Evaluation of the PHNs' Improved Access to Psychological Services in Aged Care Facilities initiative

Final report

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AHA Australian Healthcare Associates
Australia's largest health & human services consulting firm

Acknowledgement of Country

In the spirit of respect and reconciliation, Australian Healthcare Associates acknowledges the traditional custodians of Country, the Aboriginal and Torres Strait Islander peoples, and their continuing connection to land, waters, sea, and community.

Australian Healthcare Associates is located on the lands of the Kulin Nation. We pay respect to Elders past and present.

Acknowledgements

Definitions

Term	Definition
AHA	Australian Healthcare Associates
Better Access	Better Access to Psychiatrists, Psychologists, and General Practitioners through the Medicare Benefits Schedule initiative
CALD	culturally and linguistically diverse
CBT	cognitive behavioural therapy
clients	individuals who have received PHN-funded psychological services in residential aged care, as recorded in the PMHC MDS
the department	the Australian Government Department of Health
EPOA	enduring power of attorney
HREC	human research ethics committee
the initiative	Primary Health Networks' Improved Access to Psychological Services in Aged Care Facilities initiative
K10	Kessler psychological distress scale (10-item version)
K5	Kessler psychological distress scale (5-item version)
LGBTIQ+	lesbian, gay, bisexual, transgender, intersex, queer (or questioning) plus
MoUs	memoranda of understanding
LHD	Local Health District
OPMH service	Older Persons Mental Health service
PHN	Primary Health Network
RACF	residential aged care facility
the royal commission	the Royal Commission into Aged Care Quality and Safety
service provider	individual or organisation commissioned by one or more PHNs to deliver psychological services under the initiative

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Main messages

- In 2018 the Australian Government introduced the Improved Access to Psychological Services in Aged Care Facilities initiative to address a well-documented service gap in mental health care for aged care residents.

- The implementation of the initiative has coincided with a period of extraordinary disruption for aged care, with both the Royal Commission into Aged Care Quality and Safety and the COVID-19 pandemic shining a spotlight on the sector and resulting in a range of high profile, high priority reforms to policy and practice.

- It is difficult to overstate the impact of these events on the personal and professional lives of all stakeholders connected to the initiative. Capacity to implement psychological services has been reduced, at the same time as residents' need for mental health support has increased.

- Nonetheless, the initiative is now gaining traction and is supporting aged care residents' mental health with increasing effectiveness and efficiency. Moreover, it is almost universally supported as an important step forward in improving residents' access to appropriate mental health care. It now requires expansion and consolidation in order to fully realise its objectives.

- The initial guidance for PHNs, released by the Department of Health in 2018, requires updating to clarify common sources of uncertainty and inconsistency. Specifically, there is a need to more clearly define the population, referral pathways, and service characteristics that are in and out of scope.

- Initiative-funded services are available in about half of the aged care facilities in Australia. Some facilities have not had the opportunity to take part due to limited capacity of psychological service providers. Others have declined because they believe their residents are already sufficiently supported, due to concerns about having external personnel onsite, or because they are worried about the impact on staff workloads.

- Clearly, it is imperative to secure buy-in from residential aged care facilities and ensure that the initiative is implemented *with* them and not *to* them. Many PHNs and service providers are new to the aged care space, and would benefit from additional support to engage with key stakeholders and promote the initiative and its benefits to residential aged care facilities.

- Effective service delivery hinges on the ability of RACF staff to recognise the wide variety of mental health needs that are common among residents, facilitate timely and appropriate referrals, and provide additional support on an ongoing, day-to-day basis. A concerted effort is needed to ensure they have the skills, knowledge, and resources required to fulfil this role.

- Mental illness is not a normal part of ageing, and psychological services can and do deliver meaningful improvements in residents' mental health, quality of life, and relationships – as long as service providers have the flexibility to deliver services that are tailored to individual resident need.

- The needs of the mainstream resident population are now well recognised, and services that cater to them relatively well established. An essential area for development is to better understand and address the needs of residents from aged care special needs groups.

- Additional work is also required to address service gaps for older people who are transitioning into residential aged care and their families, people with cognitive impairment, and people with moderately severe mental illness.

- Optimising aged care residents' access to timely and appropriate mental health care will require addressing systemic challenges in the mental health and aged care sectors. The initiative is necessary, but on its own, not sufficient to create favourable conditions for service delivery and access.

1 Executive summary

In this section, we summarise our findings in relation to each of the key evaluation questions, including recommendations for the future.

> " This has been a service which has been lacking for many years. When this came on board, we were all so excited. I have nothing negative to say because the need is huge.
>
> *RACF staff member*

People who live in residential aged care facilities (RACFs) experience disproportionately high rates of mental illness, but have not historically had access to the government-subsidised mental health care that other Australians have access to. As part of its commitment to addressing this gap, in 2018 the Australian Government introduced the Improved Access to Psychological Services in Aged Care Facilities initiative (the initiative). Under the initiative, Australia's 31 Primary Health Networks (PHNs) are tasked with designing and commissioning services appropriate to the needs of aged care residents in their region, with the objective of increasing service access for residents with mild to moderate mental health problems.

In June 2021, the Department of Health engaged Australian Healthcare Associates (AHA) to evaluate the initiative's impact to date and identify future directions for the design and delivery of mental health care in RACFs. The evaluation asked 5 key questions:

1. Has the initiative been **implemented effectively** to support aged care residents' mental health?

2. To what extent has the initiative been **efficient** in supporting aged care residents' mental health?

3. Has the initiative been **communicated effectively** to support aged care residents' mental health?

4. Has the initiative resulted in any **unintended consequences**?

5. Drawing on the findings above, how can the initiative most effectively and efficiently be implemented and communicated to support aged care residents' mental health?

To answer these questions we conducted a desktop review of relevant documents and data, consulted with 386 people representing 5 stakeholder groups, and analysed routinely collected service use and outcome data. We synthesised information from these sources to develop a number of actions that the department, PHNs, and service providers can take to enhance the initiative. These actions fall under **9 overarching recommendations** which are designed to capitalise on the progress made during the initiative's first funding cycle:

1. Extend and expand funding to enable the initiative to realise its objectives

2. Foster integration and collaboration among all relevant stakeholders

3. Publicise the availability of psychological services in aged care

4. Encourage and support RACF participation

5. Build RACF staff capacity to support service delivery and residents' mental health

6. Clarify eligibility criteria and referral and assessment protocols

7. Match service offerings and the workforce that delivers them to resident need

8. Generate evidence of the impact of psychological services in RACFs

9. Share information to reduce inefficiencies and support continuous improvement.

Underpinning these recommendations is a detailed exploration of how the initiative has been implemented and communicated to date, and the challenges and successes encountered along the way. A brief overview of key findings is provided below.

