;4(9):516-525. doi:10.12968/jpar.2012.4.9.516.
8. Everson-Rose SA, Lewis TT. Psychosocial factors and cardiovascular diseases. *Annu Rev Pub Health*. 2005;26:469-500. doi:10.1146/annurev.publhealth.26.021304.144542.
9. Willis L, Goodwin J, Lee K-O, et al. Impact of psychosocial factors on health outcomes in the elderly. A prospective study. *J Aging Health*. 1997;9(3):396-414. doi:10.1177/089826439700900307.

10. Bisschop MI, Kriegsman DM, Deeg DJ, Beekman AT, van Tilburg W. The longitudinal relation between chronic diseases and depression in older persons in the community: the Longitudinal Aging Study Amsterdam. *J Clin Epidemiol*. 2004;57(2):187-194. doi:10.1016/j.jclinepi.2003.01.001
11. Bruce ML. Psychosocial risk factors for depressive disorders in late life. *Biol Psychiatry*. 2002;52(3):175-184.doi:10.1016/S0006-3223(02)01410-5.
12. Pronk M, Deeg DJ, Smits C, et al. Hearing loss in older persons: does the rate of decline affect psychosocial health? *J Aging Health*. 2014;26(5):703-723. doi:10.1177/0898264314529329.
13. Kramer SE, Kapteyn TS, Kuik DJ, Deeg DJ. The association of hearing impairment and chronic diseases with psychosocial health status in older age. *J Aging Health*. 2002;14(1):122-137. doi:10.1177/089826430201400107.
14. Murray J, Banerjee S, Byng R, Tylee A, Bhugra D, Macdonald A. Primary care professionals' perceptions of depression in older people: a qualitative study. *Soc Sci Med*. 2006;63(5):1363-1373. doi:10.1016/j.socscimed.2006.03.037.
15. Odell S, Surtees P, Wainwright N, Commander M, Sashidharan S. Determinants of general practitioner recognition of psychological problems in a multi-ethnic inner-city health district. *Br J Psychiatry*. 1997;171(6):537-541. doi:10.1192/bjp.171.6.537.
16. Burroughs H, Lovell K, Morley M, Baldwin R, Burns A, Chew-Graham C. "Justifiable depression": how primary care professionals and patients view late-life depression? A qualitative study. *Fam Pract*. 2006;23(3):369-377. doi:10.1093/fampra/cmi115.
17. Blaber A. *Foundations for Paramedic Practice: A Theoretical Perspective*. London, England: McGraw-Hill Education; 2012.
18. Braun V, Clarke V. Using thematic analysis in psychology. *Qual Res Psychol*. 2006;3(2):77-101. doi:10.1191/1478088706qp063oa.
19. Engel GL. The need for a new medical model: a challenge for biomedicine. *Holistic Med*. 1989;4(1):37-53. doi:10.3109/13561828909043606.
20. Lazarsfeld-Jenson A. Starting young: the challenge of developing graduates' road readiness. *Journal of Paramedic Practice*. 2010;2(8):368-372. doi:10.12968/jpar.2010.2.8.78011.
21. Newsom R. Compassion fatigue: nothing left to give. *Nurs Manage*.2010;41(4):42-45.doi:10.1097/01.NUMA.0000370878.55842.e7.
22. Marmot M, Friel S, Bell R, Houweling TA, Taylor S. Closing the gap in a generation: health equity through action on the social determinants of health. *Lancet*. 2008;372(9650):1661-1669. doi:10.1080/17441692.2010.514617.
23. Gregory S, Verdouw J. Therapeutic touch: its application for residents in aged care. *Aust Nurs J*. 2005;12(7):23-25.
24. VanItallie TB. Stress: a risk factor for serious illness. *Metabolism*. 2002;51(6):40-45. doi:10.1053/meta.2002.33191.
25. McCraty R, Barrios-Choplin B, Rozman D, Atkinson M, Watkins AD. The impact of a new emotional self-management program on stress, emotions, heart rate variability, DHEA and cortisol. *Integr Psychol Behav Sci*. 1998;33(2):151-170. doi:10.1007/BF02688660.
26. Rein G, Atkinson M, McCraty R. The physiological and psychological effects of compassion and anger. *J Adv Med*. 1995;8(2):87-105.
27. Firth-Cozens J, Cornwell J. Enabling compassionate care in acute hospital settings. https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/poc-enabling-compassionate-care-hospital-settings-apr09.pdf. Published 2009. Accessed January 11, 2017.
28. Di Blasi Z, Harkness E, Ernst E, Georgiou A, Kleijnen J. Influence of context effects on health outcomes: a systematic review. *Lancet*. 2001;357(9258):757-762. doi:10.1016/S0140-6736(00)04169-6.
29. Ross L, Jennings P, Williams B. Improving health care student attitudes toward older adults through educational interventions: a systematic review. *Gerontol Geriatr Educ*. 2017;1-21. doi:10.1080/02701960.2016.1267641.
30. Blacker N, Pearson L, Walker T, eds. *Redesigning paramedic models of care to meet rural and remote community needs*. 10th National Rural Health Conference; May 17-20, 2009; Cairns, Australia.
31. Jensen JL, Carter AJ, Rose J, et al. Alternatives to traditional EMS dispatch and transport: a scoping review of reported outcomes. *Canadian Journal of Emergency Medicine*. 2015;17(5):532-550. doi:10.1017/cem.2014.59.
32. Chen Y-M, Thompson EA. Understanding factors that influence success of home-and community-based services in keeping older adults in community settings. *J Aging Health*. 2010;22(3):267-291. doi:10.1177/0898264309356593.