APS Australian Psychological Society

Submission to the Royal Commission into Aged Care Quality and Safety

Australian Psychological Society | **Submission, September 2019**

psychology.org.au

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future, for they hold the dreams of Indigenous Australia.

Table of Contents

About the APS

The Australian Psychological Society (APS) is the premier professional association for psychologists in Australia, representing more than 24,000 members.

Psychology is a discipline that systematically addresses the many facets of human experience and functioning at individual, family and societal levels. Psychology covers many highly specialised areas, but all psychologists share foundational training in human development and the constructs of healthy functioning. While working across the entire lifespan, psychologists can make specific contributions to the older population in relation to their holistic health which includes a persons' physical, emotional, cognitive, social and spiritual wellbeing.

Psychologists represent the largest mental health workforce in Australia and have expertise in the assessment and treatment of mental health disorders, including anxiety and depression which are prevalent amongst older Australians, particularly those in residential aged care facilities (RACFs). Grief and loss, and adjustment to change are also prominent issues faced as we age. Of particular relevance to older Australians, clinical neuropsychologists and geropsychologists provide assessment of and treatment for people experiencing difficulties with memory, learning, attention, language, reading, problem-solving, decision-making or other aspects of behaviour and thinking abilities.

A key goal of the APS is to actively contribute psychological knowledge for the promotion and enhancement of community wellbeing. The APS regularly consults with psychologists, consumers of psychological services, communities and organisations, to best understand the psychological needs of the Australian population and to identify and address the individual, family and systemic issues that contribute to social problems, and to find better ways of addressing such problems.

The APS has a proud history of working in collaboration with Australian Government departments and other organisations in the successful delivery of policies and programs aimed at improving the health outcomes of Australians.

Executive summary

Increased input from psychological science, not least through the psychological profession, into Australia's aged care system has the potential to make a significant difference to the lives of older people, their families, and the professionals who care for them.

The broadening of perspectives that this would represent, in terms of opening up different approaches to addressing the care needs of older people, holds real promise for improving quality of life for older people; increasing the job satisfaction of aged care workers and bringing comfort to the families of older people requiring care. Aged care providers would benefit from access to a broader range of 'tools' with which to discharge their important mission.

Reducing reliance on pharmaceutical measures and other restrictive practices for addressing behavioural issues is but one example of this potential. Other potential opportunities are outlined throughout this submission and summarised in our recommendations.

Our recommendations emphasise:

- The effectiveness of psychological interventions
- Their importance in assessing and addressing the mental health of older people
- The importance of effective assessment of older people's decision-making capacity
- Increasing access to psychological services for people living in aged care facilities
- The need for behavioural interventions which avoid or minimise restraint
- Enabling other clinicians and care providers to obtain the input of psychologists
- The negative impact on older people and their loved ones of long waiting times for community care packages
- The important considerations for supporting older Aboriginal and Torres Strait Islander peoples in remote communities.

Increasing access to psychological services will not only improve the well-being of older people in the care system but also that of the staff and families who care for them. Such investment would be offset by reductions in expenditure on other care interventions such as pharmacological treatment and its sequelae.

APS Recommendations

Effectiveness and Delivery of Psychological Interventions

The Royal Commission recommend Government:

1. Implement measures to support timely access to evidence-based psychological assessment and interventions regardless of age or personal circumstances (e.g. geographical location, living arrangements etc.)
2. Recognise the impact of ageism on the existing aged care system and develop and implement a strategy which addresses the structural discrimination against older people.
3. Support strategies to address ageism including public awareness campaigns (e.g. EveryAGE Counts).
4. Ensure the aged care workforce has access to the appropriate education and training to be able to effectively identify, assess, manage or refer mental health issues as they arise.

Older Person's Self Determination and Decision-Making Capacity

The Royal Commission recommend that:

5. Government facilitate effective referral pathways to psychologists, particularly for complex decision-making capacity assessments.
6. Community health and RACFS establish funding for contracting of psychologists to conduct capacity assessments where in-house psychologists are not available.
7. Psychologists working within the aged care sector maintain knowledge and competencies in conducting competency assessments.

Clinical Assessment of Mental Health

The Royal Commission recommend:

8. Government promote psychometric assessments as a key criterion for clinical assessments of mental health as a basis for care, management and when required, treatment.
9. Government ensure clinical assessments of all new admissions to RACFs, in addition to other residents as appropriate, are conducted by appropriately trained mental health professionals.
10. Government develop and implement clear processes to ensure mental health issues in people residing in RACFs are identified early and escalated to the GP and mental health professional.
11. The use of appropriate tools administered by a mental health workforce to more accurately assess outcomes in older adults across government funded programs and interventions regardless of setting.

Delivery of Psychological Services in Residential Aged Care Settings

The Royal Commission recommend Government:

12. Rigorously evaluate the various service models identified by PHNs for the delivery of psychological services to RACFs to ensure that each PHN provides an adequate level of service delivery to meet consumer needs across their region. This approach to funding and service delivery may need to be revised depending on the results of the evaluation.
13. Enable people in RACFs to access all psychological services provided within Medicare's Better Access initiative.
14. Provide additional funding to RACFs to directly engage or employ psychologists to deliver psychological services to residents with mental health problems onsite and provide information about the benefits of psychological support to RACF staff, residents and families.
15. Support GPs and aged care providers to refer to psychologists for dementia support and education, and carer education and support.
16. Increase the available psychological workforce with expertise in aged care by investing in supervision of postgraduate psychology students within aged care services.

Restrictive Practices and Response Behaviours

The Royal Commission recommend Government:

17. Identify psychologists as approved health practitioners to conduct assessments aimed at a) reducing unhelpful response behaviours and the need for use of restrictive practices, and b) monitoring behaviours and interventions, as they are monitored in the disability sector.
18. Commission the formal and critical review of existing restrictive practices and the development of new policies and practices specifically for aged care settings.

Scarcity of Services in the Community

The Royal Commission recommend Government:

19. Invest more resources into community aged care to support people (and their carers) to stay in their own homes, if that is their preference, with timely and appropriate level of care.
20. Reinstate dementia-specific roles within Aged Care Assessment Teams to ensure appropriate assessment of people with dementia.

Aged Care in Remote and Indigenous Australia

The Royal Commission recommend Government:

21. Support access of older Aboriginal and Torres Strait Islander peoples to Aboriginal and Torres Strait Islander cultural advisors.
22. Support access of older Aboriginal and Torres Strait Islander peoples to tele-mental health, tele-geriatric services and tele-psychiatry to aid in addressing logistical and resource barriers for remote services.
23. Increase recruitment and retention of Aboriginal and Torres Strait Islander aged care assessors and workers (particularly males)
24. Support Aboriginal and Torres Strait Islander led and designed research, data collection and advocacy.
25. Improve and consistently provide ongoing cultural safety training, aged care assessment training, cultural advisors and carer support services particularly in remote aged care facilities.
26. Conduct a thorough consultation, implementation and systemic service change in collaboration with the Primary Health Networks and private aged care services to reduce human rights abuses and promote social and emotional wellbeing of Aboriginal and Torres Strait Islander Elders and their communities.
27. Provide specific support to help Aboriginal and Torres Strait Islander Elders stay on Country and embedded in their communities.

GP Education

The Royal Commission recommend Government:

28. Support access of GPs and other health professionals to education regarding cognitive screening, dementia, ageing in general and making appropriate referrals.
29. Commission the development of guidelines with recommendations for the minimum level of dementia-specific education and training for GPs and staff of RACFs.

Introduction

The Australian Psychological Society (APS) wholeheartedly welcomes the Royal Commission into Aged Care Quality and Safety, and is delighted to be able to contribute to the important work of the Commission to build a better system of care for older people.

The APS is committed to supporting the health and wellbeing of older Australians, and psychology has much to offer in the way of understanding what it means to age well. This includes generating an evidence base of psychological research which, for example, can be used to challenge stereotypes of ageing and inform best practice in aged care. At the heart of ageing well is the empowerment of older people themselves. Therefore it is essential that older people's perspectives are central to the work of the Royal Commission.

The APS encourages the Commissioners to acknowledge the role of the social determinants of health and mental health in their deliberations. The inequalities and discrimination faced by people (on the basis of factors such as gender, race, sexuality, income, housing, education, geographic location) across the life course has and continues to significantly impact on the health and wellbeing of older adults.[1] Marmot reported that inequalities reduce life expectancy, and as people grow older inequalities grow bigger. Furthermore social isolation is the biggest concern for the health of older people. So while evidence-based interventions at an individual level as well as equitable access to health services are important to support health and wellbeing, this needs to be complemented by interventions at the structural, political and environmental levels across the life course.

This submission will highlight the issues of most relevance to psychology and mental health, and in particular those issues that might not be addressed in other submissions. This will ensure that the expertise and experience of the psychology knowledge base and profession can inform the work of the Commission. Cross references to the Commission's Terms of Reference are provided.

The APS is aware of the recent, ongoing and necessary reforms to the aged care system particularly over the last decade. These reform processes offer the opportunity to better meet the psychological and mental health needs not only of older Australians, but also those of their families, informal and formal carers, staff and other health professionals. However, for these reforms to reach their full potential, ageism must be addressed. Ageism continues to permeate and influence every aspect of society, contributing to many of the pervasive injustices and substandard care that the Commission has been witness to in the last few months.

The APS is concerned that the appropriate identification and treatment of dementia, depression and anxiety amongst older Australians, particularly (but not only) in residential aged care, is not being sufficiently addressed in the existing aged care system, or in the current and proposed reforms. Unrecognised and poorly managed mental health conditions and conditions causing cognitive impairment contribute to:

- reduced quality of life
- an individual's distress and suffering
- poorer health outcomes for older Australians including increased risk for cognitive decline
- increased medication and health service use
- greater demands, stress and potential burnout for the aged care workforce
- physical abuse and vicarious trauma of the workforce
- higher health care and aged care costs.