Contextual factors have made implementation a challenge

The initiative's implementation has been hampered by the spotlight on, and sweeping changes introduced to, the aged care sector as a result of the COVID-19 pandemic and Royal Commission into Aged Care Quality and Safety. Nonetheless, good progress has been made towards achieving its objectives. At the time of our consultations, services were available in around 48% of RACFs across Australia and delivered to an average of 3,376 people per year; an extraordinary increase from the 78 people who received psychological services in residential aged care in the year prior to the initiative's introduction.

Psychological service providers are responsible for most aspects of the initiative's implementation, with PHNs having a relatively hands-off role. The **service models they are implementing are relatively similar to each other** and largely align with the guidance provided by the department. However, some differences in interpretation of the guidance have led to inconsistencies in eligibility criteria, referral and assessment processes, nature and scope of services delivered, and availability of capacity building for RACF staff. **We identified 4 characteristics of effective service models**, namely that: all stakeholders work collaboratively; RACF engagement and capacity building are prioritised; simple referral processes facilitate timely assessment; and residents have access to independent, holistic, and tailored support. A commitment to service monitoring and continuous improvement supports effective implementation within and across these characteristics.

RACF staff are responsible for the majority of referrals (although this is not currently captured in the minimum dataset), and **residents appear to be referred appropriately**. In keeping with the initiative's target population, most are experiencing symptoms indicative of a mild mental disorder at the time of service commencement.

The recent **expansion of Medicare-subsided mental health care to aged care residents has had little to no impact on the initiative**; this may reflect a lack of interest in working in RACFs among the mental health workforce. Several stakeholders felt that having multiple pathways to mental health care in RACFs is a positive development, although we also heard of the potential for confusion over which pathway to use and when.

The extent to which the initiative has **improved links between psychological and other support services** varies. Rather than actively developing direct connections, service providers often support improved service links by providing suggestions to GPs or RACF staff as to more appropriate services for residents not suitable for the initiative.

In addition to the overarching barriers to effective implementation posed by COVID-19, we heard of a number of more specific **challenges to service delivery and access**. These present barriers to success at each level of the initiative's implementation, from PHNs' ability to commission appropriate services, through mental health workforce and RACF engagement, to residents' willingness, capacity, and ability to participate.

The available evidence overwhelmingly suggests that **the initiative is improving the mental health of participating residents**. Outcome data show a 17.5% reduction in psychological distress on average; perhaps more importantly, interviewees reflected that residents experience wide-ranging benefits including more active participation in RACF life, fewer disruptive behaviours, improved relationships, and reduced use of psychotropic medications.

Tailored interventions mean that these benefits are realised by residents with diverse backgrounds and current symptoms and environment, even residents with long-term illness or more severe distress. However, improvements may be time limited in people with dementia or without ongoing support from RACF staff to maintain wellbeing and implement self-management strategies. Further, although there was a general view that **services are equitably available to most residents**, stakeholders did raise concerns about the extent to which the initiative is improving access to appropriate care for members of aged care special needs groups, including people who live in rural or remote areas, identify as LGBTIQ+, come from CALD backgrounds, identify as of Aboriginal and/or Torres Strait Islander origin, Forgotten Australians, and veterans, as well as older people with disabilities.

The initiative is gaining efficiency

Anecdotal evidence suggests that direct service provision has represented a relatively small proportion of initiative-funded activities to date, with **resources used primarily for service design, commissioning, and establishment**. RACF engagement and capacity building are critical to effective implementation, but are also highly resource intensive; COVID-19 placed significant burden on operational activities and staff resources which presented additional challenges to the initiative's efficient implementation. As time goes on, however, services are gaining momentum and delivering more sessions to more residents.

Given the similarity of service models across PHNs and limited available data, **it is difficult to determine whether one approach is more cost-effective than another**, although PHNs with the lowest cost per service contact all share a service provider. While this suggests efficiencies gained through economies of scale and use of provisional psychologists, lower costs *may* also be associated with smaller reductions in residents' psychological distress.

Key **challenges to efficiency** include duplication of effort associated with workforce recruitment and retention, and regional development of materials (e.g. for promotion or training) that do 'the same thing in different ways'. Efficiencies are gained through PHNs' re-commissioning of existing psychological service providers, and their ability to leverage existing networks and service linkages.

There is scope to better promote the initiative

Awareness of the initiative and the services available remains relatively low across the health and aged care sectors. In most regions, **approaches to raising awareness** of the initiative are largely the domain of service providers; PHNs contribute primarily during service design and piloting, and by distributing information to GPs and health professionals.

Communications have primarily targeted RACFs that the service provider has capacity to serve, however, within these RACFs, residents report being unaware of available supports. **Effective communication** with RACFs involves ongoing promotion of the service to management and staff; it is important to highlight the value of the service to residents, the minimal impact on staff workloads, and capacity building or other support available to staff.

Residents are most likely to be made aware of the initiative by a member of RACF staff. As such, it is important to ensure that staff understand their role in promoting the service, and have the information they need to do so. Communication with residents and their families should emphasise that services are free, and should address stigma by promoting the initiative as an emotional support program rather than a psychological or mental health service.

There has been limited emphasis to date on specifically improving awareness of the initiative among **RACF staff and residents from diverse backgrounds**. Activities most commonly involve advising

RACF staff on how to access translating and interpreting services, or utilising bilingual mental health practitioners.

The initiative has resulted in few unintended consequences

Where unintended consequences of the initiative were identified, they included both positive and negative impacts for different groups of stakeholders. For example:

- For PHNs and service providers, positive consequences include new and improved relationships with aged care stakeholders. One negative impact is the risk of financial and/or reputational harm due to unsustainable workloads
- For residents and mental health practitioners, there is a potential negative consequence of being adversely affected by mental health practitioners' inexperience working in residential aged care
- For RACF staff, the initiative has resulted in positive outcomes such as experienced increased job satisfaction and greater use and awareness of telehealth. On a less positive note, there are concerns about the potential for additional work associated with supporting access to and delivery of psychological services.

