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COMMENTARY

More evidence for problem-solving therapy: improving access is still a problem in need of solving

Problem-solving therapy (PST) already has a large body of evidence for use in older adults, for a variety of conditions, but particularly for either treating depression or preventing it in those at higher risk (e.g. following stroke, in those who are homebound or have chronic medical problems) (Choi *et al.*, 2020; Gellis *et al.*, 2014; Robinson *et al.*, 2008). PST teaches a step-by-step approach to solving problems and coping more effectively – depression improves as individuals shift toward a more problem-oriented (vs. avoidant) approach and feel less overwhelmed, frustrated, and helpless (Nezu *et al.*, 2013).

PST is simpler in principal and practice compared to other common psychotherapies, such as Cognitive Behaviour Therapy (CBT) or psychodynamic therapy, and therein lies, at least in part, its appeal. It is also time-limited (usually 6–8 sessions), can be provided by a variety of healthcare professionals after relatively brief training, and is readily adaptable to many settings and delivery methods. Importantly, in patients with mild cognitive impairment, executive dysfunction, or disability, in whom few psychological therapies have been validated, PST has shown benefits (Kirkham *et al.*, 2016). This has likely contributed to PST's increasing popularity in geriatric psychiatry research and clinical practice, since these conditions are common and can be reasons for exclusion from psychological interventions and programs. Quality of life and disability-related outcomes are often included in PST trials (Kirkham *et al.*, 2016) and also likely factor into PST's appeal, because these may be as relevant to both patients and providers as reducing depressive symptoms in old age.

The study reported by Beaudreau *et al.* (2021) adds to the growing body of evidence for PST for depression in older adults (though this study did not include older adults exclusively, the majority of the study population was >60 years of age). The authors describe significant improvements in depressive symptom scores, quality of life, and problem-solving ability in the sample of 199 homebound Veterans after a 6-session PST-based intervention. The intervention was delivered mostly by psychologists as part of home-based care for those with chronic disability due to physical or neurological conditions. The study highlights some of the reasons why PST is well suited to older adults: like in other studies of PST, PST concepts were applied in a flexible approach that included adaptations, if needed. Material was tailored to Veterans' problems, more sessions were offered if required, and participants had the option of including a family member or caregiver. Almost half of those with clinically significant depression at baseline (PHQ-9 > 10) no longer had clinically significant scores at posttreatment. Given that older adults are at double the risk of suicide compared to the general population (Alexopoulos, 2005), and the risk is even higher among Veterans (U.S. Department of Veteran's Affairs), the study's finding that suicidal ideation resolved in a similar proportion at posttreatment is especially important.

This flexible approach makes such an intervention a promising option for wider-scale implementation among Veterans' healthcare services. Even so, such an intervention is still likely only to reach a small portion of up to 16% of all older adults who have clinically significant depressive symptoms (Blazer, 2003). Participants in this study were fortunate to have access to a multidisciplinary team including integrated mental health professionals through the Veterans Health Administration (VHA). These resources, while probably insufficient to meet all the mental health needs of the VHA population, are much greater than what is available to a typical homebound older adult with mental health problems. This underscores an important issue with respect to PST or any psychological treatments: despite its benefits, many older adults' preference for psychosocial treatments, and guideline recommendations that psychotherapy be offered to most (American Psychological Association, 2019; Canadian Coalition for Senior's Mental Health, 2006), very few receive it (Olfson *et al.*, 2016). This no doubt contributes to the widespread and persistent undertreatment of geriatric depression.

Depressed older adults face many barriers to treatment with psychotherapy – the factors that put older adults at higher risk for depression, including social isolation, disability, and chronic physical illness, can also be those that may make accessing

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mental health care more difficult (Canadian Coalition for Senior's Mental Health, 2006). Incorrect beliefs that older adults are more rigid and less amenable to change also contribute to its underutilization (Wuthrich and Frei, 2015). And, last but not certainly not least, the COVID-19 pandemic has disproportionately impacted older people, creating many more challenges than usual in accessing healthcare. An in-person intervention as in Beaudreau *et al.*'s study, involving multiple care providers, would be more challenging if not impossible now. If there is any silver lining to the pandemic, it might be the rapid shift toward virtual and telehealth care, and the increasing acceptance of both by older patients and providers that will likely outlast the pandemic. Such novel delivery methods stand to improve access to mental healthcare for those older adults who are most difficult to reach, such as those who are homebound or lack transportation. PST is well suited to remote delivery and has been successfully provided by home-based videoconferencing, in which effects were comparable to in-person PST (Choi *et al.*, 2014) and by telephone (Gellis *et al.*, 2014).

