Commonwealth Department of Health

Formative Evaluation of the Aged Care Grief and Trauma Package

Final Report

11 November 2021

HealthConsult
Better thinking
Better advice

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Abbreviations

ACAT	Aged Care Assessment Teams
ACP	Aged care providers
ACPR	Aged Care Planning Region
ACGB	Australian Centre for Grief and Bereavement
ACQF	Aged Care Quality Framework
ACQSC	Aged Care Quality and Safety Commission
ACPR	Aged Care Planning Region
ACSA	Aged and Community Services Australia
AIHW	Australian Institute of Health and Welfare
BIDS	Bulk Information Distribution Service
CALD	Culturally and Linguistically Diverse
CHSP	Commonwealth Home Support Package
CMWSS	Beyond Blue's Coronavirus Mental Wellbeing Support Service
COTA	Council on the Ageing
CPD	Continuing Professional Development
CVS	Community Visitors Scheme
CWA	Country Women's Associations
DSA	Dementia Support Australia
DSG	Diversity Sub-Group
DEMP	Dementia Engagement Modelling Program
EAP	Employee Assistance Provider
EPP	Headspace's Early Psychosis Program
FECCA	Federation of Ethnic Communities Councils of Australia Inc
GP	General Practitioner
HCP	Home Care Package
LASA	Leading Age Services Australia
LGBTI	Lesbian, Gay, Bisexual, Trans and Gender diverse, and Intersex*
NDIS	National Disability Insurance Scheme
NOPRG	National Older Persons Reference Group
NSA	National Seniors Australia
OPAN	Older Persons Advocacy Network
PCC	Pearson Correlation Coefficient
PEPA	Program of Experience in the Palliative Approach
PICAC	Partners In Culturally Appropriate Care
PHN	Primary Health Network
RACF	Residential Aged Care Facilities
RAS	Regional Assessment Service
SIRS	Serious Incident Reporting System
SSD	Sector Support and Development

TIS	Translating and Interpreting Service
WHO	World Health Organisation

** This report uses the acronym LGBTI following recommendations from LGBTIQ+ Health that it is preferred by older people, who may not identify with the term “queer” due to negative historical associations.

Executive Summary

Context

The ongoing COVID-19 pandemic has taken a huge toll on the aged care sector, which was described by the Royal Commission into Aged Care Quality and Safety as already under-resourced and overworked, and now (because of the pandemic) traumatised. The "second wave" in Melbourne that started in May 2020 resulted in almost 700 deaths among people receiving aged care[1].

On 14 October 2020, the Minister for Senior Australians and Aged Care Services, Senator the Hon Richard Colbeck announced that the Australian Government was investing $12.4 million in a Grief and Trauma Response Package (the 'Package') to ensure support is available for those affected by COVID-19 across the aged care sector. This Package was part of the $171.5 million COVID-19 response plan for aged care support programs announced in August 2020. A key aim of the Package was to help people affected by COVID-19 in the aged care sector to recover and heal, with an assumption that for many, this may only be possible once the crisis had passed.

Knowing that services funded by the Package would continue to be important for the future, the Australian Government Department of Health (the Department) engaged HealthConsult to provide a formative evaluation to ensure that the supports were well informed with strong data collection processes, and adaptable into the future, and that any barriers to implementation can be identified and addressed.

While it had been thought that once Melbourne's second wave was over the pandemic in Australia was largely controlled, in June 2021 a major outbreak of the Delta strain started in Sydney and soon spread to Victoria and the Australian Capital Territory (ACT). This latest outbreak has resulted in widespread and extended lockdowns and more deaths, including in aged care. Mandatory COVID-19 vaccination requirements for workers in the residential aged care sector were announced in June 2021, with a deadline of mid-September. These elements, together with a significant reform agenda arising from the Royal Commission, have been a particular focus of the sector over the past quarter. This sets the context for what was happening in the aged care sector at the same time this Package was being promoted to the sector.

Overview of the Package

The Package involved funding four organisations to facilitate direct support to aged care recipients, their families and aged care staff through improved advocacy assistance; grief and bereavement counselling; aged care trauma-informed care training; and post COVID-19 dementia support for aged care residents.

The organisations delivering these services are experts in their field and are providing a national response, as well as surge responses in COVID-19 hot spots, where applicable. Two of the funded organisations, the Australian Centre for Grief and Bereavement (ACGB) and Phoenix Australia, work across the Australian community to provide grief and trauma resources and/or support. The other two organisations, Dementia Support Australia (DSA) and the Older Persons Advocacy

[1] "Of 907 deaths from COVID-19 in Australia, to 9 November [2020], 685 (76%) were among residents of aged care facilities, predominantly in Victoria". Independent Review of COVID-19 outbreaks at St Basil's and Epping Gardens aged care facilities, https://www.health.gov.au/resources/publications/coronavirus-covid-19-independent-review-of-covid-19-outbreaks-at-st-basils-and-epping-gardens-aged-care-facilities December 2020, p10:

Network (OPAN), are specialists within the aged care sector. The Department is overseeing the project.

It was identified that there are multiple types of, and layers to grief and trauma, which are cumulative. Left untreated, they can result in mental health issues. The rationale for developing each element of the Package and the need each of the activities were designed to address is as follows:

- **Phoenix Australia**: was commissioned because there was a gap in bespoke information and training for aged care staff, and those caring for senior Australians, to understand trauma and provide trauma-informed care.
- **DSA**: was commissioned because aged care providers and staff need additional training and support to engage people with dementia, in particular those who may be withdrawn and disengaged in response to grief and trauma caused by COVID-19 restrictions and lockdowns.
- **ACGB:** was commissioned because there was a gap in specific supports available for aged care recipients and their loved ones. Furthermore, while aged care staff who had experienced grief and trauma related to COVID-19 may have access to psychological support through their EAP, it was also recognised that EAPs generally do not provide a specialised grief service.

Note: OPAN activities were not in scope for the evaluation.

Overview of the evaluation

The evaluation was guided by the HealthConsult developed theory of change, logic model and evaluation framework which included four key evaluation questions (KEQ). Evaluation data collection infrastructure was designed to gather evidence to inform our analysis against each of the KEQ and included: aged care service providers and other key stakeholders survey (n=127); stakeholder interviews (n=40); nine case studies; survey of aged care recipients, their loved ones and carers (n=47), three focus groups with senior Australians (n=26); and secondary data sources (e.g. literature review on comparable programs, Package development, analytics of website views/ downloads, orders of printed materials, clinical activities logs etc). Analysis of the gathered data has informed the evaluation findings. A key limitation of data gathered to date is that consultation occurred at the same time as the major communications activities, thus levels of awareness reported here may be underestimates.

Evaluation Question 1: How effective has the rollout of the suite of resources and support been?

The awareness-raising of the Package has involved an ongoing and comprehensive campaign, led by the Department using their networks across the sector. The campaign commenced in ~October 2020 and included a media release, newsletter articles, promotional products, a letter and briefing to the aged care sector leadership. Referral scripts were sent to many other mental health help lines and aged care services to build referrals in the community, and emails were regularly sent to a large list of stakeholders (including aged care newsletters, Primary Health Networks (PHN), General Practitioners (GPs), nursing institutions etc) with marketing content for their use. A webinar introducing the Package was hosted by OPAN (28 October 2020[2]). These activities were supported by social media posts across four platforms, resulting in almost 900,000 impressions, and 6,700 users interacting with the posts.

[2] https://vimeo.com/470399441

To ensure the Package reached older people from culturally and linguistically diverse (CALD) backgrounds, the Department invested in material that was available in languages that represent the older CALD communities. This involved funding a radio advertisement in 10 languages and an editorial script in 64 languages that were shared with SBS radio and ethnic media (~January 2021). These communications were supported by brochures outlining the supports available under the Package in 64 languages, and a poster in 11 languages. Understanding that older people prefer to receive information in print, the Department also printed and mailed information packs about the Package (~July 2021) to three key groups: aged care providers (~N=6,000), CVS auspice organisations (~N=200) and home care recipients (~N=130,000). The letters sent to the home care recipients were provided in the home care recipients' preferred language, which is the first time the Department has done this. A brochure and social media were also created by an Indigenous designer for Aboriginal and Torres Strait Islander Peoples. This approach was comprehensive and inclusive.

All print resources, including those prepared by ACGB and Phoenix Australia, were set up at a distribution centre, where items could be delivered free of charge to any interested parties, with stakeholders encouraged to order and share in their organisations and communities.

From those that responded to the stakeholder survey, 54% were aware of services available under the Package. Of those that were aware of at least one element of the Package, 40% were from Victoria and 31% from New South Wales (NSW), with 68% working for an aged care provider. Also, 65% of them stated that the services and resources increased their awareness of grief and trauma, suggesting that the Package is achieving one of its core objectives.

Stakeholders consulted felt it was positive to have something specific for the aged care sector and anticipated high interest from providers that knew about it. At the same time, stakeholders noted that they had to be selective about which information to disseminate to their networks to not overburden recipients. Stakeholders reported that the current volume of information coming from the Department to the sector, including on regulatory requirements, COVID vaccinations, and a range of other topics has made it difficult to get across the Package detail and promote it effectively.

Factors that have negatively impacted awareness of the Package include changes in Department staffing and roles in its state and central offices due to the national COVID-19 response and vaccination rollout, perceptions that the Package was targeted to those who had experienced significant COVID-19 outbreaks, and multiple competing priorities for aged care providers including regulatory requirements. Providers and aged care peak bodies interviewed suggested the supports needed ongoing promotion so that they would be front of mind when people were ready to connect.

The communications activities carried out by the Department have been targeted to the key audiences –aged care providers, aged care recipients and their loved ones (e.g. family and carers), and aged care workers. The trend in call volumes and website traffic to funded organisations is increasing and given both the challenges of the external environment and the timeframe of data collection for the evaluation (being within only one month of the major Department communications activities) – an increasing trend is positive – it suggests there is a need and that the promotion efforts are having an impact. Printed resources have been ordered in every language available, and in every state in Australia, indicating that providers see value in offering printed information about grief and trauma to staff and aged care recipients in their preferred language.

The most successful awareness-raising activities involve sector professionals (primarily aged care providers), where awareness converted to the use of services/resources approximately half of the time (i.e., if sector professionals were aware of the Package there were more likely to use it). The aged care recipients, loved ones and carers, consulted via the survey and focus groups were not specifically targeted for their experiences of COVID-19 grief and trauma, and the numbers

consulted were small. It is therefore unsurprising that few of them indicated having used the Package. However, given the aged care recipients, loved ones and carers, were an OPAN Consumer Reference Group and OPAN was one of the four funded organisations, they are well engaged.

Suggestions to improve the rollout of the Package provided by stakeholders include:

- Provide detailed briefings on the Package to help stakeholders at all levels (including government and sector professionals) to understand how the supports offered under the Package can benefit them, which would likely improve usage. Consider hosting regional forums to do this, for example as part of the Sector Support and Development (SSD) program, which brings together stakeholders from across the sector to learn about and discuss key changes and initiatives.
- Consider how to strengthen internal Department communication channels to ensure relevant information reaches the appropriate stakeholders
- Provide “quick bites” short informational videos about Package elements to assist end-users to navigate to the resources relevant to them.
- Clearly identify how the Package links with the Aged Care Quality Standards’ requirements to provide person-centred care, in communication with aged care providers.
- Review the terminology of promotional resources and consider moving away from ‘COVID-19’ and ‘grief and trauma’ to more emotive language that people can recognise themselves in and connect with. Consider conducting market research and user testing to determine the most suitable labelling.
- Consider leveraging more existing platforms that aged care recipients and their loved ones already access to communicate information about the Package including:
  - engaging directly with community connectors and aged care navigators
  - inviting networks to call for expressions of interest and/or nominate influential members to participate in information sessions or “train the trainer” activities
  - further engaging with health providers and provider networks (such as PHNs), volunteer-based organisations, local councils, and other representative groups.

Key findings

- The Department engaged in a comprehensive campaign to promote the Package, including leveraging networks across the sector and writing directly to aged care recipients in their preferred language
- Uptake of printed resources has been strong, with information ordered in every language available and in every State and Territory.
- Over 50% of sector stakeholders consulted were aware of at least one element of the Package, and of those, over 50% had used it
- Stakeholder awareness was compromised by multiple competing priorities including regulatory requirements and COVID-19 outbreaks in parts of Australia.
- Awareness and uptake were lower among aged care recipients, their loved ones and carers, consulted, noting that the number consulted was low, the major communications activity happened at the same time as the consultation. Aged care recipients known to be affected by COVID-19 outbreaks in aged care were not specifically targeted.

- Suggestions to improve awareness and uptake include continuing to promote the Package, strengthening and leveraging existing relationships and networks, and message testing to ensure stakeholders understand the purpose and intended audience.
- The best way to reach people in residential aged care was considered to be indirectly, via the networks supporting care recipients that includes loved ones, families and carers, medical professionals, volunteers, and aged care providers. This was also considered true of older people more broadly, who may prefer to receive information through trusted networks.

Evaluation Question 2: How appropriate and relevant are the supports to the audience who need them?

After the Package was announced, the Department established a consultation group (n= 27) to ensure a co-design mechanism supported the design and implementation of the Package. The group was established to support the Department and funded organisations under the Package with ad hoc direction, testing and feedback on materials, supports and advice on implementation. As the group had expertise and networks across health, general practice, mental health, trauma, dementia, ageing, nursing, aged care (through policy, sector organisations and aged care providers) and diversity, they were established to assist with co-designing the materials to ensure they were practical to use, inclusive and culturally safe.

The evaluation found evidence that the funded organisations, as well as the Department, have sought input from the established consultation group as well as the broader community and/or sector stakeholders in a co-design approach. Examples of how the co-design approach has influenced the rollout of the Package include:

- The design of the promotional poster and brochure carefully considered how to represent the Package to diverse stakeholders i.e. photographs were of older people from a wide range of cultural backgrounds, the brochure depicted the LGBTI (rainbow) and trans flags, links were included for Translating and Interpreting Service (TIS National) and Auslan, as well as links to other mental health supports. It also included a visible inclusivity statement.
- ACGB has partnered with LGBTI, Forgotten Australians and Aboriginal and/ or Torres Strait Islander Communities to develop and refine fact sheets to better meet the needs of these audiences.
- Phoenix Australia engaged with five aged care organisations as well as diversity stakeholders and lived experience experts to understand sector experiences with and responses to trauma, develop a trauma-informed approach to aged care service delivery, and communicate this through practical resources.

Acknowledging the efforts to co-design the information and services funded under the Package, there were suggestions on how the process could be further improved by:

- seeking early feedback from relevant stakeholders on their needs for an effective co-design process, to facilitate continued engagement in the co-design process
- including larger print on Package information so that it is suitable for those with vision impairment
- ensure translation verification processes involve review by appropriate community representative(s), as it was reported that some of the translations did not maintain the intended meaning or were pitched at a level too high for the intended audience
- using Google translate (on ACGB website) is not appropriate as it lacked quality control of translated text.

The main intended users of the Package were aged care recipients, their loved ones and carers, (people receiving aged care and their loved ones), and the aged care workforce. Services provided by Phoenix Australia and DSA were focused on upskilling the aged care workforce to provide trauma-informed care and access self-care.

- There was limited data from providers who had engaged with the Package and therefore limited feedback obtained from providers about whether the Package was relevant to helping them to achieve the intended Package purpose – that is, to upskill them to trauma-informed care. Rather, much of the feedback was about the impact of the COVID-19 lockdowns on staff, and the grief and trauma they experienced themselves. A key factor was multiple competing priorities across the sector that reduced capacity to learn about and engage with the Package, which was coupled with a lack of urgency concerning the perceived need.
- There was widespread agreement from stakeholders that the Package was extremely relevant to aged care recipients and their loved ones.
- Stakeholders welcomed the efforts to improve both provider knowledge of and aged care recipient access to mental health supports.

While there may be barriers to some diverse groups accessing and utilising the supports provided through the Package, there were no reports from stakeholders of diverse groups experiencing any disadvantage because of utilising the supports.

Key findings

- Stakeholders from across the sector welcomed the Package and found it highly relevant.
- The Package was designed with consideration of stakeholders, particularly with diverse needs, using a consultative group to engage in a process of co-design. ACGB and Phoenix Australia have also undertaken specific strategies to ensure their resources and supports are culturally safe and appropriate for diverse audiences.
- There are opportunities for improvement in both information design and the translation verification processes to ensure the resources meet the need of the intended audiences. This includes preparing information in plain English, considering cultural meaning and practices around grief and trauma when preparing translated resources, and ensuring translation verification is conducted by appropriate community representative(s) with experience of the target audience.
- Limited feedback could be gathered from providers who had engaged with the Package, largely due to external factors that had reduced their capacity to fully explore it.

Evaluation Question 3: Have the supports been effective in improving the aged care sector's ability to access grief and trauma supports in a timely manner?

Providers, capacity-building organisations, and senior Australian representatives identified that people working in aged care typically understood grief as this is a key part of working in aged care; however, they may not have a good understanding of how to respond to it.

Those who had accessed the Package were positive that it had increased awareness of grief and trauma, and some reported there was an increasing awareness of grief and trauma in the health and aged care sectors, which could only partly be attributable to the Package. It is difficult to establish if the Package has increased awareness by aged care recipients, their loved ones and carers, given the recency of communications about it. It is encouraging that the ACGB is receiving a significant uptake in calls, with 71% of incoming calls in August likely because of the mass mailouts.

Based on the aged care recipient input gathered through the evaluation some senior Australians might equate “grief and trauma support” to human contact, rather than a broader meaning of the word ‘support’, encompassing information and self-care strategies. There may also be some hesitation to engage with the resources based on the contents of the information brochure alone.

> *"What I see with this package is lots of writing, lots of links... I know they’re all great organisations but what does it mean for an older person? Is there a two-minute video that gives me that conversation about, ‘you might never have reached out before but here are the reasons you might do it now’. There’s also no time to build that trust and rapport… Quite often it has to be through the human face of someone they trust.”*
>
> *-Senior Australian representative*

Strong demand for both print (100,000+ orders within 2 months) and online (3,500+ fact sheet downloads) resources is indicative of increasing access to information about grief and trauma among both aged care providers and recipients. This is expected to grow, along with a corresponding increase in awareness of grief and trauma.

Access to supports has continued to grow as they are increasingly promoted, evidenced by increases in printed resources ordered, website traffic, webinar attendance, and phone calls received; and the Dementia Engagement Modelling Program (DEMP) is working at capacity. High volumes of COVID-19-related information combined with time and workload pressures and the ongoing pressures of the pandemic were key barriers to providers accessing supports. Workers may rely on information gatekeepers to disseminate information, which is a barrier if those people are too busy or choose not to disseminate. A continued multi-pronged approach to dissemination and targeted messaging may help workers to identify and access supports via their other networks (e.g. social media, health professionals, peers). For aged care recipients and providers, there was some uncertainty if the supports were for them.

Overall feedback from the sector was very positive from those who have accessed the Package, including the range of resources and formats, languages, and representations of diversity.

> *I think the timing was unfortunate but having it in the well-rounded way of the Package is welcomed. I think it’s a lot of what the sector was wanting with regards to the support and the languages. I think that’s all great. The mixture of having the printed material and online is great as well.*
>
> *-Aged care peak body representative*

> *It was great they talked about the need to understand and respond to people’s diversity and understand that trauma is experienced by people in certain communities because of the inequality they’ve experienced.... Often, we hear the diversity is blamed for the trauma. Representation is important and hearing and seeing different voices and faces is a key aspect*
>
> *-Aged care capacity-building organisation*

Resources to support trauma-informed care have included a workbook for managers and a checklist for staff. Although these have only very recently been released, print orders were made for 1,605 copies of the workbook and 1,647 copies of the booklet.

Response to the first Phoenix Australia webinar was overwhelmingly positive, with 88% of respondents indicating they were satisfied or very satisfied with the quality, and 69% indicating the content was relevant to a great or very great extent.

> *“I am so pleased I took the time to join in today. I run an aged care facility and it is always refreshing to have an alternative way to offer to staff to consider the needs of our residents. I will definitely be looking forward to implementing the tool in my facility”*

-Phoenix Webinar #1 attendee

"What are helpful ways to care for collective trauma within aged care organisations; including staff, residents and families in their struggles?"

-Phoenix Webinar #1 attendee

Given the short timeframe of this evaluation, evidence for capacity-building around trauma-informed care is limited, as these outcomes will take time to achieve and be evaluated. One of the most consistent themes in conversation with aged care providers, workforce, and representatives, is of a sector that is exhausted and overwhelmed. This may be a key barrier to providing trauma-informed care.

"I understand why there's an aim to build capacity but there's no recognition that we're at saturation point. We've got no more to give. Is anybody listening to that?"

-Aged care provider

Despite this, of the 68 stakeholder survey respondents who were aware of at least one element of the Package 36 (53%) stated that 'the services and resources helped provide trauma-informed care, including asking clients or their loved ones about grief and/or trauma they may have experienced due to COVID-19'. Seven (10%) disagreed with the statement, and 25 (37%) were not sure.

A key challenge is that some external factors identified as impacting care providers' priorities (i.e. regulation, compliance, and COVID-19 risk management) thereby limiting engagement with the Package, are themselves causes of grief and trauma. For example, lockdown policies designed to protect aged care residents from COVID-19 have been a significant cause of grief and trauma for residents, their loved ones, and the staff who deal with the aftermath. Care providers are in the unenviable position of needing to carefully balance the risk of a COVID-19 outbreak with other risks to residents' and staff wellbeing.

The secondary data indicates a strong interest in self-care resources for the workforce with print orders including 5,447 Phoenix Australia self-care fact sheets for staff, of which more than 1,000 (combined total) were in languages other than English including Arabic, Simplified Chinese, Filipino, and Hindi; and 3,972 ACGB self-care for workers fact sheets, of which more than 700 were in languages other than English including Arabic, Chinese (Traditional and Simplified), Greek, and Vietnamese.

DEMP and ACGB staff conducted targeted outreach into facilities impacted by COVID-19 outbreaks, including providing telehealth support when physical access was not possible. In the period May-August 2021 DSA proactively contacted seven care homes in NSW and Victoria that had been impacted by COVID-19 outbreaks, to support residents living with dementia who were isolated in their rooms. DSA delivered engagement kits including recommended activity equipment and laminated activity plans and allocated a DEMP consultant to provide ongoing telehealth support as required. DSA was able to establish contact with the homes within 1-3 days of the outbreak and provide support within 3-8 days. Residents supported by DEMP include 32 from CALD backgrounds (31%).

The DEMP program was described as extremely valuable for helping to manage the psychological impacts of lockdowns for residents living with dementia, as well as developing staff capacity to improve the way they interact with residents. Residents were identified for the program if they were withdrawn and disengaged, and the DEMP consultant worked with the lifestyle staff to develop activities to engage the resident.

Stakeholders suggested stronger linkages between the Package elements and others who support aged care recipients, including family and carers, health care providers, volunteers, and trusted networks. Practical strategies for managing challenging situations were highly valued.

Linking elements of the Package to the Aged Care Quality Standards will also help drive awareness and uptake.

Key findings

- Stakeholders who had accessed the Package observed it had increased awareness of grief and trauma, but the picture is less clear for aged care recipients due to limitations of the data.
- Strong and growing demand for resources on trauma-informed care and self-care is supported by consultation data that the resources are very much needed and welcomed in the sector.
- Providers and others who had engaged with the supports reported they were very helpful for improving their knowledge and practice providing care to people who may have experienced trauma.
- Clear linkage of Package elements with Aged Care Quality Standards will assist providers to recognise the value of the Package to their service.

Evaluation Question 4: How efficient and cost-effective are all four components of the Package?

Efficiency and cost-effectiveness were evaluated using a framework for measuring service utilisation, followed by estimating a cost per output relative to similar programs.

Measuring service utilisation involved developing a utilisation index for the three funded organisations (ACGB, Phoenix Australia, DSA) and the Department. The index score consists of four phases: the first about program activities related to initiation or engagement, two phases about activities related to program implementation, and the final one to outcome-related activities. The effectiveness of each phase was estimated using the Pearson Correlation Coefficient (PCC) to determine the correlation between activities. The utilisation index score was estimated from a weighted proportion for each phase multiplied by the PCC. The maximum index score is 1, which represents a full-service utilisation. The cost per output analysis estimates the cost per unit of service, such as fact sheets.

The analysis found that all three funded organisations and the Department have utilisation index scores above the minimum threshold, classified as an effective service utilisation. Two comparable programs identified, Beyond Blue mental health supports program and headspace, were found to also have similar index scores. Unlike the Package, both these programs have been in existence for many years. In terms of cost per output, there were no significant discrepancies between providers on services such as webinars, training resources, and fact sheets. The only component of the Package to have a higher cost per output than comparable programs is DEMP, which likely reflects the higher intensity of this service compared with other identified programs. Overall given the longevity of the comparator programs and the environment in which the Package is being rolled out, the Package is considered both effective and cost-effective.

Key findings

- Overall, the Package is as effective and cost-effective as it can be given the status of the implementation and the impact of the current COVID-19 restrictions.

Suggestions for future

(1) For the future rollout of the Package a continued focus on awareness-raising activities via industry newsletters (those with large networks, such as OPAN, ACSA, LASA etc) and direct communications from the Department.

(2) As part of promotional activities including newsletter articles, share testimonials and stories of people who have accessed the supports, to help the intended audience identify the relevance and benefits for them and include examples that are representative of the diversity in the aged care service recipient population.

(3) Continue the rollout of the Package and awareness-raising activities is continued, as those who used it noted that it increased awareness of grief and trauma, which is one of the first steps to providing trauma-informed care (as per the Theory or Change in Appendix A). At a minimum, the awareness-raising activities should be targeted to providers and other stakeholders (such as government and peaks), as awareness led to use of the Package about half the time.

(4) Department conducts repeat-communications activities and ongoing communications with government stakeholders and aged care providers to account for any staffing losses/replacements during the COVID-19 pandemic response. It will also be important that future communications continue to clarify that the services/ resources are not only for those who have experienced a significant COVID-19 outbreak.

(5) Establish target uptake measures of the Package by the Department and funded organisations, so that future uptake can be assessed against a benchmark.

(6) Department and funded organisations continue to monitor the uptake of Package resources into the future given that the evaluation data collection was undertaken so close to the launch of the major communications about the Package.

(7) Department continues to ensure that all elements of the Package continue to be reviewed and endorsed by key stakeholder groups (including the consultation group) to ensure both the content and the communications strategies are tailored for people with diverse characteristics; including people from CALD backgrounds, people who identify as LGBTI, Aboriginal and/ or Torres Strait Islander Peoples, Forgotten Australians, people experiencing or at risk of homelessness and people with a vision impairment.

(8) Continue to promote the supports, and work with other mental health agencies to link them to a growing awareness of grief, trauma, and mental health to help normalise recognition of and help-seeking for grief and trauma.

(9) An ongoing omnichannel marketing approach targeting networks around the aged care workforce and aged care recipients may help drive access.

(10) Provide clear trauma-informed guidance for the sector on appropriately managing risks of causing harm through extended lockdowns. This may include developing targeted information packages to ensure facilities in hard lockdown have access to information and support and information for loved ones on what to do when the facility is locked down.

(11) Continue to build capacity for peer support to empower communities to support each other. Continue to engage with these networks to grow awareness.

(12) To maximise the cost-effectiveness of the Package review programs for which stakeholders perceive overlap. If there is overlap then the services/ support offered under the Package should be rescoped to minimise the duplication or if no overlap,

the Department should consider promoting the difference in the offerings to ensure aged care sector stakeholders appreciate the difference.

Conclusion

Early indications are that the Package meets an important need and that communications have been effective for driving access. In a sector overwhelmed with information and heavy workloads, the Package is gaining traction and uptake is continuing to grow. Stakeholders agree that it meets an important need and have welcomed the range of formats and languages. There was little feedback from aged care recipients, their loved ones and carers, who had accessed the different elements of the Package, largely because data collection occurred shortly after the major communication of the Package.

Recommendations to support the Package going forward include continued promotion using a range of channels and messaging, ensuring it is clear to network leaders and end-users what the resources are and who they are for. Uptake is likely to increase as the full suite of resources are continually promoted and benchmarked against targets. An ongoing process seeking review and endorsement from key stakeholder groups will ensure resources meet the needs of diverse audiences. Further developments of the Package may include clear trauma-informed guidance for providers for managing lockdowns to best meet the needs of residents, their loved ones, and staff. Clear guidance on how the supports differ from other, similar supports, will assist promotion and ensure the Package continues to be cost-effective.

1. Introduction

This Chapter describes the background to and features of the Aged Care Grief and Trauma Response Package (the Package) for COVID-19 pandemic support and the aims of the formative evaluation.

1.1. Context

The World Health Organisation (WHO) declared the COVID-19 pandemic on 11 March 2020. Never has the aged care sector in Australia faced a challenge like COVID-19. Of the more than 1,000 people have who have died from COVID-19 in Australia[3], the majority were over the age of 70. More than 700 of these people were receiving aged care, most of whom were living in aged care homes at the time of their deaths[4]. Most aged care COVID-19 deaths occurred prior to 31 October 2020, during Victoria's 'second wave'. The RACFs where most deaths occurred are in Melbourne's north-west, which also houses a high proportion of people from culturally and linguistically diverse (CALD) backgrounds. The Aged Care Grief and Trauma Response Package was developed to be a resource to assist the aged care sector to manage and recover from grief and trauma due to the COVID-19 pandemic. This was based on the understanding that once the crisis was over, people would be able to recover and heal.