2 Background and context

This section outlines the initiative, the complex environment it has been introduced into, and the objectives of its evaluation.

Key points

- Rates of mental illness are disproportionately high among older Australians living in residential aged care facilities.

- The Australian Government is committed to improving access to mental health care for this population, including through the Improved Access to Psychological Services in Aged Care Facilities initiative delivered through Primary Health Networks.

- The initiative has been delivered in a particularly challenging context, due to simultaneous pressure on the aged care sector from the Royal Commission into Aged Care Quality and Safety and the COVID-19 pandemic.

2.1 The need for psychological services in residential aged care

Compared to older people who live in the community, those who live in residential aged care facilities are disproportionately affected by some mental health conditions such as depression and anxiety. For example, symptoms of depression are reported by half (52%) of permanent residential aged care facility (RACF) residents in Australia (AIHW 2015) but just 10% of people outside this setting who are aged 65 years or more (Mohebbi et al. 2019). While there is little published information on the prevalence of anxiety symptoms among RACF residents in Australia, international data suggest it may be as high as 58% (Creighton et al. 2016).

The majority of older people with anxiety or depression will experience mild to moderate symptoms, for which psychological therapies are the recommended first-line treatment in preference to medication (Australian Psychological Society 2018). While RACFs are not required to provide mental health care, they do have an obligation to ensure that residents have access to appropriate services and supports for their emotional and psychological wellbeing (Aged Care Quality and Safety Commission 2018). However, access to appropriate psychological care in RACFs has historically been limited. Prior to December 2020, residents were ineligible for the mental health care available to those living in the community through the Better Access to Psychiatrists, Psychologists and General Practitioners under the Medicare Benefits Schedule (Better Access) initiative.

2.2 Improving aged care residents' access to psychological services

As part of its commitment to addressing older peoples' inequitable access to psychological services, the Australian Government introduced the Improved Access to Psychological Services in Aged Care Facilities initiative (the initiative) through the 2018–19 Budget package, More Choices for a Longer Life. With an initial commitment of $82.5 million over 4 years, the initiative requires Australia's 31 Primary Health Networks (PHNs) to collaborate with RACFs to plan and implement psychological services for residents.

PHNs are expected to focus primarily on increasing service access for aged care residents with, or at risk of, mild to moderate mental health problems. The initiative provides flexible funding so that PHNs can design and commission time-limited services that are appropriate to the needs of residents in their region. It is not intended to fund services that duplicate the role of Older Persons' Mental Health (OPMH) services[1] in providing specialist care for residents with severe and complex mental illness, or dementia services or other aged care services such as the Community Visitors Scheme (Department of Health 2018a).

The initiative represents one new avenue through which residents can access mental health care. Since December 2020, it has operated in parallel to a temporary expansion of Better Access which was introduced to support RACF residents during the COVID-19 pandemic. The expansion is slated to be available until 31 December 2022 and enables RACF residents to access up to 20 Medicare-subsidised individual psychological services per calendar year (Australian Government Department of Health 2022a). These services require a GP or psychiatrist referral and entail focused psychological strategies delivered by psychologists or appropriately trained and registered social workers, occupational therapists, GPs and other medical practitioners.

In contrast, PHNs have greater flexibility in the service models they implement under the initiative, including in how residents are referred and by whom, the number of sessions they receive, the nature of the intervention delivered, and the type of practitioner who delivers it. Thus, the initiative and Better Access aged care expansion both aim to improve access to psychological services for RACF residents but provide distinct frameworks for doing so.

2.3 A challenging time in a complex sector

The initiative has been introduced into an aged care sector with a long history of: suboptimal care; systemic issues related to funding, structure, workforce, culture, governance, and regulation; and significant policy reform (Royal Commission into Aged Care Quality and Safety 2019). Against this already complex backdrop, the initiative has faced even greater challenges than could have been anticipated, with its rollout occurring during an unusually difficult period due to the combined impacts of the Royal Commission into Aged Care Quality and Safety (the royal commission) and the COVID-19 pandemic.

While very different in nature, these events both affected the aged care sector enormously, with policy and regulatory reforms, emergency directives and day-to-day practicalities driving a raft of swift and significant operational changes for RACFs. The challenges and pressures associated with these changes were accompanied and compounded by intensified scrutiny from governments, the media, aged care consumers and the public at large.

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[1] OPMH services are jointly funded by the state and territory governments and the Australian Government, and delivered by states and territories.

2.3.1 The royal commission examines aged care quality and safety

The royal commission was established in October 2018, with a broad remit to examine the quality and appropriateness of Australian aged care services, the challenges and opportunities facing the sector, and how best to deliver aged care services in the future (Royal Commission into Aged Care Quality and Safety 2018). An interim report, released a year later, highlighted the prevalence of substandard care and neglect in the Australian aged care system and resulted in a raft of short-term measures to address some of the shortfalls identified, including the overuse of chemical restraint, inadequate care for older people living with dementia and inappropriate care for younger people with disabilities in RACFs (Prime Minister of Australia 2019). A special report examining the effects of COVID-19 on the sector (Royal Commission into Aged Care Quality and Safety 2020) resulted in further policy responses, including the Better Access aged care expansion (see above).

In their final report, the commissioners provided 148 recommendations spanning all aspects of aged care, including legislation, regulation and governance; workforce capacity and staffing; sector funding; monitoring of safety and quality; and access to health care, including mental health care (Royal Commission into Aged Care Quality and Safety 2021). As noted by the commissioners themselves, the publication of the final report represented 'just the beginning' of Australia's aged care system transformation (Royal Commission into Aged Care Quality and Safety 2021, p. 58). The Australian Government response, published 3 months later, prompted the beginning of a new wave of 'once in a generation' sector reforms (Australian Government Department of Health 2021a, Australian Government Department of Health 2021b).

2.3.2 COVID-19 hits residential aged care

The COVID-19 pandemic has had far-reaching impacts for Australians from all walks of life, but represents 'a public health crisis that has disproportionately affected aged care in Australia' (Royal Commission into Aged Care Quality and Safety 2020, p. 4). RACFs experienced significant strain associated with numerous (and changing) directions, policies and procedures that were put in place both to prevent COVID-19 coming in to RACFs and to manage outbreaks when they occurred.