The next step to enhance dissemination of this and other promising psychological treatment programs may be to consider further adaptation to an online format. Internet-delivered psychotherapy is emerging as an alternative to traditional in-person treatment that may overcome some common barriers to access. Online psychotherapy has large effect sizes (Andersson *et al.*, 2019), is cost-effective, and results in high treatment satisfaction (Musiat and Tarrier, 2014). Internet-delivered psychotherapy typically mirrors in-person therapy in content and duration and includes treatment modules, homework, and access to supplementary resources. It is more effective when accompanied by therapist guidance and feedback, either in real-time (e.g. by online chat) or, more commonly, asynchronously via email and online messaging (Andersson, 2016). Minimal therapist time is required (~10 minutes per patient per week) (Andersson *et al.*, 2019) making online psychotherapy a readily scalable option without the addition of extensive resources.

Although very few internet-based interventions have employed PST (a vast majority of internet-delivered psychotherapy is based on CBT), internet-delivered psychotherapy can be effective for older adults. For example, a large (>500 participants) trial of internet-based CBT for older adults found a significant 58% improvement in depressive symptoms at posttreatment compared to baseline (effect size 1.4), and effects were maintained at 3-month follow-up (Staples *et al.*, 2016). Not surprisingly, this trial took place in Australia, which has embraced digital treatment within a national e-Mental Health Strategy that focuses on complementing, not replacing, existing face-to-face services with online mental healthcare.

Age does not appear to impact response to internet-delivered psychotherapy in trials of mixed age populations (Andersson, 2016). Nonetheless, relatively few studies have focused on older adults specifically, perhaps due to a perception that older adults are not active users of technology. On the contrary, they represent a rapidly growing group of internet users: almost 70% of seniors in the U.S. use the internet, a majority of them daily, and rates of internet use among older adults have increased by 55% in the last two decades (Pew Research Center, 2017). Accordingly, internet-delivered psychotherapy has great potential for the treatment of depression in older adults – older adults should not be excluded from, and possibly even be targeted for, digital interventions. Still, there is a need for studies to examine internet-delivered psychotherapy specifically for older adults. As with other treatments, the evidence and approach used in younger populations cannot simply be extended to older people. For one, aging-related changes can impact interactions with technology that may necessitate digital design adaptations (e.g. maximizing screen contrast and larger font sizes (Czaja, 1997)). And, any internet-delivered therapy will likely require changes to psychotherapy process similar to those used in-person therapy with older adults. Although it is a promising avenue by which to improve access to psychotherapy, since adoption of technology among older adults is driven by younger, more educated seniors and those in higher socioeconomic classes (Pew Research Center, 2017), accessibility will still be an issue for many.

Even with novel approaches to psychotherapy delivery with the potential for widespread scaling, psychotherapy being readily available for most depressed older adults is a long ways off. Improving access to psychotherapy will require pragmatic approaches that focus not only on effectiveness but also on feasibility in real-world settings. The inclusion of such implementation outcomes in Beaudreau *et al.* is welcomed by clinicians and healthcare administrators seeking depression treatment options that are applicable and sustainable in real-world settings. For example, the use of a general but not firm cognitive cut-off for participation aligns with clinical practice in which clinician judgment, and not cognitive testing, is often a better predictor of the nuances of who is able to participate in or benefit from psychotherapy. That over half of the participants included a family or caregiver "coach" and described it as helpful speaks to the need for such practical modifications to psychotherapy interventions for geriatric populations. Incorporating

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clinician and patient feedback in this way allows for learning what aspects of interventions are most useful or could be improved and informs future scaling in a way that randomized controlled trials do not.

Finally, focusing on interventions that can be readily integrated in primary care, where a majority of older adults with depression are seen, will also be key to improving access to psychotherapy or treatment in general for geriatric depression. And, not discussed here but certainly relevant are the many hurdles related to limited availability of a skilled workforce and systemic factors impacting cost of and funding for psychotherapy. Time-limited therapies such as PST and novel delivery methods may be cost-effective but will still require substantial investment of funding and resources. Considering the costs of undertreatment of older adults with depression, including much higher use of medical services, worse outcomes from comorbid illness, and the impact on family and caregivers, it is likely a relatively small price to pay.

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