From the period October 2020 to June 2021, there were limited COVID-19 outbreaks in Australia including various cluster outbreaks in some states that were associated with brief "snap lockdowns", which have impacted RACFs. During this period the findings of the Royal Commission into Aged Care Quality and Safety (the Royal Commission) were handed down[5], and the Serious Incident Response Scheme (SIRS) also came into effect (Box 1). On 28 June 2021, National Cabinet agreed that the COVID-19 vaccination of residential aged care workers would become mandatory by mid-September 2021. Starting in mid-June 2021, the outbreak of the Delta variant in Sydney has been the most significant since Victoria's second wave, resulting in extended lockdowns across multiple states and significant numbers of infections and deaths. A weekly snapshot report of data on the impact of COVID-19 in RACFs nationally includes the number of services impacted and the number of staff and resident cases. At 27 August 2021, 260 RACFs across Australia had had a COVID-19 outbreak, with a total of 2,152 cases in residents and 2,328 cases in staff[6]. A key consequence of this development is that the aged care sector has continued to be on "high alert" regarding COVID-19, in addition to responding to sector-wide reforms.

1.2. Aims of the Package

The Package aims to provide grief and trauma support to the aged care sector, to minimise the impacts of grief and trauma due to COVID-19. It was designed with the concept of recovery, noting that people rarely have the capacity to access supports during crisis, and the impacts of grief and

[3] As of August 31, 2021. https://covidlive.com.au/report/daily-deaths/aus
[4] https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-case-numbers-and-statistics. Accessed 31 August 2021
[5] Royal Commission into Aged Care Quality and Safety Final Report: Care, Dignity and Respect. Volume 1 Summary and Recommendations (2021)
[6] https://www.health.gov.au/sites/default/files/documents/2021/08/covid-19-outbreaks-in-australian-residential-aged-care-facilities-27-august-2021.pdf. Accessed 28/9/21

trauma tend to show up six months or more after the stressor has passed. It was thought that up to 5% of aged care recipients and up to four of their close contacts may need support[7].

The theory of change, presented in Appendix A:, documents the 'big picture' of what the Package is trying to achieve, and steps through how its activities are understood to produce the overall goal. The Package aims are consistent with Chapters 4 and 12 of the Recommendations of the Royal Commission, which highlight the need to improve aged care programs and workforce capability to design and provide services for diversity and complexity including trauma-informed care and dementia care.

Box 1: Significant aged care reforms

Royal Commission into Aged Care Quality and Safety and Aged Care recommendations and Australian Government aged care reforms

The Royal Commission into Aged Care Quality and Safety was established in October 2018 to investigate the quality of aged care services and over several years of submissions, public hearings, and media coverage, uncovered serious failings within the aged care sector. The final report and recommendations for reform were handed down on 30 April 2021, followed by the Australian Government response on 11 May[8].

The Australian Government is investing $17.7 billion over 5 years into aged care reform[9], to produce a once in a generation reform of the aged care system. In 2021 these measures include new monitoring, compliance and intervention to help providers build financial sustainability, capability and resilience, and stronger clinical care standards.

The Serious Incident Response Scheme (SIRS), recommended during previous (2017) reviews[10], was prioritised as part of the response to the Royal Commission and brought forward 3 months to commence on 1 April 2021. SIRS requires every residential aged care service to establish a set of protocols, processes, and standard operating procedures that staff are trained to use for managing serious incidents.

1.3. Overview of the Package

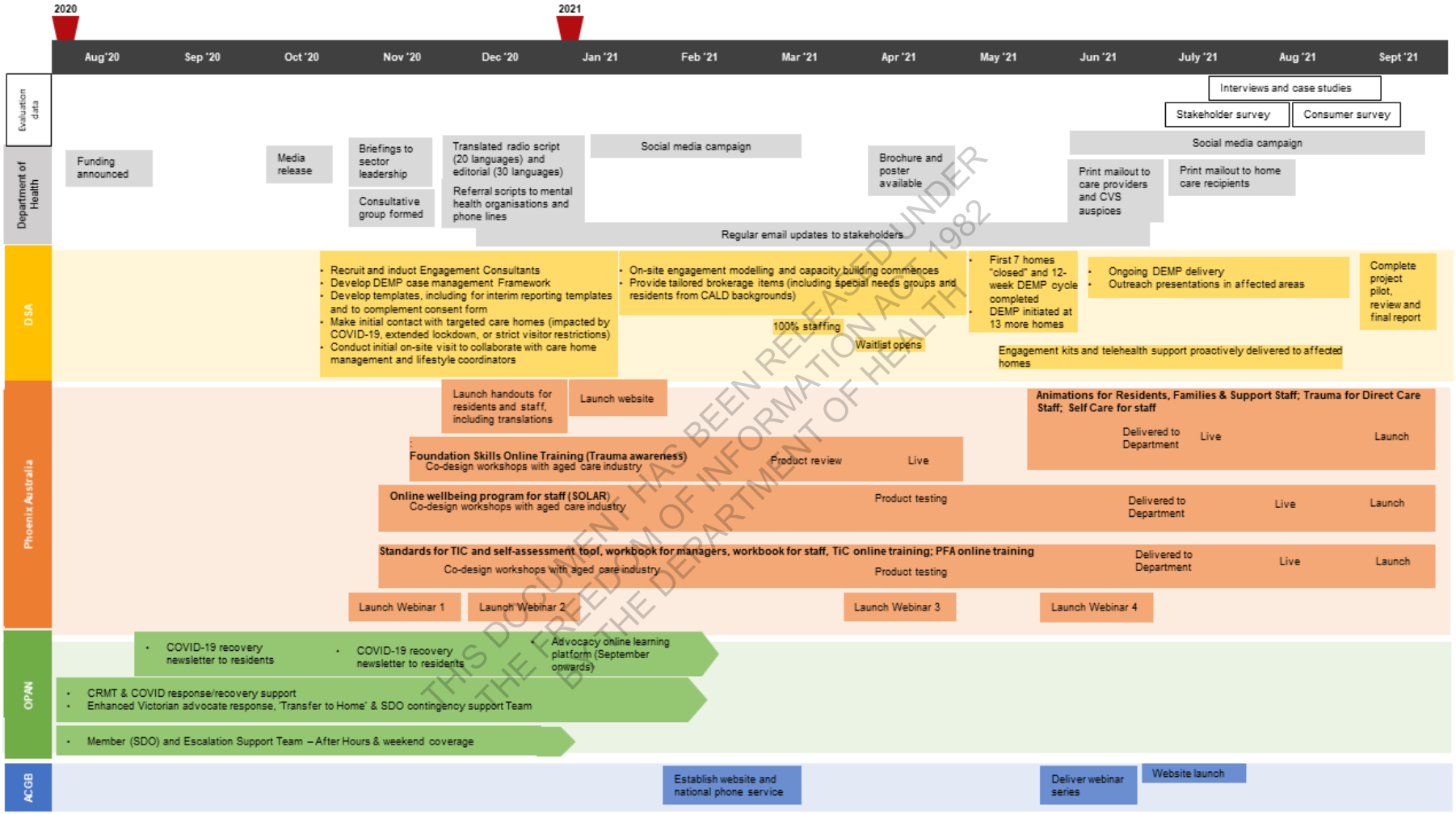
On 14 October 2020, Minister Richard Colbeck announced that the Australian Government was investing $12.4 million in a Grief and Trauma Response Package (the Package) to ensure support is available for those affected by COVID-19 across the aged care sector. The Package involved funding four organisations to facilitate providing direct support to aged care recipients, their families and aged care staff through improved advocacy assistance; grief and bereavement counselling; aged care trauma-informed care training; and post COVID-19 dementia support for aged care residents. This Package was part of the $171.5 million COVID-19 response plan for aged care support programs.

The organisations delivering these services are considered experts in their field and are providing a national response, as well as surge responses in COVID-19 hot spots, as required. Two of the funded organisations, ACGB, and Phoenix Australia, provide grief and trauma support across the Australian community and may be relatively unknown in aged care. The other two organisations, DSA and OPAN, are specialists within the aged care sector. The Department is overseeing the project.

[7] MS20-001077 Attachment A – Grief and Trauma Response Package Scoping. Callida Consulting
[8] https://www.health.gov.au/resources/publications/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety
[9] https://www.health.gov.au/initiatives-and-programs/aged-care-reforms
[10] Department of Health. Review of National Aged Care Quality Regulatory Processes. October 2017; Australian Law Reform Commission. Elder Abuse—A National Legal Response. June 2017

Figure 1 summarises the individual roles of the Department, ACGB, Phoenix Australia, DSA and OPAN[11] in implementing the Package.

Figure 1: Summary of Package components and timelines



[11] Note that OPAN activities are out of scope for this evaluation

1.4. Overview of the evaluation

The evaluation has been guided by the logic model (Appendix B) and Evaluation Framework Appendix C). It sought to assess the development, implementation and operation of the resources, training, services, and projects related to the Package, and assess the extent to which they were accessible to all those who need them, particularly those with diverse needs and/ or characteristics. The four key evaluation questions and corresponding sub-questions for the evaluation of the Package:

(1)	**How effective has the rollout of the suite of resources and support been?**
	1a. What level of awareness and understanding do the key stakeholders have of the Grief and Trauma Package (the Package) and how to access supports under the Package?
	1b. To what extent are elements of the Package being accessed?
	1c. What suggestions do key stakeholders have for improving rollout?
(2)	**How appropriate and relevant are the supports to the audience who need them?**
	2a. To what extent does the Package address identified gaps, needs and/or priorities?
	2b. Are there any diverse groups who may be disadvantaged from utilising the supports?
	2c. How can components of the Package be improved to address any gaps, unmet needs or priorities, and to remove barriers to accessing the Package?
(3)	**Have the supports been effective in improving the aged care sector's ability to access grief and trauma supports and information in a timely manner?**
	3a. How effective has the Package been in increasing awareness of grief and trauma and embedding trauma-informed care in the aged care sector?
	3b. How effective has the Package been in improving access to grief and trauma supports for those who need them?
	3c. Is the aged care sector satisfied with the supports available through the Package?
	3d. How can components of the Package be improved to make the supports more effective and accessible?
(4)	**How efficient and cost-effective are all four components of the Package?**
	4a. What are the costs of the Package relative to its use?
	4b. How do the costs of the Package relative to its use compare to similar programs?
	4c. How could the Package be more cost-effective?

1.5. Structure of this document

This document is a the final report of the evaluation. Each chapter presents the findings relevant to the research questions that guided this review. The document is structured as follow:

- **Chapter 2** presents the evaluation methods
- **Chapter 3** presents the findings related to evaluation question 1
- **Chapter 4** presents the findings related to evaluation question 2
- **Chapter 5** presents the findings related to evaluation question 3
- **Chapter 6** presents the findings related to evaluation question 4
- **Chapter 7** presents our conclusion and recommendations.

2. Methods

This Chapter describes the evaluation methods and data collected to inform this evaluation report. It also presents the sample characteristics and response rates (where applicable).

2.1. Consultation with the aged care sector

2.1.1. Stakeholder survey

A survey was developed to collect data from aged care providers and other key stakeholders across the sector. Questions were designed to explore providers' level of awareness, knowledge and understanding of the Package, enablers and barriers to implementation, and suggestions for improvement. The survey included a mix of multiple-choice, Likert scale and short answer response options.

An electronic invitation to complete the survey was included in the Protecting Older Australians newsletter and was sent to aged care providers and staff in Australia through the Department's Bulk Information Distribution System (BIDS), various aged care peak bodies and distribution lists. Initially planned as a standalone notice, the rapid escalation of COVID-19 outbreaks in NSW and Victoria at that time meant that vaccination notices took priority, so it went into a Protecting Older Australians newsletter among other important updates. The survey was shared weekly in the newsletter, shared on Department social media channels and with stakeholder groups. The survey was hosted on the JotForm software platform and was first disseminated on 27 July 2021 and closed on 2 September 2021. Survey data were extracted into a HealthConsult database and analysed against the evaluation questions using Microsoft Excel.

A total of 137 individuals responded to the survey. Of these, 10 did not identify as an aged care provider, aged care stakeholder organisation (e.g. aged care capacity-building organisation, professional association), community visitor scheme network/auspice or other types of service/organisation in the aged care sector, and therefore did not complete the survey. This left a final sample of 127 respondents.

2.1.2. Stakeholder interviews

The purpose of the interviews was to understand how well known and accessed the supports were across the aged care sector, how effective they were perceived to be, and any suggestions for improvement. The identification of interview respondents was intended to capture a breadth of perspectives including from representatives of senior Australians from diverse backgrounds and experiences. Interviews were conducted with individuals or small groups during the period July to September 2021 and were guided by a discussion guide that was circulated to participants in advance. One person responded to the interview questions via email.

Participants were invited from across the aged care sector, including Australian Government representatives, aged care providers, aged care and senior Australian peak body organisations, and senior Australian representative organisations. As illustrated in Table 1, senior Australian representatives were consulted, including those from CALD backgrounds, LGBTI, and care leavers. Other people with special needs including people who live with disabilities and people living with dementia were also represented. In total 22 interviews were conducted with 40 individuals.

Table 1: Description of interview participants

Stakeholder type	Representing	Number of consultations	Number of individuals	Jurisdictions
Australian Government representatives	Australian Department of Health aged care section (state offices)	3	10	VIC, TAS, SA, NT
Peak bodies	Aged Care Peak bodies (ACSA, LASA)	3	5	VIC
	Nursing/Midwifery Peak bodies	2	2	NSW, VIC
Senior Australian representatives	Commissioner for Senior Victorians	1	1	VIC
	People from CALD backgrounds	1	2	National
	Partners in Culturally Appropriate Care (PICAC)	3	6	VIC, SA, NT, WA,
	LGBTI elders	1	4	NSW, VIC, QLD
	Aboriginal and/ or Torres Strait Islander Elders	1	1	VIC
	Forgotten Australians	1	2	VIC
	Dementia Australia	1	1	National
	Australian Deaf Elders	1	1	National
	OPAN	1	2	National
Aged care workers	Home care case manager	1	1	VIC
Aged care provider	CHSP provider	1	1	NSW
	People experiencing or at risk of homelessness	1	1	VIC
Total		**22**	**40**	

2.1.3. Case studies

The purpose of the case studies was to explore in detail aged care providers' experiences with accessing and using the supports under the Package, including RACFs and home care providers. Providers were asked which elements of the Package they were (or were not) using, their experiences, successes, and challenges with this, and their reflections on what was working well and what can be improved.

Most case studies were identified via the stakeholder survey. Thematic analysis of the case study interview data was analysed together with the thematic analysis from the interview and focus group data to address the evaluation questions.

Respondents to the stakeholder survey (refer Section 2.1.1) were invited to self-nominate to participate in a follow-up case study by providing their contact details. This yielded 21 nominations, seven of whom later declined to participate or could not be contacted. Two others were out of scope for the evaluation. Four survey respondents, who were not aged care providers and/or had not accessed the Package, were followed up by interview (rather than case study). Two case study sites that had participated in the services provided by DSA were identified in consultation with DSA. In total, nine case studies were completed, across a mix of aged care settings (residential and home care), service size and metropolitan and regional settings. This includes four residential care providers and two home and community care providers. Three capacity building service organisations, with the function of upskilling aged care providers and staff, for example in responding to diversity and/or providing trauma-informed care, were also included. Participants were from both metropolitan and regional settings (Table 2).

Table 2: Characteristics of case study participants

Service type	Jurisdiction	Remoteness	Size	Target groups	Number of participants
Residential care provider	SA	Metropolitan	156 beds across 2 locations	Veterans	1
	QLD	Regional	48 beds	All	1
	NSW, QLD	Metropolitan, Regional	43 residential homes, 3000 residents	All	4
	VIC	Metropolitan	104 beds	All, including secure dementia unit	1
In home and community care	WA	Metropolitan	> 800 clients from 67 backgrounds	CALD and LGBTI	1
	NSW, QLD, VIC	Metropolitan, Regional	>150 home care employees	Culturally, religiously, gender-appropriate care. Currently 22 different client languages and culture groups	1
Capacity building service	VIC	Metropolitan	7 LGAs	Embedding diversity, reablement, and wellness practice in HCP	2
	VIC	Regional	25 CHSP and HCP providers	Providing safe and inclusive services in-home care	1
	QLD	Regional	Training project with 6 regional residential providers	Includes specialist Aboriginal and/ or Torres Strait Islander providers	1

2.2. Consultation with expert diversity advisors

Three expert advisors were engaged for the duration of the project, to provide advice on the consultation approach and the Package itself with a particular focus on suitability for diverse audiences. Together, they provided advice about older people from CALD backgrounds, older people who identify as LGBTI, and Aboriginal and/ or Torres Strait Islander older people.

The expert advisors provided advice on designing consultation instruments and the consultation approach, including networks for the dissemination of surveys. They also provided individual advice on the accessibility of Package elements for diverse audiences via a combination of group discussions, written feedback, and individual discussions. Their views are reported together with those of senior Australians.

2.3. Consultation with aged care recipients, their loved ones, and carers

Consultation with senior Australians was aimed at people receiving aged care and their loved ones and focused on the elements of the ACGB and Phoenix Australia resources and supports designed for them. It was not anticipated that this audience would have any awareness or understanding of the DEMP service provided by DSA due both to the very specific nature of that service and its small footprint.

Discussions with advisors identified that some Greek communities in Melbourne had been heavily impacted by the pandemic and may benefit from resources under the Package. Greek-speaking migrants represent one of the largest and most strongly established CALD communities in

Australia, making up approximately 2% of all older people born overseas[12]. Moreover, stakeholders connected with Greek communities identified they had previously been willing to engage with surveys disseminated online and thus may offer insights into awareness and uptake of the resources among CALD communities.

2.3.1. Survey of aged care recipients, their loved ones, and carers

A survey of aged care recipients, their loved ones and carers was developed to determine the:

- level of awareness of the Package among these cohorts
- effectiveness of the Package in increasing awareness of grief and trauma
- components of the Package that could be improved to make it more effective and accessible.

The survey was targeted towards people receiving aged care and their loved ones. Survey questions were designed to explore how aged care recipients, their loved ones and carers, accessed the available grief and trauma services, and their preferred method to hear about ways to access these services. The survey included a mix of multiple-choice, Likert scale and short answer response options.

The survey was submitted to and approved by Bellberry Human Research Ethics Committee in August 2021. It was translated into Greek by Polaron translation services. The English and Greek versions were both prepared as an online version in addition to a downloadable printable pdf in large font that respondents could return to HealthConsult by reply paid mail.

The English language survey was disseminated together with an accompanying article in the Protecting Older Australians (BIDS) newsletter and via senior Australian networks including OPAN and Council on the Ageing (COTA) as well as the Department of Health Facebook page. It was disseminated to Community Visitors Scheme (CVS) auspice organisations by the CVS networks. The Greek version was sent to Greek aged care providers including Pronia, and networks including Partners in Culturally Appropriate Care (PICAC) on 19 August and was open until 13 September 2021.

Survey data were extracted into a HealthConsult database and analysed against the evaluation questions using Microsoft Excel.

A total of 54 responses to the online survey were received, including one response to the Greek version. One person who initiated the Greek survey did not consent to their data being reported and therefore did not commence the survey. All respondents reported completing the survey on their own without assistance. Seven responses were excluded from analysis because they were not eligible[13] or empty. No paper responses were received. The final data sample consisted of 47 respondents:

- 38 had loved ones who had received/ were currently receiving aged care
  - 34 received care in a residential facility, including two who also received care at home or in the community
  - four received care exclusively at home or in the community

[12] Older Australia at a glance. Australian Institute of Health and Welfare (September 10, 2018) https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/demographics-of-older-australians/culturally-linguistically-diverse-people. Accessed 27/9/21)

[13] Eligible respondents were those receiving aged care or with a loved one in aged care. Two respondents did not receive or have a loved one receiving aged care. Three respondents worked in aged care.

- seven had received/were currently receiving aged care themselves
  - All received care at home or in the community
- two received care and had a loved one receiving care
  - For one respondent both they and their loved one received care in a residential facility; whereas, for the other, both people received care at home.

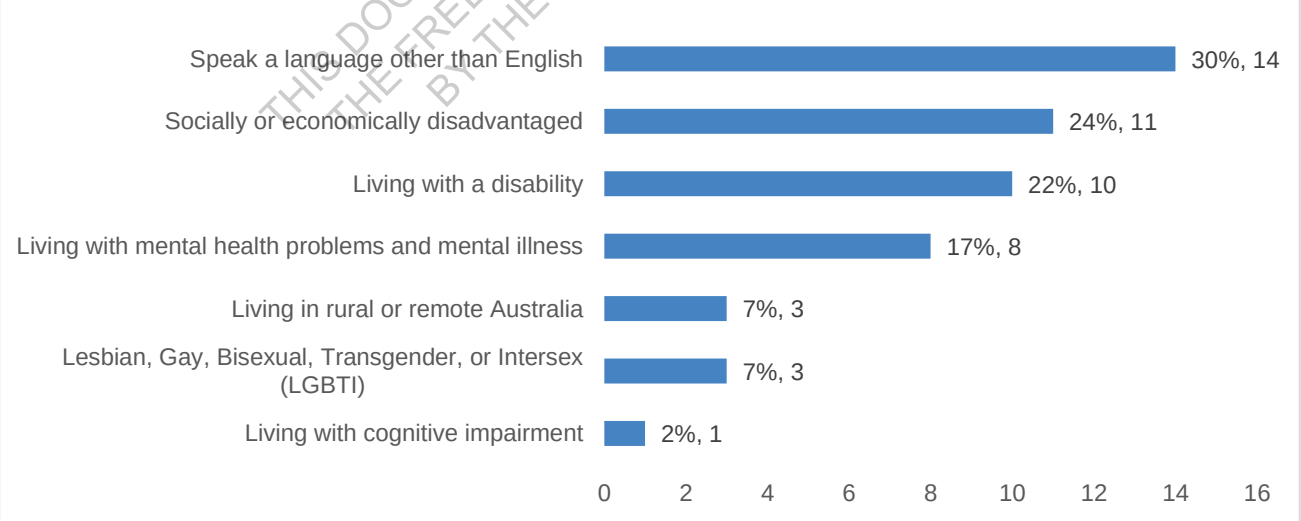
A full breakdown of survey respondents by jurisdiction, age group, gender and Aboriginal and Torres Strait Islander status is provided in Table 3. No respondents identified as Aboriginal and/ or Torres Strait Islander. Approximately one-third of survey respondents (14, 30%) reported speaking a language other than English and almost a quarter reported they were socially or economically disadvantaged (11, 23%) and/ or were living with a disability (10, 21%). This diversity is captured in Figure 2. Notwithstanding the small sample size, with some limitations, this sample offers a reasonable representation of the diversity of people accessing aged care services.

Table 3: Characteristics of respondents to survey of aged care recipients, their loved ones and carers

Jurisdiction of residence	Age group		Gender			Aboriginal and Torres Strait Islander		Total
	Less than 65 years	65 years or older	Female	Male	Prefer not to say	No, neither	Prefer not to say	
Australian Capital Territory	3	0	3	0	0	3	0	3
New South Wales	7	10	12	4	1	17	0	17
Queensland	2	3	4	1	0	5	0	5
Victoria	16	5	16	5	0	20	1	21
Western Australia	0	1	1	0	0	1	0	1
Total	**28**	**19**	**36**	**10**	**1**	**46**	**1**	**47**

Source: Survey of aged care recipients, their loved ones and carers

Figure 2: Characteristics of respondents to survey of aged care recipients, their loved ones and carers*



*n=47 respondents. Note that respondents could identify multiple characteristics

2.3.2. Older Persons COVID-19 Support Line survey

To test awareness of the Package amongst older people, a brief telephone survey of inbound callers to the Older Persons COVID-19 Support Line (the support line) was conducted. The support

line service, funded by the Department, has a wide reach and makes and receives calls from thousands of senior Australians, to help manage concerns related to COVID-19.

The support line is staffed by five organisations. The general information line, which has the highest volumes of inbound calls, is managed by National Seniors Australia (NSA; 240-320 inbound calls per month) and COTA Australia (150-170 inbound calls per month).

From the period 12 August 2021 to 6 September 2021, callers to the general information line were invited to respond to a three-question survey about the Package. The first question screened whether they were part of the target demographic (i.e. an aged care recipient or loved one). If the person was part of the eligible demographic the next questions concerned whether they were aware of the ACGB or Phoenix Australia supports, followed by optional questions that requested gender and postcode. Respondents who indicated that they nor a loved one were receiving aged care were thanked for their time and the survey was closed.

NSA collected 56 survey responses between 16 and 31 August 2021 inclusive. COTA collected 84 survey responses between 12 August to 6 September 2021 inclusive. Of these 140 responses, only 29 were from eligible respondents; with eligibility defined as respondents who were either receiving aged care or had a loved one receiving aged care. Most eligible respondents (27 of 29, or 93%) were surveyed by COTA Australia. Eligible respondents were mostly female (17 of 29, or 59%), and primarily from NSW (16 of 29, or 55%) and Victoria (9 of 29, or 31%).

2.3.3. Senior Australian focus group

The National Older Persons Reference Group (NOPRG), coordinated by OPAN, is a group of 35 older Australians, including aged care recipients and their loved ones, who meet regularly via Zoom to bring the voice of older people to OPAN's work and to the Government. The group includes representatives from several diverse groups, including people from CALD backgrounds, LGBTI people, Aboriginal and Trees Strait Islander Peoples and people living with dementia. Many members are connected to wider advocacy networks.

Three HealthConsult representatives attended the August 2021 meeting of the NOPRG to discuss the Package. HealthConsult had previously introduced the group to the Package at the June meeting and shared some of the information materials (including the brochure) via the agenda papers and screen sharing during the meeting. After reviewing the aims of the Package and the evaluation with the full group, participants were allocated to one of three breakout rooms to discuss their impressions of and experience with the Package in more detail with a HealthConsult consultant. Small group discussions took approximately 20 minutes.

In total 26 people (15 women and 11 men) participated in the focus groups of 8 or 9 people. Participants were from metropolitan and regional, areas across Australia, and included aged care recipients, carers, CVS volunteers, and former aged care nurses.

2.4. Secondary data

Secondary data were collected from the Department and from the four funded organisations to inform the evaluation. This included information about Package development, analytics of website views/ downloads, orders of printed materials, clinical activities logs, and case studies.

2.5. Literature review

A literature review was carried out to identify a comparable program (the 'Alternative Program') that has available output data on the following, which informed the analysis of the efficiency and cost-effectiveness of the Package:

- call rates to services regarding grief and bereavement
- website traffic relating to program
- webinar attendance rates for relevant webinars
- social media post-click rates, click-throughs, downloads etc
- material order rates from National Mail and Marketing.

The following database and sources were searched using terms designed to identify programs to address the psychological impact of grief and/or trauma:

- **PubMed** database was searched on 15 February 2021 and 3 March 2021, using the search terms "*grief and trauma program*" and/or "*bereavement program*" and/or "*mental health program*" and/or "*aged care*" and/or "*cost-effectiveness*" and/or "*program evaluation*" and/or "*COVID-19*" and/or "*pandemic*" (the first 50 citations were retrieved and screened)
- **ScienceDirect (Elsevier**) was searched on 15 February 2021 and 3 March 2021, using the search terms "*grief and trauma program*" and/or "*bereavement program*" and/or "*mental health program*" and/or "*aged care*" and/or "*cost-effectiveness*" and/or "*program evaluation*" and/or "*COVID-19*" and/or "*pandemic*" (the first 100 citations retrieved were retrieved and screened)
- **Wiley Online Library and BMJ online** were searched on 15 February 2021 and 4 March 2021, using the search terms "*grief and trauma program*" and/or "*bereavement program*" and/or "*mental health program*" and/or "*aged care*" and/or "*cost-effectiveness*" and/or "program evaluation" and/or "*COVID-19*" and/or "*pandemic*" (the first 50 citations were retrieved and screened)
- **Google and Google Scholar** were searched on 15 February 2021 and 4 March 2021, using the search terms "*mental health program*" and/or "*grief and trauma program*" and/or "*bereavement program*" and/or "*aged care*" and/or "*cost-effectiveness*" and/or "*program evaluation*" and/or "*COVID-19*" and/or "*pandemic*" (the first 200 sources and citations were retrieved and screened).

Results of the literature review are presented in Appendix D. The two most comparable programs were Beyond Blue's Coronavirus Mental Wellbeing Support Service (CMWSS) and headspace's Early Psychosis Program (EPP). They were selected as they have many comparable elements to the Package; they are based in Australia, and have service utilisation and costing data available (via annual reports) to inform the cost-utility analysis.

2.6. Cost-utility analysis

A cost-utility analysis was undertaken to determine the cost of the Package relative to its 'use', compared to similar program(s). Further details about this are presented in Chapter 6.

2.7. Limitations

The data that informed this evaluation has limitations that have implications for interpretation:

(1) Responses to the stakeholder survey were low with fewer than 150 responses (compared to over 400 responses for other projects conducted by HealthConsult with the same stakeholder groups), which limits the generalisability of responses. This is likely to be due to external factors, including a high volume of competing COVID-19 notices to the sector at that time:

- At the time of data collection, a significant COVID-19 outbreak that started in Sydney in mid-June 2021 had escalated into regional NSW, the ACT, and Victoria, with other jurisdictions on high alert.

- There were multiple competing priorities for the sector at the time of data collection. This includes responding to the aged care reforms announced by the Australian Government in response to the Royal Commission, and the September 2021 deadline for mandatory COVID-19 vaccination for aged care workers.
- Significant staff turnover in the aged care sector during 2020-2021 has reportedly resulted in a loss of organisation memory, including at facilities highly affected by COVID-19 outbreaks, and the new management may not fully appreciate the impacts of grief and trauma on staff and care recipients.

(2) The most significant communications about the Package to date both to the sector and direct to aged care recipients (i.e. mass mailout) occurred from June to August 2021, while the primary evaluation data (i.e. surveys, interviews, and case studies) were collected from July to September 2021. This may have been insufficient time for stakeholders to fully engage with the resources and build them into referral and training systems.