The magnitude and complexities of these arrangements are highlighted by the *National guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia* published by the Communicable Diseases Network Australia (2021). These guidelines were updated 3 times in the year following their original release in March 2020 and articulate the many roles and responsibilities of RACFs during COVID-19. These include, for example, delivering staff education and training, ensuring adequate supplies of personal protective equipment, preparing an outbreak management plan, facilitating staff and resident vaccinations, screening staff and visitors for symptoms of infection, other monitoring and surveillance activities, and collaborating with other relevant agencies (e.g. health departments and the Aged Care Quality and Safety Commission). Even without the need to manage active cases, it is easy to imagine that many – if not all – RACFs found themselves significantly under-resourced in light of these new requirements.[2]

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[2] It is worth noting that infection control is not a new responsibility for RACFs, with outbreaks of influenza or gastrointestinal illness relatively common. Typically, however, these outbreaks are confined to one site; COVID-19 and the measures put in place to manage it have been unusual in both scale and duration, as well as the level of public scrutiny and negative press.

Initially, the spotlight was focused on high rates of COVID-19 infections and mortality in RACFs, with 75% of COVID-19 deaths in Australia to March 2021 occurring in this environment (Australian Institute of Health and Welfare 2021).[3] However, it soon became evident that the pandemic and its management also had significant consequences for residents' mental health. For example, the royal commission noted that:

> The suffering [due to COVID-19] has not been confined to those homes which have experienced outbreaks. Thousands of residents in homes that have not suffered outbreaks have endured months of isolation which has had and continues to have a terrible effect on their physical, mental and emotional wellbeing
>
> *(Royal Commission into Aged Care Quality and Safety 2020, p. 25).*

Thus, the initiative's introduction has coincided with a potentially considerable increase in depression, anxiety and stress, at a time when access to RACFs and the people living in them has been more difficult than ever.

2.4 Evaluating the initiative

In June 2021, the Department of Health (the department) engaged our team at Australian Healthcare Associates (AHA) to evaluate the initiative. Conducted as the initiative entered the final year of its current funding commitment, the evaluation sought to understand the impact of the initiative and whether it is meeting the mental health needs of RACF residents, and identify future directions for ensuring RACF residents have equitable access to mental health care.

2.4.1 Key evaluation questions

To address the overarching evaluation objectives, the evaluation was guided by 5 key evaluation questions, underpinned by several more specific secondary questions.

1. **Has the initiative been implemented effectively to support aged care residents' mental health?**
   a. What service models have PHNs implemented under the initiative?
   b. Which service models have been effective and/or ineffective in supporting aged care residents' mental health and why?
   c. Where clinically appropriate, have aged care workers and practitioners assessed and referred residents for support under the initiative? If not, why not?
   d. In what ways, if any, has the Better Access aged care expansion impacted implementation of the initiative?
   e. To what extent have PHNs promoted linkages and information exchange with broader support services for residents, including dementia and OPMH services?
   f. Have PHNs and their commissioned providers experienced any barriers or challenges around delivering services under the initiative?
   g. Have eligible aged care residents experienced any barriers or challenges around accessing support under the initiative?
   h. Have services delivered under the initiative been equitably available among eligible residents, including culturally, linguistically and geographically diverse aged care residents?
   i. Has the initiative improved the mental health of participating aged care residents?

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[3] As of 15 March 2022, Australia had recorded a total of 1,844 COVID-19 deaths among RACF residents from 18,884 cases, driven primarily by outbreaks in Victoria and New South Wales (Australian Government Department of Health 2022b).

2. **To what extent has the initiative been efficient in supporting aged care residents' mental health?**

   a. How efficiently have resources been used under the initiative?

   b. Which approaches implemented under the initiative have been cost-effective and/or not cost-effective and why?

   c. What are the key factors that have impacted the efficiency of the initiative?

3. **Has the initiative been communicated effectively to support aged care residents' mental health?**

   a. What communication approaches have PHNs used to raise awareness around the support available under the initiative to aged care workers, practitioners, residents and their family/friends?

   b. Which communication approaches have been effective and/or ineffective in raising awareness and why?

   c. Are culturally, linguistically and geographically diverse aged care workers, residents and their family and friends aware of the support available and how it can be accessed?

4. **Has the initiative resulted in any unintended consequences?**

5. **Drawing on the findings above, how can the initiative most effectively and efficiently be implemented and communicated to support aged care residents' mental health?**

2.5 About this document

This report brings together all aspects of the evaluation and is structured as follows:

- Section 3 describes how we conducted the evaluation.
- Section 4 presents findings related to the implementation, communication, and unintended consequences of the initiative, addressing evaluation questions 1 through 4.
- Section 5 addresses evaluation question 5, providing 9 recommendations and a series of specific actions within each to improve aged care residents' access to and outcomes of psychological services.

This report is accompanied by a technical supplement, which provides:

- an overview of relevant published literature
- additional information about our stakeholder interviews
- results of our analysis of health professional and service provider survey, resident survey, and routinely collected service use and outcome data
- further details of the service models implemented to date (supporting the information provided in section 4.1 of this report).

3 Approach

Here we outline the 3 streams of work that informed the evaluation and our approach to data collection and analysis for each.

This project commenced on 9 June 2021, with data collection concluding on 9 December 2021. Our approach was designed in consultation with the department's project team and incorporated 3 streams of work: a desktop review, stakeholder consultations, and extraction of routinely collected service use and outcome data from the Primary Mental Health Care Minimum Dataset (PMHC MDS). Below, we provide an overview of the activities in each of these workstreams, and our approach to analysing and synthesising the information obtained.

3.1 Desktop review

We collated both initiative-specific and other relevant information (e.g. PHN regional characteristics, aged care data and royal commission reports and submissions) to inform our understanding of service models rolled out under the initiative, the regional contexts into which they were introduced, and the challenges and successes encountered along the way.

We continued to identify and source relevant information, data, and documents throughout the project, through our consultations, online searches and direct communication with PHNs, service providers, and the department (all of whom provided information not available in the public domain). We also searched recent peer-reviewed and grey literature for information on the design and delivery of psychological services in RACFs, to ensure our findings and recommendations align with current evidence in the field (see section 1 of the technical supplement for a summary of this literature).

