The Beverly Hospital/ Applied Gerontology Institute Caregiver Support Training Program Valentine M. Villa, Ph.D. (PI) Anh-Luu Huynh-Hohnbaum, Ph.D. (Co-PI) January 8, 2007

Executive Summary

The intent of this program is to improve the health and well-being of persons providing care for individuals with chronic illnesses through a Caregiver Support/Training Program. Beverly Hospital and the Applied Gerontology Institute at California State University, Los Angeles with funding from the UniHealth Foundation have developed, implemented, and evaluated a comprehensive caregiver training program for family caregivers with direct charge of patients. The model is adapted from the "Coping with Caregiving" model developed and tested by Gallagher- Thompson and her associates as part of the multi-site study: REACH. During Years 1 and 2 of the project, the Caregiver Support Training Program was administered to 199 participants residing in the Beverly Hospital service area.

An extensive outreach strategy was developed to recruit participants and inform the community about the training program. Activities and materials developed for the project outreach campaign included the establishment of the project 800 number (1-800 – 884-1443) at the Applied Gerontology Institute. Project staff identified and complied a mailing list of over 400 service agencies, organizations, health care providers, hospitals, medial offices, senior centers, clinics, adult day care centers, churches, educational and social service network. A mass mailing was conducted to sources on the list providing them a recruitment letter, flyers and intake forms. This activity resulted in 199 participants being recruited to the Caregiver Support Training Program.

The program was modified by the project staff with advice of the advisory board and family caregivers to include eight rather than ten training sessions. Two of the training sessions were condensed and the content material was "piggybacked" onto another session. The curriculum was further modified by beginning with a psycho-educational session followed by skills training and ending with psycho-educational instruction rather than starting with skills training. The advisory board and caregivers felt that this sequencing would better hold the participants interests. This program builds upon previous caregiver intervention research developed by Dolores Gallagher-Thompson at Stanford University by developing and implementing a multifaceted culturally sensitive curriculum modeled on the traditional support model and a psycho-educational program.

There were 199 participants recruited to the support/training program, with the majority being female (84.43%), Hispanic (63.82%), and married (52.76%). The average age of the participants was 54.40 years old. Asian Americans made up the next largest group (18.09%), followed by Caucasians (14.57%), and there was two percent African Americans. Approximately one third of the participants were single. The majority spoke English as their primary language at home (57.79%) and almost one third spoke Spanish

(27.14%). All of the Asian languages were combined, and about 15% of the participants' predominant language at home was an Asian language. A slight majority was born in the US (52.76%) and the mean number of years in the U.S. was 47.24. With respect to education, approximately one third were on each end of the spectrum with less than 8 years of education and a college degree or more, with a slightly larger percentage (35.67%) in the former group. As for annual income, the majority made between \$10,000-\$24,999 (31.66%), with the least amount making between \$40,000-%54,999 (14.07%).

Depressive symptomatology was assessed using the Center for Epidemiological Studies Depression (CES-D) scale, which is designed to measure the current level of depressive symptoms in the general population ({ HYPERLINK "http://gerontologist.gerontologyjournals.org/cgi/content/full/43/6/817" \l "GRNT-43-05-09-RADLOFF1#GRNT-43-05-09-RADLOFF1" }). Whereas a formal diagnosis for depression requires a clinical examination, the self-reported CES-D emphasizes subjective and affective elements of depressive symptoms ({ HYPERLINK "http://gerontologist.gerontologyjournals.org/cgi/content/full/43/6/817" \l "GRNT-43-05-09-MCDOWELL1#GRNT-43-05-09-MCDOWELL1" }). The response categories were "rarely or none of the time (less than 1 day)," "some or a little of the time (1-2 days)," "occasional or a moderate amount of the time (3-4 days)," and "most or all of the time (5-7 days)," coded 0 through 3, respectively. Items 4, 8, 12 and 16 are reverse coded. An overall score was obtained by adding the items, producing a scale that ranges from 0 (least depressed) to 60 (most depressed). Researchers (Blazer & Hybels, 2004; Moskowitz, 2003; Sheehan, Fifield, Reisine, & Tennen, 1995) performing a factor analysis of the 20-item scale have identified four factors: negative affect: seven items (could not shake the blues, felt depressed, thought life was a failure, felt fearful, felt lonely, had crying spells, and felt sad), positive affect: four items (felt as good as other people, felt hopeful about the future, felt happy, and enjoyed life), somatic complaints: seven items (bothered by things, appetite poor, trouble concentrating, felt everything an effort, sleep restless, talked less than usual, and could not get going), and interpersonal problems: two items (people were unfriendly and felt people disliked me). The scale had a high internal consistency; the Cronbach's alpha for this study was .87.

Caregiving burden was measured using the Caregiver Burden Scale (Zarit *et al.*, 1980), a 22-item self report Likert-type inventory. This is a commonly used scale in the literature to assess caregiver burden (Pinquart & Sorenson, 2006). The scale covers the areas most often mentioned by caregivers as problems. These include caregivers' health, psychological well-being, finances, social life and the relationship shared by the caregiver and care recipient. Item responses range from 'never' (0) to 'nearly always' (4). Scores from 21 to 40 represent little or no burden, while scores from 41 to 60 represent feelings of moderate to severe burden. Reported reliability for the scale is high with coefficient alphas in the 0.90s (Thompson *et al.*, 1993; McConaghy & Caltabiano, 2005) and split half reliability of 0.92 (Smith, 1996). Cronbach's alpha coefficient for the current study was 0.92, demonstrating a strong internal consistency.

A paired samples t-test was used to examine if the Caregiver Support/Training Program produced an effect by lowering participants' level of depression (i.e. the CES-D and its subscales) and their degree of caregiver burden (i.e. ZBI). The pre- and post- test means and standard deviations for the CES-D and its subscales and the ZBI are presented in Table 2. Overall, results indicate at least a moderate level of success for this program. The prediction that participants would have greater well-being after the intervention was supported in terms of depression. Results revealed a statistically significant difference such that participants had a lower level of depression after participating in the Caregiver Support/Training Program, t (198) = 2.00, p = 0.047. With respect to the subscales, only Positive Affect showed statistically significant differences between the pre and post test level, t (198) = 2.23, p=0.027. There were no significant differences with respect to caregiver burden, which was measured by the ZBI. It is important to note that the dropout rate was low (under 10%) suggesting that caregivers were deriving some benefit from the program and the average attendance was 6 sessions out an 8 week class.

Taken together, the Beverly Hospital/Applied Gerontology Institute Caregiver Support Training project was highly successful. An advisory board was assembled and convened and a multiprong recruitment strategy was developed and implemented. The curriculum was modified such that it was culturally competent and meshed with the needs of the Beverly Hospital Service area population. These activities resulted in the recruitment of 199 participants that completed the training. The measurement of participants depression and burden utilizing the CESD depression scale and the Zarit burden Index, find that indeed levels of depression and burden improved among participants after completion of the eight week program. Year 2 of the project included the nine in-service training sessions for hospital staff. The results of the in-service training program find that hospital staff were more knowledgeable about aging, organizational, cultural, and caregiving issues after completing the program. The primary suggestion for further activity centered on offering the program in multiple languages, primarily Spanish.