(3) The consultation with aged care recipients, their loved ones and carers did not purposively target individuals known to be bereaved by COVID-19 who may have received targeted communications about the Package.

(4) Awareness of ACGB and Phoenix Australia resources and supports should be interpreted in light of the fact that both were new to aged care and relatively unknown across the sector, at the time the Package was launched.

(5) Several key resources, including Phoenix Australia's trauma-informed care training for staff and managers, Phoenix Australia's staff wellbeing program, Phoenix Australia's animations, were either not yet live and/or had not been fully launched at the time of data collection. The ACGB website had only been live for a couple of months. This may have impacted access to and understanding of the Package and led to a level of awareness about the Package that was not commensurate with the large-scale communications activities carried out by the Department to advertise it.

3. Effectiveness of the rollout

This Chapter presents findings in relation to KEQ 1: *How effective has the rollout of the suite of resources and support been?*

3.1. Question 1A: What level of awareness and understanding do the key stakeholders have of the grief and trauma package and how to access supports under the Package?

This question is answered by firstly exploring the activities undertaken to promote the Package before presenting the level of awareness and understanding by the sector and then aged care recipients.

3.1.1. Activities to promote the Package

Each of the funded organisations promoted the Package and their specific elements to their networks. All the organisations promoted their services through social media and direct outreach to affected residential aged care facilities (RACFs) and remained flexible to adapt their services to an environment of evolving lockdowns and outbreaks. For example, ACGB[14] and DSA delivered support via telehealth to locked-down facilities.

The Department supported the awareness-raising of the Package through their networks across the sector, noting that two of the four providers of the Package were new to the aged care sector. The Department campaign commenced with a media release (~October 2020), newsletter articles, promotional products, and a letter and briefing to the aged care sector leadership. This information was also shared with the consultative group and stakeholders. A social media campaign (posts and accompanying text) on four Department platforms resulted in almost 900,000 impressions (i.e. the number of times content was displayed to someone's social media feed), and 6,700 users interacting with the posts to August 2021. OPAN assisted with hosting a webinar for the Department, introducing the Package, and talking through the services/supports provided by funded organisations. This was followed by audio and transcripts for a radio advertisement in 10 languages[15] (Appendix F.1) and an editorial script in 64 languages that were shared with SBS radio and ethnic media (~January 2021). These communications were supported with an information brochure in 64 languages (Appendix F.1), a poster in 11 languages, and emails to stakeholders with marketing content for their use. A brochure and social media posts were also created by an Indigenous designer for Aboriginal and Torres Strait Islander Peoples.

The Department was aware that older people prefer to receive information in print and understood that many older people would like to receive information in a language other than English. The Department printed and mailed information about the Package (~July 2021) and the available supports to three key groups:

- **Approximately 6,000 aged care providers** (RACFs and home care providers) for them to share with aged care recipients, staff, and communities. The mailout included an information starter pack containing a letter, 20 information brochures, 5 x information posters, 20 x

[14] ACGB have also been funded to undertake a marketing campaign with Clemenger BDO. Market research has been underway doing 2021 with launch expected later this year

[15] https://www.health.gov.au/resources/translated/coronavirus-covid-19-radio-grief-and-trauma-support-for-those-impacted-by-covid-19-in-the-aged-care-sector-other-languages Accessed 221021

brochures on the CVS, and a resources order form to order extra resources and translated content. These packs of information were intended to ensure that every aged care provider knew about the Package, and displayed the posters to raise awareness for aged care recipients and staff, and to take pressure off aged care staff at a busy time so that services would not have to place an initial order themselves.

- **Approximately 200 CVS auspices** were mailed the same packs that were sent to aged care providers, with a tailored cover letter for CVS auspices. This letter identified that supports were available for CVS volunteers and their friends who receive aged care.
- **Approximately 130,000 home care recipients and their nominated representatives, including those who are approved for a package and on the waiting list** received a letter and brochure directly from the Department, which were translated into their preferred language as nominated on their My Aged Care profile. The letter and brochure explained the supports available under the Package. This was the second time that the Department has undertaken a mail out to home care recipients that wasn't related directly to their care package, and the first time that the Department has communicated with aged care recipients in their preferred language.

Other modes of communications from the Department about the Package included:

- **The COVID-19 specific aged care sector newsletter and Department social media** to provide reminders about what free services are available and launch the Package resources and supports as they became available.
- **Sharing with other services and websites** to raise awareness at the community level. The Department has shared referral scripts, brochures and posters with other mental health services including Lifeline, Beyond Blue, OPAN, the Older Persons COVID-19 Support Line, CVS networks, DSA, Friend Line, HealthDirect, the My Aged Care Call Centre and Q Life. The Department also ensured that information about the package was available on the Head to Health gateway and My Aged Care websites. They also regularly provided information to Aged Care Assessment Teams (ACAT) and Regional Assessment Service (RAS) teams, who perform aged care assessments at the community level, so that they can share information and make referrals as needed.
- **Sharing with allied health and PHN and nursing organisations** in newsletters and via presentations. The Department presented to the PHN CEOs at the commencement of the Package and regularly communicated updates. Information has been shared in GP newsletters from the Department, in nursing newsletters from the Department (via the Chief Nursing and Midwifery Officer), through direct contact with nursing unions and nursing mental health organisations, and in mental health webinars from the Department to mental health practitioners.
- **Sharing with Department contacts** through sending updates to the State and Territory networks, working regularly with mental health stakeholders in the Department, and presenting to the leadership of the Ageing and Aged Care Group (including the Aged Care Quality and Safety Commission (ACQSC)) on elements of the Package.

3.1.2. Awareness and understanding of aged care providers, peak bodies and government

A snapshot of the level of awareness of elements of the Package (to date) among providers and other stakeholders who responded to the stakeholder survey is below:

- 68 of 127 respondents, or 53.5% were aware of at least one of the services (noting that respondents could select more than one response):

  - 40 of 127 (31.5%) were aware of services provided by Phoenix Australia, with 21 of 40 (52.5%) having used it or recommended it to someone else
  - 58 of 127 (45.7%) were aware of services provided by ACGB, with 17 of 58 (29.3%) having used it or recommended it to someone else
  - 38 of 127 (29.9%) were aware of services provided by DSA, with 13 of 38 (34.2%) having used it themselves or recommended it to someone else.
- 59 of 127 respondents, or 46.5%, were not aware of any of the services provided by ACGB, DSA or Phoenix Australia

The distribution and service type of respondents who were aware of at least one element of the Package is outlined in Table 4. Of 68 respondents who were aware of at least one element of the Package, 27 (39.7%) were from Victoria and 21 (30.9%) from NSW with 46 of 68 (67.6%) working for an aged care provider.

Table 4: Location of survey respondents aware and/or had used elements of the Package

State/Territory	Aware of at least one element of the Package	
	Number	Percent
Australian Capital Territory	1	1.5
New South Wales	21	30.9
Northern Territory	0	0.0
Queensland	7	10.3
South Australia	7	10.3
Tasmania	2	2.9
Victoria	27	39.7
Western Australia	3	4.4
Not reported	0	0.0
TOTAL	**68**	**100**
Service type		
Aged care provider	46	67.6
Community Visitor Scheme network/ auspice	4	5.9
Aged care stakeholder organisation	5	7.4
Other organisations in the aged care sector	13	19.1
TOTAL	**68**	**100**

*Calculated as a proportion of the 68 respondents who were aware of at least one element of the Package

Of the 68 respondents who were aware of at least one element of the Package:

- The most common modes of learning about the Package were via a newsletter article (Protecting Older Australians notice, OPAN, Aged and Community Services Australia (ACSA), Leading Age Services Australia (LASA) or other); cited by 36 of 68, or 52.9%, respondents and 32 of 68 (or 47.1%) became aware via direct communication from the Department (see Table 5); and
- 44 (64.7%) stated that ‘the services/ resources increased my awareness of grief and trauma among aged care recipients’. Five (7.4%) disagreed with the statement, and 19 (27.9%) were not sure.

Table 5: How stakeholder survey respondents became aware of the Package

Source of awareness (could select more than one)	Number of respondents	Percent*
Newsletter article	36	52.9
Organisation providing the service	11	16.2
Direct communication from the Department of Health	32	47.1
Aged care stakeholder/industry body	14	20.6
Printed brochure/poster	7	10.3
Employer	5	7.4
Website search	3	4.4
Social media	3	4.4
Community Visitor	3	4.4
Word of mouth	2	2.9
Other	2	2.9
TOTAL respondents	**68**	**-**

*Calculated as a proportion of respondents who were aware of at least one element of the Package. Stakeholders could select more than one option therefore totals are not additive

Interviews with Department staff provide some context to the results of the stakeholder survey and the reasons awareness was low in some instances. Four individuals reported that the volume of information coming through at times made it difficult to get across the detail to promote it effectively.

> *"The fact that we're all sitting here but none of us know much about it and so can't promote it to our sector is an important piece of feedback."*
>
> *-Government stakeholder*

Staff from one of the four consulted State Offices had initially understood the consultation to be about a different grief and trauma program that was funded via a PHN. This office noted that while they usually learned about new programs and services via trusted contacts in Canberra, a significant number of people had changed roles as part of the Australian Government COVID-19 response and vaccination rollout, and they may need to develop new relationships.

All State and Territory Offices reported that aged care providers sought to engage with them on issues around regulation and requirements, and other services took a lower priority. One representative noted that they have a regular meeting with peak bodies in their state; however, issues relevant to the Package had never been raised and were therefore not discussed. There was a shared perception that the Package was targeted towards specifically providing support for COVID-19 outbreaks, so in areas without a significant outbreak, there may not have been a perceived need to investigate and understand the supports. This includes areas that had experienced lockdowns, suggesting there may also be low awareness of trauma caused by lockdowns because the Package may not have been taken up.

Department officers working in areas that had been severely affected by outbreaks noted that there had been massive demand for mental health services, increased carer stress, and significant impacts on care provider staff. They felt it was positive to have something specific for the aged care sector and anticipated high interest from providers that knew about it. At the same time, stakeholders noted that they had to be selective about which information to disseminate into networks to not overburden recipients.

Providers and peak bodies interviewed reported an awareness of information that had been circulated about the Package, but not a detailed understanding of how it works in practice or how to access the supports. Several noted that timing was important and that people are often unable to connect with information while deep in crisis, a comment that was echoed by the expert

providers ACGB and Phoenix Australia. They suggested the supports needed ongoing promotion so that they would be front of mind when people were ready to connect.

Providers and peak bodies noted that the volume of daily correspondence, changed regulatory environment, and significant reforms, combined with ongoing challenges from the COVID-19 pandemic, meant most did not have the capacity to engage with non-urgent matters. The changes included the recent introduction of the SIRS and upcoming deadlines for mandatory COVID-19 vaccination, on top of increased workloads and costs associated with COVID-19 risk management. A common theme was that providers were just "coping".

> *"One of the things we're suffering from is information fatigue. It is just unbelievable. I can't take any more on".*
>
> *– Aged care provider*

One learning and development manager from a large provider organisation reported that while they were sharing information about the Package, they were not educating people about them. This person was conscious of wanting to provide clear and consistent messaging to staff and did not want to confuse them if there was perceived overlap or duplication with other supports (e.g. Employee Assistant Program). They had not yet taken the time to understand the resources that were available and how to integrate them into the learning management system. Another individual who surveyed a personal network of aged care providers caring for Aboriginal and Torres Strait Islander Peoples reported receiving a request for someone to visit and talk to them about the Package. This provider had expressed interest in learning about the Package but wanted a personalised discussion to understand it.

One provider who specialised in delivering services to people from CALD backgrounds expressed enthusiasm for the number of languages that are covered and thought it was a great resource.

> *"I'm very impressed with the number of languages. This is a great great resource for CALD communities. I'm very pleased [the Department of Health] considered grief. Most of our communities have families overseas who are severely impacted and it's hard to digest when you are not able to be there … hopefully this resource can make a difference"*
>
> *-Aged care provider*

They noted that while they had only learned about the Package two weeks prior to the consultation, they had been sharing different resources for grief and trauma over the previous six months. While they were looking forward to receiving and sharing the print resources they had ordered, they reported there could be an overload of information at times.

Another provider, whose core client base includes people who have experienced high levels of trauma, reported that their staff appreciated receiving the poster, and had considered it high quality and useful enough to put on the wall. The same provider reported that they offer multiple supports to staff who need it, but they were not aware of any staff that needed grief counselling due to COVID-19. Another mentioned that repeated communications using different messages and media would be needed to reach the sector. They noted that they expected people would be interested in the supports but may lack the time to understand what is on offer.

One peak body representative mentioned they were aware of the workforce development aspect of the Package but had not known there was also an element to directly support senior Australians. This person expressed the view that communications needed to carefully differentiate the supports provided under the Package (e.g. that they are evidence-based specialist services developed by experts in the field) from those provided by the EAP. This may help to drive interest in the Package. Similarly, one religious-based provider considered the pastoral care offered within the organisation would meet people's needs. Although no stakeholders specifically mentioned other mental health support services, it is plausible that other services with higher brand recognition may

also have been reaching out to offer support to the sector. This suggests the differences between the Package and other supports, including suggested referral pathways, may need to be more clearly articulated.

3.1.3. Senior Australians and their representatives

Of the 29 eligible respondents to the Older Persons COVID-19 Support Line survey, almost a quarter (7, 24%) were aware of the ACGB supports, and two (7%) were aware of the Phoenix Australia supports, of which one person was aware of both. Half of these people (4, 14%) were from NSW. It is encouraging that the grief supports were reasonably well known among the sample; however, this finding is moderated by the small sample, comprised of individuals who are already accessing government supports via the Older Persons Coronavirus Support Line and thus might be more informed than many.

Of the 47 respondents to the survey of aged care recipients, their loved ones, and carers, 10 (or 21%) were aware of ACGB's counselling service and five (or 11%) were aware of Phoenix Australia's resources (Table 6). The most common source of awareness was via the HealthConsult survey.

Table 6: Source of aged care recipients', their loved ones' and carers' awareness of the Package

Package element	Source						Total
	Letter from the Australian Government	Health professional	HealthConsult survey	Not sure	Friends/ family	Online	
ACGB	1	1	6	2	0	0	10
Phoenix Australia	0	0	3	0	1	1	5

Source: Survey of aged care recipients, their loved ones and carers

Further context to these findings was provided by participants in the three senior Australian focus groups, none of whom reported any awareness of any elements of the Package, nor could recall receiving any correspondence about it. Senior Australians had questions about what would happen if they called the (ACGB) 1800 number, suggesting some uncertainty about what the supports involved.

The three expert advisors, who work closely with senior Australians including aged care recipients, observed they were not aware of people talking about or accessing the supports, including computer literate senior Australians who are engaged with the system. This led one to conclude that the most vulnerable may not have heard of it either. All conceded that the observation that they had not heard mention of the Package within their networks did not in itself mean that people were not aware of or using the supports.

Amongst advocacy groups and representatives of senior Australians consulted for the evaluation there was limited understanding of the supports funded by the Package. Two reported hearing about the supports during the development phase but were not familiar with the details. Two representatives of CALD communities who had consulted within their networks about the Package reported there was some awareness among providers, but limited awareness among aged care recipients. One commented that while the translations may be technically correct, the language also needed to be at the right pitch for the target audiences, in simple and conversational forms.

Two OPAN representatives discussed promoting the Package, including during meetings with families affected by COVID-19 outbreaks, and one reported that six home care recipients contacted her after receiving the letter and brochure from the Department, and were unclear about what the Package would do for them.

3.2. Question 1B: To what extent are elements of the Package being accessed?

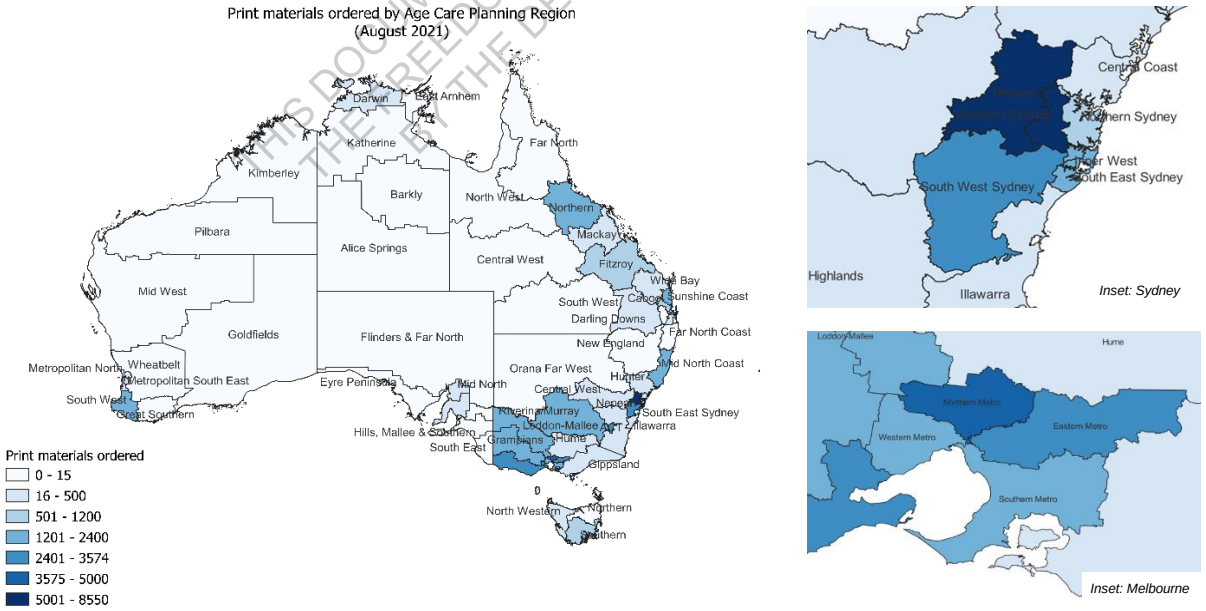
This question is answered by firstly exploring the reach and uptake of the Package and secondly exploring how many of those who were *aware* of the Package *actually used* it.

3.2.1. Reach and uptake

In July and August around 100,000 copies of printed resources including posters, brochures, and fact sheets, were ordered from the Department by 115 aged care providers across Australia. This represents approximately 1% of aged care services (outlets)[16]. These orders were in addition to the initial mailout of an information pack to every aged care provider across Australia (described in Section 3.1.1). Of the resources available to order in print, every resource available (noting that the brochure was available in 63 languages, and in an Indigenous design) has been ordered in every language. This could suggest that aged care providers do want and need information in languages other than English and in print if they know how to access it.

Large numbers of resources ordered by some providers suggests a willingness to disseminate them more widely in the community. A summary of the distribution of hard copy resources ordered by aged care providers according to Aged Care Planning Region (ACPR) is shown in Figure 3. It indicates that providers in all capital cities have ordered printed resources, with a greater concentration on the eastern seaboard and the highest density in the Sydney ACPRs of Nepean and Western Sydney. This period also coincided with a major outbreak concentrated in south-western and western Sydney. Interestingly, as Figure 3 indicates, the distribution in Melbourne does not reflect the likely magnitude of COVID-19-related grief and trauma in the aged care sector in 2020. Noting that the supports were not available during the peak of the 2020 outbreaks, this also suggests that the supports are not yet widely known and/or that those affected may have accessed other supports or had no support.

Figure 3: Distribution of printed resources ordered by aged care providers at August 31, 2021



Source: Billing and order detail report August 2021

[16] https://www.gen-agedcaredata.gov.au/Topics/Providers,-services-and-places-in-aged-care. Accessed 270921

The target and actual use of Package services and resources are provided in Table 7.

Table 7: Target and actual use[17] of the Package

	Package element	How many people were expected to have access to and/or use each element	Measured use
Department	Information about supports available	All aged care recipients (residential and home care) and loved ones. All aged care staff and managers	• Information pack sent to 6,000 aged care providers and 200 CVS auspices • Letter and brochure in preferred language to 130,000 home care recipients • 10,218 additional brochures ordered in print • 899 additional posters ordered in print • 991 additional downloads of brochure • 456 additional downloads of poster • 6,700 Department website users
ACGB	Counselling services	Note: Expected use was not specified It was estimated that up to 14,954 aged care recipients plus four close contacts for each recipient (total 74,771 aged care recipients and their loved ones*) may need to use it.	• 190 calls to National toll-free helpline • 160 counselling sessions • 22 support groups (with 5-7 people in most groups) • Half of the 10 positions filled so far are filled by multilingual staff
	Fact sheets		• 1,223 downloads • 29,971 hard copies ordered
	Website		• 5,389 website hits • 294 app downloads
	Webinar attendees		• 878 attendees
Phoenix Australia	Webinars	Expected use not specified; and note that the focus of the work by Phoenix Australia was to develop webinar content, rather than to launch them†. The target audience was aged care recipients and their loved ones who may have experienced grief and trauma (74,771 people*) and aged care staff and managers (366,027**)	• 2,812 aged care employee registrants • 1,963 attended live and/or viewed recording • 399 slides downloaded
	Website		• 28,339 page views • 2,790 users
	Fact Sheets		• 2,644 downloads of resources: • 625 older people and their loved ones; 1,371 managers and workforce; 72 veterans • 62,220 hard copies ordered
	Staff Checklist and Manager Workbook		• 3,252 hard copies ordered
	Trauma awareness training		• 142 users have accessed training • 38 requests to download scorm†† files
DSA	Completions	Not specified	• 104 residents • 19 RACFs
	In progress		• 17 RACFs • 13 due to commence Sept
	Referrals		• 306 1:1 resident referrals which resulted in comprehensive analysis, trial and evaluations

† Launch date for the majority of Phoenix Australia supports is end of September 20201 (referFigure 1).
†† scorm files enable users to integrate the training with the learning management system

[17] Actual use at 16 August 2021

*Based on documentation received from the Department of Health for this evaluation, whose estimates were sourced from sourced from https://www.gen-agedcaredata.gov.au/Resources/Access-data/2020/March/GEN-data-People-using-aged-care
**Mavromaras, K., Knight, G., Isherwood, L, Crettenden, A., Flavel, J, Karmel, T., Moskos, M., Smith, L., Walton, H, and Wei, Z. 2017. The Aged Care Workforce, 2016. Australian Government Department of Health. Available: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/Workforce/The-Aged-Care-Workforce-2016.pdf

Further information on the distribution of materials from the Department are as follows:

(1) Of the print materials described above, information brochures to promote the resources were ordered in print for each of the 64 languages produced. This indicates a strong willingness from providers to communicate with aged care recipients in their preferred language, in formats preferred by older people.

(2) The Department tracked 187 communications about the Package including their own communications and those by funded organisations. A summary of the different modes of communication, the goals of the communication initiatives, and the audience of each of these initiatives is presented in Appendix F.1. In summary:

- The most common modes of communication were via emailing marketing and/ or stakeholder kits (70 of 187, or 37.4%), followed by communication on social media (44 of 187, or 23.5%), and in the form of newsletters (13 of 187, or 7%).
- The most common communication goal of the initiatives was to share general information about the Package on available resources (100 of 187, or 53.5%).
- 19 of 187 initiatives (or 10.2%) included goals to build referral links and 25 (or 13.4%) were to promote trauma resources or trauma-informed care.
- 101 (or 54.0%) of these communication initiatives were targeted at all stakeholders while 29 (or 15.5), 12 (or 6.4%), and 20 (or 10.7%) initiatives were specifically targeted to aged care providers, government bodies and aged care recipients/ their loved ones, respectively.

3.2.2. Use of the Package by aged care providers

Of the 68 stakeholder survey respondents who were aware of any element of the Package, a majority (35, 51.5%) stated they had used it or recommended for someone else to use it. Most survey respondents who had used the Package or recommended it to someone else (22 of 35, or 62.9%) were aged care providers (Table 8).

Table 8: Type of organisation who had used elements of the Package

Service type	Accessed at least one element of the Package, or recommended it to someone else	
	Number	Percent*
Aged care provider	22	62.9
Community Visitor Scheme network/ auspice	1	2.9
Aged care stakeholder organisation	4	11.4
Other organisation in the aged care sector	8	22.9
TOTAL	**35**	**100**

Source: Stakeholder survey
*Calculated as a proportion of respondents who had used at least one element of the Package

Table 9 shows that eight of the 40 (20%) stakeholder survey respondents who were aware of services provided by Phoenix Australia recommended it to a person receiving aged care or their family, carer, or loved one; and 10 of 58 (17%) who were aware of the services provided by ACGB recommended it to an aged care recipient or loved one.

Table 9: Elements of the Package survey respondents had used or recommended

Package element	Used themself (%)*	Recommended to other staff/organisation (%)*	Recommended to aged care recipient/ loved one (%)*	Total**
Phoenix Australia	15 (37.5)	10 (25.0)	8 (20.0)	40
ACGB	3 (5.2)	10 (17.2)	10 (17.2)	58
DSA	10 (26.3)	5 (13.2)	N/A	38

Source: Stakeholder survey
*Percentage calculated as proportion of total number of respondents who indicated that they had used and/or recommended use of the Package to someone else.
**Total number of respondents who were aware of each element of the Package. Total number of stakeholders who were aware of the Package is 68

Stakeholders interviewed noted that they did not know of many providers who had used the Package; but that those who had used it provided positive feedback. For example, one aged care peak body representative who had shared the Package mentioned that some providers had expressed gratitude to now have resources they could direct care recipients and families to when there were challenges.

Aged care providers and peaks emphasised that other, more urgent, pressures within the sector would limit the use of the Package in the immediate term. This includes SIRS and COVID-19 compliance, which are immediate threats to an organisation's viability and therefore take precedence over other issues.

> *"There are pockets that will do really well, because it's a good resource. All three organisations produce excellent resources. But you have to know what you're dealing with at the moment with our industry. We are not resourced to manage this... It's costing me $30,000 a month just to manage COVID compliance. We need to be realistic in terms of what that penetration might be".*
>
> *– Small residential aged care provider*

3.2.3. Use of the Package by senior Australians, their loved ones and carers

Aged care recipients, their loved ones and carers who replied to the survey and were aware of services and resources provided by ACGB and Phoenix Australia reported very low actual use:

- Of the 10 respondents who were aware of the services available from ACGB, only three had used them.
- Of the five respondents who were aware of the resources available from Phoenix Australia, only one had used them.

This finding might be expected, given early estimates that only around 5% of affected people may need to access support (see 1.2). As outlined earlier, access is likely to increase firstly as more people become aware of the available supports, and secondly, as the pandemic subsides, people may be in a better space to recover.

Following from limited knowledge of the Package among aged care recipients, their loved ones and carers, surveyed, there was little evidence of widespread use the Package among senior Australian focus groups participants, noting that the consultation was prior to the main home care mailout.

Stakeholders who were familiar with the OPAN family meetings reported that this was an effective way of promoting the supports to people who needed them most. One senior Australian representative who had worked with families bereaved by COVID-19 observed that the feedback from aged care recipients, their loved ones and carers who had used the Package was very positive.

Senior Australians who participated in the focus groups, as well as expert advisors, noted the following barriers to using the Package:

- Older people tend to be less computer literate and typically prefer to receive information in print and/or through a recommendation from a trusted network, a point acknowledged by the Department in making printed resources available free of charge.
- People may not recognise their grief or recognise that they may need support to manage their grief; yet much of the promotional information about the Package assumes that people do recognise this need. Stakeholders commonly observed that this generation of older people may have more stoic attitudes to mental health and be less likely to seek talking therapies.

3.3. Question 1C: What suggestions do key stakeholders have for improving rollout?

Suggestions by Department representatives, peak bodies, aged care providers, and aged care recipients, their loved ones and carers to improve the rollout are listed below:

- **Provide detailed, sustained briefings on the Package.** Several Department State Office representatives requested a detailed briefing of the Package (e.g., by phone or webinar) which would help them to understand the supports that were available so that they could disseminate information about the Package, noting that they were selective about which information they forwarded and wanted to ensure they understood resources before promoting them.

  There was widespread agreement that information disseminated by email had tended to get lost amongst the deluge of pandemic-related and regulatory information. In addition to this, key stakeholder groups, including peak bodies and care providers, became gatekeepers to information, wary of overloading their networks with too much information even when they could see great value in the resources being offered.

  Department representatives, aged care providers, and advocacy groups suggested that they wanted to be "walked through" the elements of the Package that were relevant to them, expressing a preference for personal contact such as a phone call or meeting, or by webinar or video. Further suggestions included strengthening internal Department messaging to ensure State and Territory representatives are adequately briefed on program information and empowered to promote it to the communities they are responsible for, to ensure a nationally consistent approach.

  Further suggestions included holding regional forums where people can discuss their concerns and understand what is available from the Package. An example of this can be found in forums run as part of the Sector Support and Development (SSD) program to help support Commonwealth Home Support Package (CHSP) providers embed diversity, wellness and reablement approaches into their strategies and models:

  > *"The function of SSD is to build the capacity of aged care providers [by hosting] sector development forums. They're usually one and a half hours focused on specific topics and have guest speakers."*
  >
  > *– Service provider*

  In a report on the review of SSD[18], several SSD providers cited facilitating regional forums with local CHSP service providers to discuss current and local issues relating to dementia

[18] Commonwealth Department of Health. 18 September 2020. *Review of Sector Support and Development (SSD). Final report.*

care and to share learnings on best practice service delivery practices. Examples of these forums, which could be adapted to raise awareness and understanding of the Package are:

- The Inner West Area Sector Support Development and Training Service invited service providers to attend a best practice forum focused on quality in aged care. The forum aimed to ensure CHSP funded organisations implement evidence-based strategies to meet the Aged Care Quality Standards, Diversity Framework and to adopt wellness and reablement approaches to service delivery. The forum was also an opportunity to link CHSP funded organisations with each other. This enabled the sharing of learnings and resources in relation to the implementation of the Aged Care Quality Standards. Some CHSP funded organisations noted that partnerships formed at the forum also resulted in joint service delivery initiatives.
- Following the introduction of the RAS, some SSD providers facilitated forums for hospital social workers, allied health professionals, GPs, local government representatives, RAS assessors and CHSP service providers. The forums provided service providers with an opportunity to understand the changes in the assessment processes and to meet their local RAS organisations.