3.2 Stakeholder consultations

Between August and December 2021 (Figure 3-1), we consulted with 386 individuals representing 5 stakeholder groups:

- PHNs
- Peak bodies in the health, mental health, and aged care sectors
- Health professionals and service providers
- Staff working in participating RACFs
- Residents living in participating RACFs.

Representatives of these groups were consulted via a survey (using the Qualtrics platform), interview (using Microsoft Teams), or both. Below we outline our approach to engagement and consultation for each stakeholder group. More information on participant characteristics is provided in sections 2-4 of the technical supplement.

Figure 3-1: Timeline of stakeholder consultations
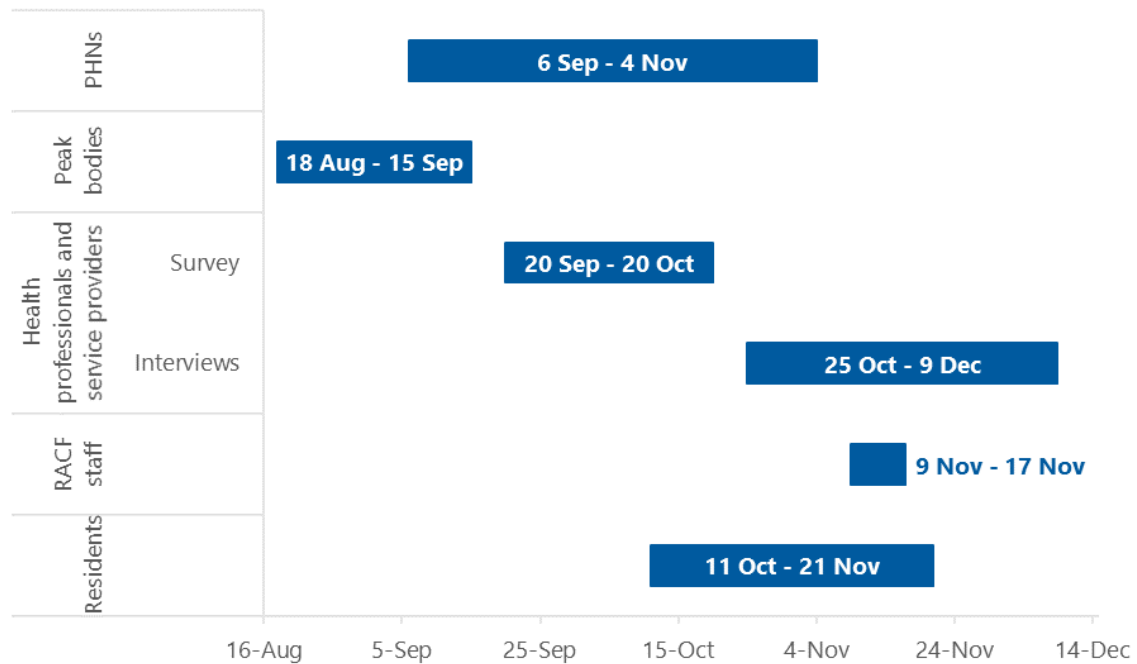
Note: All dates refer to 2021.

3.2.1 Interviews with PHN representatives

We met separately with each PHN – except the 3 PHNs in Western Australia, which participated as a single entity– for a total of 29 interviews. Each interview involved between one and 8 PHN representatives and was loosely structured around a discussion guide designed to explore the PHN's implementation approach, challenges and successes, and suggestions for improvement.

3.2.2 Interviews with peak body representatives

We interviewed representatives of 21 peak bodies to understand their awareness of and engagement with the initiative, and gather feedback on how aged care residents' mental health can be effectively supported. Discussions were flexible and were guided by the nature of each representative's experience of residential aged care and psychological services for aged care residents.

3.2.3 Consultations with health professionals and service provider representatives

We consulted with health professionals and service providers through 2 separate but related activities: a survey and interviews. Survey questions were tailored to address the experiences of 3 groups:

- health professionals who refer residents to psychological services under the initiative
- mental health practitioners who deliver those services
- managers in service provider organisations.

The survey asked respondents about the referral pathways and mental health services available in their region, their experience of referring or delivering services under the initiative, their perspectives on the initiative's impact to date, and opportunities to improve.

Respondents had the option of submitting their survey anonymously or providing contact details to register their interest in a follow-up interview to explore the initiative's implementation and impact in

more detail. Thirty one of the 144 survey respondents opted in to this aspect of the evaluation; we also received direct requests for interview from 4 service provider managers. After following up with all those who opted in or requested an interview, we were able to complete a total of 11 interviews with 22 individuals.

3.2.4 Interviews with RACF staff

Commencing in early October 2021, we employed a multifaceted approach to inviting RACF staff to contribute to the evaluation, which yielded a total of 5 interviews (each with a single RACF staff member). Interviews focused on the process by which residents in their RACF access mental health care, the information and support they have received from their PHN about the initiative, the impacts of the initiative for themselves and the residents they care for, and their perspectives on how the initiative could be improved.

3.2.5 A survey of aged care residents

Bellberry Human Research Ethics Committee (HREC) approved our survey of aged care residents. To recruit participants, we distributed information to PHNs, health professionals, service providers and RACFs, and sought their assistance in promoting the survey to the residents. The survey was available online, in hard copy, or over the telephone.[4] It took around 15 minutes to complete. Residents were able to complete the survey on their own or with assistance, or a family member or other support person could complete it on the resident's behalf. We received a total of 121 responses from 12 PHN regions.

The survey was divided into 3 sections. The first section focused on respondent characteristics, including awareness and use of the mental health services available in their RACF. Respondents who had accessed mental health care since moving into their RACF were directed to the second section, which asked about their experience. Respondents who had not accessed mental health care were directed to the third section, which asked about the reasons for this.

3.3 Extraction of PMHC MDS data

Our application to extract and analyse PMHC MDS data was reviewed and approved by Bellberry HREC and the department's data and analysis section. The department then submitted a request to the data custodian for the period January 2016 to October 2021. This dataset, which we received on 4 November 2021, included data on 352,778 individuals who had consented at the point of service delivery to their anonymised data being released to the department.