The APS supports best practice and evidence-based assessment and interventions. Key issues highlighted in this submission include the use of restrictive practices, addressing the mental health needs of people living in residential aged care, older person's self-determination and assessment of decision-making capacity for the purposes of encouraging supported decision-making in those people with compromised capacity, access to services, including in rural and remote communities, and enhancing education of GPs.

The APS is also concerned about the mental health and wellbeing of the aged care workforce itself, which directly impacts on its capacity to care for aged care consumers. Having a strong and vibrant workforce culture, underpinned by core values of care and compassion, is essential to support some of the most vulnerable and deserving people in our community.

The APS welcomes the new Aged Care Quality Standards adopted in July 2019 and sees an important, and currently under-utilised, role for psychologists in ensuring the safety and quality of life for people using aged care services (See Appendix 1).

A Reference Group of members was convened to provide expert advice to inform the APS response to the Commission.

1 Mental Health and Wellbeing of Older Australians (Terms of Reference c)

Australia has an ageing population, with the proportion of people aged over 65 years in Australia growing each year. In 2016, 15% (3.7 million) of Australians were aged 65 and over and this is projected to grow steadily over the coming decades.[2]

While the majority (72% in 2014-15) of older Australians report their overall health as good, at a population level, ageing generally means more ill health.[3] For example, 25.2% of those aged 65-74 and 30.8% of those aged over 75 report their health as poor or fair[3] and

- 50.7% of older people are living with disability, with one in every four women (27.1%) and one in every five men (20.7%) aged 85 years and over having a psychosocial disability
- 87.2% have one or more long-term health conditions
- 6.5% have a mental or behavioural disorder as their main condition, with 2.8% reporting Dementia or Alzheimer's disease as their main long term health condition.[4]

Data from the 2007 Australian National Survey of Mental Health and Wellbeing suggest that around 3% of Australians aged 65-74 and around 2% of those aged 75-85 are likely to experience a depressive disorder in any year. Around 6% of those aged 65-74 and 4% of Australians aged 75-85 will experience an anxiety disorder. Other studies suggest 10 to 15% of older people experience depression and about 10% experience anxiety.[5, 6]

The rate of suicide is also high amongst older Australians aged 85 and over. In 2016, the standardised death rate from suicide for males aged 85 and over was the highest of any age group at 34 deaths per 100,000 people (compared to 11.7 across the whole population and 27.5 for males aged 30-34, the second highest).[7] However, these rates are likely to be an underestimate as the true incidence of suicide in older adults might not be fully captured by official statistics as suicide mortality data for this age group are frequently underreported.[8]

Dementia is now a highly prevalent health condition within the older population, with one in 10 Australians aged 65 years or above having dementia and three of every 10 persons aged 85 years and above.[9] Over the next 40 years, the number of Australians with probable dementia is projected to increase 2.75 fold from 413,106 adults living with dementia in Australia in 2017 to 1,100,890 by 2056.[9] Dementia disease burden is second only to cardiovascular disease burden in Australia. Dementia is the leading cause of death for Australian females, and the second leading cause of death (after ischaemic heart disease) in males.

The prevalence of mental health disorders and dementia is even greater amongst older Australians in RACFs:

- In 2016-2017, there were over 290,000 older adults residing in residential aged care facilities (RACFs), with the majority being a permanent resident.[10] This figure will rise with the growing number of older adults.
- Of those living in RACFs on 30 June 2018, 52% had dementia, 86% had at least one diagnosed mental health or behavioural condition, and 49% had a diagnosis of depression.[11]
- While research into the prevalence of anxiety disorders and symptoms of anxiety in RACFs is limited compared to that for depression, a recent systematic review found that 3.2–20% of residents were diagnosed with anxiety disorder, while up to 58.4% experienced clinically significant anxiety symptoms.[6]

Elder abuse is also a big concern. The prevalence of elder abuse in the community is between 2% and 16%.[12, 13] Unfortunately and unacceptably, a limitation of existing prevalence studies is that they do not include people living in institutional care or people with a cognitive impairment.[14] Compared with older people living in the community, people in RACFs may be particularly vulnerable to abuse and neglect, on account of being older and more frail, having higher rates of dementia, and higher rates of psychotropic medication use.[15, 16]

2 Effectiveness and Delivery of Psychological Interventions (Terms of Reference a, c)

The APS recognises the Australian Government's Stepped Care approach as central to mental health service delivery in Australia. The Department of Health defines stepped care as a "staged system comprising a hierarchy of interventions, from the least to the most intensive, matched to the individual's needs" (p.2).[17] Many people working within the aged care sector do not understand the role and skills of psychologists within this model as compared to other mental health workers. Psychologists, with their capacity to deliver evidence-based psychological treatment, can and do provide support to people at **all stages** and steps on this continuum (see Figure 1). While a range of mental health professionals can provide support at the less severe end of the spectrum and provide vital case management, they do not necessarily have the appropriate training and capacity to deliver evidence-based psychological treatment to people that need it. Inappropriate matching of skill levels with needs may compromise the delivery of sustainable, high quality and safe care. Furthermore, self-help resources and digital mental health services may not be appropriate for some older people.

Societal ageist attitudes also compromise high quality and safe care, and contribute to the low uptake of psychological services by older people. Prevailing attitudes of professionals and public alike are based on false beliefs that older people won't benefit from psychological interventions (they're too old and stuck in their ways), or that there's no point in wasting money (they're going to die soon anyway). Contrary to public belief, psychological interventions are effective for older people, significantly improve outcomes, and potentially reduce expenditure in the long term (e.g.[18]). In particular, early intervention can be more cost-effective than waiting until people become very distressed and require more intensive interventions down the track.

Best practice management of mental health disorders and dementia among older Australians involves appropriate and thorough assessment and non-pharmacological management of psychological problems as a first line treatment. There is also a body of evidence supporting the use of psychological approaches for other clinical conditions commonly experienced in later life, including the management of

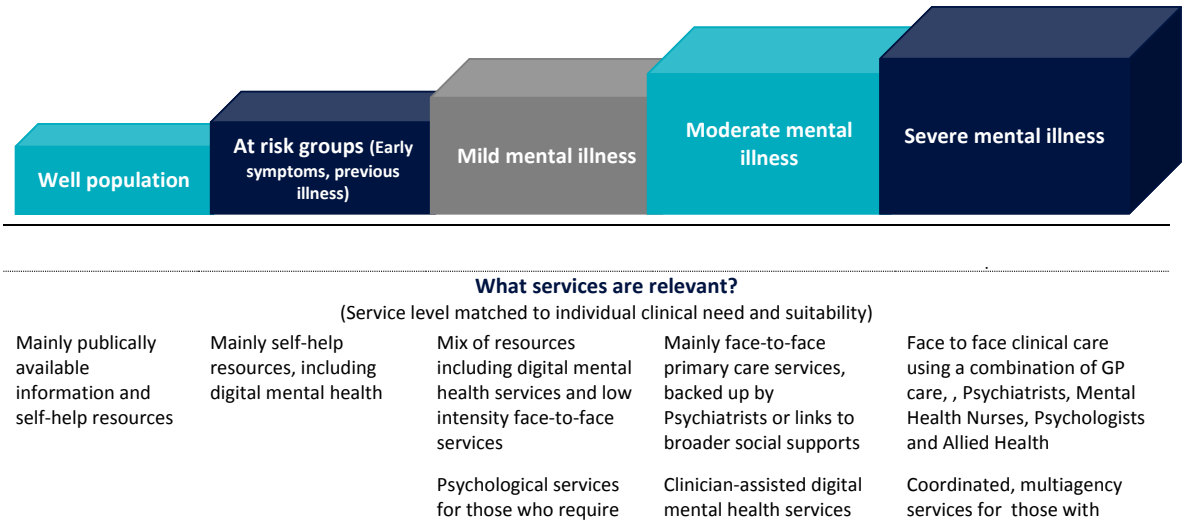

Figure 1. Stepped care model (adapted from Department of Health, n.d., p.3)

chronic pain, sleep disorders and treatment adherence for chronic medical conditions, as well as support for bereavement, and adjustments to functionality and living conditions (including moving to a RACF). All of these approaches can assist older people to maintain their independence to the greatest extent possible and enhance their overall wellbeing.

The evidence points to the effectiveness of psychological interventions for late-life depression, anxiety and dementia in community and residential settings.[19, 20] Interventions such as reminiscence therapies, behavioural activation, cognitive behavioural therapy, and mindfulness-based approaches have been proven to be beneficial via scientifically rigorous research. Systematic research has demonstrated that psychological approaches are effective in treating behavioural and psychological symptoms of dementia,[21] as well as reducing levels of staff stress and the number of medical consultations by visiting general practitioners.[22]

The quality of life for many residents in aged care facilities could also be greatly enhanced by reducing reliance on the pharmacological management of mental health problems and dementia and replacing it with more cost effective, evidence-based psychological and behavioural therapies. There are also significant financial and quality of life gains to be made from shifting the existing, predominately pharmacological, treatments currently being used to effective, psychological and behavioural interventions that do not incur the often harmful side effects seen with pharmacological treatments. Studies have demonstrated that the implementation of non-pharmacological interventions in RACFs can lead to reductions in antipsychotic use, and fewer visits by GPs or hospitalisations being.[23, 24]

Delivery of psychological services in RACFs will be addressed further in section 6. Ultimately though it would be better for many older people to defer entry to a RACF until all community-based options are exhausted – which at present are in insufficient supply.

Supporting the aged care workforce to identify early signs of mental illness

Mental health problems are prevalent among older Australians, but often go undetected and untreated. Aged care staff interact with older Australians on a regular basis and are well placed to notice changes in older people's mental health and wellbeing. However, frontline workers in the aged care sector need to be better informed about mental health problems among older Australians so that changes are recognised and acted upon, not dismissed as a normal sign of ageing. Staff also need to be equipped with information about appropriate referral pathways for further assessment and treatment and how to initiate a conversation with older people and their families about accessing help.

The lack of staff training in recognising mental health problems is not only a result of variable provision of ongoing professional education, but also the relatively low level qualifications required of the majority of aged care staff. Aged care staff are not skilled at identifying mental health issues in older people in RACFs and the community setting.