- **Link with accreditation to the Aged Care Quality Standards.** Providers and peaks were unanimous in their observations that the sector is overworked and overwhelmed, and people do not have capacity to engage with information that is not urgent or mandatory. Two providers thought that mandating trauma-informed training would address this, but most suggested a softer approach, such as linking it with the Aged Care Quality Standards and attaching accreditation points to it. This would provide an incentive to engage with the staff development elements of the Package:

  "It should also be written out which accreditation standard it would meet. You need all that written out and matched so when they take it to their hierarchy, they can say, 'by doing A, B, and C we can give support to our staff that doesn't cost anything. We can give the best of expert services to our clients'. What you are doing is making a one stop shop in a document... you have this free resource to help your families at no cost, but also to support the other most valuable asset you have in aged care, your staff."

  – Senior Australian representative

Update the language of Package resources. Some stakeholders, including government representatives, identified that the reference to 'COVID-19' together with 'grief and trauma' implied that the supports were targeted at outbreaks and associated deaths, and therefore not relevant for them. Without identifying specific wording that may address this issue, stakeholders suggested that naming the feelings people may be experiencing may help them to identify its relevance. For example, a senior Australian representative who had worked closely with families impacted by grief and trauma suggested storytelling to communicate the purpose of the Package and its potential relevance:

"…you need them to help people to identify that they might be feeling a similar way to the person in the story, and therefore the service might be useful for them too. It's more about just saying there's a service available. We need to help people understand and identify the feelings they're experiencing."

– Senior Australian representative

Senior Australian representatives, including people representing people from CALD backgrounds, Aboriginal and Torres Strait Islander Peoples, and aged care providers and peaks highlighted that the words "grief" and "trauma" have quite specific meanings, and that

people who had experienced significant mental health challenges in the wake of COVID-19 may not necessarily see themselves reflected in that terminology:

> *"What's the definition of grief? Is grief associated with death, or not? In most cultures, it is. In English it is too. If you speak with people on the street, they will associate grief with death. That could be an issue with people understanding what this is about."*
>
> *– Expert advisor*

One senior Australian representative noted that the terminology of 'trauma-informed care' is unfamiliar to most of the aged care workforce, which would be a barrier to them accessing it or disseminating the Package further. Others identified that for older people, their trauma related to COVID-19 may be more related to loneliness, disconnection, social isolation, and fear, which is not represented in the word 'grief':

> *"… we need to think about the language and the way we describe the service elements and make it clear that we're talking about different kinds of trauma. I think, there's an assumption that is more the catastrophic types of trauma we're talking about. But the big impact on people isn't in that form yet. We're talking about reduced wellbeing, lack of confidence in reengaging with the community…the language needs to shift and the service to be seen to fit that."*
>
> *– Senior Australian representative*

- **Change the way aged care recipients, their loved ones and carers are engaged.** Senior Australian representatives suggested changes to the messaging around the supports that would resonate more with older people.

  Those familiar with community connectors and aged care navigators suggested building on this approach by targeting local councils or networks around older people and working with networks to identify "champions" who can become a reference point for knowledge and information about what resources are available and how to access them. This might involve inviting networks to call for expressions of interest and/or nominate influential members to participate in information sessions or "train the trainer" activities. These might be informal networks within organisations and informal key leaders within a group, including community organisations such as Vinnies, Meals on Wheels, local government and councils, church groups, advanced care planning organisations, U3A, Lions Club, Probus groups, interest groups, and country women's associations (CWA). For Aboriginal communities, for example, that might involve writing to CEOs of Aboriginal Land Councils and attending gatherings of Aboriginal Elders.

  > *"You've got to go where the people have trust, and that will be with whatever community organisation or group they consider their representative, and then build their capacities."*
  >
  > *– Senior Australian representative*

  Representatives of CALD communities were encouraged to see information and resources in multiple languages but some were cautious about the perceived value of these for many communities if they are underpinned by western concepts of death and dying. Several representatives advocated for resources to be co-designed with relevant communities (not just representative stakeholders) to ensure the information and resources were meaningful to them. A co-design approach would give them a sense of ownership in the resources and might help promoting them.

  One healthcare peak body identified that while aged care providers may be an ideal channel to disseminate information about the Package, staff are completely overwhelmed, the

expectations on them are high, and they will see it as another thing on top of already untenable workloads.

Key stakeholders' suggestions to improve senior Australian engagement and awareness of the Package to build on already existing strategies but also consist of some additional ideas including:

- **advertise on media** including more ethnic radio and on satellite television, and print media available at healthcare locations (e.g. The Senior magazine).
- **use print channels accessed by older people**, for example enclose a brochure with council rates notice or electricity bills.
- **continue to engage further with the health providers/ health provider networks** that older people use (e.g., aged care units in hospitals, College of Psychiatrists, PHNs and GPs, pharmacists) and build awareness of the resources into the intake procedures for new clients, including community and residential care.
- **direct communication/letters** to people affected by COVID-19 deaths in aged care, using language that the affected person can identify with, and let them know supports are available. This could be a personalised letter by the Minister or someone of note.
- **continue to work further with volunteer-based organisations**, such as CVS auspices to understand what support volunteers might need, and how they can convey information about the supports to the older people they work with
- **continue to engage more with LGBTIQ+ Health and QLife**, to review information and resources, and endorse and promote information and resources.

4. Appropriateness and relevance

This Chapter presents findings in relation to Evaluation Question 2: *How appropriate and relevant are the supports to the audience who need them?*

4.1. Question 2A: To what extent does the Package address identified gaps, needs and/or priorities?

This question is answered by:

- exploring whether there was evidence that the Package could address grief and trauma
- exploring whether there was input from intended users and industry experts, including in inclusive practices
- exploring the extent to which stakeholders reported that the supports aligned with expectations and were relevant to the target audience.

4.1.1. Evidence that the activities could respond to grief and trauma

The theory of change (presented in Appendix A) provides the rationale for the design of the Package. In summary, the Department had identified that there are multiple types of, and layers to grief and trauma, which are cumulative. Left untreated, they can result in mental health issues. The rationale for developing each element of the Package is below; and they indicate that the activities were designed to address the identified need:

- **Phoenix Australia**: The work by Phoenix Australia was commissioned because there was a gap in bespoke training and support for aged care staff to understand trauma and provide trauma-informed care.
- **DSA**: The work by DSA was commissioned because aged care providers and staff need additional training and support to engage people living with dementia, in particular those who may be withdrawn and disengaged in response to grief and trauma caused by COVID-19 restrictions and lockdowns.
- **ACGB:** The work by ACGB was commissioned because, while aged care staff who had experienced grief and trauma related to COVID-19 may access support through their EAP, there was a gap in specific supports available for aged care recipients and their loved ones, and EAP support doesn't necessarily provide specialised grief and trauma support.

4.1.2. Evidence of input from intended users and inclusive practices

Mechanisms used by funded organisations and the Department to ensure input from intended users is outlined below. Of note is that the Department and funded organisations met monthly to discuss progress and learnings, pivot as needed, ensure they presented to the sector as a united front and ensure they provided a coordinated response.

- **The Department** established a consultation group as a co-design mechanism. This was a new approach for the Department, and the aim of the group is to support the Department and providers of the Package with ad hoc direction, testing and feedback on materials, supports and advice on implementation. As the group had expertise and networks across health, general practice, mental health, trauma, dementia, ageing, nursing, aged care (through policy, sector organisations and aged care providers) and diversity they were able to assist with co-designing the materials to ensure they were practical to use, inclusive for all and culturally

safe. With wide networks across the sector, the consultative group was also able to assist with regularly sharing information into their communities. Given the size of the group and breadth of the Package, it wasn't considered feasible to meet regularly, so the group agreed on an ad hoc approach, with the Department inviting any suggestions, directions, or feedback on how to continue to improve in every communication with the group.

Some stakeholders involved with the consultative group stated that they had provided some feedback early in 2021 around accessibility of the supports, but otherwise had little involvement. This may indicate a need to strengthen relationship building within the group and clearly communicate expectations engagement both to generate a sense of shared ownership and ensure nether party is disappointed by the extent of engagement.

- In the design of the promotional poster and brochure it was carefully considered how to represent the Package to diverse stakeholders. For example, photographs were of older people from a wide range of cultural backgrounds, the brochure depicted the LGBTI (rainbow) and trans flags, links were included for TIS National and Auslan, as well as links to other mental health supports. It also included a visible inclusivity statement. The Aboriginal flag could not be included due to licensing issues; therefore, the Department prepared a separate brochure with Indigenous design elements. Both the consultative group and stakeholders outside the group assisted the Department and funded organisations to meet the needs of different stakeholder groups. For example, after the initial release, information about the Package was provided in Auslan videos. **ACGB** recognised that around 50% of the aged care cohort have cognitive difficulties and many do not have access to a phone; and so while face-to-face engagement would have been ideal, they have had to orient the program to a remote working environment. As of August 2021, the focus has been on peer training and peer support, with activities in this area set to expand significantly. The peer support element is designed to target people and communities who may be reluctant to engage with counselling services and provide avenues for peers to support each other.

  ACGB is aware of the preference for people to be able to speak in their language, and have been seeking bilingual staff where possible to fill their necessary roles. After working with the consultative group, ACGB also ensured that all of their intake and counselling staff underwent cultural safety training to be able to support communities of Aboriginal and Torres Strait Islander Peoples in culturally safe and appropriate way. ACGB is currently partnering with LGBTI, Forgotten Australians and Aboriginal and Torres Strait Islander Peoples to develop and refine fact sheets to better meet the needs of these audiences.

- **Phoenix Australia** engaged in a process of co-design to ensure their resources were appropriate for the target audience. Although the initial scope for the project was to deliver resources for residential aged care, Phoenix Australia has expanded this remit to ensure the language is inclusive of people receiving aged care in the home and community. They engaged with five aged care organisations to understand sector experiences with and responses to trauma, develop a trauma-informed approach to aged care service delivery, and communicated this through practical resources. From the consultations they identified that providers' requirements to deliver person-centred care would be key to motivating staff and organisations to use the resources, and that key messages needed to be distilled into "bite size" information to meet the needs of time-poor staff.

  Several aged care representatives and advocacy group representatives stated that they had been consulted early in the design of the Package to provide feedback on the Phoenix Australia components. As an example, Phoenix Australia had planned to prepare a booklet for Aboriginal and Torres Strait Islander Peoples but was advised during consultation that this was unlikely to resonate with the intended audience. In response, they prepared this information as a series of animations. The co-design was viewed positively, although some

representatives of CALD communities expressed a strong wish to be involved in the design, rather than simply providing feedback on resources that had been developed.

- **DSA** are well known in the aged care sector, and their programs are designed to deliver person-centred care that meets the unique needs of each individual. DEMP was created in response to an identified need to support care providers who were struggling to engage people living with dementia during lockdowns. DSA reported that some indicators of diversity such as country of birth and veteran status will normally be uncovered in their personal history taking. The extent to which DSA engaged in a co-design process with diverse groups is unclear.

Some specific feedback on the inclusiveness of the Package is provided below:

- Some stakeholders experienced with diversity identified some supports as lacking signposts that would identify the funded organisations as inclusive, and some translated resources did not have the right language level and/ or content to reach their intended audience:

> *"You need a cultural response. I looked at the guides about supporting someone and it said do not give advice. Who says? Somebody has decided that, but it may not work. It also says maintain eye contact unless culturally inappropriate... What we have are translations of English text, but we don't have a specific developed resource that is inclusive."*
>
> *-Expert advisor*

- People with a vision impairment may not be able to access the Package easily. To this end, ACGB received feedback from a legally blind person that the print needs to be enlarged.
- While many people working with CALD communities commended the breadth of translations, there were also criticisms. One representing CALD communities commented that while they were invited to provide feedback on language and content, they could only do this for the English form, and this was an incomplete process for designing resources that are culturally appropriate. One senior Australian representative commented that the images of older people in the brochures looked "too five-star" and felt they did not adequately capture the reality of older people's lives.
- One stakeholder observed that the Google translate function on the ACGB website was inappropriate as it would deliver incorrect meanings. They described the translated resource bundles (i.e. all fact sheets for one language in a single downloadable pdf document) as 'difficult to navigate' and assumed that the person accessing them online could read the language other than English. They suggested that best practice would be to 'publish' each document in English with corresponding translation as a single document.

4.1.3. Relevance of the Package to intended users

The main intended users of the Package were aged care residents, recipients, their loved ones and carers; and the aged care workforce, as services provided by Phoenix Australia and DSA were focused on upskilling the aged care workforce to provide trauma-informed care.

There was little feedback from providers about whether the Package was relevant to helping them achieve this purpose – that is, to upskill them to trauma-informed care. Rather, much of the feedback was about the impact of the COVID-19 lockdowns on staff, and the grief and trauma they experienced themselves. For example, one small regional provider described how residents had gone through a period of immense grief during lockdown, families were upset, and while staff had tried their best to support residents, there was no one to support the staff.

One aged care worker who, together with colleagues, was left deeply traumatised in the wake of Melbourne's second wave, discussed how they and their colleagues had articulated a need for

group support to their management, but instead had been referred to the EAP. This person found that approach profoundly unsatisfactory, and felt a strong need to connect as a group with colleagues to reflect on their shared experience. They self-organised a peer group session, facilitated by someone with appropriate expertise, where colleagues could talk about their experiences and start to process what had happened. They felt that the group support was an important precursor to begin healing at an individual level, and were encouraged that expert supports were now available from providers who understood the situation and context.

> *"It was all so intense and new … like… is this really happening? Has this really happened?"*
>
> *– Aged care worker*

With regards to the relevance of the Package to aged care recipients and their loved ones, there was widespread agreement from stakeholders that the Package was extremely relevant. They welcomed the efforts to improve both provider knowledge of and aged care recipient access to mental health supports. Another noted that carer stress had increased exponentially, particularly for those people whose loved ones might normally be in residential care but who were living at home because it was considered safer, making the Package very relevant:

> *"Mental health is huge. I've had some older people that normally wouldn't talk about a topic like that actually say, 'I don't think I can take this anymore'".*
>
> *-Senior Australian representative*

> *"I like the webinars. You get people with lived experience on there talking, which is what people want. They don't want things out of a book, they want people who have been through it and the strategies they can give them".*
>
> *-Expert advisor*

4.2. Question 2B: Are there any diverse groups who may be disadvantaged from utilising the supports?

While there may be barriers to some diverse groups accessing and utilising the supports provided through the Package, there were no reports from stakeholders of diverse groups experiencing any disadvantage because of utilising the supports.

Despite significant efforts to address diversity in the development and communication of the Package, some gaps remain. The rapid development and rollout reduced the time available for consultation and co-design, meaning some translated resources may lack cultural nuance.

> *"The translation is fine, however, things like "family of choice" is a white people concept and doesn't translate well. It sounds odd. It needs to be put through the plain English lens first, as always."*
>
> *-Senior Australian representative*

4.3. Question 2C: How can components of the Package be improved to address any gaps, unmet needs or priorities, and to remove barriers to accessing the Package?

This question is answered by firstly identifying the main barriers intended users face (or may face) which accessing the Package, and secondly exploring potential solutions either suggested by stakeholders or developed in response to the issues. These are presented in Table 10.

Table 10: Description of gaps, unmet needs, unmet priorities and barriers to accessing the Package, along with suggested improvements*

Gaps/ unmet needs/ unmet priorities/ barriers	Suggested improvement
Phoenix Australia	
• Due to lockdown, it is very difficult for providers to disseminate the information to family members and other staff members, as it is mainly in hard format. • Due to communication barriers, people in the CALD community are not aware of the resources. • Forgotten Australians not considered in workforce awareness and training. • Some language used in webinars, such as "highly demented", is inappropriate. There was emphasis on asking questions about trauma rather than letting people tell their story using a softer approach. Some of the approach and phrasing wasn't as client or senior Australian centred as it could have been. • There was some confusion about the meaning of, and differences between, person-centred care and trauma-informed care.	• Develop an email that can be sent out to families and representatives, which may contain a fact sheet or something similar. • Review dissemination strategies and target CALD communities. • Develop resources to inform workforce about history and needs of Forgotten Australians. • Provide information to help RACFs respond to people from CALD backgrounds, where staff do not speak the language spoken by the resident. • Clearly establish the difference between person-centred care and trauma-informed care. • Webinars and other resources could include ways in which trauma can present in the home, as well as residential settings.
ACGB	
• Limited regional face-to-face services available. • General lack of awareness in the community of the counselling services available. • The Google translate widget on the website is not appropriate, particularly for sensitive content. • Default website font is very small, and therefore not appropriate for people with a visual impairment. • Aboriginal and Torres Strait Islander Peoples and Forgotten Australians may not engage with resources that have a "government" look given past traumas engaging with government services. • There was reported to be a generational stigma around talking through problems. Many senior Australian representatives, and a majority of CALD representatives, questioned whether older people would be willing to engage in telephone counselling.	• Continue with recruitment drive to employ more face-to-face counsellors. • Stronger promotion of the capacity building element may encourage community leaders to engage/ provide feedback and consultation. • Website: Remove Google Translate widget and increase font size. • Ensure the supports offer counselling by Aboriginal and Torres Strait Islander counsellors. This may be particularly so on highly sensitive issues such as grief and trauma, that demand a shared cultural understanding. • Continue to build peer support element for aged care workforce, and emphasise points of difference compared with EAP.
Department	
• Some languages (e.g., Tagalog) are pitched at a level too high for most readers • Some concepts (e.g., 'family of choice') may not translate well across languages and cultures • Language of 'COVID-19 grief and trauma' does not always resonate, and people may not understand how they may benefit from supports. Further to this, the promotional activities had tended to focus on informing people that support was available and directing them where to find it, whereas both providers and senior Australians and their representatives requested clearer information on what the supports meant for them	• Review translated resources to ensure they are pitched at the right level and are culturally appropriate and inclusive by preferably using a co-design process, particularly on issues such as grief and trauma where cultural practice may differ across cultures. • Review resources to ensure clear messaging about the relevance of the supports for the intended audience. For example, 'When you call the 1800 number….'
All	
• Aboriginal and Torres Strait Islander Peoples expect to see a reference to the importance of Country and will look for an Aboriginal flag and Aboriginal artwork to identify a resource as relevant to them – and as it stands, this is not overly apparent. • People who identify as LGBTI will look for a rainbow flag and trans flag to identify an organisation as culturally safe and inclusive. If the organisation is unknown to the community, they may be more likely to phone QLife.	• Engage with diverse communities to review materials and ensure they are relevant to people from diverse backgrounds, and that if they are, that they present visual design cues to communicate this.

Gaps/ unmet needs/ unmet priorities/ barriers	Suggested improvement
• Veterans recognise a watermark of medals as a visual cue identifying resources relevant to them.	
• People from CALD communities, and those from deaf communities, may be unlikely to discuss sensitive topics via an interpreter service because it changes the dynamic and flow of conversation and there may be perceived issues of privacy. • Furthermore, access for people from CALD backgrounds is limited if they need to navigate in English to find a bilingual counsellor.	• All resources, including translated ones, need to be pitched at the right level and appropriately adapted for a diverse audience, preferably using a co-design process, particularly on issues such as grief and trauma where cultural practice may differ across cultures and life experiences.
• People experiencing or at risk of homelessness often have poor experience of government services, and mainstream services often lack relevance for this cohort. They may be less receptive to resources with a "government" look.	• Engage with organisations that work with people experiencing or at risk of homelessness to seek feedback on the best methods to engage with this population.
• Representatives of Forgotten Australians observed that COVID-19 had caused many people to lose their avenues for physical supports, which is also how they obtain and share information.	• Review dissemination strategies and engage with organisations that advocate for Forgotten Australians, such as the Alliance for Forgotten Australians.
• Much of the information was contextualised to residential care only.	• Review materials to ensure they are also relevant to home care settings.
• While only approximately one quarter of respondents (16 of 68, or 23.5%) thought the services of the Package overlapped with supports offered by their employer or employee assistance program, over a third (25 of 68, or 36.8%) agreed that they overlapped with other resources/ services (such as Beyond Blue CMWSS and Head to Health gateway). In both cases over 40% of respondents didn't know (Table 24).	• Review the extent to which the Package overlaps with other resources/ services (such as Beyond Blue CMWSS and Head to Health gateway). If there is overlap, consider re-scoping the service, or changing the service offering to minimise overlap. Ensure communications materials clearly articulate differences between services, with consideration to suggestions to change some of the wording of the Package to reflect feelings and experiences during the pandemic.

*No suggestions for DSA were provided. Sources: Stakeholder survey; stakeholder interviews; senior Australian focus groups; case studies; survey of aged care recipients and their loved ones; and Slido analytics report for Phoenix Australia webinar 1, *Identifying and Managing Trauma Within the Aged Care Sector* and webinar 2, *Understanding Dementia and Trauma in Aged Care.*

5. Improvements in access

This Chapter presents findings in relation to Evaluation Question 3: *Have the supports been effective in improving the aged care sector's ability to access grief and trauma supports and information in a timely manner?*

5.1. Question 3A: How effective has the Package been in increasing awareness of grief and trauma?

5.1.1. Providers

Providers, capacity-building organisations, and representatives of aged care recipients, their loved ones and carers, identified that people working in aged care typically understood grief as this is a key part of working in aged care; however, they may not have a good understanding of how to respond to it. One representative who had spoken with several providers indicated that "many" organisations had already implemented strategies for coping with grief, trauma, and the effects of lockdown, which presented challenges for prioritising the Package. Two providers commented it was too early to say whether it had improved awareness as they had only recently learned about the Package.

An aged care capacity-building organisation noted that their trauma awareness was minimal but there was increasing interest in the topic and providing responsive care. Another thought providers were generally very good at recognising what grief and trauma are for other people, but less so for themselves. Two identified that "trauma" often had connotations of a physical injury or event like a car accident. One religious-based care provider identified that they had high awareness across the organisation and had additional supports in the form of pastoral care. One aged care peak commented there was generally a lot more awareness about grief and trauma, but it couldn't be solely attributed to the Package.

5.1.2. Aged care recipients, their carers, and loved ones

There was limited evidence of senior Australian opinion on the effectiveness of the Package due to the small sample, few of whom had engaged with it.

- Of the two respondents to the survey of aged care recipients, their loved ones and carers who had used the services provided by ACGB (both loved ones of an aged care recipient), one reported it helped a little to manage grief and distress due to COVID-19, although they found it a bit generic. The other was profoundly dissatisfied with the service and organised their own psychologist elsewhere.
- None of the respondents to the survey of aged care recipients, their carers, and loved ones reported using the resources by Phoenix Australia.

Senior Australians, their loved ones and carers might equate "grief and trauma support" to human contact, rather than a broader meaning of the word encompassing information and self-care strategies. There may also be some hesitation to engage with the resources based on the contents of the information brochure alone.

> *"What I see with this package is lots of writing, lots of links.. I know they're all great organisations but what does it mean for an older person? Is there a two-minute video that gives me that conversation about, 'you might never have reached out before but here are the reasons you might do it now'. There's also no time to build*

that trust and rapport… Quite often it has to be through a human face of someone they trust."

- *Senior Australian representative*

Several aged care providers reported having shared resources with residents' families and loved ones, typically via email. The extent to which they did this was dependant on the mechanisms they already had in place to communicate with families for example via email lists or zoom meetings. They did not have information about whether aged care recipients, their carers, and loved ones had accessed the supports.

One small regional provider who had not used the Package commented that the resources would have been very useful for managing the overwhelming grief of being in complete lockdown, which was compounded by restrictions on grieving practices, and the stress of trying to keep the facility safe. In the absence of the Package, this organisation took learnings from another source, the Program of Experience in the Palliative Approach (PEPA), to transform their organisational response to grief, and have since held two full funeral services at the facility. They have since adopted practices within the facility to formally acknowledge and farewell a resident who has passed and have observed positive impacts for residents and staff.

5.2. Question 3B: How effective has the Package been in improving access to grief and trauma supports for those who need them?

5.2.1. Growth in access to supports

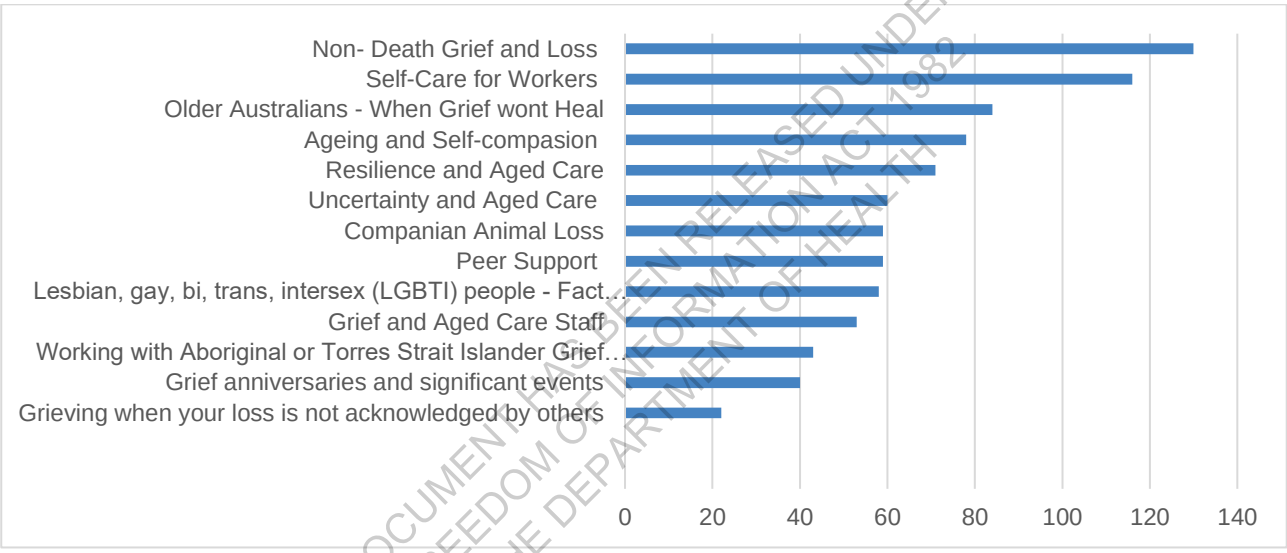
The secondary data provides an indication of the extent to which engagement with elements of the Package increased over time.

- **ACGB counselling services**. There was an increase in access to aged care counselling services between October 2020 and August 2021; from 39 total in the period from 5 October 2020 to 14 March 2021, to 52 during July and August 2021. Total number of counselling calls was 160.
- **ACGB 1800 phone line**. Most (51 of 72, 71%) of the incoming calls in August were due to the mailout to home care recipients. Of these, 9 (18%) were booked for counselling intake or call back.
- **ACGB website traffic**. The ACGB aged care website went live in June 2021 therefore data were not available to measure whether there were increases in website traffic over time. In total, ACGB indicated that there were 5,378 page visits to their aged care website, including 2,570 to the aged care landing page. Figure 4 summarises the ACGB fact sheet downloads.
- **ACGB MyGrief app downloads**. Downloads of the MyGrief app typically number around 200 per month. In December 2020, coinciding with the first communications release from the Department, app downloads increased by 400 on their usual downloads. There were 294 downloads of the MyGrief app in July 2021, of which an unknown percentage are due to communications about the Package.
- **Phoenix Australia website traffic**. Activity on the Phoenix Australia website is significant given the short time it has been live, and appears linked to webinar dates, with increased traffic associated with the webinars and webinar attendance (Figure 5).
- **Phoenix Australia webinar attendance**. Registrations for webinars have increased substantially since launch of the website and other promotional activities. Webinar 4 on

wellbeing and self-care strategies received some of the highest views despite being available for the shortest time.

- **DEMP residents and RACFs supported**. The DEMP program has been working at capacity since March 2021. The number of RACFs and residents supported by DEMP was as follows:
  - 6 RACFs and 36 residents in May 2021, average service duration 116 days
  - 4 RACFs and 21 residents in June 2021, average service duration 118 days
  - 9 RACFs and 47 residents in July 2021, average service duration 124 days.
- The **DSA website**, which was not funded by the Package but was promoted in the Department communications campaigns, has recorded an increasing trend in page views since June 2021 including their landing page (34% increase) and resources pages (66% increase). It is unclear if this is due to promotional activities of the Package or other DSA campaigns[19]. Similar trends are not apparent for the DSA phone support line.