All providers of PHN-commissioned primary mental health care services are contractually required to submit service delivery data to the PMHC MDS; the data are used by PHNs and the department to plan and monitor service delivery and make commissioning and funding decisions. The PMHC MDS does not indicate funding source, so to identify services most likely to have been funded by the initiative, we filtered for those delivered:

- in residential aged care
- since July 2018
- to people aged 65 or older (or 50 years for people of Aboriginal or Torres Strait Islander origin).

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[4] All survey information highlighted that interpreter services were available on request; however, this option was not taken up by any residents.

Applying these filters resulted in a dataset of 8,623 unique individuals, henceforth referred to as 'clients'. This dataset, which formed the basis for our subsequent analysis, provides information on the characteristics of the clients receiving services, the mental health practitioners delivering those services, the services themselves, and the clinical outcomes realised as a result. Clinical outcomes are assessed using the Kessler psychological distress scale (10-item version) (K10; Kessler et al. 2002), a measure of nonspecific psychological distress that can be used to categorise the likely severity of mental disorder.[5]

3.4 Data analysis

Our approach to analysis depended on the source and nature of the data.

Quantitative data collected through multiple choice or numeric survey questions were summarised using standard descriptive statistics. For multiple choice items, we calculated the number and proportion of survey respondents who selected each response option, while for numeric items we calculated measures of central tendency (e.g. mean, standard deviation, median, interquartile range). For the resident survey, where appropriate, we calculated responses by selected subgroups (e.g. gender, membership of one or more special needs groups), to explore whether their experience and perspectives of mental health support in residential aged care differs.

Quantitative data extracted from the PMHC MDS were also summarised using standard descriptive statistics, calculated overall and within individual PHNs. For K10 data, this included calculating means on raw data, and frequencies after transforming numeric values into pre-defined categories. Where relevant, we also calculated statistics by financial year and by different units of service delivery, namely clients, episodes of care, and service contacts (referred to elsewhere in this report as sessions).

Qualitative data collected through interviews were analysed thematically, using NVivo to extract and code information relevant to each key evaluation question (a deductive approach). Additional codes were created within each evaluation question to capture emerging themes (an inductive approach).

Qualitative data from free-text survey responses were also subject to thematic analysis, although in this case NVivo was not used as responses were fewer and less detailed, and our framework was more immediately dictated by the survey design and findings of the quantitative analysis.

Information on service models and context for each PHN was extracted from materials identified in the desktop review and summarised using structured templates, which allowed us to identify their shared and unique features and any gaps or challenges to be addressed.[6]

Different team members independently analysed data collected from different sources, or related to different evaluation questions, before meeting to discuss the findings and the emerging themes. We then re-reviewed the data to explore themes emerging from other data sources. Detailed results of our analysis of the health professional and service provider survey, resident survey, and PMHC MDS data are provided in sections 3, 4, and 5 of the technical supplement, respectively. Interview data are woven throughout this report but not presented separately to protect participant privacy.

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[5] The K10 is scored from 10 to 50, with higher scores indicating more severe distress. Scores of less than 20 suggest no mental disorder, scores between 20 and 24 suggest mild disorder, scores between 25 and 29 suggest moderate disorder, and scores 30 and above suggest severe mental disorder.

[6] Each PHN was provided the opportunity to review its own populated template. Final versions were submitted to the department in October 2021

4 Findings

This chapter presents findings for evaluation questions 1 through 4, examining the initiative's effectiveness, efficiency, communication, and unintended consequences.

Key points

- The initiative's implementation has been more challenging than might have been anticipated, with around half of RACFs in Australia having taken part to date.

- Participating facilities have made progress towards improving access to and outcomes of psychological services for residents, and increasing mental health literacy among staff.

- PHNs have a relatively hands-off approach; once commissioned, service providers are primarily responsible for implementing the initiative and communicating its availability to RACFs.

- The evaluation did not identify any adverse consequences, although there may be some potential workload, financial, reputational, and wellbeing risks.

- The initiative has fostered new relationships between PHNs, service providers, and the aged care sector, increased job satisfaction among RACF staff, and supported RACFs to use telehealth.

The 386 individuals who contributed to this review generously shared their perspectives and experiences of the initiative to date. These perspectives were remarkably consistent within and across stakeholder groups, and aligned with data collected through our desktop review and extracted from the PMHC MDS.[7] Below we bring all available data together to provide a detailed picture of the initiative's implementation, including the service models in place, similarities and differences across regions, and difficulties and achievements experienced by stakeholders at all levels.

4.1 Has the initiative been implemented effectively?

> What we have seen, anecdotally, is that everyone does want to help, and this has helped make this program a success.
>
> *PHN representative*

The evidence collected in this evaluation suggests that the initiative has been well received by a historically underserviced sector. Despite the contextual challenges described in section 2.3, **all stakeholders are committed to making the initiative a success and have made substantial progress towards effectively supporting aged care residents' mental health**. Below we consider implementation achievements in terms of reach at 3 levels, namely service provider(s), RACFs, and aged care residents.

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[7] As noted in section 3, detailed findings of our desktop review, stakeholder surveys, and PMHC MDS data analysis are provided in the technical supplement to this report.

Service providers

- Twenty-nine PHNs have commissioned a total of **40 service providers** to deliver psychological services to aged care residents. At the time of our consultations, the remaining 2 PHNs were still in the process of commissioning services (although both had completed a trial phase of service delivery).

- Nine service providers work across multiple PHNs, accounting for 22 of the 53 contracts to deliver services under the initiative.

- Fifteen PHNs have engaged multiple service providers; those with more service providers tend to have a large rural footprint.

RACFs

- **Almost half of all RACFs** across Australia (48%, 1,303 RACFs) were currently or had previously been involved in the initiative (excluding those without active service delivery).

- Participation ranges from 6% to 91% of RACFs in individual PHNs. It is important to note that different PHNs define RACF participation differently[8] so these figures should be interpreted with caution.