Recommendations

The Royal Commission recommend Government:

1. Implement measures to support timely access to evidence-based psychological assessment and interventions regardless of age or personal circumstances (e.g. geographical location, living arrangements etc.)
2. Recognise the impact of ageism on the existing aged care system and develop and implement a strategy which addresses the structural discrimination against older people.
3. Support strategies to address ageism including public awareness campaigns (e.g. EveryAGE Counts).
4. Ensure the aged care workforce has access to the appropriate education and training to be able to effectively identify, assess, manage or refer mental health issues as they arise.

3 Older Person's Self Determination and Decision-Making Capacity (Terms of Reference e)

Supporting older people's self determination is vital given pervasive societal ageist attitudes and structures, and the prevalence and risk for older people to be subject to abuse and injustice.

Maintaining self-determination is a basic human right that is important at any age, and for people of all abilities. The capacity to make your own decisions about personal, health care, lifestyle and legal matters is enshrined in law. Overturning the legal presumption of capacity does not depend on age, diagnosis or the making of bad decisions. Thus, having a diagnosis of dementia or a mental health condition does not mean that a person no longer has capacity to make decisions for themselves.

While definitions of the test for capacity differ from State to State in Australia, the core tests[25] include that the person can:

1. Understand the facts, choices and current circumstances involved
2. Weigh up the consequences of their decision; and
3. Communicate the decision.

However, these three tests must each be considered in the context of different matters:

- Time (e.g. the person is in an acute delirium vs a stable treatment phase)
- Domain (e.g. personal and health decisions including accommodation; financial decisions)
- Weight of Decision (e.g. to have a flu vaccination vs high risk surgery, or manage finances of $100 vs $100,000).

Scenarios that may trigger the need for an assessment of someone's decision-making capacity include:

- Presence of cognitive impairment or confused mental state, **and** the need to make an important or complex decision
- 'Red flags' of unusual behaviour changes or decisions (e.g. disinhibition, ceasing treatments, giving large sums of money away)
- Heightened concern by others for a person's safety
- Request for voluntary assisted dying (in Victoria) and when the medical practitioner is unsure about the person's decision-making capacity.

Once a trigger for a capacity assessment is identified, the legal necessity is to presume that the person can make their own decisions until evidence is gathered to the contrary. The ethical balance should be in favour of ensuring the person's right to self-determination whilst mitigating any risk within reason and, most importantly, within the context of that person's life values.

A person's capacity to make a decision on a particular matter is not always obvious, and brief interviews or cognitive screens are usually not sufficient to understand the person's decision-making ability relevant to the particular matter. Capacity assessments can be quite lengthy and should usually span two separate appointments to assess for consistency of understanding, reasoning and any undue influence. Given that capacity assessments are often triggered by heightened concern for safety, they often need to be conducted with some degree of urgency.

Decision-making capacity is a very complex area that spans legal and medical sectors ("medicolegal"). Due to these complexities, capacity assessments are by necessity conducted by a select few professions, classically medical doctors, specialists, lawyers and psychologists. Psychologists are in a unique position to conduct capacity assessments for several reasons. Psychologist's core skills include combining evidence-based assessments of cognition and behaviour, with the ability to differentiate between the impact of certain conditions (e.g. mental illness, dementia, delirium) on decision-making. Specifically, clinical neuropsychologists, forensic and geropsychologists are acknowledged for their skills in conducting capacity assessments for complex matters.

Clinical neuropsychologists and geropsychologists have the skills to differentiate between delirium, dementia and depression. This is important, because delirium, for example, is a common condition in older adults with medical illnesses and can adversely affect decision-making capacity.[26] Delirium is most prevalent in hospital settings and can easily go undetected. However, the presence of delirium does not automatically impair capacity. Likewise, mental illness does not mean a person lacks the capacity to make decisions (e.g.[27]).

While psychologists frequently take the lead for assessing capacity within health settings, the opinions and evidence from a range of professionals and family or other informants are sought for specific matters in question (e.g. financial, intimacy, request for voluntary assisted dying etc).

In summary, processes to support people to make their own decisions and be heard are fundamental

to ensure aged care services are person-centred. Psychologists' skills are critical for assessing and documenting if a person can make complex decisions, or, if a substitute or supported decision maker may be required for a specific matter.

Recommendations

The Royal Commission recommend that:

5. Government facilitate effective referral pathways to psychologists, particularly for complex decision-making capacity assessments.
6. Community health and RACFS establish funding for contracting of psychologists to conduct capacity assessments where in-house psychologists are not available.
7. Psychologists working within the aged care sector maintain knowledge and competencies in conducting competency assessments.

4 Clinical Assessment of Mental Health (Terms of Reference c)

Assessment or diagnosis in any health or mental health context is a critical pre-cursor to evidenced based treatment, and the earlier the better.

When people enter a RACF, for example, they can experience high levels of distress and anxiety, which could be significantly minimised with better pre entry planning. This should include assessment at entry point supported by regular mental health and psychological assessments. It's important, however, to acknowledge that mental health issues can develop at any point, not just on admission to RACFs. There are many risk factors for people developing mental illness including losses (e.g. ill health or injury, divorce or widowhood, retirement or redundancy), loneliness, diagnosis of physical health conditions, and admissions to hospital. Better awareness amongst aged care staff of emerging mental health issues would improve their ability to identify when to escalate to a mental health professional for assessment.

Currently, the psychometric assessments used to screen mental health status in RACFs are routinely administered by registered nurses with the purpose of the assessment relating to the funding and subsidies for support, in this instance the behaviour supplement. For example, the Cornell Scale for Depression in Dementia (CSDD) is used to screen for depression in RACFs. The questionnaire includes 18-items which relies on self-assessment and input from an informant. The assessment scale has been found to be ineffective for screening depression as it is shown to have low diagnostic accuracy and requires an understanding of depressive symptoms by the informant that may not have been acquired.[28] Further, there appears to be little clinical implication for the scores on mental health screening measures, apart from determining the funding allocated to the consumer through the Aged Care Funding Instrument (ACFI).

There are other objective measures available for screening the mental health status of older people, however those measures are not routinely being used, particularly given the wide range of professionals who are currently involved in screening mental health in this population. Other well-validated measures include the Geriatric Depression Scale (GDS), Geriatric Anxiety Inventory (GAI) and the Quality of Life – Alzheimer's disease – nursing home version. While such tools are more suitable for older adults due to the use of more appropriate language, the caveat is that these measures are rarely useful in people with compromised insight as part of their mental health condition or dementia.

Other existing issues with the clinical assessment of mental health include:

- Screening measures currently completed by aged care staff (RNs and Care Team Staff) with little to no training in mental health.
- These screening measures are used as part of the Aged Care Funding Instrument (ACFI)[i] but do not necessarily trigger escalation of concerns to GPs or referrals to mental health professionals.
- Higher rating on these screening measures lead to higher funding for the facility, and provides no incentive to support recovery.[2]
- Primary Health Networks inappropriately assess outcomes of their funded programs using the Kessler Psychological Distress Scale (K10+, which is designed to measure anxiety and depression) regardless of the age of the individual.
- Clinical diagnosis by psychologists incorporating age (and cognitive) appropriate measures, clinical interviews and interventions are not routinely and consistently delivered for a population which has such high prevalence of mental health disorders.
- Screening tools do not screen for suicidality, which highlights the importance of appropriately trained mental health professionals.

Assessment is a core competency of psychologists, and therefore psychologists are well positioned to provide or support aged care providers to conduct evidence-based assessments. Access to assessment tools is a critical issue, particularly for practitioners in regional, rural and remote areas

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i The APS acknowledges that ACFI is soon to be replaced with the proposed new model for funding residential aged care and is expected to address some of the issues listed.

ii However, it is acknowledged that the proposed new funding model for residential aged care seeks to address this issue.

It's important to differentiate between assessments for mental health (which might include mood screens and cognitive screens) and a neuropsychological assessment (which assesses cognitive capacity and dementia). Clinical neuropsychologists should be regarded as a specialist and on a referral pathway for complex diagnostic and capacity issues.

Recommendation

The Royal Commission recommend:

8. Government promote psychometric assessments as a key criterion for clinical assessments of mental health as a basis for care, management and when required, treatment.
9. Government ensure clinical assessments of all new admissions to RACFs, in addition to other residents as appropriate, are conducted by appropriately trained mental health professionals.
10. Government develop and implement clear processes to ensure mental health issues in people residing in RACFs are identified early and escalated to the GP and mental health professional.
11. The use of appropriate tools administered by a mental health workforce to more accurately assess outcomes in older adults across government funded programs and interventions regardless of setting.

5 Delivery of Psychological Services in Residential Aged Care Settings (Terms of Reference a, d, f)

There is a clear benefit to aged care provider organisations, the health system and older people if psychological services can be provided within aged care settings.

The transition to residential care is often described as being difficult for the older person and their families. The proportion of residents in RACFs diagnosed with a mental health condition is unacceptably high and continually on the rise. There are several contributing factors for this trend which include later admission to RACFs. Furthermore, despite high levels of mental health and behavioural issues, residents have extremely limited access to mental health interventions.[19]

Psychologists play a vital role in supporting individuals with mental health conditions and improving the clinical outcomes across the lifespan. However, the number of psychologists working with older people is limited. In general, Australia lacks mental health services for older people when compared with other countries including the United Kingdom and the United States. In countries like the Netherlands, psychologists' role is well established within RACFs.[29]

Psychologists can have a very central role in the assessment, training, development, and supervision of mental health service delivery in RACFs. By involving psychologists in the assessment and coordination of mental health service delivery this process would ensure that appropriate assessment tools are used to screen the emotional needs of this population and that appropriate intervention is delivered based on the identified needs. While some forms of psychological intervention could be more cost-effectively *delivered* by mental health workers, for example low intensity or preventative interventions, in the interest of maintaining the integrity of the intervention, a psychologists' skills could be effectively utilised to supervise or oversee such programs.