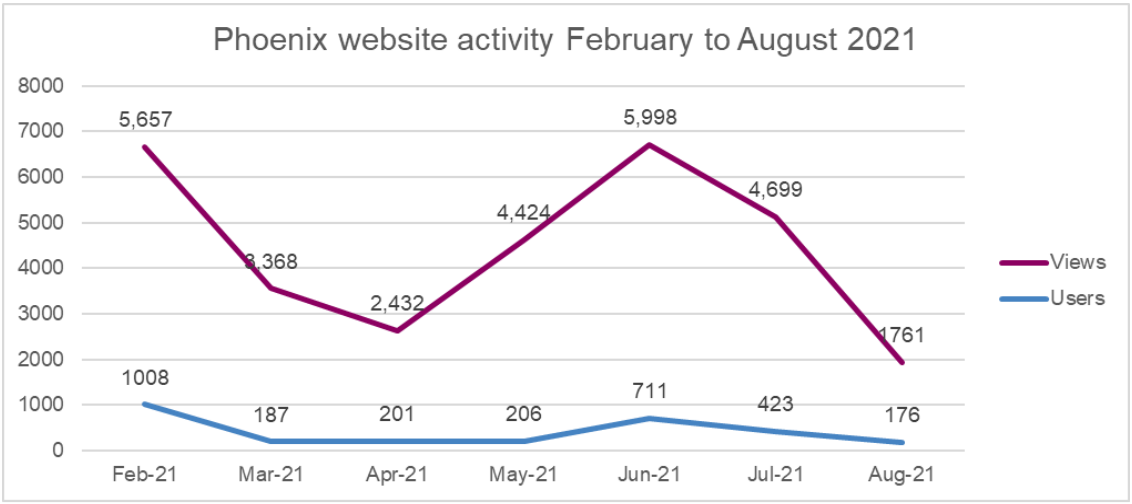
Figure 4: ACGB fact sheet downloads July-August 2021

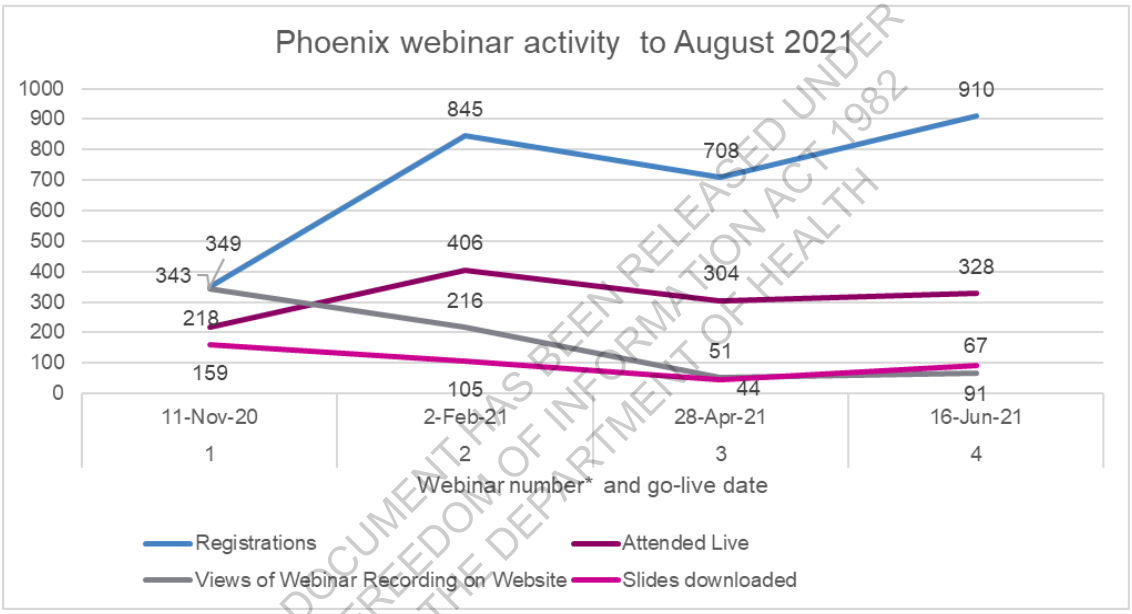


Source: Australian Centre for Grief and Bereavement

[19] DSA analysis of their marketing campaigns from Jan-Jun 2021 indicates a 44% uplift in awareness during that period. DSA note that key regulatory changes including introduction of SIRS and requirements around restrictive practice have also driven interest in DSA services.

Figure 5: Phoenix Australia website activity and webinar attendance to August 2021





*Webinar titles:
1. Identifying and Managing Trauma within the Aged Care Sector
2. Understanding Trauma and Dementia in Aged Care
3. Trauma-informed practice in aged care: Practical strategies
4. Trauma-Informed Practice in the aged care workforce: wellbeing and self-care strategies for individuals, teams and organisations

Source: Phoenix Australia

- **Brochures and fact sheets despatched**: A total of 94,742 resources relevant to the Package were ordered from the Department by 115 (of around 9000 possible) aged care providers across Australia and despatched from July to September. This is in addition to the 20 “Impacted by COVID-19 in aged care -DL” brochures and 5 “Impacted by COVID-19 in aged care” posters provided to every aged care provider in Australia in the provider mail out from the Department. A summary of the ten most represented languages in which resources were ordered is in Table 11 and examples of the types of resources that were ordered is presented in Table 12. In addition to the ‘Impacted by COVID-19 in aged care? DL Brochure’ (22,204 copies in 64 languages), fact sheets that were frequently ordered were the ‘Trauma and Dementia Fact Sheet’ (5,193 copies) and ‘Impacts of trauma Fact Sheet’ (4,911 copies).
- **Resources in languages other than English**: Resources ordered in languages other than English were most commonly ordered in Simplified Chinese, Greek, and Arabic (Table 11).

This also reflects availability of the different supports in these different languages, with Phoenix Australia and ACGB preparing translations for different audiences.

Table 11: Most common languages of printed resources ordered in July-September 2021

Language	Type*	Number of orders despatched	Number of resources despatched	Percent of orders
English	All	3,630	64,633	48.2
Arabic	I, G, T-S	466	3,328	6.2
Chinese Simplified	All	613	3,508	8.1
Chinese Traditional	I, G, T-C	341	2,444	4.5
Greek	I, G, T-C	544	3,418	7.2
Hindi	I, T-S	338	2,626	4.5
Indigenous design (English)	I	72	564	1.0
Italian	I, T-C	350	3,905	4.6
Tagalog/Filipino	I, T-S	375	1,934	5.0
Vietnamese	I, G	203	1,640	2.7
Other	All	601	6,742	8.0
TOTAL		**7,533**	**94,742**	**100**

*Number of resources ordered reflects both uptake and availability of resources in different languages. Each order represents a request for a different resource so the same fact sheet ordered in 2 languages by the same provider is counted as 2 orders..
Key: I – information from Australian Government, G – Grief supports (consumers and staff), T-C Trauma supports for consumers, T-S Trauma supports for staff/workers. All-all resources

Table 12: Common print resources despatched in July-September 2021

Publisher / Type of resource	Total* resources ordered		Non-English/ Indigenous	
	Number	Percent (of total)	Number	Percent (per resource)
Department of Health Information about the Package	23,878	25.2	13,292	55.7
Impacted/ Affected by COVID-19 in aged care? DL Brochure	22,204		12,478	56.2
Australian Centre for Grief and Bereavement Fact sheets about grief	23,725	25.0	5,286	22.3
What is grief Fact Sheet	3,259		828	25.4
Non-Death grief and loss Fact Sheet	2,971		698	23.5
Resilience and aged care Fact Sheet	3,220		655	20.3
Self-care for workers Fact Sheet	3,272		542	16.6
Uncertainty and aged care Fact Sheet	2,899		664	22.9
Phoenix Australia Fact sheets about trauma and self-care	47,139	49.8	11,531	24.5
Trauma and Dementia Fact Sheet (including fact sheet for veterans)	5,193		1,358	26.2
Impacts of trauma Fact Sheet (including fact sheet for veterans)	4,911		1,306	26.6
Self-care for families and loved ones Fact Sheet (including fact sheet for veterans)	4,795		996	20.8
Self-care for staff Fact Sheet	4,175		985	23.6
Caring for older people: How can trauma affect me?	3,628		818	22.5
Supporting a loved one Fact Sheet	3,444		1,047	30.4
TOTAL*	**94,742***		**30,109***	31.8

Source: Documentation from the Department ('Adv Aggregate Order Report Grief and Trauma – 1.06.21 to 30.09.21').
*Note: This table is not exhaustive and lists only the most commonly ordered items. Lines in grey indicate totals per publisher, which are summed to produce the grand total.

5.2.2. Barriers to accessing supports

Stakeholder survey respondents who were aware of at least one element of the Package (n=68) identified key barriers to accessing the Package (Table 13). The most common barriers identified by these participants were that it was not well promoted (reported by 38 of 68 respondents who were aware of the Package, or 55.9%) and staff not having time to access training (reported by 30 of 68 respondents who were aware of the Package, or 44.1%). Around one fifth of respondents (20.6%) considered it a barrier that the providers were unknown or that other services meet the need (19.1%). Lack of internet access was also a considerable barrier (42.6%). This was echoed by senior Australian representatives, who articulated that some older people, including those who are socially and/ or financially disadvantaged, and/ or experiencing or at risk of homelessness, and/ or Forgotten Australians, often did not have access to telephone or internet.

Table 13: Barriers to people accessing the Grief and Trauma support services

Barriers to people accessing the Grief and Trauma support services	Respondents	Percent*
Not well promoted	38	55.9
Staff do not have time to access training	30	44.1
Staff do not have time to help clients access supports	29	42.6
Language barriers	29	42.6
Difficult to access internet	27	39.7
Limited capacity	23	33.8
Providers not known or not trusted	14	20.6
Other services meet need	13	19.1
Difficult to access telephone	10	14.7

*Calculated as a proportion of respondents who were aware of least one element of the Package (i.e., 68); noting that some respondents selected more than one barrier.

As discussed earlier, identification of the supports with COVID-19 created a dual barrier of on the one hand risking being drowned out by the noise of multiple COVID-19-related messages, and secondly creating a perception that it was only relevant for people and organisations that had experienced COVID-19-related deaths or had COVID-19-related concerns.

Of the 68 stakeholder survey respondents who were aware of at least one element of the Package:

- 27 (39.7%) stated that 'the services/ resources helped people from diverse groups access supports in a timely manner'
- 10 (14.7%) disagreed with the statement
- 31 (45.6%) were not sure.

A consistent finding from discussions with aged care providers about training resource was the many competing demands for training time. Providers mentioned that "more training" was regularly touted as a solution for the industry when there are already many hours of mandated training, and it is difficult to make space for additional content.

> *"Webinars just aren't accessible for carers and EN level. They're just not spending their time watching webinars unless the organisation prompts them to, which is what we're doing. Now the webinars are out, we're getting staff together to do a half day workshop where we're going through two of the webinars and then having a conversation. That's how we're going to encourage people to get a bit more engaged."*
>
> *-Aged care provider*

With respect to counselling and self-care supports, one provider suggested uptake of the counselling service may be low, citing their own EAP data indicating uptake for that service was low. While larger aged care providers may have inhouse teams to promote wellness and access to EAPs, these roles may also act as gatekeepers to information about other services. They may choose not to disseminate the supports or information so as not to confuse their messaging. One strategy to manage this is to more clearly articulate how the Package differs from other supports.

Aged care workers may also prefer to access a more specialised service that understands their specific context and/ or that is not connected with their employer. Smaller and community-based aged care providers may have fewer in-house resources but are likely to have lower capacity to identify, understand, and implement the supports available based on the information packs. These providers, especially those in regional areas where it can be harder to attract staff, may be most in need of the supports as they will also have lower resilience to high staff turnover.

The multiple languages and considerations for inclusive design were highly welcomed across the sector, particularly for providers working with clients from many different cultural and linguistic backgrounds. Some concerns were expressed by advocacy group representatives that the resources (including translated resources for staff) may not have been culturally adapted to the extent that may be required. Cultural barriers around seeking help and/ or talking to a stranger were also mentioned; however, the peer support element was a useful way to make support more accessible and helping people to understand it is ok to seek help. Some found the brochures too wordy and suggest text may be better presented as bullet points.

Many senior Australian representatives, and a majority of CALD representatives, questioned whether older people would be willing to engage in something like telephone counselling, observing that the current generation of older people did not have a good understanding of what mental health encompasses. There was also reported to be a generational stigma around talking through problems, which is according to some stakeholders more pronounced in some cultures.

> *"..reaching out for help for most older Australians is not something they're used to doing.*
>
> *-Senior Australian representative*

Several mentioned that people who are full-time carers don't have time to look for information on support services, or that people could access known services such as BeyondBlue that they saw advertised on TV. One of two respondents to the survey of aged care recipients, their loved ones and carers, who reported accessing the ACGB service and had lost a loved one in a RACF due to COVID-19, reported having lobbied persistently for 4-5 weeks to gain access to a social worker. This issue was reported to ACGB via OPAN.

5.3. Question 3C: Is the aged care sector satisfied with the supports available through the Package?

Feedback from the aged care sector is overall very positive from those who have accessed the Package, including the range of resources and formats, languages, and representations of diversity.

> *I think the timing was unfortunate but having it in the well-rounded way of the Package is welcomed. I think it's a lot of what the sector was wanting with regards to the support and the languages. I think that's all great. The mixture of having the printed material and online is great as well.*
>
> *-Aged care peak body representative*

> *It was great they talked about the need to understand and respond to people's diversity and understand that trauma is experienced by people in certain*

communities because of the inequality they're experienced.... Often, we hear the diversity is blamed for the trauma.... Representation is important and hearing and seeing different voices and faces is a key aspect

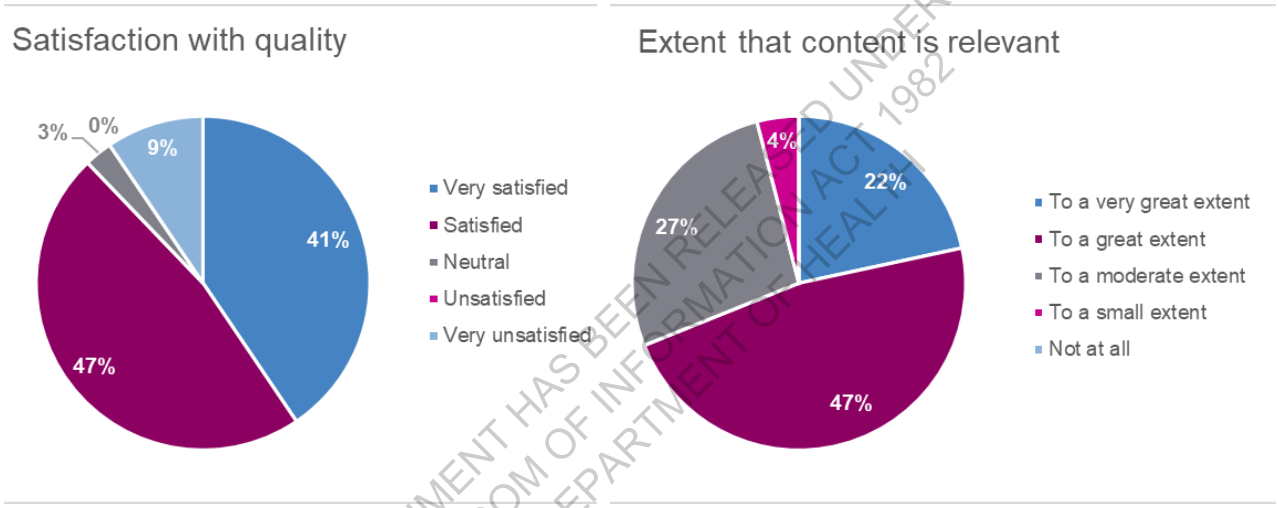
-Aged care capacity-building organisation

5.3.1. Building workforce capacity to provide trauma-informed care

Resources to support trauma-informed care include a workbook for managers and checklist for staff. Although these have only very recently been released, print orders were made for 1,605 copies of the workbook and 1,647 copies of the booklet.

Response to the first Phoenix Australia webinar was overwhelmingly positive, with 88% of respondents indicating they were satisfied or very satisfied with the quality, and 69% indicating the content was relevant to a great or very great extent. Only 4% found it relevant to only a small extent (Figure 6).

Figure 6:Example feedback from Phoenix Australia webinar on trauma-informed care



Source: Phoenix Australia aged care webinar #1: Identifying and Managing Trauma Within the Aged Care Sector (n=74 participants). Slido event summary report

Given the short term timeframe of this evaluation, evidence for capacity-building around trauma-informed care is limited, as these outcomes will take time to achieve (see Appendix B:). One of the most consistent themes in consultation with aged care providers, workforce, and representatives, is of a sector that is exhausted and overwhelmed. This may be a key barrier to providing trauma-informed care.

"I understand why there's an aim to build capacity but there's no recognition that we're at saturation point. We've got no more to give. Is anybody listening to that?"

-Aged care provider

Despite this, of the 68 respondents who were aware of at least one element of the Package 36 (52.9%) stated that 'the services/ resources helped provide trauma-informed care, including asking clients or their loved ones about grief and/or trauma they may have experienced due to COVID-19'. Seven (10.3%) disagreed with the statement, and 25 (36.8%) were not sure. It would be challenging for aged care staff who do not share a language that a resident speaks to provide trauma-informed care of this nature.

A key challenge is that some external factors identified as impacting care providers' priorities (i.e. regulation, compliance, and COVID risk management) thereby limiting engagement with the

Package, are themselves causes of grief and trauma. For example, lockdown policies designed to protect aged care residents from COVID-19 have been a significant cause of grief and trauma for residents, their loved ones, and the staff who deal with the aftermath. Aged care providers are in the unenviable position of needing to carefully balance the risk of a COVID-19 outbreak with other risks to residents' and staff wellbeing.

As an example, respondent to the survey expressed profound anguish at observing a loved one experiencing dehydration, malnutrition, and cognitive decline because the family were not considered "essential workers" and therefore not permitted in to share meals and provide care. This distress was magnified by the sense of injustice that while the respondent reported avoiding interactions with other people to reduce their own risk, they observed that paid care staff continued to move about in the community, thereby potentially risking bringing COVID-19 into the home.

One provider with an existing understanding of trauma described that they had continued to permit visits from key people even as other providers around them were electing to go into total lockdown:

> *"We had severe restrictions in place, but we always stayed open to some extent for one or two nominated people. We did that in no small part due to our understanding of people living with trauma in aged care and the supportive benefits that that routine and support from the family networks can have, both ways, because the children of those who suffer trauma are often impacted as well."*
>
> *-Aged care provider*

This provider observed that many in the industry may lack understanding of what a support community is for vulnerable groups, and that it may not be a family member or church minister for example.

A senior Australian representative identified that this was an important issue to address with the ACQSC, expressing the view that RACF provider overreach was compounding issues of grief and trauma in the sector, some of which was avoidable and preventable. This suggests an opportunity to work with the sector to manage lockdown policies in a trauma-informed way; however, it may require clear and firm guidelines from the Australian Government on how to navigate this balance.

One provider who has been sharing the Package supports with the leadership team and workers echoed the comments of others that the industry was barely keeping up with mandated activities, and felt that trauma-informed care was less likely to gain traction if the onus was placed solely on providers to embed it. This provider suggested working with the communities around the older person, to empower people entering care to ask the right questions to find out if the home can meet their needs. This approach helps to empower the aged care resident to have a conversation about what is important for them, and to have some control over the key two or three things that matter to them. Feedback from their residents so far has been very positive, and residents' sense of control has improved. This approach is summarised in Box 2.

Box 2: Suggestions for embedding trauma-informed care in residential aged care

(1) Work with communities to empower new residents at the point of choosing care

- Involve peak bodies, clinical networks, and psychiatrists to support resident empowerment and facilitate continuity of care
- Help communities and loved ones identify the important questions to ask the provider. This enables the conversation about what is important to the person
  - *This is my history, this is what it means to me to be…..*
  - *These are my needs*
  - *This is my support person*
  - *This is my treating doctor*
  - *I don't like to…….please don't make me*
  - *I do like to…..please support me to do that*

- Empower residents to choose a care provider that is willing and able to have these conversations and meet these needs
- Provide information and resources to help carers and support persons

(2) Embed a trauma-informed admission process

- Use tools/ proformas to capture a trauma history
  - Be prepared to have those conversations with the resident over weeks or months
- Help residents to reflect their desires, wishes, fears in a care plan.
- Find what is important to people and (where possible) giving them control over the 2 or 3 things that are important to them
- Ensure the care plan will survive staff changes and shift rosters

(3) Enable ongoing training for managers and staff

- Support ongoing professional development in trauma-informed care for managers
- Provide regular broad training for care staff in mental health awareness
- Ensure trauma awareness and care

Source: Aged care provider case study

One large provider that had accessed the DEMP program at multiple sites identified that the program helped the lifestyle teams and care staff learn how to improve their interactions with residents.

> *"When [lockdowns] started it was pretty confusing; CVS visits stopped and all that but luckily DEMP started and the consultant who was here for a few weeks was really helpful especially with a few residents that have dementia who were really starting to fall through the cracks"*
>
> *-RACF Lifestyle manager*

5.3.2. Supporting the workforce to practice self-care

The secondary data indicates strong interest in self-care resources ordered by providers for their workforce including 5,447 Phoenix Australia self-care fact sheets for staff, of which more than 1,000 (combined total) were in languages other than English including Arabic, Simplified Chinese, Filipino, and Hindi; and 3,972 ACGB self-care for workers fact sheets, of which more than 700 were in languages other than English including Arabic, Chinese (Traditional and Simplified), Greek, and Vietnamese.

Some providers reported sharing resources to support the workforce to practice self-care. None offered examples of how they had implemented resources from the Package to support worker self-care.

> *There're so many good resources out there but there's just a lot going on; staff don't recognise their own burnout*
>
> *Aged care provider*

The aged care workforce includes many types of workers from personal care staff, kitchen, and cleaning staff, who are often low paid, low skilled, and working numerous jobs to get by. In contrast to professional and allied health staff, these workers may lack professional training and support on how to maintain their mental health. Many are from non-English speaking backgrounds and/or have families overseas who have suffered during the pandemic and may have different cultural expectations and practices about managing grief and trauma. Some may have difficulties communicating in English and/ or have limited literacy. It is difficult to see how workers could be expected to provide trauma-informed care if they do not share language with the people they are caring for. Talking therapies and translation of content based on western norms also may not meet the needs of these workers, meaning this section of the workforce may have limited access to tools for managing their own mental health. This in turn could also limit their capacity to provide trauma-informed care to others.

5.3.3. Reaching aged care recipients who need them most

DEMP and ACGB staff conducted targeted outreach into facilities impacted by COVID-19 outbreaks, including providing telehealth support when physical access was not possible. In the period May-August 2021 DSA proactively contacted seven care homes in NSW and VIC that had been impacted by COVID-19 outbreaks, to support residents living with dementia who were isolated in their rooms. DSA delivered engagement kits including recommended activity equipment and laminated activity plans and allocated a DEMP consultant to provide ongoing telehealth support as required. DSA was able to establish contact with the homes within 1-3 days of the outbreak and provide support within 3-8 days. Residents supported by DEMP include 32 from CALD backgrounds[20] (31%).

The DEMP program was described as extremely valuable for helping both to manage the psychological impacts of lockdowns for residents living with dementia, as well as developing staff capacity to improve the way they interact with residents. Residents were identified for the program if they were withdrawn and disengaged, and the DEMP consultant worked with the lifestyle staff to develop activities to engage the resident.

One provider who had accessed DEMP valued the DEMP consultant identifying when staff were speaking inappropriately to clients and offering support and modelling for how to do it differently. Another found the program enormously beneficial but thought the model was not sustainable for the lifestyle program to maintain after the DEMP consultants left due to funding limitations on lifestyle programs.

The DEMP program collected stories about residents who had benefited from the program to illustrate how residents have benefited from the program. Some of these stories are shared below in Box 3 (see also Appendix F.3.1). Note that names have been changed and the cultural background of the case study subjects was not recorded.

Box 3: Example case studies of residents who benefited from the DEMP program

DEMP Case Study 1: Daryl

Daryl was referred to DEMP as staff were concerned that he was withdrawn and self-isolating and that he could be aggressive at times. Daryl preferred to remain in bed, looking out his window. A DEMP consultant spent some time talking with Daryl about his life in Tasmania, the consultant then brokered some photo books about Tasmania which allowed Daryl to show his aged care staff the places he had been.

The DEMP consultant modelled the use of "Conversation Kit", which contains books, photos, articles, and a variety of items that promote conversation and reminiscence discussions with residents.

Daryl is now leaving his room to go to the dining room for meals, where he is engaging with others. He enjoys going outside in the courtyard and is joining in with small group activities including quizzes, entertainers, and the visiting petting farm, where he patted a llama. The Lifestyle Coordinator reports that the most profound outcome is that he joins other residents in the dining room for dinner, engaging with them and with staff. The Lifestyle Coordinator reports that "Daryl is a new man."

DEMP Case Study 2: Carmel

Carmel is living with Lewy body dementia. Carmel has limited mobility and spends her time in a princess chair or bed. The DEMP consultant liaised with Carmel and she talked about her old dog Bill, she said he was an Airedale and she loved and missed him very much.

The DEMP consultant contacted a member of the local Airedale Club and it was agreed that the person would bring her dog into the care home the following week to see Carmel. When the dog was brought into the care home to meet Carmel, her whole face lit up and she broke into a huge smile. She said "Bill" right away and began patting the dog and reminiscing about Bill. A weekly arrangement has been made to bring "Bill" in to see Carmel.

[20] As identified from their personal history.

Care home staff have reported that Carmel's interaction with others have increased. In addition to meeting the needs of Carmel, this arrangement has managed to bring together the care home with a local member of the community.

DEMP Case Study 3: Ian

Ian has a complex health history: including Lewy body dementia, posterior cortical atrophy (PCA), Parkinson's disease, and vision loss. Due to the progression of Ian's dementia, Ian no longer tolerated interventions that previously worked well for him including music engagement and sensory objects to hold. Staff were finding it difficult to find ways to engage with Ian as he often would become agitated in group activities and mainstream activities that did not meet his needs.

The Dementia Consultant trialled the "InmuRELAX" with Ian to provide sensory stimulation that may ease his distress and agitation. (InmuRELAX has artificial intelligence that responds to the heartrate and movement of the client and adjusts the music and vibration accordingly to relax the user).

DEMP provided modelling and coaching with staff on how to use the product. Staff were encouraged to provide this to Ian if they notice he is becoming increasingly agitated or unsettled. Ian's responded well to the InmuRELAX, reducing his episodes of agitation and restlessness.

Care home staff informed that his interactions with his family and staff have increased. Ian's wife stated that the intervention has made a "significant difference in Ian's life"

5.4. Question 3D: How can components of the Package be improved to make the supports more effective and accessible?

A common question from senior Australians and other stakeholders concerned linkage of the supports to local services. This suggests opportunities to integrate the Package with local supports to provide more integrated mental health care, which might involve targeted linkage with existing organisations and services. This could include working with capacity-building organisations in the aged care sector and health professionals who interact with other people and their loved ones to build knowledge of the Package and apply learnings. Linkage to Continuing Professional Development (CPD) requirements will support capacity-building among doctors, allied health staff, and others with professional memberships. There may also be opportunities to share resources with EAP providers to support capacity-building within those providers.

> *"I would like to see more integration; a national approach is great, but it's got to be integrated with the local level resources and supports and that's always a challenge when you have a national project, how does it interface at the local level?"*
>
> *-Aged care peak body representative*

There are opportunities to build **communication of the Package**, as discussed in earlier sections. Aged care recipients, their carers and loved ones had a slight preference to receive information from health care providers (such as doctors, nurses etc) with 23 of 47 survey respondents (or 49%) indicating that these are their preferred sources. This was closely followed by direct mail (22, 47%) and social media (preferred by 20 of 47 respondents, or 43%,Table 14). It is encouraging that direct mail and social media are preferred source of information for this cohort given that these have been the primary avenues for communication from the Department.

Table 14: How aged care recipients, their carers and loved ones would like to receive information about available support services

Preferred source	Total*
Doctor, nurse or health care worker	23
Direct mail	22
Social media	20
Television	14
Newsletter	14
Brochure/poster	13
Radio	13
Other (e.g. email, friends, community organisations)	13

*n=47 respondents. Respondents could choose more than one option.

Stakeholders consistently identified the trusted networks around older people as key opportunities to raise awareness of the Package and reduce barriers to uptake.

Feedback on **ACGB services** indicates opportunities for improvement in building the peer support and capacity-building elements. This would enable more localised service delivery and improve sustainability of services. ACGB reported that peer groups are currently growing. The current "missing element" identified by ACGB concerns supporting people in the decision-making process around engaging with the service. ACGB are currently working on this element.

Phoenix Australia have collected continuous feedback to inform development of supports to meet stakeholder needs, including through the webinars (Box 4). Suggestions were highly focused on practical considerations including referral, pathways and working with people with complex needs. Most resources have only recently been released so feedback is not yet available.

Box 4: Selected suggestions for improvement from Phoenix Australia webinar attendees

Referral to other services

Perhaps more detail about when staff should refer clients on who are too traumatised i.e. how the clinical indicators intensity & duration translate into aged care settings?

I'm supporting an elderly mother trying to cope with her daughter's cPTSD but the daughter won't accept help. How can we connect ppl with the help they need?

Implementation strategies

Encouraged by the fact that future webinars will deal in greater detail with some the issues in implementing Trauma-Informed Care

I would suggest that the panel does not really know the limits on aged care staff to engage in these sorts of case plan discussions & follow through with care

People with diverse needs

Trauma-informed care within CALD communities in aged care space please!

Care specifically for veterans please

A large no. of residents in aged care facilities are from a CALD background, reverting to the first language. This complicates the individual's capacity to manage their trauma reactivity. How do you suggest facilities address the lack of this critically important communication mechanism?

You're assuming ppl can discuss their concerns especially if they come from a traumatic background & may have dementia as a co-morbidity.

Vicarious trauma

Will you be discussing vicarious trauma and potential for staff?

How do you support the family and staff who may be exposed the trauma that have resurfaced for their residents?

Working in different aged care settings

Hello, will Trauma-Informed Care be included within CHSP and HCP consumers, staff and managers?

How can casual/agency staff deal with clients they don't know

How do we manage this in community when we are not with them all the time and when we may not know as much about their backgrounds?

Would like to hear more about aggression in RACFs

Working with traumatised people

What level of detail do we need to understand the resident's experience of trauma to manage it (triggers etc)? What's the best approach for this conversation?

How do you deal with someone with obvious issues but will not or cannot get across to you what/how/why?

What are helpful ways to care for collective trauma within aged care organisations; including staff, residents and families in their struggles?

we have always been taught to work within the reality of the person living with dementia and not drag them back to our reality. How does this transfer to trauma?

I believe it is very important to know the type of dementia a person has in able to provide the correct type of care. How is the type of dementia assessed?