Clients

- The PMHC MDS suggests the initiative has had a substantial impact on the number of older people receiving psychological services in RACFs, with an **average of 3,376 clients per year** recorded since its introduction, compared to just 78 in the 12 months prior (refer to section 4.2 for more information on the volume of services delivered).[9]

4.1.1 What service models have been implemented?

Overall, **service models are relatively similar across PHNs**, and consistent with the guidance provided by the department (Department of Health 2018a). Most PHNs reported that their service model was informed by extensive consultation (most commonly involving RACF representatives, GPs, and psychological service providers; see technical supplement, section 6.1, for more detail) and refined after pilot testing in a small number of RACFs. Following the pilot phase, PHNs have had a relatively hands-off role, with service providers typically responsible for most aspects of the service model's broader rollout.[10] Importantly, this includes leading the engagement of RACFs, and encouraging their commitment to effective implementation. The degree to which RACF engagement, and the associated terms and conditions, are formalised varies across PHNs, service providers, and RACFs. Many service providers have established a dedicated RACF engagement role to take responsibility for these activities (although this was not feasible in smaller organisations); a small number encourage RACFs to identify a staff member who can take carriage of championing the initiative internally.

Below we explore service model characteristics relating to sections 2 through 6 of the department's guidance (client eligibility, referral and assessment, services provided, and collaboration). In addition, we discuss capacity-building activities for RACF staff and the approaches that PHNs and service providers have taken to monitoring the initiative's implementation.

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[8] For example, any RACF that: has been provided with information about the service, has signed an MoU with the service provider, is actively referring residents, or has referred at least one resident since the service provider was commissioned.

[9] These data underestimate the true reach of the initiative as not all clients consent to their information being released to the PMHC MDS.

[10] Notable exceptions to this approach include some PHNs with highly dispersed RACFs and/or small service provider organisations that provide only partial coverage of the region.

Client eligibility

In most PHNs, RACF residents who have – or are at risk of – mild to moderate mental illness and are not more appropriately managed by other services are eligible for initiative-funded services, consistent with the department's guidance. Many regions also specify that residents must be able to participate in treatment, which can be a difficult judgement to make (see section 4.1.3).

> The service provider has also been seeing residents who have more severe mental health illnesses, because they have the capacity [to do this] and because there is a bit of gap between our tertiary OPMH service and what our program has been commissioned to deliver.
>
> *PHN representative*

In some PHNs, eligibility criteria have been **expanded** to allow access to the service for older people living in the community, all new residents (regardless of their mental health status), all residents required to isolate in their rooms due to COVID-19 restrictions, or clients of the National Aboriginal and Torres Strait Islander Flexible Aged Care program. On the other hand, a small number of PHNs have **restricted** eligibility to exclude residents who are aged under 65 (or 50 – and in one region, 55 – for Aboriginal and/or Torres Strait Islander people) or those who live in an RACF that is not Commonwealth-funded.

It is worth noting that several stakeholders highlighted ongoing service gaps for residents with dementia and those with severe mental illness unable to be managed by service providers responsible for delivering initiative-funded services (see 'What type of support is available' on the next page) but not severe enough to be seen by OPMH services (see Services provided, below, and section 4.1.4 for information on service linkages and stepped care arrangements for these residents).

Referral and assessment

Referral processes[11] under the initiative tend to follow those of other PHN-commissioned services, with some modifications in most regions in terms of who can refer, and how.

Who can refer to the initiative, and who does?

Most service providers accept referrals from a broader range of sources than are permitted in other settings, with the pool of potential referrers including GPs, RACF staff, residents and their families, and other people that come into contact with residents (e.g. Community Visitors). However in some regions, restrictions on referral sources differ by service intensity, as they do in the community; lower intensity services may be available on self- or family referral, while psychological therapies require a referral initiated by a GP or registered nurse.

We heard from PHNs, service providers, and residents alike that RACF staff (primarily, registered nurses) are responsible for the majority of referrals. However, because the PMHC MDS does not include nurses or aged care staff as referral options, it may not be capturing their role in connecting residents to initiative-funded services. Instead, it is likely that RACF-led referrals are being recorded as having come from 'other' sources, with this unspecified category accounting for 44% of referrals, compared to 37% for GPs.

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[11] The department's guidelines distinguish between a 'request for services', which can come from any source, and a formal 'referral', which should be completed by an appropriately qualified health or mental health professional. In practice, the line between these is not clear cut and we therefore refer to both processes as referrals throughout this document.

How are referrals made?

RACF staff take a number of approaches to identifying and referring residents who may need mental health support. Sometimes referrals occur in response to resident request or following behavioural issues or incidents. Some facilities conduct mental health screening as part of the admission process. Others prioritise referrals for residents without family support, and several engage in case conferencing or discuss possible referrals with GPs, service providers, family members, and/or the resident themselves.

For residents identified as requiring support, most PHNs have implemented a direct-to-provider referral pathway that is not always in place for mental health activities outside of the initiative. The small number that have opted for a central intake model have typically done so in combination with a direct-to-provider option, supporting a 'no wrong door' approach to service access.

Despite relative consistency in open referrals and direct-to-provider pathways, there are some variations in the formality of the referral process. For example in some regions, service providers accept verbal referrals while on site at an RACF, while others require submission of a structured referral form providing information about suicide risk, dementia, or delirium. Different protocols may reflect different understandings of government requirements, with one service provider commenting that 'the government guidelines do require us to have a referral completed by a GP, nurse or psychologist and it does require a certain number of things ticked in a box for us to accept a referral'.

> Residents don't need to be referred by a GP to access the program. They can self-refer or RACF staff can also refer. Then the resident will go through the assessment process to place them at the right level of intervention.
>
> *PHN representative*

What happens next?

Regardless of how referrals are made and by whom, the outcome is that the service provider assesses the resident's suitability for their service and the different types of support it offers (see Services provided, below). We heard few examples of what this assessment entails, and frequent uncertainty about how best to determine a resident's treatment needs (e.g. the severity of mental illness and likely impact of other relevant conditions). Nonetheless, while the content and structure of assessment is unclear, it appears that service providers take into account information gathered through discussions with RACF staff and/or the resident's GP, and a meeting with the resident themselves (and potentially, their family members). Following the assessment, the service provider will advise the GP and/or RACF staff of whether the resident is appropriate for and willing to accept their service, or would be more suitable for alternative support.

Services provided

> The objective [of our service model] was to deliver a more dynamic response for somebody rather than just relying on talking therapies delivered in a traditional format.
>
> *PHN representative*

The brief to provide RACF residents with support that is 'consistent with other mental health services commissioned by PHNs' (Department of Health 2018a) appears to be met, as most service providers are also commissioned to deliver PHN-funded psychological services in community settings. At the same time, services delivered in RACFs appear to be more flexible and broader in scope than traditional psychological therapies and other mental health services commissioned by PHNs, in terms of the types of support available, the way it is delivered, and who it is delivered by.