Unfortunately, many older Australians, particularly those in RACFs, lack access to non-medicalised approaches to managing their health and wellbeing. A survey of 90 Australian RACFs found that residents were rarely referred to psychological services, and that only 14% of RACFs employed psychologists.[30]

Psychologists offer a wide scope of practice and could be invaluable in meeting the emotional and psychological needs of people living in RACFs, their families, and RACF staff. Some examples are:

- Provide support and education to families about dementia or mental health issues
- Similarly, provide tailored education and training to staff
- Improve staff wellbeing and engagement, to decrease carer strain and burnout
- Assessment, monitoring and provision of effective strategies for response behaviours
- Be part of an inter-disciplinary team decision around end of life issues
- Provide therapeutic input in relation to grief and loss, and adjustment issues
- Facilitate integration with local community e.g. visitors programs and dementia- specific therapeutic initiatives
- Contribute to research in the field of geriatric psychology.

The new Aged Care Quality Standards adopted in July 2019 demonstrate the many areas where psychologists could play a vital role in ensuring the safety and quality of life for people using aged care services. Some specific examples are provided in Appendix 1 as they relate to each standard.

There has historically been a significant gap in the availability of psychology services within RACFs as funding models have not supported treatment by psychologists. While older Australians in the community can access up to 10 Medicare rebates for psychological treatment of a mental disorder, commonwealth funded permanent aged care residents are not eligible. The APS has a long history of advocating for the mental health and wellbeing for our ageing population and for improved access to psychological services through Better Access for people living in RACFs.

The Aged Care Act 1977 clearly outlines the expectations that the RACF has the responsibility to ensure that all the health needs of consumers are met. On a practical level this currently equates to escalating mental health concerns to treating doctors and, through doctors, facilitating referrals to local hospitals and outpatient support, for example, Older Persons Mental Health Team.

The recent funding provided by the Department of Health through the Primary Health Networks (PHNs) is a welcome initiative. However, a local response through PHNs alone will not adequately meet the needs of people living in RACFs. We are aware of the argument about duplicate funding for psychological

care in RACFs however we remain concerned that our ageing population will continue to be underserviced. While PHN funding goes part way to ensuring people living in RACFs can access treatment for mental health issues, it likely that funding will only be enough to service a fraction of those who need it.[31] Furthermore, the funding is only available for four years and, as with past funding (e.g. Aged Care Access Initiative), is not secured beyond that timeframe. The funding is also limited to providing services directly with people living in RACFs which is commendable but does not fully access the benefit that psychologists could provide to RACFs (such as working with staff and management, as well as families and carers).

Due to the current lack of mental health service provision in RACFs, the lack of experience that mental health professionals currently have of working in the RACF environment is a major concern. As a consequence, the provision of training to the mental health workforce is critical to successfully implementing these new services. The current funding for the APS to develop and deliver online training to ensure mental health practitioners engaged by PHNs are adequately equipped and informed to support residents with mental health issues addresses this gap.

While RACFs could fund private psychology sessions directly, there is no history of psychological service provision in aged care in Australia. Furthermore, RACF managers may not be aware of the evidence for this treatment approach nor how to access a psychologist, not to mention insufficient funding to meet needs. Similarly, Aged Care Assessment Team staff, Regional Assessment Service (RAS) assessors, and Home Care Package staff may lack information about how to facilitate access to psychological services for older Australians in the community, or, as noted above, not recognise the need or benefits.

Very few RACFs employ a psychologist directly or refer residents for psychological therapy. In a recent survey of 81 RACFs, only 11 employed psychologists, mostly on a casual or part time basis, with only one setting having a full time psychologist, and referrals to psychologists occurred significantly less often than to other service providers.[30] Employing more suitably qualified staff (which includes psychologists) emerged as the top suggestion for improving aged care homes in an Australian survey of 174 relatives and visitors.[32] An employment model is preferable to contracted services as it allows greater flexibility of services to address the mental health needs of older people residing in RACFs. For example, intervention is often required to be slower paced, shorter duration, and require greater inclusion of family and staff (more integration of care).

Addressing the shortage of psychologists in the aged care sector

The extent to which psychological approaches can be employed in residential aged care services is limited not only by funding, but also by the lack of psychologists working in the Australian aged care sector workforce. In the sections that follow, we look internationally to the role of psychologists within RACFs as a way to guide what good practice might look like, as well as propose a model to increase the numbers of psychologists working in aged care.

Geropsychologists' role in RACFs in the Netherlands

Looking internationally can provide ideas and solutions for in Australia. In the Netherlands, for example, there are a large number of geropsychologists who have a significant role in RACFs. The nature of the role comprises:[29]

- Focus on resident's wellbeing as well as treatment or prevention of problems
- Responsibility for the multi-disciplinary (MD) care plan
- Teaching and coaching nursing staff in person-centred care
- A multi-disciplinary team must discuss a resident a few weeks after admission and then review them on an ongoing and regular basis but at least twice a year. Psychologists role in these meetings are to:
  1. Bring expertise in the psychological function of older adults in general, older adults with neurological progressive diseases, and person-centred approaches
  2. Use their communication skills and analytic approach to clarify the needs of the resident based on what the other disciplines bring to the table
  3. Use an analytical approach and methodological skills to evaluate the outcome of care or interventions.
- Scoring the quality of life instrument (Qualidem) following rating by professional care-givers
- Involvement in the differential diagnosis to determine if depression is present with other co-morbidities (e.g. stroke, dementia, etc)

- Trial treatment for depression when the diagnosis is not able to be determined due to co-morbidities
- When there are valid reasons for doing so, a psychologist will determine decision-making capacity within specific areas
- Use mediation therapy which, in this context, means treating the client indirectly by advising 'mediators' (e.g. family, nursing staff). Used when resident's behaviours are causing distress (e.g. increased aggression) following a functional analysis.
- Conducting research within facilities to improve the strength of the discipline to enhance and optimise the quality of life of residents.

Psychology placements in residential aged care

Access to psychological services for older Australian's with mental disorders is currently limited due to funding constraints (particularly via Medicare rebates) and limited engagement of psychologists in the aged care sector workforce. Currently psychologists have little exposure to the aged care sector which is partly due to the lack of incentives to work in the field.

Only 6% of psychologists in Australia specialise in treating older adults.[33] Despite increasing interest from postgraduate psychology students to undertake placements within aged care services, there is a lack of funding for appropriate supervision. Funding for such placements, with appropriate supervision, into ACATs and RACFs would not only provide much needed services to the residential aged care sector, but also provide a sound training and orientation of trainee psychologists to such a sector, thereby encouraging them to stay and work in the area. This is especially the case in regional, rural and remote areas.

As noted, very few RACFs employ a psychologist directly or engage psychologists to deliver services within the RACF. While there is a lack of research into the barriers to engaging psychologists, anecdotal reports to the APS indicate a lack of specific funding and a lack of awareness about the benefits of engaging psychologists are the main barriers.

A funding investment to supervise psychology students in RACFs would enable the students to provide the following services:

- Collaborate with medical staff on the accurate diagnosis of mental health or neurological conditions
- Provide evidence-based, non-drug interventions for particular clients or client groups
- Provide consultations about understanding behavioural changes in dementia, and strategies and techniques for managing Response Behaviours in residents
- Provide psychological interventions for sufferers of chronic diseases thereby reducing symptoms, improving compliance with treatment and lessening distress
- Provide emotional and practical support for RACF staff and
- In-service and staff consultative opportunities.

Recommendations

The Royal Commission recommend Government:

12. Rigorously evaluate the various service models identified by PHNs for the delivery of psychological services to RACFs to ensure that each PHN provides an adequate level of service delivery to meet consumer needs across their region. This approach to funding and service delivery may need to be revised depending on the results of the evaluation.
13. Enable people in RACFs to access all psychological services provided within Medicare's Better Access initiative.
14. Provide additional funding to RACFs to directly engage or employ psychologists to deliver psychological services to residents with mental health problems onsite and provide information about the benefits of psychological support to RACF staff, residents and families.
15. Support GPs and aged care providers to refer to psychologists for dementia support and education, and carer education and support.
16. Increase the available psychological workforce with expertise in aged care by investing in supervision of postgraduate psychology students within aged care services.

6 Restrictive Practices and Response Behaviours[iii] (Terms of Reference a, b, d)

This section provides an overview of the key evidence and highlights the best practice approach in relation to restrictive practices within aged care. The APS acknowledges the background paper released by the Commission on this topic and offers some additional and relevant information to support ongoing and essential work in this area. While there are no easy solutions, the APS agrees with the Commission that:

> *"Further inquiry is required into the nature and extent of restraint occurring in residential aged care, how best to deliver person-centred care services to people residing in aged care facilities (including those who have impaired cognition such as those living with dementia), and the systems including legal frameworks required to ensure the safety and quality of residential care services." (p.24)*[34]

Older people in RACFs are placed on a range of pharmacological medication for the purpose of gaining 'compliance' or managing challenging behaviours rather than for their health, which is acknowledged as breaching a person's human rights (Queensland Human Rights Act, 2019). A study carried out in 44 RACFs in Sydney found that about half the residents were prescribed psychotropic medications.[35] Across both the acute and community sectors, including Residential Aged Care, there is now strong agreement for the need to decrease pharmacological treatment and increase non-pharmacological treatment for symptoms and behaviours associated with mental health and neurocognitive disorders. The APS acknowledges that decreasing pharmacological treatment cannot occur without a national commitment to increasing non-pharmacological treatments. Increasing the use of person-centred psychological interventions to address the myriad symptoms experienced by vulnerable older persons will be essential to ensuring an overall reduction in restrictive practices, including inappropriate prescribing/de-prescribing practices.