Frequently residents haven't disclosed trauma to family. By the time of admission they may be unable to verbalise their experience

How would you recommend the management of disclosed traumas that may have been caused by family members that are still involved in their life?

Source: Slido analytics report for Phoenix Australia webinar 1, Identifying and Managing Trauma Within the Aged Care Sector; and webinar 2, Understanding Dementia and Trauma in Aged Care

One stakeholder suggested that a pocket resource to help staff find the language to have conversations about grief and trauma would be a useful addition. This could be a wallet-sized fold-out sheet with different conversation prompts that staff can use as a tool to support difficult conversations. This tool might incorporate strategies from all elements of the Package.

6. Efficiency and cost-effectiveness

This Chapter presents findings in relation to Evaluation Question 4: *How effective of service utilisations and cost per output are of the Package?*

6.1. Question 4A: What are the costs of the Package relative to its use?

ACGB, Phoenix Australia and DSA provided activities to support staff, aged care recipients, and their families dealing with trauma and grief due to COVID-19. Data on program activities from October 2020 to August 2021 include:

- **ACGB**: Intake and assessment for grief and trauma support, counselling for family members, aged care recipients and staff, peer support, group support, national toll-free helpline, online information, and telehealth.
- **Phoenix Australia**: Webinars and training sessions for aged care workers and other relevant audiences, online information on trauma, grief, and loss for older people, aged care workers, and veterans.
- **DSA**: Implement DEMP to help aged care residents living with dementia that are at risk of changing behaviours due to COVID-19 restrictions.

Table 15 describes the framework used to measure service utilisation which follows a recent study that estimates utilisation and cost for comprehensive range of health and care services.[21] A utilisation index is developed to measure the effectiveness of the program. These include program activities related to initiation or engagement, two program implementations, and outcome-related activities. The effectiveness for each phase was estimated by using Pearson Correlation Coefficient (PCC) to determine the correlation between activities. The utilisation index score was estimated from weighted proportion for each phase multiply by the Pearson's coefficient. The maximum index score is 1, where it represents a full-service utilisation.

Table 16 presents details on the key activities and total cost of the funded organisations under the Package, including support activities from the Department.

Table 15: The framework of service utilisation index

Parameter	Phase 1	Phase 2	Phase 3	Phase 4
Classification	Initiation or engagement activities	Activity1 of the program	Activity 2 of the program	Outcome-related activity
Index score method	PCC 1	PCC 2	PCC 3	PCC 4
Weighted index score	0.2	0.25	0.25	0.3
Score	PCC1*0.2	PCC2*0.25	PCC3*0.25	PCC4*0.3

Sources: Data on service provisions from ACGB, Phoenix Australia, DSA from October 2020 to August 2021.

[21] Kalseth, J, Halvorsen, T, 2020, "Health and care services utilisation and cost over the life-span: a descriptive analysis of population data", *BMC Health Services Research*, v.20, pp. 1-14.

Table 16: Service provisions and allocated funding for each organisation and the Department under the Package

Parameter	ACGB	Phoenix Australia	DSA - DEMP	Department
Role	Provide specialist information and support to aged care residents and home care recipients and their families who have been affected by COVID-19	Deliver a sector-wide trauma-informed care package that provides trauma training and resources for aged care recipients, their families and aged care staff, including through the establishment of a dedicated website	Implement a proactive engagement program to help alleviate the impacts of lockdown on aged care residents living with dementia	Provide support to raise the awareness of the program under the Package. This includes campaigns and communications in several channels including social media networks
Service provisions	➢ Intake and assessment for grief and bereavement services. ➢ Grief and bereavement counselling for family member, carer, and relative/friend. ➢ Grief and bereavement counselling for aged care recipients and age care staff. ➢ Peer support counselling. ➢ Group support counselling. ➢ Provide online materials about grief, loss, and resilient in other languages. ➢ Provide national toll-free helpline. ➢ Provide telehealth for in-person clinical support. ➢ Provide telehealth for individual counselling in RACFs. ➢ Provide telehealth for group-based counselling in RACFs.	➢ A dedicated website that provides information about trauma, loss, and grief. ➢ Package online information (fact sheet and video animation) of trauma, loss and grief for older people, families, and carers. ➢ Package online information (fact sheet and video animation) of trauma, loss, and grief for age care workers and managers. ➢ Package online information (fact sheet and video animation) of trauma, loss, and grief for veterans. ➢ Factsheet and online materials about trauma in languages other than English. ➢ Provide webinar series related to managing trauma within the aged care sector. ➢ Provide trainings for aged care workers dealing with trauma, loss, and grief.	➢ Implement DEMP to help aged care residents dealing with COVID-19 restrictions. ➢ Referral activities to contact aged care homes that have impacted from COVID-19. ➢ DEMP consultant delivers engagement kits for those isolated residents living with dementia. ➢ DEMP consultant provides ongoing telehealth support as required for aged care homes. ➢ DEMP consultant support aged care homes staff to help residents in using the package kits.	➢ Communication and campaign supported by brochures, posters, emails marketing content and templates. ➢ Social media posts and accompanying text, audio files, and an editorial script that have been shared with SBS radio and ethnic media in languages other than English. ➢ Brochure and social media specifically designed for Aboriginal and Torres Strait Islander Peoples. ➢ Send printed information on the available supports to all aged care providers and CVS auspices. ➢ Send letter and brochure in preferred language to 130,000 home care recipients. ➢ Provide printed copies of brochures, posters and factsheets on demand.
Allocated funded (in $million)	$5.48	$2.22	$2.41	$0.92
Current expenditure[1] (in $million)	$0.72	$0.48	$1.60	$0.37
Ratio budget to expenditure (%)	13.1%	21.8%	48.1%	40%

Sources: Department of Health, ACGB, Phoenix Australia, and DSA.

Note: [1]costing data for each organisation under the Package were reported between June and August 2021

Table 17 shows the calculated utilisation index score for the activities conducted by three of the funded organisations and the Department.

- Utilisation index score for ACGB was estimated at 0.90. Phase 1 measures the correlation between referral activities through social media and the engagement with the live webinar. Phase 2 and Phase 3 were estimated based on the correlation between counselling activities and telehealth provisions. Phase 4 measure the growing trend of counselling, peer support and group support.
- Utilisation index score for Phoenix Australia is 0.84. Phase 1 measures the correlation between the engagement activities through a series of live webinars and online users accessing materials in the Phoenix Australia website. Phase 2 and Phase 3 estimate the correlation between total attendees in live webinars and total materials downloaded, including specific materials related to grief and trauma for senior Australians, families, aged care workers, and veterans. Phase 4 measures the ongoing activity in Phoenix Australia website between total page views and all materials downloaded.
- Utilisation index score for DEMP-DSA was estimated at 0.92. Phase 1 estimates the correlation between proactive referral activities and program initiations at age care homes impacted by COVID-19 restrictions. Phase 2 and Phase 3 measure the DEMP program activity such as the distribution of package kits for aged care residents living with dementia, the length of service provision in age care homes, and the correlation between initiation and program completion. Phase 4 measures the correlation between program completions and total supported aged care residents.
- Utilisation index score for the Department was estimated at 0.94. Phase 1 estimates the correlation between campaign activities through social media posts and engagement online. Phase 2 and Phase 3 measure the correlation between translated information by type (brochures, posters, and factsheets) and total number of print orders. Phase 4 determines the correlation between distribution activities of the information and location by postcodes and by state/territories.

Table 17: Utilisation index score

Phase	ACGB	Phoenix Australia	DEMP - DSA	Department
Phase 1	Referral activities and webinar	Engagement in webinar and online users	Referral activities and initiations	Social media posts and online engagement
Phase 2	Counselling and telehealth activities	Rates of attendees in live webinar, recording, and downloaded webinar materials	Supported RACFs, distribution of brokerage items, length of DEMP service provision (days)	Availability of translated brochures and posters and total print orders
Phase 3	Counselling and resources downloaded	Users' activity and page views	Initiations and program completion	Availability of translated factsheets and total orders
Phase 4	Trend counselling, intake and assessment, peer support, group support	Page views and downloaded materials for families, carers, workforce, and veterans	Program completion and supported aged care resident	Distribution of total ordered information and location of recipients by postcodes and by states/territories
Utility index score	**0.90**	**0.84**	**0.92**	**0.94**

Sources: Data on service provisions from the Department, ACGB, Phoenix Australia, DSA from October 2020 to August 2021, HealthConsult analysis

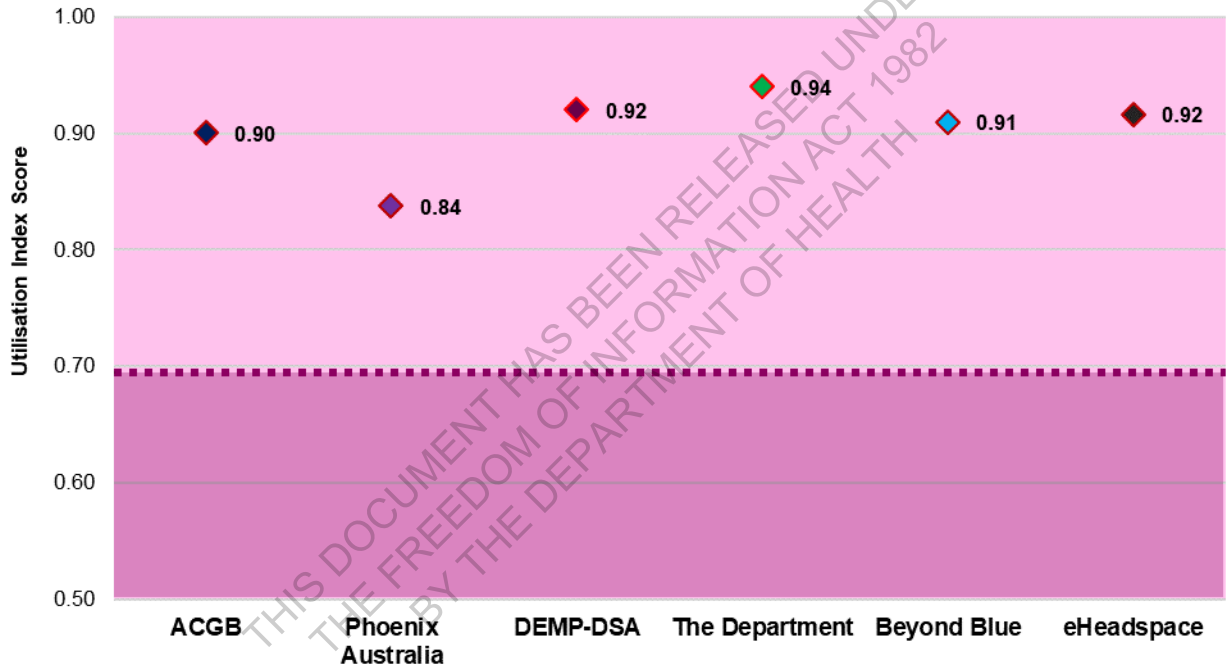
A review of the literature identified two similar programs that provide support through web-based resources to use as comparators to the Package. The first program is mental health supports from

Beyond Blue, and for the purpose of this analysis, the service utilisation data is limited to their website activities for the period 2015-2018.[22] Data on service utilisations to estimate the index include total pageviews, total website visitors, session durations, and bounce rates, which are similar with service utilisation data from Phoenix Australia. The index score from these activities was estimated at 0.91.

The second program is the web-based national mental health support program for young people provided by headspace. Like Beyond Blue, service utilisation data are limited to their activities in online counselling program through eheadspace for the period 2017-2019.[23,24] The components to estimate the utilisation index include total occasion of service, total online service for young people via national hotline, total online counselling, and total logins to eheadspace. The index score from these activities is 0.92.

Figure 7 shows the service utilisation index from three organisations under the Package and compares to the two comparable activities from Beyond Blue and eheadspace.

Figure 7: Utilisation index under the Package and comparable programs



Sources: Data on service provisions from ACGB, Phoenix Australia, DSA, the Department, and HealthConsult analysis
Notes: Utilisation index for Beyond Blue is limited to their activities in website traffic, and utilisation index for eheadspace is limited to their activities in online counselling supports. The index effectiveness threshold of 0.7 is based on Kalseth and Halvorsen (2020)

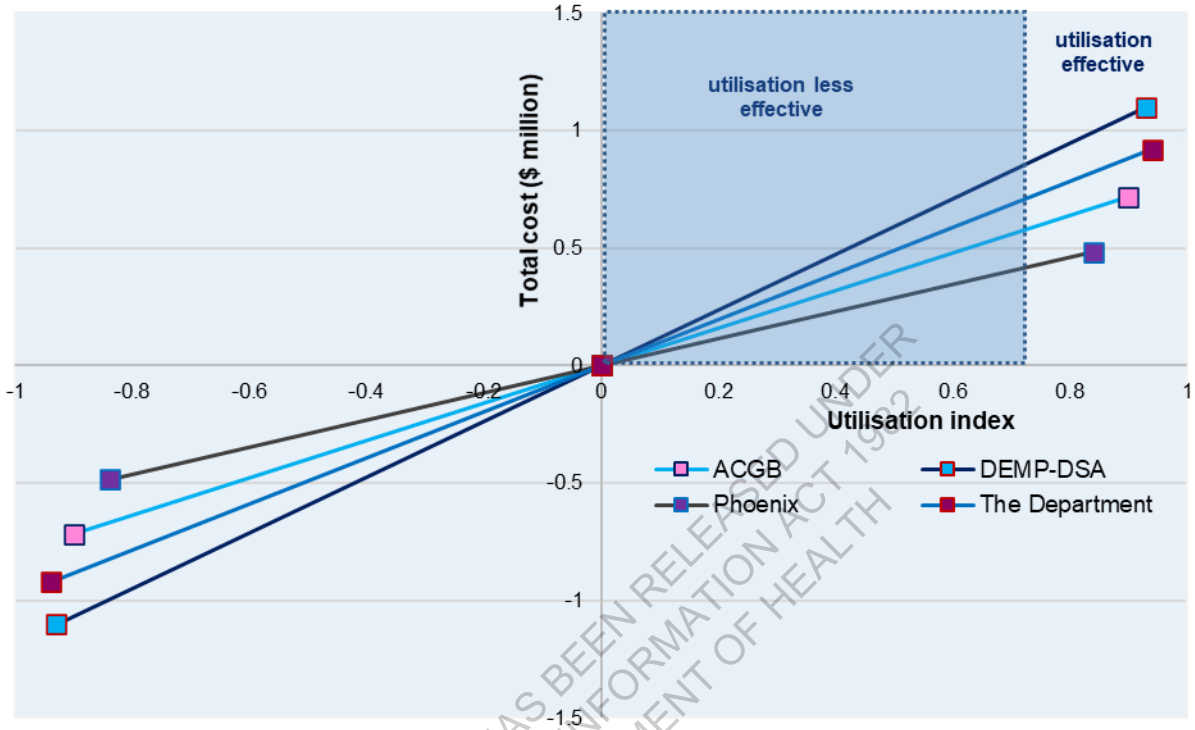
It is important to note that the service utilisation index was developed based on correlation between activities based on available data. All programs were identified to have effective utilisation, and differences between utilisation indices above the threshold may not be meaningful.

[22] Beyond Blue, "*Final evaluation of Beyond Blue 2015-20*18", Siggins Miller (2018).
[23] Headspace evaluation snapshot report, "*Accessibility of headspace centre services*", Headspace (2021).
[24] Hilferty, F., Cassells, R., Muir, K., Duncan, A., Christensen, D.,
Mitrou, F., Gao, G., Mavisakalyan, A., Hafekost, K., Tarverdi,Y., Nguyen, H., Wingrove, C. and Katz, I. (2015). *Is headspace making a difference to young people's lives?* Final Report of the independent evaluation of the headspace program. (SPRC Report 08/2015). Sydney: Social Policy Research Centre, UNSW Australia.

Further, these data represent the implementation of ongoing programs, whereas the comparison programs from Beyond Blue and headspace have been implemented for a significantly longer time.

In terms of the total cost, Figure 8 shows the utilisation index against the total cost to deliver the service.

Figure 8: Utilisation index and current total cost under the Package



Sources: Data on service provisions and total cost from ACGB, Phoenix Australia, and DSA. HealthConsult analysis.

6.2. Question 4B: How do the costs of the Package relative to its use compared to similar programs?

This section presents cost per output analysis for each service provider, including the Department, from October 2020 to September 2021. Given the formative stage of this project the analysis can be defined as a short-run cost analysis where cost per output is not at maximum efficiency. In the long-run, cost per output is expected to decrease. In terms of comparing the unit cost, key outputs from ACGB and DEMP-DSA are comparable to similar programs by headspace and Dementia Australia.

6.2.1. Cost per output analysis

The estimated total expenses have been reported from each service provider to deliver the output. Table 18 summarises the expenditure data provided for staff wages and salaries, operational cost, administration cost, and other costs.

Table 18: Costing data received from organisations funded under the Package

Provider	ACGB	Phoenix Australia	DEMP - DSA
	in $ and (%)	in $ and (%)	in $ and (%)
Labour cost: staff salary and wages	$388,140 (54.1%)	n/a	$863,978 (74.4%)
Operational cost, administration cost, and other costs	$329,094 (45.9%)	n/a	$296,598 (25.6%)
Total expenses	**$717,234**	**$483,000**	**$1,160,576**

Sources: Costing data on service provisions from ACGB, Phoenix Australia, DSA, HealthConsult analysis.
Notes: Costing data were reported in June 2021 for ACGB, July 2021 for DSA, and August 2021 for Phoenix Australia. Phoenix labour costs and operational costs are not specified separately

6.2.2. ACGB cost per output

The outputs from ACGB include a dedicated website for grief and trauma support, fact sheets, webinars, short courses, telehealth, intake and assessment, and counselling services. Table 19 shows cost per output for ACGB.

Table 19: Cost per output - ACGB

ACGB outputs	Total outputs at Sep 2021 (estimated)	Cost allocation per output (%)[1]	Total cost ($)	Cost per output ($)
1. Website establishment	1	allocated	$83,032	**$83,032**
2. Fact sheets	16	5%	$31,710	**$1,982**
3. Webinars	6	20%	$126,840	**$21,140**
4. Short courses	4	20%	$126,840	**$31,710**
5. Telehealth service establishment	5	15%	$95,130	**$19,026**
6. Telehealth support services	8	5%	$31,710	**$3,964**
7. Intake and assessment	56	5%	$31,710	**$566**
8. Individual counselling	230	20%	$126,840	**$551**
9. Peer support and group counselling	33	10%	$63,420	**$1,922**
Total	**359**	**100%**	**$717,234**	

Source: ACGB costing data per June 2021
Notes: Total outputs were estimated in September 2021.
[1]cost allocation per output is an assumption due to limited costing information

6.2.3. Phoenix Australia cost per output

Through the establishment of a dedicated website, Phoenix Australia provides trauma-informed care information, training, webinars, and self-care resources for aged care staff, aged care recipients and their loved ones. Table 20 shows cost per output for Phoenix Australia.

Table 20: Cost per output – Phoenix Australia

Phoenix Australia outputs	Total outputs as Sep 2021 (estimated)	Cost allocation per output (%)	Total cost ($)	Cost per output ($)
Website establishment	1	26%	$125,000	**$125,000**
Trauma awareness training (including co-design/consultation, product testing and project management)	4	23%	$112,000	**$28,000**
Video animation of trauma, losses, grief, dementia, self-care	7	3%	$16,600	**$2,371**
Handouts/fact sheets for aged care recipients and their families, aged care workers, managers, and veterans, including translation	68	31%	$149,400	**$2,197**
Webinars (including staff time and project management)	4	17%	$80,000	**$20,000**
Total	**84**	**100%**	**$483,000**	

Source: Phoenix Australia costing data per August 2021
Notes: Total outputs were estimated in September 2021.

6.2.4. DEMP-DSA cost per output

The cost to deliver DEMP-DSA was mostly allocated for consultants or staff to provide support for RACFs impacted by COVID-19 restrictions and to help residents living with dementia in using the brokerage kits. Table 21 shows cost per output for DEMP-DSA.

Table 21: Cost per output – DEMP-DSA

DEMP-DSA outputs	Total outputs to September 2021 (estimated)	Cost allocation per output (%)	Total cost ($)	Cost per output ($)
1. DEMP-DSA consultants	100	92%	$1,069,755	**$10,698**
2. Brokerage kits package	46	1%	$9,082	**$197**
3. Brokerage kit items	749	7%	$81,739	**$109**
Total	**895**	**100%**	**$1,160,576**	

Source: DEMP-DSA costing data per August 2021.
Notes: Total outputs were estimated in September 2021.

Based on an estimated number of 212 residents supported by DEMP-DSA to September 2021, the average cost per resident was $4,152.

6.2.5. Department cost per output

Table 22 shows cost per output of communication activities provided by the Department. The costs incurred were mostly in mailing information to CVS auspices and home care recipients. Other communication services include designing social media content and translating brochures and posters.

Table 22: Cost per output: Department

Communication outputs	Total outputs per September 2021 (estimated)	Cost allocation per output (%)	Total cost ($)	Cost per output ($)
Design and social media content	1	8%	$35,000	**$35,000**
Indigenous logo and image	1	1%	$6,000	**$6,000**
Translating brochures into 63 languages and posters into 10 languages	73	5%	$24,000	**$329**
Mail out 1: sending information starter pack of 20 brochures and 5 posters	6,000	20%	$86,000	**$14.30**
Mail out 2: sending information starter pack to CVS Auspice	190	1%	$5,700	**$30**
Mail out 3: sending personalised mail to home care recipients	130,000	50%	$220,000	**$1.70**
Other printing/packing*	94,742	14%	$60,000	**$0.63**
Total expenditure			436,700	
Balance of funding for ongoing print orders			*$484,300*	
Total	**231,007**	**100%**	**$921,000**	

Source: The Department costing data September 2021
*These figures are averaged per piece, noting that items of different size/weight will attract different costs

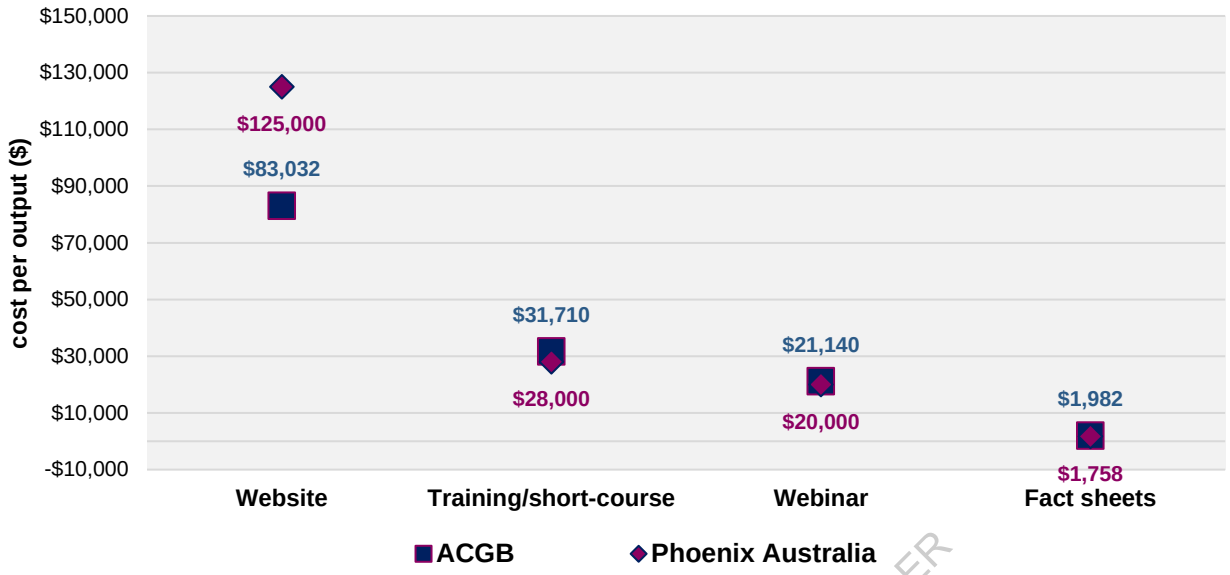
6.2.6. Cost per output comparison

Figure 9 presents cost per output comparison between ACGB and Phoenix Australia. The output includes website establishment, training or short course, webinar, and fact sheet.

To compare cost per output with similar programs, Table 23 shows cost per output comparison. The outputs include the following:

- **Cost per output for individual counselling**: in the ACGB cost per output data (Table 23), the unit cost for individual counselling was estimated at $551. The similar program from headspace (2015) show that individual counselling cost was $446. Both figures are in 2021 price.
- **Average care cost of people living with dementia**: in the DEMP-DSA, it was estimated that the average care cost was $5,474. The average cost includes not only counselling and telehealth services, but also assisting and supervising staff and residents in using the engagement kits. Data from Dementia Australia shows that, with Government funding of $10 million, the average care cost for people living with dementia was $3,311, which includes counselling services only. Both figures are in 2021 prices. It is likely that the DEMP program is more intensive and specific than that provided by Dementia Australia, which could account for the increased unit cost. The analysis also does not consider access to existing DSA supports (e.g. online videos. telephone support line) that may have occurred in connection with the Package.

Figure 9: Cost per output comparison between ACGB and Phoenix Australia



Sources: Cost per output for ACGB and Phoenix Australia, HealthConsult analysis

Table 23: Cost per output comparison with other programs

Output	Provider under the Package	Cost per output (in 2021 price)	Program comparison	Cost per output (in 2021 price)
Individual counselling	ACGB	$551	headspace (per occasion of service)	$446[†]
Average care cost of people living with dementia	DEMP-DSA	$5,474	Dementia Australia	$3,311[††]

Sources: ACGB and DEMP-DSA cost per output, headspace (2015), Dementia Australia (2021), HealthConsult analysis (2021).

Notes: [†] cost per output was inflation adjusted to 2021 price based on headspace report (2015)

[††] cost per output based on total government funding of $10 million and 3,020 people with dementia and their family members attended counselling services.

6.3. Question 4C: How could the Package be more cost-effective?

The stakeholder survey asked respondents if they perceived any overlap of the services/ resources or support offered under the Package with other programs.

Table 24 shows that 37% agreed that the Package services/ resources overlap with other resources/ services (e.g. Beyond Blue CMWSS, Head to Health gateway) and 24% felt they overlapped with supports offered by their employer or EAP. It is not clear from these data the extent to which respondents were familiar with the mental health supports and gateway listed, and/or how a specialised grief and trauma service may be different.

Table 24: Extent to which the Package was thought to overlap with other services

Extent to which survey respondents agree to the following statement:	Agree		Disagree		Not sure		Total	
	n	%	n	%	n	%	n	%
The services/ resources overlapped with other resources/ services (e.g. Beyond Blue Coronavirus Mental Wellbeing Support Service, Head to Health)	25	36.8	13	19.1	30	44.1	68	100
The services overlapped with supports offered from my employer or EAP (Employee Assistance Program)	16	23.5	24	35.3	28	41.2	68	100

Suggestions provided by stakeholders about how the Package could be more cost-effective:

- Access to the supports can be optimised by ensuring translations are culturally relevant and suitable for the intended audience.
- Ensure there is clarity of purpose of the Package and how it complements/ differs from other already developed programs (e.g. BeyondBlue, grief and trauma program that is funded via the PHN).

7. Conclusion

This Chapter considers the learnings derived from Chapters 3-6 and presents a series of recommendations to support the future rollout and promotion of the Package.

7.1. Effectiveness of the rollout

The Department and funded organisations carried out extensive communications activities to promote the launch of the Package. Results from the stakeholder survey reflected these activities, with 53.5% of aged care providers and stakeholders who responded to the stakeholder survey indicating they were aware of at least one element of the Package. Most of these respondents were from NSW or Victoria. The most common modes of learning about the Package were via direct communications from the Department and via industry newsletters; suggesting that these modes of communications activities carried out by the Department were effective. Finally, 44 of the 68 stakeholders who were aware of an element of the Package noted that the services/ resources increased their awareness of grief and trauma, suggesting that since inception the Package is achieving at least one of its core objectives.

Factors that may have impacted government stakeholders *not* being aware of the Package yet were changes in Department staffing and roles in state and national offices of the Department due to the Australian Government COVID-19 response and vaccination rollout, and perceptions that the Package was targeted providing support to those that had experienced COVID-19 outbreaks. Government stakeholders also noted that they were, at times, selective in what information they disseminated to their networks to not overburden recipients.

Providers and provider peak bodies interviewed suggested the supports need ongoing promotion so that they would be front of mind when people were ready to connect; and noted that they were suffering from 'information fatigue', and so, as with government stakeholders, were selective both in what they paid attention to and what they disseminated to their staff.

Aged care recipients, their loved ones and carers, who responded to a survey indicated a much lower level of awareness of the Package with only 21% indicating they were aware of ACGB's counselling service, and 11% indicating they were aware of Phoenix Australia's resources. These findings were similar to those obtained by the senior Australian focus groups and expert advisors. This is likely impacted by the small sample size, and because, at the time the survey was disseminated, the major communications by the Department directly to aged care recipients had only just been disseminated.

(1) For the future rollout of the Package a continued focus on awareness raising activities via industry newsletters (those with large networks, such as OPAN, ACSA, LASA etc) and direct communications from the Department.

(2) As part of promotional activities including newsletter articles, share testimonials and stories of people who have accessed the supports, to help the intended audience identify the relevance and benefits for them and include examples that are representative of diversity in the aged care service recipient population.

(3) Continue the rollout of the Package and awareness raising activities, as those who used it noted that it increased awareness of grief and trauma, which is one of the first steps to providing trauma-informed care (as per the Theory or Change in Appendix A). At a minimum the awareness raising activities should be targeted to providers and other stakeholders (such as government and peaks), as awareness led to use of the Package about half the time.