There is evidence that some mental health symptoms, including unhelpful response behaviours seen in dementia care, are related to the over use of physical and chemical restraints within RACFs. The 2017 Review of National Aged Care Quality Regulatory Processes expressed grave concerns about the use of restrictive practices, highlighting such use as a human rights issue and noting "the use of alternative means for behaviour management should become the norm" in RACFs (p.114).[36] The Review recommends the aged care sector significantly reduce the use of all restrictive practices and that elimination of such practices is a goal that both government and providers should aspire to. Reducing or eliminating the use of restrictive practices requires addressing the barriers to using other methods of behaviour support. Research has highlighted that barriers to reducing the use of restraints include a lack of staff education about alternatives such as psychosocial interventions.

The Review highlights two successful interdisciplinary and multifaceted educational research initiatives in Australia - the Reducing Use of Sedatives (RedUSe) program and the Halting Antipsychotic use in Long Term Care (HALT) study.[36] Both studies emphasise the importance of education about the limited benefit and increased harm of antipsychotics, the potential causes of response behaviours, and encourage the use of non-pharmacological and person-centred approaches to management. The Review also acknowledges that a lack of access to mental health and allied health professionals' expertise for assessment, guidance on behavioural interventions and appropriate use of medicines, particularly in rural and remote areas is a barrier to reducing restrictive practices. This is despite the existence of the Dementia Behaviour Management Advisory Service (DBMAS) and Severe Behaviour Response Team (SBRT) funded by the Australian Government to address this issue.

Geriatric long stay residential care is a high risk setting for response behaviours and consequently the use of restrictive practices. Older people with cognitive impairment are more likely than the general population to be restrained and more likely to experience adverse outcomes relating to the use of restraint (2017 Statement ACSQHC - www.safetyandquality.gov.au).

iii Response Behaviours were formerly known as challenging behaviours or behavioural and psychological symptoms of dementia (BPSD)

The best practice approaches to prevent and reduce the use of restrictive practices, based on a summary of requirements under the Queensland Disability Act 2006 and QCAT Tribunal reporting requirements, are to:

- Clearly define what restrictive practices are (e.g. mechanical, physical, seclusion, chemical etc.), and are not (medications or prescribed safety aids and equipment for a medical condition)[iv]
- Develop / adhere to policies regarding restrictive practices
- Assess the person (comprehensive bio/neuro/psycho/social factors)
- Assess the behaviours (intensity, duration, frequency, onset, offset etc.)
- Develop a multidisciplinary plan
- Provide information and education to support staff and families
- Seek Guardian level approvals (and regular reviews) for use of any restrictive practices (include justification for least restrictive methods to support helpful behaviours, and also the methods to reduce the reliance and use of restrictive practices over time)
- Mandatory use of accurate, reliable recording of each instance of restrictive practice
- Review the person, the behaviours and the use of restrictive practices at set intervals
- Demonstrate compliance with restrictive practices policies and reductions in the use of restrictive practices at accreditation.

There is an abundance of good information on reducing restrictive practices in Disability Services (Queensland introduced the first legislation in 2006 and the APS developed guidelines for psychologists in 2016) and in Mental Health Services, and the Queensland Office of the Public Advocate[37] released a paper in 2017 on the Legal Framework regarding the use of restrictive practices. South Australia Health has also developed some well researched policies and toolkits.[38]

In April 2019, then Minister for Senior Australians and Aged Care, the Hon Ken Wyatt AM, MP, introduced new requirements concerning the use of restraint in residential aged care services in Australia. In his statement, he said:

> *"I intend to amend the Quality of Care Principles 2014 and require providers to satisfy a number of conditions before restraint can be used, including assessment by an approved health practitioner (physical restraint) or assessment by a medical practitioner or nurse practitioner who has prescribed the medication (chemical restraint)."*

Psychologists have specific skills and experience in behaviour assessment and behaviour change. The APS recommends that an approved health practitioner needs to include a psychologist (Clinical/Gero/Neuro) to seek to understand / assess the unhelpful response behaviours leading to the identified need for any restrictive practices. This would align with the implementation of the Queensland Disability Act which requires the specialist restrictive practice teams be led by a clinical psychologist and to include assessments by clinical neuropsychologists as necessary for complex cases.

Further to an assessment, the psychologist should work together with the person's guardian, medical or nurse practitioner to decide on which restraint / dose would be the least restrictive. Not including a psychologist as a necessary approved person in these amendments, will lead to a limited understanding and rationale for the use of a restrictive practice and the potential for no assessment or understanding of the alternative behaviour support measures. It is these questions (1. What factors are contributing to the behaviour in the first place, and 2. What alternatives have you tried?) that Guardianship Tribunals focus on to justify approvals for restrictive practices.

While the APS acknowledges that there is a lot of work going on regarding de-prescribing inappropriate medications and medication stewardship, without an increase in appropriate education and application of non-pharmacological management of response behaviours then there is the potential for increased associated risks. An example would be an increase in harm to the person or others which may directly lead to a reactive increase in prescribing of drug treatment.

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iv A clear definition is required despite an inevitable and contentious debate. There is existing uncertainty about what does and doesn't constitute restrictive practice (e.g. wrist bands, GPS devices, locks on dementia wards etc.). The protection of the rights of the resident, for example, may inadvertently lead to neglect of the rights of others not to be harmed.

The APS has concerns that in the acute sector, staff with inadequate training are attempting to manage response behaviours (with varying levels of success). Having access to trained psychologists who have specific and relevant skills in relation to assessment and management of the response behaviours that typically trigger the use of restrictive practices is essential.

Recommendation

The Royal Commission recommend Government:

17. Identify psychologists as approved health practitioners to conduct assessments aimed at a) reducing unhelpful response behaviours and the need for use of restrictive practices, and b) monitoring behaviours and interventions, as they are monitored in the disability sector.
18. Commission the formal and critical review of existing restrictive practices and the development of new policies and practices specifically for aged care settings.

7 Scarcity of Services in the Community (Terms of Reference a, b, d)

Optimising the health and wellbeing of older Australians is an increasingly important economic and health system challenge. The extensive aged care reform in the last decade is testament to this. Most people want to stay in their own homes. Together with the unacceptably high rates of mental illness in RACFs and high financial costs to Government associated with residential aged care, the APS supports significantly greater investment into community aged care to support people to age in place and reduce the burden often placed on their families.

The APS share concerns already raised by many others regarding the inadequacy of community supports available to those over 65. The My Aged Care (MAC) National Waitlist for some community packages of care has grown to the point where MAC are quoting people a 12 to 18 month wait for a Level 4 package. The community care package system is designed to keep people in their homes longer and reduce unnecessary and premature admissions to hospital and RACFs. When the wait for services grows this long this objective is nullified: older people are often unable to stay in their homes by the time a package becomes available, a process that can be hastened by the shortfall in the level of support provided in the community. Not addressing needs early can lead to higher costs and negative implications for health in the longer term.

To offset the increasing demand on aged care community services, it has come to our attention that Aged Care Assessment Teams (ACATs) nationally have been advised to only approve people for services that their own family or friends cannot provide. While this appears a sensible solution to preserve and stretch limited government resource funding, the reality is often very different. The following case studies of people with dementia and their care givers illustrate common scenarios and problems that can arise.

Case study: Mia and Marcus

Mia is 75 years old, has dementia and lives with her 82 year old partner Marcus in a regional Victorian town. She requires high level monitoring and supervision as she has a moderate degree of cognitive impairment including compromised insight into her abilities. While Mia is often appreciative of the care being provided by Marcus, she is oblivious to his exhaustion. When she was assessed, the report concluded that she needed very little to no help, and that she would likely decline any offers of help or support. Marcus is already under significant strain and is vulnerable to burnout due to the constant vigilance required to keep his loved one safe. Without significant supports to provide in-home respite, Marcus gets really tired, and his ability to cope with assessments and express his own needs have become compromised. Marcus was unwilling to emphasise to the assessor his specific needs. This happened for various reasons including: love and dedication driving him to put himself last, pride and determination that he can do it alone, the thought that no one can care for his partner as well as he can, stoicism, the thought that others' needs must be more important, the shame of being seen as not being willing or able to provide more care.

Case study: Boris and Lina

Boris is 78 years old, has moderate to severe dementia and lives in his own home in a surburban neighbourhood. He was approved by ACAT for a Level 2 package of care, where any other person with his very high care needs would automatically have warranted a Level 4 package. This approval was justified because Lina his 30 year-old daughter had given up her job to move in with her father, as she had been too worried about her father's safety living alone. With only a Level 2 package (approximately 3-4 hours a week community support) Lina now feels obligated to stay in the role of full-time carer. Sadly, the severity of the Boris' dementia will likely mean that Lina will quite quickly burnout with only a few hours a week of respite.

These case examples highlight the assessors' limited understanding of dementia, and the lack of understanding of how carer burnout can lead to an underestimation of care needs. Coupled with the current edict to Aged Care Assessment teams, the APS is concerned that many people with dementia-specific care needs are going to receive MAC and ACAT approvals that vastly underestimate the level of support they will require to stay in their own home. Anecdotal reports from APS members who work in the aged care community sector confirm that inaccurate assessments have resulted in increased hospital admissions and premature permanent placements in RACFs. The implications of these examples of inaccurate assessments are far reaching across moral, ethical, fiscal and societal realms.

In summary, the current lack of community resources and long national waitlist for community care packages is negatively impacting care recipients and their carer's health and wellbeing, increasing carer strain, and leading to more hospital admissions and premature admissions to RACFs. Addressing the extensive waiting times for home care packages should be a priority.

Recommendation

The Royal Commission recommend Government:

19. Invest more resources into community aged care to support people (and their carers) to stay in their own homes, if that is their preference, with timely and appropriate level of care.
20. Reinstate dementia-specific roles within Aged Care Assessment Teams to ensure appropriate assessment of people with dementia.