(4) Department conduct repeat-communications activities and ongoing communications with government stakeholders and aged care providers to account for any staffing losses/ replacements during the COVID-19 pandemic response. It will also be important that future communications continue to clarify that the services/ resources are not only for those who have experienced a significant COVID-19 outbreak.

The communications activities carried out by the Department of Health have been provided to a very large audience – including individual information packs disseminated to 6,000 aged care providers and translated (if required) letters and brochures to approximately 130,000 home care recipients. The projected/goal actual use of elements of the Package was not specified, therefore whether the actual usage of the Package met or exceeded expectations cannot be determined. Regardless of this, call volumes and website traffic to funded organisations appears reasonable given the timeframe of data collection (being within only one month of the Department communications activities).

Of the 68 stakeholder survey respondents who were aware of the Package, 35 (or 51.1%) indicated that they had used one or more element of it. This indicates that, among aged care providers and other stakeholders (excluding aged care recipients, their loved ones and carers), awareness converted to use approximately half of the time.

Very few aged care recipients and their loved ones indicated having used the Package via the survey and focus groups. As with other findings, this is not surprising given the timeframe of data collection and Department communications activities.

(5) Establish target uptake measures of the Package by the Department and funded organisations, so that future uptake can be assessed against a benchmark.

(6) Department and funded organisations continue to monitor uptake of Package resources into the future given that the evaluation data collection was undertaken so close to the major communications launch of the Package.

Department representatives, peak bodies, aged care providers and aged care recipients, their loved ones and carers, provided several suggestions to improve the rollout of the Package. These included:

- Provide detailed briefings on the Package to help stakeholders at all levels (including government and sector professionals) to understand how the supports offered under the Package can benefit them, which would likely improve usage. Consider hosting regional forums to do this, for example as part of the SSD program, which brings together stakeholders from across the sector to learn about and discuss key changes and initiatives.
- Consider how to strengthen internal Department communication channels to ensure relevant information reaches the appropriate stakeholders
- Provide “quick bites” short informational videos about Package elements to assist end users to navigate to the resources relevant to them.
- Clearly identify the how the Package links with the Aged Care Quality Standards’ requirements to provide person-centred care, in communication with aged care providers.
- Review the language of Package resources and consider moving away from ‘COVID-19’ and ‘grief and trauma’. Market research currently underway by Clemenger and user testing may help to determine the most suitable labelling/ terminology.
- Consider leveraging existing platforms that aged care recipients and their loved ones already access to communicate information about the Package. Avenues include:
  - engaging directly with community connectors and aged care navigators

- inviting networks to call for expressions of interest and/or nominate influential members to participate in information sessions or “train the trainer” activities
- engaging with health providers and provider networks (such as PHNs), volunteer-based organisations and other representative groups.

7.2. Appropriateness and relevance

The theory of change, as well as information provided by stakeholders interviewed, showed that there was a clear, evidence-based rationale for the design of the Package. Specifically the work by:

- Phoenix Australia was commissioned because there was a gap in bespoke training and support for aged care staff to understand trauma and provide trauma-informed care
- by DSA was commissioned because aged care providers and staff need additional training and support to engage people living with dementia, in particular those who may be withdrawn and disengaged in response to grief and trauma caused by COVID-19 restrictions and extended lockdowns; and
- by ACGB was commissioned because there was a gap in specific supports available for aged care recipients and their loved ones. Furthermore, while aged care staff who had experienced grief and trauma related to COVID-19 may have access to psychological support through their EAP, it was also recognised that EAPs generally do not provide a specialised grief service.

Intended users provided input into the Package, and co-design principles were utilised broadly despite the short timeframes in which the Package was developed. While the Package was largely seen as being inclusive due to the number of languages the resources were translated into, some limitations were identified around both language level (pitch) and cultural considerations about grief and trauma.

There were no reports of any diverse groups being disadvantaged by using the supports, noting that only limited data was collected from people who had used the support. The main issue was being sure to reach the disadvantaged groups in the first place, by ensuring the design of, and messaging around, the Package was appropriate.

(7) Department continue to ensure that all elements of the Package continue to be reviewed and endorsed by key stakeholder groups (including the consultation group) to ensure both the content and the communications strategies are tailored for people with diverse characteristics; including people from CALD backgrounds, people who identify as LGBTI, Aboriginal and Torres Strait Islander Peoples, Forgotten Australians, people experiencing or at risk of homelessness and people with a vision impairment.

Other key suggestions include:

- Communications about the Package need to be reviewed to ensure they are presented in plain English.
- All translated materials should be appropriately reviewed to ensure accuracy of meaning and cultural appropriateness.
- In addition to using visual cues such as the Aboriginal flag, the rainbow flag and/or a watermark of medals to indicate the appropriateness of services to target groups, continue to seek endorsement by the representative groups.
- Ensure that materials are targeted to people receiving home care, not just residential care.

7.3. Improvements in access

Prior to introduction of the Package, grief (as relating to death) was very well known within the aged care sector and trauma less so, although this does not mean that staff were well equipped to recognise or respond to it. There were reports of a growing awareness of grief and trauma in the health sector and to a lesser extent aged care, which may be only partly a result of the Package but nevertheless is likely to increase as the Package becomes more well known. Aged care staff were considered vulnerable to burnout and potentially lacking insight into their own distress. Providers consulted for the evaluation had some understanding that staff were at risk, and some had implemented other sources of support prior to the Package being introduced. Discussions with funded organisations indicated that management changes within aged care services meant that new managers did not recognise grief and trauma in their staff who had worked through the worst of the pandemic. One aged care worker who had been exposed to grief and trauma observed their employer had no understanding that staff needed help or what help they needed.

Aged care recipients, their loved ones and carers, have responded to communications about the Package, with a significant uptick in people accessing the ACGB support line following the major communications campaign.

(8) Continue to promote the supports, and work with other mental health agencies to link them to a growing awareness of grief, trauma, psychological first aid, and mental health to help normalise recognition of and help-seeking for grief and trauma

Access to supports has continued to grow as elements of the Package continue to be released and promoted. This includes access to printed fact sheets, websites and webinars, as well as counselling, and the DEMP program is working at capacity.

For the aged care workforce, time and workload pressures were key barriers to accessing supports. Implicit in this barrier is that access to information about the Package is currently received by a smaller number of people, who may not read it or may choose not to disseminate for other reasons. Barriers to senior Australians accessing support include lack of trust in unknown organisations and attitudes to mental health, as well as lack of clarity if the supports were designed for them.

(9) An ongoing omnichannel marketing approach targeting networks around aged care recipients, their loved ones and carers, and the aged care workforce may help drive access.

Those in the sector who have accessed the supports are generally satisfied with the resources and supports. The efforts to address diversity and inclusion were highly welcomed, as was the ability to access information in a range of formats.

There was enthusiasm to build sector capacity to deliver trauma-informed care, notwithstanding limits on time available. Feedback on Phoenix Australia resources was strongly positive, and the manager resources had received strong initial interest. Approximately half of 68 stakeholder survey respondents who had used the Package (36, 52.9%) agreed that the Package had helped them provide trauma-informed care. An ongoing challenge for providers is navigating the balance between on the one hand protecting aged care residents from infection and on the other hand protecting them from accelerated decline, grief, and trauma of loneliness and isolation. For RACFs that experienced a COVID-19 outbreak, targeted in-reach to locked down facilities by both ACGB and DEMP ensured timely support was available to aged care recipients that need it most and a strong response to the mailout from home care recipients indicates the supports are reaching those who need them.

(10) Provide clear trauma-informed guidance for the sector on appropriately managing risks of causing harm through extended lockdowns. This may include developing targeted

information packages to ensure RACFs in hard lockdown have access to information and support and information for loved ones for what to do when the facility is locked down.

There was recognition that the workforce has been heavily impacted by grief and trauma, and strong interest in self-care resources evidenced by access to print and online resources. Predicted workforce shortages due to COVID-19-related turnover may be a key motivator for providers to focus on staff wellbeing. The peer support element of the Package, while still relatively new, may be a viable way for workers to share their experiences in a safe and supported way.

(11) Continue to build capacity for peer support to empower communities to support each other. Continue to engage with these networks to grow awareness.

7.4. Efficiency and cost-effectiveness

In the context of limited interactions due to COVID-19 restrictions, providing support to cope with grief and trauma in the aged care sector requires coordination of care and communication between funded organisations under the Package. In reviewing the cost-effectiveness of the Package, evidence on key activities and costing data were used to measure the effectiveness of service utilisations. There is no single approach to assessing cost-effectiveness, and due to limited information provided by each funded organisation, a service utilisation index was determined and applied to measure key activities of the Package. The utilisation index presents correlations between activities at the initial stage and output-related activities.

The evaluation found that each of the funded organisations has a utilisation index above the minimum threshold[25] and can be classified as an effective service utilisation. Using the same method, two comparable national programs indicated similar index scores of highly effective service utilisation. In the absence of benefit data, the approach is not able to extend the analysis to consider whether a more or less costly program provides better service utilisations. The analysis illustrates that with a range of total current costs between $0.5 and $1.2 million, the utilisation is effective for each funded organisation. Hence the evaluation concludes that relative to its use, the cost of the Package for each organisation provides an effective service utilisation.

To compare programs, comparable health outcomes and evaluation timeframes from baseline to follow-up are required. In the context of the Package, there are limited outputs from each funded organisation that are comparable with similar programs therefore several different approaches were employed.

The first compared outputs between providers, specifically the similar outputs between Phoenix Australia and ACGB. The analysis found that there was no significant discrepancy of cost per output in conducting training or webinars and providing information about grief and trauma.

The second approach identified specific outputs that are comparable in the context of cost per output. In this case, cost per unit of individual counselling provided by ACGB is comparable with cost per unit of individual counselling by headspace. The average care cost for a person living with dementia is higher for DEMP-DSA than Dementia Australia, which likely reflects the higher intensity service.

Finally, because, there are no specific outputs from the funded organisations that are comparable to similar programs elsewhere, the cost per output between providers was compared. This found

[25] Kalseth and Halvorsen (2020).

that there is no significant discrepancy in providing services such as webinars, training, and fact sheets.

To improve the cost-effectiveness of the Package there would be value in understanding any perceived overlap with other services and supports and either re-scope the service/ support offered under the Package to minimise the duplication or promote the difference in the offerings to ensure aged care sector stakeholders appreciate the difference and know which to access and when and how. For context, between 24% and 37% of stakeholders who responded to the survey reported perceived overlap between the Package services/resources and supports compared to other programs/ services respectively.

Overall, the evaluation concludes that the Package is as effective and cost-effective as it can be given the status of the implementation and the impact of the COVID-19 restrictions.

(12) To maximise the cost-effectiveness of the Package, review programs for which stakeholders perceive overlap. If there is overlap then the services/ support offered under the Package should be rescoped to minimise the duplication or if no overlap, the Department should consider promoting the difference in the offerings to ensure aged care sector stakeholders appreciate the difference.

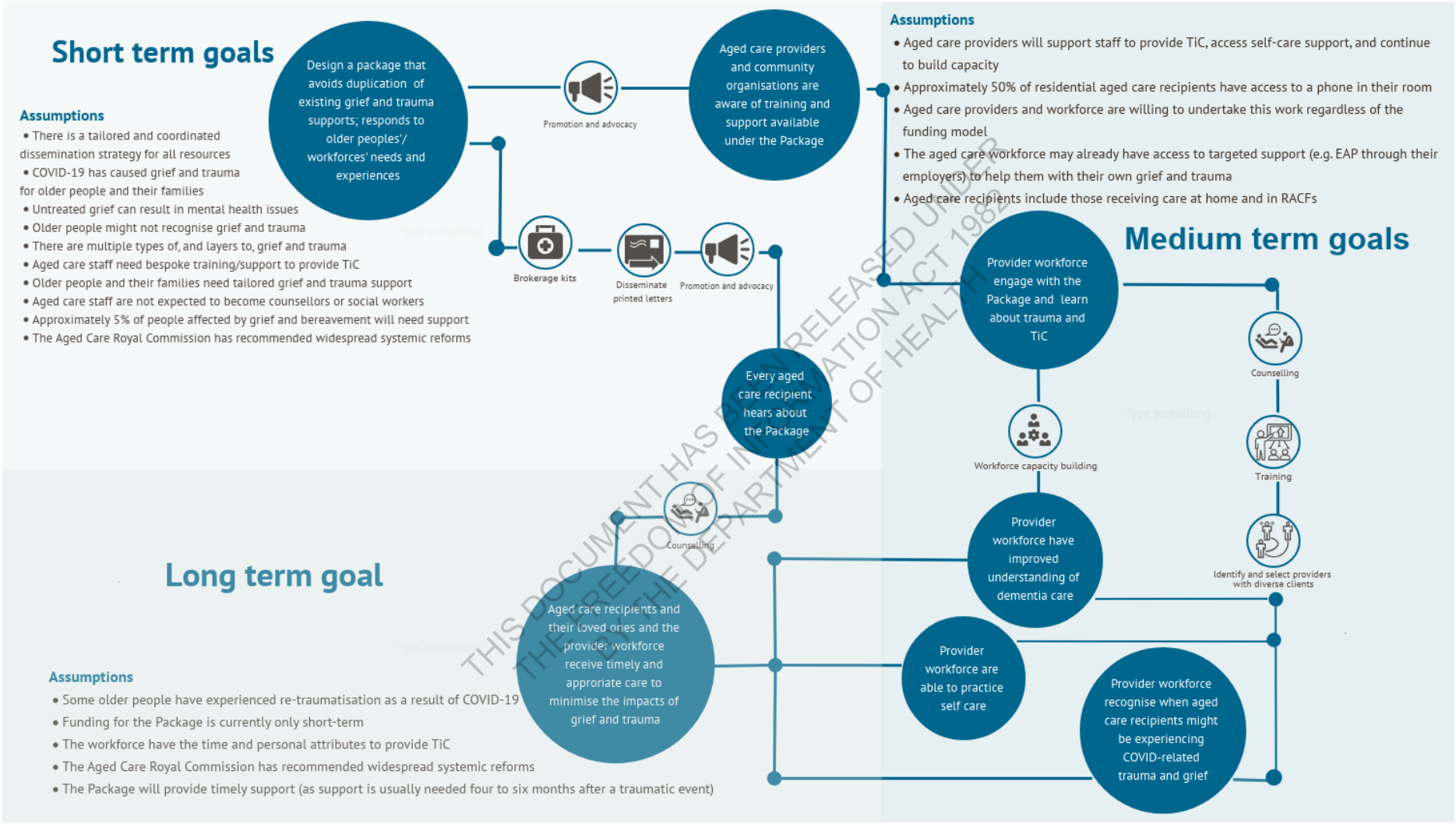
7.5. Summary

Early indications are that the Package meets an important need and the communications so far have been effective for driving access. In a sector overwhelmed with information and heavy workloads the Package is gaining traction and uptake is continuing to grow. Stakeholders agree that it meets an important need and have welcomed the range of formats and languages.

There was little feedback from aged care residents and recipients who had accessed the different elements, largely because data collection occurred shortly after the major communication of the Package. Recommendations to support the Package going forward include continued promotion using a range of channels and messaging, ensuring it is clear to network leaders and end users what the resources are and who they are for.

Uptake is likely to increase as the full suite of resources are continually promoted and should be benchmarked against targets. An ongoing process continuing to seek review and endorsement from key stakeholder groups will ensure resources are appropriate for diverse audiences. Further developments of the Package may include clear trauma-informed guidance for providers for managing lockdowns to best meet the needs of residents, loved ones, and staff. Clear guidance on how the supports differ from other, similar supports, will assist future promotion and ensure the Package continues to be cost-effective.

Appendix A: Theory of change



Appendix B: Logic Model

Situation Statement: The COVID-19 Grief and Trauma Package (the Package) announced in August 2020, aims to increase access to and availability of grief and trauma support for people in the Aged Care Sector impacted by the pandemic. The COVID-19 pandemic has had widespread impacts across the Aged Care Sector, most significantly for residents in Residential Aged Care Facilities (RACF). Of people in Australia who died due to COVID-19, three quarters were living in RACF, resulting in significant grief and trauma among families, fellow residents, and staff at affected facilities. Mitigation measures aimed at protecting vulnerable people from exposure to COVID-19 also had profound impacts including social isolation of older persons and changes to aged care staff and volunteer activities and working arrangements. For some the social impacts of COVID-19 triggered past trauma, including of previous pandemics (e.g. HIV) and institutional abuse. People with dementia, who are a significant subset of aged care recipients, may have had difficulties understanding why they were being isolated and/or exhibited behavioural disturbances; and staff may have lacked the skills and experience to know how to provide appropriate care. The Aged Care Diversity Framework emphasises the need to provide culturally competent care in aged care settings.

Objectives: The key objectives of the Package are to: (1) provide short and long-term grief and bereavement counselling and trauma support to those in and around the Aged Care Sector; (2) provide direction to longer term, more complex and culturally appropriate services

Inputs

Infrastructure
- Aged Care Diversity Framework
- Telephone network / devices
- Internet and devices
- Printed materials

Department of Health funding
- Enhanced advocacy assistance ($2.4M)
- Increased availability of Grief and Trauma support ($10M)

Funded organization (ACGB, Phoenix, DSA, OPAN) staff and contractors
- Translators and interpreters
- Psychologists, social workers, bereavement specialists
- Dementia specialists
- Communications

Other organisations
- Volunteers
- GPs and other health professionals
- Aged care providers

Community supports
- Community organisations and community ambassadors
- Family and friends of residents

Activities

ACGB
- Provide counselling services
- Provide self-care information in a range of formats
- Build community capacity
- Dedicated in-reach program to RACF

Phoenix Australia
- Provide information about trauma, loss and grief
- Develop trauma education resources for individuals and organisations

DSA
- Develop website, resources, brokerage kits
- Assess RACF and residents, develop engagement plans
- Collect data for CQI

OPAN
- Increase capacity and reach
- Link/refer to other services

Department of Health
- Communicate the Package

Outputs Products/services

- Communication and marketing resources in multiple languages and formats
- Referral networks
- Telephone support and referral in multiple languages
- Website and online portal specifically for aged care grief and trauma resources
- Translated printed resources (information and self-care support) for aged care recipients and their loved ones
- Webinars, videos, app
- Resources to support delivery of peer support sessions
- Trauma support and trauma-informed care training for RACF staff and management, including self-care
- Brokerage kits for dementia care
- Engagement plans for people with dementia
- Grief and Trauma policy and practice support resources for organisations

Participation

- Department of Health

Service Providers
- Phoenix Australia
- Australian Centre for Grief and Bereavement
- Dementia Support Australia
- Older Persons Advocacy Network
- Residential Aged Care Facilities
  - Management
  - Care providers
  - Support staff
- Community Visitors Scheme
- Aged care peak bodies
- Community organisations
- GPs and other relevant health practitioners

Consumers
- Residential Aged Care recipients
- Home care recipients
- Family and loved ones of people receiving aged care
- Community leaders and representatives

Outcomes

Short term

Consumers
- Understand that support is available under the package and learn about how to access it

Aged Care Provider
- Receive information and access to training about grief and trauma
- Develop an awareness of trauma informed care

Aged Care system
- Awareness, engagement and buy-in and advocacy across the sector

Medium term

Consumers
- Aged Care recipients and their loved ones receive counselling, support, or referral to appropriate service
- Enhanced support for RACF residents with dementia

Aged Care Provider
- Receive counselling and bereavement support
- Awareness of grief and trauma in the aged care setting
- Able to practice self-care

Aged Care system
- Aged care staff feel more equipped to manage grief, dementia and traumatic responses to COVID-19, which will also help to raise awareness about these issues in aged care more generally

Long term

Consumers
- Long term impacts of grief and trauma are minimised
- Enhanced engagement of RACF residents with dementia

Aged Care Provider
- Capability to recognise grief and trauma in self and others
- Understanding of Trauma Informed Care
- Improved understanding of dementia care

Aged Care system
- A trauma-Informed framework for aged care
- A more grief, trauma and dementia informed aged care leadership and workforce

Assumptions

- Stakeholders including Aged Care management, staff, and consumers, are engaged with and support the program which is provided at the right time
- Grief is a normal part of healing following a traumatic experience - approximately 5-10% would need to seek support usually 4-6 months after the event
- Resources produced under the Package will have enduring value for supporting grief and trauma responses in the aged care sector
- Aged care services are sufficiently resourced to engage in a meaningful way and staff are capable of building required skills
- Resources (including translated resources) will be culturally appropriate and acceptable to the communities they are intended to serve
- Long term impacts demonstrate ongoing need to improving grief and trauma care

External factors

- COVID-19 outbreaks in Australia
- Vaccination rollout to priority Australians (Phase 1a and 1b) commencing February 2021
- Australian government funding and policy support for the program
- Other catastrophic events (e.g. bushfires, floods) resulting in a need for grief and trauma support
- Report of the Royal Commission into Aged Care Quality and Safety and subsequent reform agenda
- Staff turnover within aged care providers

Appendix C: Evaluation framework

Evaluation question	Indicator	Data sources	Analysis method(s)
1. How effective has the rollout of the suite of resources and support been?			
1a. What level of awareness and understanding do the key stakeholders have of: the Grief and Trauma Package (the Package) how to access supports under the Package?	Aged care providers' (ACPs) level of awareness and understanding of each component[1] of the Package and how to access them	Survey of aged care providers Interviews with funded organisations	Thematic analysis of qualitative data, descriptive analyses of quantitative data, including (where possible) sub-group analysis by resource/ support, language and format of resources, State/Territory, rurality, diverse characteristics.
	Aged care recipients', their loved ones' and carers' level of awareness and understanding of each component[1] of the Package and how to access them	Survey of care recipients/ loved ones Interviews with • Senior Australian representative groups • funded organisations	
	Peak bodies and representative groups' level of awareness and understanding of each component1 of the Package and how to access them	Interviews with: • aged care provider peak bodies • funded organisations	
	Description of reactions by the aged care sector to each of the three1 components of the Package and the Package as a whole	Survey of ACPs Interviews with: • aged care provider peak bodies • Department of Health State and Territory Directors of Aged Care • funded organisations	
1b. To what extent are elements of the Package being accessed?	Reach and uptake (if available) of Package resources and supports compared to estimated demand, including number of downloads of resources/supports, phone calls, website visits, referrals to other services	Secondary data[2]: Analytics data (where available) from resources accessed on provider websites/ via social media and other electronic formats ABS remoteness (ARIA) and socioeconomic (SEIFA) index codes for postcode of residence (where available) Estimated demand for the Package Referral documentation	
	Extent to which ACPs are accessing the Package, taking into consideration: that in-person visits to RACFs have drastically reduced the ability of funded organisations to develop relationships with RACFs funded organisations' experience with the aged care sector.	Survey of ACPs Interviews with: • aged care provider peak bodies • Department of Health State and Territory Directors of Aged Care	

Evaluation question	Indicator	Data sources	Analysis method(s)
	Extent to which care recipients and loved ones are accessing the Package, taking into consideration: funded organisations' experience with the aged care sector that in-person visits to RACFs have drastically reduced the ability of funded organisations to deliver in-person support to older persons that many aged care recipients in RACFs lack telephone access and/or have experienced cognitive decline, thus finding telephone communications challenging.	Survey of: • ACPs • Aged care recipients/ loved ones Interviews with aged care provider peak bodies	
1c. What suggestions do key stakeholders have for improving rollout?	Description of the processes each funded organisation has used to implement their components of the Package	Interviews with funded organisations Planning documents	
	Suggestions by stakeholders to: improve communication and promotion of the Package to target populations (including diverse groups) improve uptake of Package resources	Interviews with: • funded organisations • aged care provider peak bodies • Survey of ACPs	
2. How appropriate and relevant are the supports to the audience who need them?			
2a. To what extent does the Package address identify gaps, needs and/or priorities?	Evidence that rationale and design for the supports was based on evidence that the activities could contribute to the identified need input from intended users	Theory of change Interviews with: • stakeholders involved in the development/ design of the Package • Senior Australian representative groups	Thematic analysis of qualitative data, descriptive analyses of quantitative data, including (where possible) sub-group analysis by Package component, and as a whole. Evaluation question 2c will be answered via the data sources shown, as well as by reviewing the findings related to evaluation questions 2a and 2b.
	The extent to which funded organisations engage with industry experts in inclusive practices when designing/ implementing activities	Interviews with: • aged care provider peak bodies • funded organisations • Senior Australian representative groups	
	Extent to which some components of the Package are more utilised than others	Secondary data[2] Interviews with: funded organisations aged care provider peak bodies	
	Extent to which key stakeholders report that the supports align with expectations are relevant to the target audience	Survey of ACPs Case studies Interviews with: • funded organisations	

Evaluation question	Indicator	Data sources	Analysis method(s)
		• aged care provider peak bodies	
2b. Are there any diverse groups who may be disadvantaged from utilising the supports?	Identification of diverse groups who have been disadvantaged from utilising the supports, and description of their experiences	Interviews with • funded organisations • aged care provider peak bodies • Senior Australian representative groups Case studies	
2c. How can components of the Package be improved to address any gaps, unmet needs or priorities, and to remove barriers to accessing the Package?	Detailed description of the Package Description of unintended consequences of using the Package Description of overlap between the Package and similar existing services Description of ways that resources/supports can be improved Reported lessons learned by key stakeholder groups on the design and implementation of the Package, by component	Case studies Survey of ACPs Interviews with • funded organisations • Senior Australian representative groups • aged care provider peak bodies • other Department stakeholders	
3. Have the supports been effective in improving the aged care sector's ability to access grief and trauma supports and information in a timely manner?			
3a. How effective has the Package been in increasing awareness of grief and trauma?	Stakeholder opinion of increase in awareness of presence and prevalence of grief and trauma before and after the Package was introduced	Interviews with: • aged care provider peak bodies • funded organisations Survey of: • care recipients/ loved ones	Thematic analysis of qualitative data, descriptive analyses of quantitative data, including (where possible) sub-group analysis by Package component, and as a whole. We will also compare the demographics of people who have accessed the Package to those of the population impacted by COVID, to determine whether the Package is reaching its target audience.
3b. How effective has the Package been in improving access to grief and trauma supports for those who need them?	Increase in number of calls made to the Australian Centre of Grief and Bereavement and DSA Increase in website traffic to funded organisations Increase in attendance to webinars Increase in distribution of materials from mail and marketing (where relevant) Time from bereavement event to accessing support	Secondary data[2] including analytics data (where available, including resulting downloads, consults and referrals) from resources accessed on provider websites/ social media/ phonelines/ webinars/ other Interviews with: • aged care provider peak bodies • funded organisations	
	Description of barriers experienced by the target populations and diverse groups in accessing and using the resources/supports Extent to which stakeholders report that people from diverse groups access relevant supports in a timely manner	Secondary data[2]: demographic characteristics of people accessing supports under the Package (where available) including gender, language, socioeconomic status	

Evaluation question	Indicator	Data sources	Analysis method(s)
	Extent to which ACPs have embedded trauma-informed care into their service model as a result of the Package	(postcode as proxy), Aboriginal and Torres Strait Islander status time between traumatic event and access to the Package, if available Interviews with: • funded organisations • aged care provider peak bodies Case studies Survey of ACPs	
3c. Is the aged care sector satisfied with the supports available through the Package?	Aged care sector opinion on the effectiveness of the supports in Building workforce capacity to provide trauma-informed care Support the workforce to practice self-care Reaching aged care recipients who need them the most	Interviews with: • funded organisations • aged care provider peak bodies • Senior Australian representative groups Case studies	
3d. How can components of the Package be improved to make the supports more effective and accessible?	Suggestions from stakeholders to improve Package awareness, access and supports	Interviews with: • funded organisations • aged care provider peak bodies • Senior Australian representative groups Case studies Survey of: • ACPs • care recipients/ loved ones	
4. How efficient and cost-effective are all four components of the Package?			
4a. What are the costs of the Package relative to its use?	Costs of elements of the Package Improvements in access to grief and trauma supports relative to outputs of the Package	Document review Interviews/ group discussions with: • funded organisations • Senior Australian representative organisations Secondary data[2]	Utilising the method outlined in Appendix A, we will carry out the cost utility analysis. We will use the outcomes of this method in combination with stakeholder opinions on areas of duplication and suggestions for improvements to determine the efficiency and cost-effectiveness of the Package.
4b. How do the costs of the Package relative to its use compare to similar programs?	Identification of alternative programs that utilise similar methods to improve the mental health of targeted populations Improvements in access to mental health supports relative to outputs of the alternative program	Literature review Costing data from alternate program Secondary data[2]	

Evaluation question	Indicator	Data sources	Analysis method(s)
	Comparison of funded organisations' and alternative grief and trauma packages' costs and utility of services		
4c. How could the Package be more cost-effective?	Identification of duplicated activities/resources Description of aspects of the Package that can be improved to ensure cost-effectiveness	Interviews with: • funded organisations • ACPs • Senior Australian representative organisations	

1. Note that OPAN activities are out of scope for this evaluation
2. Secondary data likely available for the evaluation:

ACGB data

- Data from the Penelope case management system, which captures information at every clinical contact (including contact via the MyGrief app). The ACGB already have Penelope set up for their other services, and are developing a new aged care COVID service file for the Package. It is used to collect data (Appendix A) and also to predict which (if any) services are most likely to benefit a person. Data collected at (or close after) the initial counselling session, also known as 'feedback informed intake', will measure emotional and practical support, meaning making (ISLE scale) and prolonged grief (PG13, mapped to ICD grief disorder condition). Other data will include demographics, nature of bereavement event, time since bereavement event, interval between referral and bereavement event, sleep patterns, mental health, and high level referral source (for example GP, OPAN).
- Data from the MyGrief app (download factors, SMS activity data, google analytics e.g. of website downloads, and user ratings of webinars).