8 Aged Care in Remote and Indigenous Australia (Terms of Reference a, c, d)

Older age for Aboriginal and Torres Strait Islander peoples is defined by the Australian governments' aged care planning policy as 50 years and above due to lower life expectancies, as compared to over 65 years for the rest of the population.[v] This is testament of the inequality of health outcomes. The number of older Aboriginal and Torres Strait Islander peoples is projected to treble by 2026, but knowledge gaps remain as to how to optimise their health outcomes, well-being and quality of life for the most rapidly ageing population in Australia.[39] Aboriginal and Torres Strait Islander Elders play key roles in the health of their communities relying on their memory to pass down cultural rights and responsibilities, traditional lore and language; caregiving for extended families and providing community leadership.[40, 41] Australian research has demonstrated alarmingly higher and earlier rates of dementia (three to four times higher and 10 to 15 years earlier onset).[42, 43] Thus the impact of this dementia epidemic on the social and emotional wellbeing of entire communities can be devastating. It needs to be addressed.

Furthermore, from middle age onwards the rates of other chronic diseases that impact quality of life and mortality are significantly increased in Aboriginal and Torres Strait Islander communities, including heart disease, frailty and falls, stroke, lung disease and type 2 diabetes.[44, 45] Aboriginal and Torres Strait Islander peoples do not age at an accelerated rate, instead, they face a greater burden of conditions at an earlier age that lead to the premature onset of complications typically seen with ageing in non-Aboriginal and Torres Strait Islander Australians. In addition to this, aged care assessments are conducted less than 50% of the time for Aboriginal and Torres Strait Islander Elders –suggesting the figures above could be underestimates and that serious reforms need to be put in place to Close the Gap in a culturally appropriate manner.[vi]

Preventive measures could delay the onset of these conditions if implemented in a timely, thorough and culturally sensitive manner. The complexity of barriers that impact Aboriginal and Torres Strait Islander ageing and inequity in aged care, include the constellation of access and cost issues in remote regions, disjointed care due to health service gaps, language comprehension barriers, cultural differences, poor health literacy, and the cumulative effect of multiple additional needs. For example, individuals may experience homelessness, mental ill health, socio-economic disadvantage and low education status. Culturally adapted cognitive screeners and assessments like the Kimberley Indigenous Cognitive Assessment, need to be more thoroughly researched and validated in various Aboriginal and Torres Strait Islander communities and implemented systematically in person and via telehealth.[46] Cultural sensitivity trained tele-geriatricians, tele-psychologists and tele-psychiatrists need to be used if adequate social emotional wellbeing cannot be provided in the aged care setting. These telehealth solutions could also vastly improve the ability for Aboriginal and Torres Strait Islander Elders to stay on Country. There is no clear connection between aged care policy for Aboriginal and Torres Strait Islander peoples and Closing the Gap health strategies for general and psychological wellbeing. These factors uniquely impact Aboriginal and Torres Strait Islander Elders and require tailored and additional solutions to those identified in most aged care research.

The National Health Priorities include mental health (4th priority) and dementia (9th priority) which highlight that these are significant issues for all Australians. For Aboriginal and Torres Strait Islander Elders, who have poorer health outcomes as previously described, the need to address these issues are even more urgent.[47]

The poor health trajectories and outcomes of Aboriginal and Torres Strait Islander Elders in comparison with the majority population reflects the persistent social, emotional and physical disadvantage experienced by the Aboriginal and Torres Strait Islander peoples. All of these factors relate to the long-term psychological effects of intergenerational trauma and need to be considered and improved upon in the aged care sector. Additionally, with up to one in three Aboriginal and Torres Strait Islander children between 1910 and the 1970's being from the Stolen Generation, the aged care sector needs to be attuned to the unique needs of this group who have experienced early childhood trauma and negative early experiences of racially prejudiced institutions.

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v www.myagedcare.gov.au/support-aboriginal-and-torres-strait-islander-people

vi www.aag.asn.au/documents/item/2860

These both uniquely influence Aboriginal and Torres Strait Islander patients and their families from seeking care in systemically White institutions in the present.

Currently Aboriginal and Torres Strait Islander peoples have lower use of carer and residential services despite higher levels of disabilities, and account for 21% of preventable hospital admissions including for older people. Aged care policy needs to better comprehend the diversity of circumstances and needs of older Aboriginal and Torres Strait Islander peoples across different locations in both urban and remote settings. The reforms that ensue from this Commission need to step up and meet the needs of Aboriginal and Torres Strait Islander Elders and their communities.

In considering the complex needs and discrepancies in health outcomes for Aboriginal and Torres Strait Islander Elders there also needs to be a greater awareness of what ageing "well" looks like in a remote context. This includes: being respected, comfortable, mobile, healthy, and as culturally secure as possible.[48]

Health care and social assistance is the primary employment industry of Aboriginal and Torres Strait Islander peoples aged 15 to 64 years in Australia.[49] Thus a key part of the Royal Commission's improvements need to focus on supporting and training Aboriginal and Torres Strait Islander and non- Aboriginal and Torres Strait Islander staff in appropriate ongoing cultural safety courses, culturally appropriate assessment tools and culturally relevant service delivery to improve their work, reduce burn out rates and improve the wellbeing of carers and their older patients. More training pathways are needed for Aboriginal and Torres Strait Islander health workers to become aged care assessors and social emotional wellbeing specialists. Increased funding for carer support, aged care advocacy, accurate and consistent data collection, community influenced aged care research and evidence based training in remote settings would also facilitate the development and improvement of sustainable and healthier remote communities as well as increased economic opportunities in areas of traditionally low employment. An Aboriginal and Torres Strait Islander aged care workforce training and employment strategy as well as measures to promote recruitment and retention of Aboriginal and Torres Strait Islander aged care employees will also further contribute to the social and emotional wellbeing of Aboriginal and Torres Strait Islander Elders and their communities.

Remote aged care facilities need to improve significantly to adequately care for remote older patients. Local Aboriginal and Torres Strait Islander Cultural Advisors in partnership with the Australian Association of Gerontology's Aboriginal and Torres Strait Islander Ageing Advisory Group need to be consulted in terms of service improvement, delivery and cultural knowledge. These multifaceted improvements in service delivery, better training staff, cultural practice education with Elder consultation, managing carer burnout, facility improvement, delivering specialised care and diagnostic care, needs to be addressed by thorough consultation and systemic service change with the Primary Health Networks and private aged care services. Like Aboriginal Community Controlled Health Organisations services, aged care services need to be holistic, Aboriginal and Torres Strait Islander specialised and to focus on social emotional wellbeing.

Anecdotal evidence from an APS member working in the Northern Territory consulting nurses, support workers, clients and Aboriginal and Torres Strait Islander Elders highlights the following issues:

- Aged care services are consistently understaffed meaning that residents are often subjected to severe neglect (e.g. sitting in their own excrement for up to a day, having a shower every second day, not being seen to by nurses/doctors regarding their pain and mental distress).
- Health and safety issues for staff working individually with dementia patients as they do not feel safe and reports of being hit by an unwell patient.
- Residents are frequently very distressed, crying, and screaming.
- Not enough aged care beds, so aged care patients are often placed in the hospital. This means sometimes patients stay in hospital for years, with no access to wellbeing and physical movement groups which affect general mental wellbeing and impact cognitive decline. Open wards reduce sense of dignity, opportunities for physical activity, and interrupt sleep patterns.
- There are almost no remote placements and if there are any, they are very low care, with any high care patients going to the hospital that is ill-equipped. This results in a lot of shame for

patients, staff and families, and disruption of cultural and family connections and relationships.
- Language and communication barriers have implications for meeting cultural needs, understanding treatment and supporting quality of life.
- High rates of burn out and significant burden on families and hospital staff to provide emotional care. However, they are not trained or supported to do this work.
- Aged care and health systems ill-equipped to support culturally appropriate consultation regarding identification of kin and guardianship.

Case study

Eddy (an Aboriginal and Torres Strait Islander Elder, aged 65) was becoming frail and his family decided that he needed support from a bigger community like Katherine. Eddy was taken off his Country which gave him great sadness. At the time of him coming to Katherine, the aged care centres were full so he went to hospital for a recent fall. After assessment it was decided that Eddy needed more support than his extended family in Katherine could give, so he stayed in hospital. He felt a lot of shame there, with only curtains between him and other patients and most of the nurses that cleaned him were younger white women. He also couldn't understand some of what they were saying. Sometimes for big decisions interpreters came which was useful. Eddy was often alone in bed as the nurses were very busy and he had difficulty sleeping in a public ward with no sound protection. Finally Eddy got moved to the aged care facility three months later. He found this place better in terms of privacy but also found that the workers were too busy to give him much time or many activities to do. His family found that his cognition started to decline rapidly and at times they found him sitting in his own excrement from several hours past. When they reported this to the support workers they said that they were understaffed and doing what they can. Another time Eddy's family visited he appeared visibly distressed and had scratches down one arm. When questioning the support workers about this they said that they did not know what had happened. The family decided to move Eddy to another community with some aged care services but on Country and near family. Back on Country, many of the workers spoke his language and understood his needs even if at times he was still alone or had not many activities to do.

Aboriginal and Torres Strait Islander Elders overwhelmingly prefer to remain in their communities and connected to their family and on Country. It is important to recognise that families and communities are an integral part of Aboriginal and Torres Strait Islander Elders aged care support structure and the social and emotional well-being of Aboriginal and Torres Strait Islander communities. Upskilling, supporting and improving local services would help improve culturally appropriate care. There is also the potential to avoid costly, futile and inappropriate care, and correspondingly an opportunity to enhance outcomes including satisfaction with care and improve quality of life of older people and their carers through better understanding of their conditions. Culturally and linguistically appropriate discussions must be incorporated into Advance Care Planning as well as early identification and treatment of health problems to reduce complex care and reduce physical and emotional distress.

Recommendations

The Royal Commission recommend Government:

21. Support access of older Aboriginal and Torres Strait Islander peoples to Aboriginal and Torres Strait Islander cultural advisors.
22. Support access of Aboriginal and Torres Strait Islander Elders to tele-mental health, tele-geriatric services and tele-psychiatry to aid in addressing logistical and resource barriers for remote services.
23. Increase recruitment and retention of Aboriginal and Torres Strait Islander aged care assessors and workers (particularly males)
24. Support Aboriginal and Torres Strait Islander led and designed research, data collection and advocacy.
25. Improve and consistently provide ongoing cultural safety training, aged care assessment training, cultural advisors and carer support services particularly in remote aged care facilities.
26. Conduct a thorough consultation, implementation and systemic service change in collaboration with the Primary Health Networks and private aged care services to reduce human rights abuses and promote social and emotional wellbeing of Aboriginal and Torres Strait Islander Elders and their communities.
27. Provide specific support to help Aboriginal and Torres Strait Islander Elders stay on Country and embedded in their communities.

9 GP Education (Terms of Reference a, c, d)

General medical practitioners (GPs) are often the first point of contact for older people who have a health problem whether they live in the community or in residential care. Therefore, GPs are in an ideal position to identify and manage mental health problems early.

Much like the general public, GPs and health professionals may share common misunderstanding about older people and ageing, for example, that depression or memory loss are a normal part of ageing or that psychological therapy is not appropriate or effective for this age group. This means that many older people miss out on appropriate interventions, potentially exacerbating symptoms and leading to more costly interventions down the track. This also highlights the need for more accountability for treatment decisions made by GPs, for example signing statements to confirm that medication is clinically indicated and have a beneficial effect with no extreme side effects.

GPs as our front line health care providers for older people are faced with a number of challenges. One of the most complex areas surrounds differential diagnosis of many cognitive and behavioural symptoms that can occur as we age. GPs have to determine the cause of the symptoms to work out a suitable treatment or referral pathway. To do this they have to be well versed in not only the medical tests, but also in the selection and use of the appropriate mood and cognitive screening tools. Some of the factors that impact on cognition include:

- Mood disturbance, most commonly depression and anxiety
- Stress and adjustment (such as moving into an aged care facility)
- Grief and loss
- A variety of transient and permanent medical conditions are associated with cognitive dysfunction. Several common conditions in older people that affect cognition include Vitamin B12 deficiency, urinary tract infections, constipation, and infections leading to delirium
- Several classes of medication are associated with cognitive dysfunction.

Additional attention needs to be paid to those at increased risk, such as males over the age of 85 who have the highest rates of suicide compared to any other age group. Assessing cognitive impairment in this population is particularly important, as certain cognitive functions when they are impaired, can directly increase risk of suicidal ideation, and suicide attempts. Specifically the executive function of inhibition when it is impaired leads to disinhibition and impulsivity.

Particularly within RACF environment, resident health care is often predominantly delivered by the GP. As residents tend to age in place, monitoring of their cognition over time becomes an essential part of their overall health care plan.

Enhanced screening methodology in combination with education will enhance GP confidence in determining the correct referral pathways. Enhanced cognitive screening by GPs aligns with the new National Safety and Quality Health Service Standards which commenced in January 2019. In Queensland, for example, these standards now require State Health facilities to incorporate best practice strategies for early recognition, prevention, treatment and management of cognitive impairment and delirium in care plans. The guidelines identify several scenarios where cognitive screening is now expected to occur including for those over 65, those with known cognitive impairment/dementia, severe illness or risk of dying, hip fracture and reported cognitive or behavioural concerns.

Cognitive screening with the correct screening tool can assist GPs with several other areas of decision-making in the care of their patients (in the community and those living in aged care facilities) including:

- Providing guidance on when is an appropriate time for the GP to be considering including family in discussions about the care of their loved one; and balancing that need with respecting a patient's privacy and autonomy. This includes addressing any resistance or barriers to receiving aged care services.

- Assist them to gauge the level of risk of those living with memory loss and cognitive impairment in the community e.g. gauging when memory loss may be affecting medication compliance; and allow them to recommend risk mitigation strategies.
- Assist them to gauge when cognitive impairment may be impacting on their patient's safety to drive, facilitating referral to a specialist e.g. particular cognitive functions are associated with driving and can be screened by using the correct screening tool.

Recommendation

The Royal Commission recommend Government:

28. Support access of GPs and other health professionals to education regarding cognitive screening, dementia, ageing in general and making appropriate referrals.
29. Commission the development of guidelines with recommendations for the minimum level of dementia-specific education and training for GPs and staff of RACFs.

APS Activities related to Aged Care

The APS are committed to working to promote the quality of life of older Australians. Recent and ongoing work relating to ageing and aged care which may be of interest includes:

- Membership of the National Aged Care Alliance (NACA)
- White Paper addressing the mental health needs of older Australians (2017)
- Membership of the Mental Health Reform Stakeholder Group (Mental Health and Aged Care Sub Group) to facilitate the PHN Implementation Guidance for Provision of Mental Health Services in Aged Care Settings
- APS submissions related to ageing and aged care related government inquiries:
  - Queensland Inquiry into aged care, end-of-life and palliative care and voluntary assisted dying (2019)
  - Aged Care Workforce Strategy Taskforce (2018)
  - Victorian Voluntary Assisted Dying Bill Discussion Paper (2017)
  - Australian Human Rights Commission National Inquiry into Employment Discrimination Against Older Australians and Australians with Disability: Willing to Work (2015)
  - Senate Inquiry regarding the adequacy of existing residential care arrangements for young people with severe physical, mental or intellectual disabilities in Australia (2015)
- Psychology and Ageing Interest Group
- APS Ethical Guidelines for Working with Older Adults (2014)

Acknowledgements

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References

1. Marmot, M. (2018). *Social determinants of health, the life course, and healthy ageing. Gary Andrews international Fellow.* Paper presented at the 2018 Australian Association of Ageing National Conference. 21-23 November, Melbourne.
2. Australian Institute of Health and Welfare. (2017). GEN fact sheet 2015-16: People's care needs in aged care. Canberra: AIHW.
3. Australian Bureau of Statistics. (2015). *National Health Survey: first results, 2014-15. ABS cat. no. 4364.0*. Canberra: ABS.
4. Australian Bureau of Statistics. (2016). *Disability, Ageing and Carers, Australia: Summary of Findings, 2015. ABS cat. no. 4430.0*. Canberra: ABS.
5. Bruce, M. L., McAvay, G. J., Raue, P. J., Brown, E. L., Meyers, B. S., Keohane, D. J., . . . Weber, C. (2002). Major depression in elderly home health care patients. *American Journal of psychiatry, 159*(8), 1367-1374.
6. Creighton, A. S., Davison, T. E., & Kissane, D. W. (2016). The prevalence of anxiety among older adults in nursing homes and other residential aged care facilities: a systematic review. *International Journal of Geriatric Psychiatry, 31*(6), 555-566.
7. Australian Bureau of Statistics. (2017). *Causes of Death, Australia, 2016. ABS cat. no. 3303.0*. Canberra: ABS.
8. De Leo, D., & Arnautovska, U. (2016). Prevention and Treatment of Suicidality in Older Adults. In R.C. O'Connor & J Pirkis (Eds.), *The international handbook of suicide prevention*. Hoboken: John Wiley & Sons, Incorporated.
9. The National Centre for Social and Economic Modelling. (2017). Economic Cost of Dementia in Australia 2016-2056. Canberra: NATSEM
10. Australian Institute of Health and Welfare. (2018). Older Australia at a glance. Canberra: AIHW. https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/health-and-aged-care-service-use/aged-care.
11. Australian Institute of Health and Welfare (Producer). (2019). GEN Aged Care Data: Admissions into aged care. Retrieved from https://www.aihw.gov.au/reports/aged-care/gen-aged-care-data-admissions-into-aged-care/contents/summary
12. World Health Organization. (2015). World Report on Ageing and Health. Geneva: WHO. https://www.who.int/ageing/publications/world-report-2015/en/.
13. Yon, Y., Mikton, C., R., Gassoumis, Z. D., & Wilber, K. H. (2017). Elder abuse prevalence in community settings: A systematic review and meta-analysis. *Lancet Global Health, 5*, e147-e156.
14. Australian Government. (2016). *Elder Abuse: Understanding Issues, Frameworks and Responses. Research Report No. 35.* Melbourne: Australian Institute of Family Studies. https://aifs.gov.au/publications/elder-abuse.
15. Hill, K. D., & Wee, R. (2012). Psychotropic drug-induced falls in older people: A review of interventions aimed at reducing the problem. *Drugs and Aging, 29*, 15-30.
16. Kojima, G. (2015). Prevalence of frailty in nursing homes: A systematic review and meta-analysis. *Journal of the American Medical Directors Association, 16*, 940-945.
17. Department of Health. (n.d.). *PHN Primary Mental Health Care Flexible Funding Pool Implementation Guidance: Stepped Care*. Canberra: Department of Health. http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Mental_Tools.
18. Fiske, A., Wetherell, J. L., & Gatz, M. (2009). Depression in older adults. *Annual Review of Clinical Psychology, 5*, 363-389.
19. Davison, T. E., Koder, D., Helmes, E., Doyle, C., Bhar, S., Mitchell, L., . . . Pachana, N. (2017). Brief on the role of psychologists in residential and home care services for older adults. *Australian Psychologist, 52*(6), 397-405.
20. Wells, Y., Bhar, S., Kinsella, G., Kowalski, C., Merkes, M., Patchett, A., . . . van Holsteyn, J. (2014). What works to promote emotional wellbeing in older people: A guide for aged care staff working in community or residential care settings. *Melbourne: beyondblue*.
21. O'Connor, D. W., Ames, D., Gardner, B., & King, M. (2009). Psychosocial treatments of behavior symptoms in dementia: a systematic review of reports meeting quality standards. *International Psychogeriatrics, 21*(2), 225-240.
22. Bird, M., Llewellyn-Jones, R. H., Smithers, H., & Korten, A. (2002). Psychosocial approaches to challenging behaviours in dementia: A controlled trial. Report for the Office for Older Australians. Canberra: Commonwealth Department of Health and Ageing.
23. Bird, M., Jones, R. H. L., Korten, A., & Smithers, H. (2007). A controlled trial of a predominantly psychosocial approach to BPSD: treating causality. *International Psychogeriatrics, 19*(5), 874-891.
24. Davison, T. E., Hudgson, C., McCabe, M. P., George, K., & Buchanan, G. (2007). An individualized psychosocial approach for treatment resistant behavioral symptoms of dementia among aged care residents. *International Psychogeriatrics, 19*(5), 859-873.
25. Law Society of New South Wales. (2003). Client Capacity Guidelines: Civil and Family Law Matters. Sydney: NSW Law Society.
26. Liptzin, B., Peisah, C., Shulman, K., & Finkel, S. (2010). Testamentary capacity and delirium. *International Psychogeriatrics, 22*(6), 950-956.
27. Jeste, D. V., Depp, C. A., & Palmer, B. W. (2005). Magnitude of impairment in decisional capacity in people with schizophrenia compared to normal subjects: an overview. *Schizophrenia Bulletin, 32*, 121-128.
28. Jeon, Y.-H., Li, Z., Low, L.-F., Chenoweth, L., O'Connor, D., Beattie, E., . . . Brodaty, H. (2015). The clinical utility of the cornell scale for depression in dementia as a routine assessment in nursing homes. *The American Journal of Geriatric Psychiatry, 23*(8), 784-793.
29. Pot, A., & Willemse, B. (2010). Clinical geropsychology practice in long-term care facilities. In N. A. Pachana, K. Laidlaw & B. G. Knight (Eds.), *Casebook of Clinical Geropsychology: International perspectives on practice* (pp. 263-277). New York: Oxford University Press.
30. Stargatt, J., Bhar, S. S., Davison, T. E., Pachana, N. A., Mitchell, L., Koder, D., . . . Helmes, E. (2017). The availability of psychological services for aged care residents in Australia: A survey of facility staff. *Australian Psychologist, 52*(6), 406-413.
31. Leading Age Services Australia. (2018). Improved access to psychological services in residential care: LASA members' observations LASA. https://lasa.asn.au/wp-content/uploads/2018/07/18-07-19-Consultation-on-mental-health-supports-in-RACFs-final.pdf
32. Russell, S. (2017). Living Well in an Aged Care Home. Melbourne: Research Matters.
33. Koder, D. A., & Helmes, E. (2008). The current status of clinical geropsychology in Australia: A survey of practising psychologists. *Australian Psychologist, 43*(1), 22-26.