Phoenix Australia data

- From webinars: Engagement scores (based on total number of times questions were engaged with, total number of likes within the webinar and total number of poll votes captured); number of active users (that is, those who engaged with an upvote, poll vote or question); Questions/comments posted by users in response to poll feedback to questions (e.g. *How satisfied were you with the overall quality of this webinar?* and *To what extent was the webinar content relevant to your work?* and *Is there anything else you would like to tell us about your overall impressions of the webinar? Please provide any suggestions for improvement, or for topic of future webinars you would be interested in attending*); Wordcloud of most popular topics.
- From online resources: Google analytics (downloads) will be available for resources accessed on the website.

DSA data

- The Goal Attainment Scale (GAS), a structured qualitative measurement to evaluate the outcomes of the support and brokerage interventions; the Engagement in Preferred Activities Scale (EPASS) which measures engagement; activity data including days on-the-ground, number of people supported (staff and older people), proportion of aged care homes supported, and number of PHN; referral source for callers through the main DSA 1800 number.

Department of Health data

- Website/social media analytics.

Appendix D: Package components

D.1. The Australian Centre for Grief and Bereavement

The ACGB's Key performance indicators (KPIs) for the Package are to:

- establish the National Telephone Support Service
- develop and distribute printed resources in plain English and translated into five major languages
- establish an aged care specific website
- develop and deliver webinar series of at least four webinars
- develop peer support session pack.

The ACGB is the largest provider of grief and bereavement in Australia with over 24 years' experience. ACGB is providing a range of clinical and educational supports for people in the aged care sector experiencing grief and loss due to COVID; and supporting capacity-building with community groups and other organisations across the sector.

Clinical support is being provided by team leaders and counsellors from ACGB all of whom are specialist bereavement practitioners and experienced clinicians focused on supporting those in the aged care sector. Staff are a mix of contractors and full-time staff; and include bilingual staff. ACGB are facilitating access to services through the Translation and Interpretation Service (TIS) and Australian Sign Language (Auslan) where required.

The primary presenting issue for those accessing clinical support must be related to COVID-19; however, grief may relate to loss, including loss of lifestyle, and not only to bereavement from death. Clinical support provided under the Package includes:

- a national toll-free telephone service, using a dedicated 1800 number, to immediately link aged care recipients and their loved ones who have been impacted by COVID-19 with counsellors
- video-based telehealth support from counsellors
- in-person counselling in residential aged care facilities (RACFs) (including group-based and individual)
- SMS service to access information and referral to counselling and support
- support and advice via the MyGrief App.

Educational resources are housed on a dedicated aged care support website: https://aged.grief.org.au

ACGB is providing self-care resources including a series of four webinars and printed resources for families, loved ones and aged care staff. Resources are translated into five major languages (using Polaron translation services) and plain English. One webinar is currently available: *Missing Our Loved One in Time of COVID-19 Webinar.* Fact sheets include:

- Grieving when others do not acknowledge your loss
- Strategies for Managing Grief and COVID-19 Related Anxiety
- COVID-19, Aged Care Restrictions, End of Life Care and Grief and Loss

- Support for Healthcare Workers Dealing With COVID-19 Related Distress, Death and Bereavements
- Living in Uncertain Times
- Social Support and Bereavement during the Coronavirus (COVID-19) Outbreak
- Funeral Support and Physical Distancing.

Capacity-building support involves creating a peer-led support pack, including resources and a training program to support the delivery of peer-led support sessions within aged care facilities and communities. ACGB will provide consultancy and advice to other community groups to help build the capacity of the leadership to work with grief and trauma, which will be supported by a specific webinar. This is designed to enable those leaders to reach out and respond effectively in their communities. This support is primarily targeted at communities of people (e.g., CALD) who may be unlikely to contact a stranger for advice and are more likely to engage with their religious, spiritual, and community leaders. Building the capacity of the leadership to work with grief and trauma, then indirectly helps the community

Peer Support Group: The purpose of peer support is to offer mutual support, connection, gain knowledge, build community, foster empowerment, improve wellbeing, validate, improve self-care, gain a sense of belonging, provide a sense of understanding and empathy and improve morale. Two Peer support group sessions (6 participants per group) are due to commence on the 2 September 2021 face-to-face in RACF's.

ACGB are working with a communications agency (Clemenger BBDO Melbourne & Hearts & Science) to advertise the services and promote uptake. These activities will commence at the end of 2021.

Given that a key aim of the services delivered by ACGB under the Package is prevention of mental health disorders due to untreated grief, this element is consistent with the Royal Commission's recommendations to provide outreach mental health services to older persons.

D.2. Phoenix Australia

Phoenix Australia's KPIs for the Package are to:

- establish an online portal for trauma-informed aged care resources
- develop and deliver a webinar series of at least four webinars
- develop trauma-informed care policy resources for organisations
- develop trauma-informed practice and support resources for staff
- develop trauma awareness and support resources for care recipients and their families, including targeted handouts for at least five vulnerable populations.

Phoenix Australia is Australia's National Centre of Excellence in post-traumatic mental health. As part of the Package, Phoenix Australia have been funded to develop a sector-wide trauma-informed care package that provides trauma training and resources for the aged care recipients, their families, aged care staff (including direct care staff and support staff) and organisations (including ACPs and aged care peak bodies).

The resources form an integrated package that aims to support the implementation of trauma-informed practice in aged care organisations. The package aims to raise awareness of trauma, to encourage effective and timely access to support, to teach skills to deal with stress and trauma and prevent the development of post-traumatic stress mental health issues such as depression and

post-traumatic stress disorder, and support implementation of trauma-informed care in aged care organisations. They are housed on a dedicated aged care website portal and include:

- trauma-informed care policy resources and implementation tools for organisations
- trauma-informed care practice and self-care resources for both care and support staff that have regular interactions with people in residential care
- trauma awareness and support resources for care recipients and their loved ones.

The delivery formats include:

- downloadable brief written materials
- tools to assist aged care organisation leaders to implement trauma-informed care, including a workbook and online implementation checklist
- four online courses that include interactive education and training materials, including “bite size” demonstration videos
- illustrative animations
- webinars
- an online staff wellbeing program.

This is consistent with the Royal Commission’s strong recommendation for trauma-informed care to be established as a core competency across the aged care sector. Of note is that it is not intended that anyone who uses the resources will become trauma experts or are expected to be counsellors or social workers. In addition, although the current funding round does not cover implementation of trauma-informed care into organisations to embed it into the system, this project represents a step in this journey.

D.3. Dementia Support Australia

DSA’s KPIs for the Package are to demonstrate:

- resources and brokerage kits are developed
- website is updated/ available to support the program
- care home and resident assessments have been conducted, activity plans developed to help engage residents living with dementia who are experiencing behavioural issues such as withdrawal, self-isolation and minimal participation in social interaction.
- Individual, personalised brokerage kits and general brokered equipment provided to care homes.
- Provision of coaching and capacity-building to care home staff
- data is collected and analysed to test, refine and validate the program and enable continuous quality improvement
- communication and marketing strategies implemented.

DSA has dementia consultants located across each State and Territory of Australia and is funded to deliver free, nationwide dementia behaviour support programs. It is a program of the Dementia Centre, which is part of HammondCare. As part of the package, DSA have been funded to deliver

an engagement program to help alleviate the emotional, psychological and social impacts of COVID-19 lockdown and restrictions on aged care residents with dementia.

The engagement program, known as the Dementia Engagement Modelling Program (DEMP), involves implementing a proactive outreach model to engage RACFs known to be impacted by COVID-19 lockdowns. RACFs can also self-refer through the DSA website and a 1800 phone line.

The aim of the DEMP is to help RACFs build capacity so that staff can:

- identify clients living with dementia who have experienced trauma as a result of COVID-19
- have the capacity and knowledge to engage these clients and minimise the impact of the trauma.

The DEMP largely revolves around on-the-ground (when possible) DEMP engagement consultants working with RACF staff. DSA have filled 10 full-time-equivalent (FTE) engagement consultant roles in Queensland, NSW/ACT and Victoria supplemented by the broader DSA team. Once DEMP is engaged with an RACF, one or two DSA engagement consultants go into the RACF for two weeks. They:

- meet with/get to know RACF lifestyle and care staff and get to know the environment and their routine of care
- develop engagement plans for up to six individual clients living with dementia who staff have referred for behaviours such as withdrawal, self-isolation and minimal social interaction.
- integrate into the care home (without providing clinical care) so that staff feel comfortable asking questions about how to talk to someone living with dementia, how to invite them to an activity, what sort of activity may be preferred by the resident and how to modify activities if required,
- remain on-site for the two-week period, trialling and modelling activities and providing client-specific activity plans and provide coaching and development sessions so that staff can continue to engage residents and implement activities.
- remain in contact with the RACF weekly by email or phone or in-person to support staff to implement activities and provide further brokered items as required for a further 10 weeks

Resources DSA will develop/implement to support the DEMP include:

- Resources to help services develop tailored engagement plans for residents.
- ‘Brokerage kits’ consisting of additional resources to meet residents’ personal engagement needs - for example, tablets with pre-loaded content tailored to individual residents, Bluetooth headphones robotic animals, sensory products, table-top activities. The kits are not designed to replace or add to the RACF’s usual cupboard stock and may not be in the form of standard equipment. DSA may also broker for some larger projects to meet individual residents’ needs, such as to broker expertise about designing a sensory garden or setting up communal activity areas
- Environmental audits and recommendations.

This work is consistent with the high priority placed by the Royal Commission on the need for significant and immediate improvement in standards of dementia care, including aged care staff knowledge of the needs of people living with dementia.

D.4. Older Persons Advocacy Network

OPAN holds the lead contract to deliver the Australian Government’s National Aged Care Advocacy Program (NACAP) until June 2022. They work with a network of nine State and Territory

service delivery organisations[26] (SDOs) who combined employ over 50 experienced staff across 21 locations. They deliver advocacy, information and education services to older people in Australia to address issues related to Commonwealth funded aged care services, including:

- providing advocacy services
- helping them understand and access the aged care system
- informing them of their aged care rights
- educating Australian Government-subsidised aged care service providers about advocacy and consumer rights[27].

During the COVID-19 pandemic and the resulting lockdown of RACFs, there was a disconnect in communications between families and friends with residents. At the time, OPAN provided support to help families and loved ones engage with ACPs and residents and provided warm referrals to other services including the Aged Care Safety and Quality Commission if needed. They also conducted liaison activities between RACFs, government departments, and aged care recipients and their families.

OPAN then received an additional $2.4m under the Package to continue this work and increase advocacy of and assistance to family members and loved ones who, in turn, provide support and assistance to recipients of aged care. There are no formal KPIs for OPAN.

[26] ACT Disability, Aged and Carer Advocacy Service (ADACAS) – Australian Capital Territory; Advocacy Tasmania Inc. – Tasmania; Advocare – Western Australia; Aged and Disability Advocacy Australia – Queensland; Aged Care Advocacy Service, CatholicCare – Central Australia NT; Aged Rights Advocacy Service (ARAS) – South Australia; Elder Rights Advocacy (ERA) – Victoria; Seniors and Disability Rights Service of Darwin Community Legal Service – Northern Territory; Seniors Rights Service – New South Wales.

[27] Noting that OPAN is not funded as a peak to undertake systemic policy work like other aged care consumer peak organisation.

Appendix E: Results of literature review

This Appendix provides a synopsis of health interventions similar to the Package, and provides rationale for selecting the suitable programs to use f

or the cost utility analysis.

The literature review identified six programs comparable to the Package:

- The Coronavirus Mental Wellbeing Support Service, provided by Beyond Blue in Australia[28]
- The Skylight Mental Health and Bereavement Support, provided by Skylight in New Zealand[29]
- The Cruse Bereavement Program, provided by Cruse Bereavement Care in the UK[30]
- The NY Project Hope Coping with COVID, provided by NY Project Hope and New York State Office of Mental Health in the USA[31]
- The headspace Early Psychosis Program, provided by headspace in Australia[32]
- The Health-in-Mind during Program, provided by Health-in-Mind on the UK[33].

These programs are summarised in Table 25. These programs were reviewed to determine elements that were comparable to the Package, namely: service provision, referral, training, resources, capacity-building and advocacy support. The two most comparable programs were Beyond Blue's CMWSS and headspace's EPP. They were selected as they have many comparable elements to the Package; they are based in Australia; and have service utilisation and costing data available (via annual reports) to conduct the cost utility.

[28] Details of the CMWSS program are available at < https://coronavirus.beyondblue.org.au/>
[29] Details of the Skylight Mental Health and Bereavement Support are available at <https://www.skylight.org.nz/>
[30] Details of the Cruse Bereavement Program are available at < https://www.cruse.org.uk/>
[31] Details of the NY Project Hope Coping with COVID are available at < https://nyprojecthope.org/>
[32] Details of the Headspace Early Psychosis Program are available at < https://headspace.org.au/our-services/eheadspace/>
[33] Details of the Health-in-Mind during Program are available at < https://www.health-in-mind.org.uk/>

Table 25: Programs comparable to the Package

Program and provider	Description	Modality	Training and material	Recent statistics	Costing
The Coronavirus Mental Wellbeing Support Service (CMWSS) Provider: Beyond Blue (Australia)	The free service to support mental health during COVID-19 pandemic launched April 2020 and funded by the Government. The services are through digital sites for easy access to a range of services The program is delivered by trained mental health professionals	Phone support services: individual counselling and peer-to-peer support Web chat support service Webinar or online community forum Suicide and crisis support	Conduct regular mental health trainings for staff through internal and external source Booklet and handout for personal wellbeing during COVID-19 Online material to support mental health disorders	31,943 counselling calls from April to June 2020 500,000 visitors to the CMWSS website 16,129 new registrations to the online forum or webinar 900,000 social media followers across platforms 847,899 resources were also downloaded	Available and can be estimated from the Annual Report
The Skylight Mental Health and Bereavement Support (COVID-19) Provider: Skylight (New Zealand)	Skylight provides “one stop shop” to support individuals, families, and communities in grief, trauma, and bereavement during COVID-19 period	Phone support and individual counselling dealing with trauma and loss Face-to-face counselling service Group program Family and caregiver’s mental health support Provide personalised support pack from its resource centre	Conduct facilitators training Conduct 8-week bereavement training during the lockdown Provide e-pack for COVID-19, grief, trauma, bereavement, family violence, mental health and suicide Free library services	1,800 phone counselling sessions 200 personalised e-packs for COVID-19, 120 for grief, 190 for bereavement, and 55 for trauma 76 facilitators trained 275 attended group and family support	Available and can be estimated from the Annual Report
Cruse Bereavement Program Provider: Cruse Bereavement Care (the UK)	Cruse Bereavement Care provides support to people who have suffered bereavement through a nationwide network of trained bereavement volunteers, the Cruse websites and through a national helpline, and works to raise awareness of the needs of bereaved people and to promote their interests	One-to-one support including phone, online, and face-to-face (suspended due to COVID-19) Bereavement support groups Bereavement counselling Email support services The Hope Again website for young people Information and literature Freephone helpline	Conduct training for all staff who are in contact with bereaved people Provide bereavement training for external organisations Workshop for health professionals Free booklet online for trauma, loss, suicide, and dementia Provide link information and educational videos	6,538 brief support (online and phone) 15,469 phone through helpline (individual and families) 940 email responses 59,329 people given information 708,300 visitors to the website 33,879 Facebook likes 12,147 Twitter followers 4,949 Instagram followers	Available and can be estimated from the Annual Report

Program and provider	Description	Modality	Training and material	Recent statistics	Costing
NY Project Hope Coping with COVID Provider: NY Project Hope and NY State Office of Mental Health (USA)	The NY Project Hope Coping with COVID program is New York's COVID-19 emotional support helpline to help people manage and cope with changes because of COVID-19 pandemic	Emotional support helpline: individual – focuses on young and older people Provide educational material: webinar, short-video and update through NY project one social media platforms Referrals to health services	Provide external training for Counsellors Online materials for stress, anxiety and depression for youth, family and older people	Recent statistics are not available 10,400 Twitter followers 1,876 Instagram followers 20,100 Facebook likes and followers	Not available
Headspace EPP Provider: headspace (Australia)	Headspace EPP focuses on early intervention, providing young people and their families access to specialist supports. The program also provides services during COVID-19 period and link to other providers such as Lifeline, Kids Helpline and Disability Information Helpline	Telehealth services Phone and online counselling (eheadspace) Group chat and supportive online communities Online media support and webinar Referrals to specialists	Provide external training and support for counsellors A range of online booklets and information for mental health and wellbeing Interactive educational videos Social media update	31,292 phone counselling (individual) 41,634 engagements with students 78,437 attendances for online sessions 2,974,761 visitors to headspace website 337,862 social media followers	Available and can be estimated from the Annual Report
Health-in-mind during the pandemic program Provider: Health-in-mind (UK)	Health-in-mind pandemic program provides a range of support and services for mental health, trauma, grief, and wellbeing	Trauma counselling online (individual): phone or video counselling Group and peer-to-peer support iThrive: online mental health and wellbeing services Free online workshop, courses, and webinar (new services started in 2021)	Provide mental health training Provide online course for Trauma Skilled Practice Provide online course of Trauma-Informed Practice – Level 1 Videos for mental health and wellbeing A range of booklets about mental health, trauma and wellbeing	351 trauma phone counselling 75,593 visitors to the website 1 094 registrations for online sessions 11,000 social media followers	Available and can be estimated from the Annual Report

Table 26: Comparable costing elements of the CMWSS, EPP and Package for the Cost Utility Analysis

Element	The CMWSS	EPP	The Package
Referrals	Provide referrals for mental health services online and by phone	Provide referrals to specialists for further support and services	**ACGB** Provide referrals for grief and bereavement services
Training	• Online training for mental health counsellors • Online training for people to promote healthy environment during the pandemic	• Provide training and external educational supports for counsellors	**ACGB/ Phoenix Australia** • Online trainings and placement for staff to deliver counselling services • In-depth online training for trauma and informed practice
Capacity-building	• N/A	• Engage with service delivery partners and schools	**DSA/ACGB** • Engage with consultants on-the-ground to deliver services through Dementia Support Engagement Program • ACGB creating the peer-led counselling kit, and building capacity to manage grief in aged care providers and community groups
Service provision	• Phone support services • Telehealth support for mental health • Web chat services and online community forum		**ACGB** • Phone counselling supports • Telehealth support • Online chat and mobile applications
Resources	• Dedicated website and social media platforms • A range of booklets and online handouts • Educational videos through social media platforms • Webinar series		**ACGB/ Phoenix Australia** • Centralised/dedicated website • Handouts for grief, trauma and bereavement • Educational videos • Webinar series

Appendix F: Secondary data

F.1. Department of Health

Table 27: Description of communications disseminated by the Department and funded organisations about the Package

	Number	Percent
Type of communication		
Media release	4	2.1
Social media	44	23.5
Newsletter	13	7.0
Email	70	37.4
Other	56	29.9
TOTAL	**187**	**100**
Goal		
Invitation to access supports	20	10.7
Information about the Package	100	53.5
Build links	19	10.2
Trauma-informed care	25	13.4
Other	23	12.3
TOTAL	187	100
Audience		
Government	12	6.4
Aged care providers	29	15.5
Aged care recipients/ loved ones	20	10.7
All stakeholders	101	54.0
Others	25	13.4
TOTAL	187	100

Source: D21-141638 Comms plan tracking for grief and trauma package

Table 28: Language of radio ad and transcript

Language of radio ad – audio with transcript	
Arabic	Korean
Cantonese (with transcript in Traditional Chinese)	Laotian
English	Mandarin (with transcript in Simplified Chinese)
Greek	Spanish
Italian	Vietnamese

Source: https://www.health.gov.au/resources/translated/coronavirus-covid-19-radio-grief-and-trauma-support-for-those-impacted-by-covid-19-in-the-aged-care-sector-other-languages

Table 29: Languages and number of print orders or language of DL brochure

Language	Qty Despatched	Language	Qty Despatched	Language	Qty Despatched
Albanian	9	Hazaragi	57	Punjabi	178
Amharic	7	Hebrew	13	Rohingya	7
Arabic	569	Hindi	443	Romanian	27
Armenian	54	Hmong	7	Russian	567
Assyrian	92	Indigenous	564	Samoan	74

Language	Qty Despatched	Language	Qty Despatched	Language	Qty Despatched
Bengali	7	Indonesian	80	Serbian	258
Bosnian	129	Italian	1104	Sinhala	38
Bulgarian	45	Japanese	61	Slovak	49
Burmese	118	Karen	58	Slovenian	66
Chin Hakha	123	Khmer	32	Somali	17
Chinese Simplified	638	Kirundi	7	Spanish	652
Chinese Traditional	769	Korean	298	Swahili	62
Croatian	429	Kurdish	12	Tagalog/Filipino	368
Dari	177	Laotian	14	Tamil	12
Dinka	57	Macedonian	444	Thai	107
Dutch	315	Malayalam	37	Tibetan	7
English	9726	Maltese	260	Tigrinya	7
Finnish	53	Nepali	250	Turkish	128
French	169	Pashto	7	Ukrainian	53
German	306	Persian/Farsi	86	Urdu	137
Greek	768	Polish	283	Vietnamese	642
Gujarati	17	Portuguese	54		

Source: Adv Aggregate Order Report Grief and Trauma 1.06.21 to 30.09.21

Table 30: ACGB fact sheets downloaded

Fact sheets - downloaded	July	August	number of downloads
What is Grief	55	89	144
Non- Death Grief and Loss	71	59	130
Ageing and Self-compassion	34	44	78
Resilience and Aged Care	30	41	71
Older Australians - When Grief won't Heal	44	40	84
Uncertainty and Aged Care	24	36	60
Self-Care for Workers	43	73	116
Companion Animal Loss	37	22	59
Grief anniversaries and significant events	23	17	40
Grieving when your loss is not acknowledged by others	7	15	22
Grief and Aged Care Staff	7	46	53
What do I say when someone is Grieving	86	106	192
Having a Yarn - Final Footprints: My Culture, My Kinship, My Country	14		14
Lesbian, gay, bi, trans, intersex (LGBTI) people - Fact Sheets	35	23	58
Working with Aboriginal or Torres Strait Islander Grief and Bereavement - A Resource for Workers	24	19	43

Fact sheets - downloaded	July	August	number of downloads
Peer Support	59		59
Total			1223
Webinar	**Attendees**	**Downloads**	**shares**
Webinar 1: The loss and grief experienced by aged care staff in the wake of COVID-19	878	302	147
Digital resources	**page hits/active users**	**referral source (social media)**	
Website	5389		
Mobile iOS application	179	75	
Mobile Android application	115	43	
Telehealth	**Frequency**		
Number of calls to National toll-free helpline	190		
Online register for support	31		
In-person counselling in RACFs (individual)	22		
In-person counselling in RACFs (group-based)	10		

Source: AGCB

F.2. Phoenix Australia

Table 31: Phoenix Australia page views

Since launch, page views	Web page	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Since launch
Total page views	https://www.phoenixaustralia.org/aged-care/	5,657	3,368	2,432	4,424	5,998	4,699	1,769	28,347
Home page	https://www.phoenixaustralia.org/aged-care/	2,200	971	795	1,028	2,365	1,456	611	9,426
Older people, families and carers page	https://www.phoenixaustralia.org/aged-care/older-people-families-and-carers/	456	800	241	279	460	478	260	2,974
Workforce page	https://www.phoenixaustralia.org/aged-care/aged-care-workforce/	557	546	592	1,656	1,430	984	249	6,014
Managers page	https://www.phoenixaustralia.org/aged-care/aged-care-managers/	322	290	205	263	448	253	133	1,914
Veterans page	https://www.phoenixaustralia.org/aged-care/veterans/	63	61	20	14	28	25	221	432
About page	https://www.phoenixaustralia.org/aged-care/about/	88	112	74	91	114	83	53	615
Webinars page	https://www.phoenixaustralia.org/aged-care/webinars/#selfcare	655	306	299	598	28	1,005	221	3,112

Source: Phoenix Australia

F.3. Dementia Support Australia

F.3.1. DEMP Case studies

The case studies that follow were developed by the DEMP team to illustrate the impact of the DEMP program on aged care residents living with dementia. Note that residents' names have been changed and may not reflect their cultural background.

DEMP Case Study A1: Ron

Ron was referred to the DEMP program for "social isolation, withdrawal and decreased appetite". Ron is living with long standing cognitive impairment indicative of alcohol-related dementia. The DEMP consultant liaised with Ron about his previous interests and Ron informed that always enjoyed painting and drawing landscapes.

The Dementia Consultant recommended that the Lifestyle Officer invite Ron to the "Drawing with Memory" Program. Ron attended this activity and was engaged with the others painting poppies and reminiscing about his earlier life. DEMP brokered Ron a 72 set of Staedtler pencils and a dementia specific colouring in book of antique cars.

Ron is attending group activities more including "Creative Time", the "Drawing with Memory" program, and is also attending the dining room for meals.

DEMP Case Study A2: Nancy

Nancy is living with Alzheimer's disease. Nancy's engagement opportunities had decreased as the impact of COVID-19 restrictions resulted in the cancellation of several small group activities. Nancy was an avid bushwalker, artist, musician, and writer throughout her life. Nancy showed the DEMP consultant her artwork and they discussed hiking throughout the Blue Mountains.

The DEMP consultant brokered a Samsung Galaxy Tablet and downloaded bushwalking videos which included a YouTube clip of Nancy at a "Sydney Bushwalkers Reunion" and Nancy was able to identify all the other members in the group which brought her great joy.

DEMP recommended that Nancy be invited to join the art group at the care home and supported the introduction of an "Art Gallery" where Nancy and other residents could showcase their artwork.

Nancy has been coming out of her room more often and has begun to attend other activities again.

DEMP Case Study A3: Jeannie

Jeanie is living with frontotemporal dementia. Jeannie was referred to DEMP due to a tendency to remain in one area while unoccupied and/or uninterested in engaging in social activities with others. Jeannie also had difficulty in articulating her needs and wishes.

DEMP trialled fresh cut flower arranging with Jeannie resulting in a prolonged period of engagement and she asked staff to look at what she had accomplished.

During a follow-up visit on-site, the DEMP consultant noted Jeannie appeared relaxed and engaged in the flower arranging.

The Lifestyle Coordinator reported that staff were now setting up the flowers and equipment and Jeannie was self-initiating with flowering arranging.

DEMP Case Study A 4: Evelyn

Evelyn lives with unspecified dementia. Evelyn was referred to DEMP due to staff reports of Evelyn experiencing agitation, self-isolation and fearfulness. At the time of the DEMP visit Evelyn was spending much of her time in her room and was reluctant to participate in group activities.

The DEMP consultant trialled aqua painting with Evelyn in her room. Evelyn showed a high level of participation in this activity and expressed her 'excitement' about having received the activity.

DEMP recommended that care staff photocopy the paintings for Evelyn to display on her wall.

Staff now report that Evelyn walks around to the administration area to personally request a photocopy of her Aquapaint pictures. Staff state that Evelyn continues to display a high level of engagement with this activity.

DEMP Case Study A 5: Susan

Susan is living with Alzheimer's disease. Susan had been referred to the DEMP program as she had been "withdrawn and self-isolating, not participating in activity programs as much as she had previously". Susan had experienced the impacts of COVID-19 as restrictions had prevented her husband from visiting her regularly as he normally would. Further, her normal activities outside the home were restricted and she was unable to participate in her walking group. Susan is also legally blind. Susan is an avid lover of music and enjoys listening to Andrea Bocelli and The Carpenters.

The DEMP consultant trialled headphones and a galaxy tablet with music by The Carpenters and noticed an immediate response to the music from Susan. She smiled blissfully, her shoulders relaxed, and she sang along to the music. DEMP also observed Susan attempting to share her music with another person who resides at the care home. DEMP brokered Susan a tablet, jack splitter, and two sets of headphones so that she could share her music with a friend or with her husband when he visited.

The Lifestyle Coordinator reports that Susan is less anxious and shares her music with her husband and other residents. Night staff have also been able to utilise this strategy at night when Susan has been disturbed during the night, to assist her to relax and go back to sleep.

DEMP Case Study A 6: Margaret

Margaret is living with Alzheimer's disease. Margaret informed that she has always loved dogs and misses going out with her daughter to spend time at her home with her two rottweilers (care home has been in lockdown/visitor restrictions/no outings).

The DEMP consultant brokered a robotic dog which Margaret named "Honey". Margaret enjoyed "minding" the dog and started bringing "Honey" to meals and attended a group activity for the first time.

Another resident stated to the DEMP consultant "I wanted to tell you that Honey has changed Margaret's life, I haven't seen Margaret smile in the last 12 months. It brings a tear to my eye that Honey has brought Margaret so much joy".

DEMP Case Study A 7: Marion

Marion is living with Alzheimer's disease. Marion had been referred to DEMP as the home reported that she was self-isolating and withdrawn. Maria had a wide range of interests ranging from oil painting, animals, reading, cooking, and listening to Greek music.

Then DEMP consultant trialled Greek music on headphones with Marion and she appeared to enjoy the experience. DEMP brokered an E-shuffle headphone pre-loaded with Marion's favourite music.

Staff reported that Maria continues to enjoy the music engagement and shows a high level of participation tapping her foot and singing along to some of the songs.

DEMP Case Study A 8: Orsola

Orsola is living with Alzheimer's disease. Orsola had been referred to DEMP as she had an increase in agitation and anxiety. Orsola has always worked hard and was always busy at home raising and caring for her family. Although Orsola worked night shift at a cigarette factory her daughter informed that Orsola would always be home to make breakfast for her family and would always be awake to have food ready for her when she came home from school for lunch.

DEMP trialled the use of child representation doll while on-site. Orsola was seen to be singing, cuddling, and kissing the "baby".

Orsola is supported by staff each day to have time with the baby where she is observed to hold, sing to and fuss over the baby. Staff report that when Orsola has the baby she is less restless and anxious