34. Commonwealth of Australia. (2019). Restrictive practices in residential aged care in Australia: Background Paper 4. Canberra: Royal Commission into Aged Care Quality and Safety. https://agedcare.royalcommission.gov.au/publications/Documents/background-paper-4.pdf.
35. Snowdon, J., Galanos, D., & Vaswani, D. (2011). A 2009 survey of psychotropic medication use in Sydney nursing homes. *The Medical Journal of Australia, 194*(5), 270-271.
36. Carnell, K., & Paterson, R. (2017). Review of National Aged Care Quality Regulatory Processes. https://www.health.gov.au/sites/default/files/review-of-national-aged-care-quality-regulatory-processes-report.pdf.
37. Office of the Public Advocate. (2017). *Legal frameworks for the use of restrictive practices in residential aged care: An analysis of Australian and international jurisdictions*. Queensland: OPA. https://www.justice.qld.gov.au/__data/assets/pdf_file/0005/524426/restrictive-practices-in-aged-care-final.pdf.
38. South Australia Health. (2015). Minimising Restrictive Practices in Health Care Toolkit. Adelaide,: SA Health. https://www.sahealth.sa.gov.au/wps/wcm/connect/Public+Content/SA+Health+Internet/Clinical+resources/Clinical+topics/Restrictive+practices+in+health+care/.
39. Australian Bureau of Statistics. (2013). *Australian Aboriginal and Torres Strait Islander Health Survey: First Results (2012-13)*. Canberra: ABS.
40. Smith, K., Flicker, L., Shadforth, G., Carroll, E., Ralph, N., Atkinson, D., . . . LoGiudice, D. (2011). 'Gotta be sit down and worked out together': views of Aboriginal caregivers and service providers on ways to improve dementia care for Aboriginal Australians. *Rural & Remote Health, 11*(2), 1650.
41. Warburton, J., & Chambers, B. (2007). Older Indigenous Australians: Their integral role in culture and community. *Australasian Journal on Ageing, 26*(1), 3-7.
42. Giudice, D. L., Smith, K., Fenner, S., Hyde, Z., Atkinson, D., Skeaf, L., . . . Flicker, L. (2016). Incidence and predictors of cognitive impairment and dementia in Aboriginal Australians: A follow-up study of 5 years. *Alzheimer's & Dementia, 12*(3), 252-261.
43. Radford, K., Mack, H. A., Draper, B., Chalkley, S., Daylight, G., Cumming, R., . . . Broe, G. A. (2015). Prevalence of dementia in urban and regional Aboriginal Australians. *Alzheimer's & Dementia, 11*(3), 271-279.
44. Australian Institute for Health and Welfare. (2015). The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015. Cat. no. IHW 147. Canberra: AIHW.
45. Hyde, Z., Flicker, L., Smith, K., Atkinson, D., Fenner, S., Skeaf, L., . . . Giudice, D. L. (2016). Prevalence and incidence of frailty in Aboriginal Australians, and associations with mortality and disability. *Maturitas, 87*, 89-94.
46. Russell, S., Quigley, R., Strivens, E., Miller, G., Norrie, J., Craig, D., . . . Muller, R. (2019). Validation of the Kimberley Indigenous Cognitive Assessment short form (KICA-screen) for telehealth. *Journal of telemedicine and telecare*, 1357633X19860309.
47. Australian Institute for Health and Welfare. (2018). Improving Australia's burden of disease. Factsheet. Canberra: AIHW
48. Commonwealth of Australia. (2013). *National Aboriginal and Torres Strait Islander Health Plan of 2013–2023 (NATSIHP)*. Canberra: Department of Health. https://www1.health.gov.au/internet/main/publishing.nsf/Content/natsih-plan?Open=&utm_source=health.gov.au&utm_medium=redirect&utm_campaign=digital_transformation&utm_content=natsihp
49. Australian Bureau of Statistics. (2016). *Census of Population and Housing: Reflecting Australia - Stories from the Census, 2016. Cat No. 2071.0*. Canberra: ABS.
50. Commonwealth of Australia. (2019). *Proposal for a new residential aged care funding model: Consultation paper*. Canberra: Australian Government Department of Health. https://consultations.health.gov.au/aged-care-division/proposed-new-residential-aged-care-funding-model/

Appendix 1. Aged Care Quality Standards

The new Aged Care Quality Standards adopted in July 2019 demonstrate the many areas where psychologists could play a vital role in ensuring the safety and quality of life for people using aged care services. Some examples are provided below.

Standard 1: Consumer Dignity and Choice

On admission to a RACF there is an adjustment period where people come to terms with many losses including the loss of their home, their independence, their mobility, and often their community. As a result, they experience a loss of identity as they go through adjusting to their change in circumstances.

- Psychological intervention at this point can assist people to maintain their identity and come to terms with the changes.[7]

Standard 2: Ongoing assessment and planning with consumers

Older people bring with them a lifetime of experiences, differing personalities, and cultures.

- In the presence of cognitive impairment psychologists are able to conduct capacity assessments to determine if the person can continue to independently make their own decisions; or whether they may require support in making specific decisions.
- Psychologists offer a perspective on people that reside in RACFs that assists others in understanding their individuality, including consideration of bio-psychosocial and spiritual factors.

Standard 3: Personal care and clinical care

Many issues can arise during this period of people's lives that are treatable through psychological intervention.

- Psychologists can treat symptoms of anxiety, depression, grief, interpersonal difficulties, pain management, and processing of past issues and/or relationships.
- Specific to dementia, one of the most common symptoms of dementia can be a loss of insight which can directly impact on a person's personal and clinical care. Skilled assessment and individually-tailored approaches are necessary to offset the behaviours that can accompany a person with compromised insight.

Standard 4: Services and supports for daily living

Psychological issues can create a barrier for people to do things which optimise their quality of life.

- Psychologists facilitate inter-disciplinary teams to form and work collaboratively toward the wellbeing of the person.

Standard 5: Organisation's service environment

There are many aspects of an organisation's physical environment which can be designed to better promote a sense of safety and belonging, independence, function and enjoyment.

- Psychologists work with organisations and building developers to increase consumers quality of life.

7 The proposal for a new residential aged care funding model identifies the need for a 'one-off adjustment payment' for new residents to account for the additional care and assessment needs required at this critical time (Commonwealth of Australia, 2019). The APS supports the introduction of the payment, however notes that facilities should be allowed to contract out to third party providers (such as allied health practitioners) so that resident needs relating to the transition can be quickly and effectively addressed.

Standard 6: Feedback and complaints

People who reside in RACF are very vulnerable and are aware of this vulnerability. They may express concerns in a confidential appointment with a psychologist's but hesitate to provide feedback due to fears of retaliation and retribution. They also have poor understanding of the feedback loops due to the circumstances of their admission.

- Psychologists work with the people to increase their confidence in providing feedback (both positive and negative) to the RACF.
- Psychologists also ensure that pathways and organisation structures are well understood by people.
- Specific to dementia, symptoms including memory impairment and delusional thinking are common. A skilled clinical assessment to differentiate real circumstances from possible confabulation[8] is essential, particularly in relation to where complaints are being made.

Standard 7: Human resources

Cultures vary amongst the workforce in RACFs with most people having good intentions to perform their role well but organisational constraints can make it difficult.

- Psychologists can improve the culture of workplaces. Some examples are: measuring the culture of the workplace, suggesting ways to improve the culture (e.g. support a mentoring program for nursing staff), and monitoring the outcome of strategies.
- Psychologists also specialise in communication skills and interpersonal relationships and can therefore bring their specific skills to bear to enhance workplace interpersonal dynamics and team cohesion.

8 Confabulation is a specific symptom of dementia where the person unintentionally invents false information. It is purported to perhaps be an attempt by the brain to fill in missing information. Sadly, while often mistaken for falsehoods or lying, confabulation is a very common symptom of dementia that left undetected can lead to devastating consequences.