4. Findings

What type of support is available?

PMHC MDS data show that the initiative primarily offers **low– to moderate-intensity support**, with psychological therapy and low-intensity interventions accounting for 55% and 43% of services delivered, respectively.

Interventions based on the principles of cognitive behavioural therapy (CBT), acceptance and commitment therapy, adjustment and reminiscence therapies, interpersonal therapy, and narrative therapy are common. Music therapy is a feature of many planned or active group programs,[12] as is support for new residents transitioning to the RACF environment and those dealing with grief and loss. While a small number of service providers offer standardised interventions (notably NewAccess),[13] most appear to draw on and blend relevant components of both evidence-based and other approaches as required, to help achieve goals such as:

- building skills to cope with change
- managing stress
- increasing pleasure and enjoyment in life
- increasing confidence
- making new friends and staying connected with old ones.

Service providers reported that allowing sufficient time to build rapport is critical, and many provide practical support to address environmental factors that impact the resident's wellbeing.

Several service providers have a clearly defined stepped care service model offering distinct low intensity and psychological therapy interventions, enabling residents to be stepped up or down (e.g. transitioning from coaching to individual therapy) according to need. In addition, in most regions, service providers are also funded by their PHN to deliver community-based services at one or more levels of treatment intensity. These models afford service providers some flexibility to offer higher or lower intensity care if required, even if these services are not explicitly included in the service model for the initiative itself.

> " In terms of clients needing lower intensity service, the service provider has a volunteer program. Residents therefore have the opportunity to exit the core service, but can continue to have some continued support at a lower intensity, delivered by trained volunteers.
>
> *PHN representative*

PMHC MDS data and PHN feedback also suggests that a small number of service models include a care coordination or case management element. In these models, the provider works with the resident to identify the services they are already receiving and what else may be needed, to ensure appropriate care and minimise duplication of services.

Where are services delivered?

Most PHNs aim to deliver face-to-face services onsite at the resident's RACF where possible. A notable exception is one PHN with a large rural footprint, which was set to introduce a telehealth-only model in late 2021.[14] PHN representatives and service providers suggested there has been a transition to telehealth in response to COVID-19, although survey and PMHC MDS data indicate that at least 95% of

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[12] In one region, the service provider also plans to introduce music therapy groups specifically for younger people living in RACFs.

[13] NewAccess is a low-intensity CBT-based program developed by beyondblue, entailing an initial assessment followed by coaching and support over 5 weekly sessions of 30 minutes each.

[14] As services in this region had not yet commenced at the time of our consultations, it is not clear whether and how challenges to the use of telehealth in RACFs (see section 4.1.6) are encountered and addressed.

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services are still delivered in person. One PHN also noted that their service provider includes the option for support via email or letter, should residents desire, while another noted a forthcoming expansion of their telehealth options to include group CBT.

How are services delivered?

Although residents and mental health practitioners suggested that, to date, services have primarily comprised **individual sessions**, PHNs and service providers indicated that their service model includes provision for both group and individual support. Many suggested that group and individual support options are designed to work hand-in-hand, such that residents initially receiving individual therapy are 'stepped down' to a group when ready, or those initially participating in a group can 'step up' to more intensive individual therapy if desired.

How much and how often are services delivered?

Our interviews identified some variation across PHNs in the number, frequency, and duration of sessions delivered under the initiative. In some regions, these service characteristics are designed to replicate the Better Access model, or are dictated by the use of standardised interventions;[13] in others, the 'dose' of support is more flexible and depends on individual residents' needs and preferences. While differences in duration and frequency may reflect regionally appropriate service models, as identified through PHNs' consultation and codesign activities, in some cases they are an artefact of service provider capacity. This is particularly true for rural and remote areas; for example we heard of one service provider who is only able to attend part of the catchment once every 3 weeks.

These variations aside, it appears that **intended** service models most commonly comprise an initial course of 5 or 6 sessions of low intensity services, and 6 or 10 sessions of psychological therapy, with no discernible difference in the planned frequency (weekly or fortnightly) or duration (30 to 60 minutes). PMHC MDS data confirms that **actual** patterns of service delivery result in low intensity interventions and psychological therapies that are broadly similar, with the former commencing 3 days sooner after referral and incorporating only one less session on average (Table 4-1).[15] Of course, this refers only to session numbers and length; these data patterns should not be taken to imply similarity in session content. Across all service types, clients wait an average of 20.6 days after referral for their first session[16] and receive 7.1 sessions on average, most of which (56%) last between 46 and 60 minutes.

Table 4-1:   Characteristics of low intensity services and psychological therapy

Characteristic	Psychological therapy	Low intensity intervention
Mean days between referral and first session	20.7	17.5
Mean sessions per client	7.8	6.6
Session duration		
<30 mins	14.6%	18.8%
31-45 mins	12.6%	18.0%
46-60 mins	64.0%	52.2%
61-75 mins	3.9%	4.3%
>75 mins	4.9%	6.7%
Total number of sessions	**37,785**	**22,302**

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[15] For further detail on less common service types, please refer to the technical supplement, section 5.4.

[16] Compared to an average of 44.9 days across all PHN-funded mental health care; see technical supplement section 5.2.

Note: Percentages may not sum to 100 due to rounding

In many PHNs, residents can be re-referred for additional sessions as part of the same episode of care, for a total of up to 20 sessions.[17] Processes for re-referral, like initial referrals, appear to be relatively straightforward and service providers are responsible for determining the appropriateness of the re-referral and delivering additional sessions only if clinically indicated.

Some service providers noted that, while the intention of the initiative is to deliver time-limited interventions, much **longer-term support is sometimes required** (and provided) – for example, to provide ongoing relapse prevention for residents discharged by an OPMH service, or support those in palliative care through to the end of their life.

Who delivers services?

According to the PMHC MDS, services are primarily delivered by general psychologists (27%) and low-intensity mental health workers including provisional psychologists (21%).[18] Some types of practitioners may have more of a presence in future; for example, one service provider indicated that their organisation is about to establish and train a workforce of peer volunteers to provide ongoing check-ins and low-intensity support to residents after they have completed psychological therapy.

Collaboration and team-based care

> GPs play a crucial role in the uptake of this service, and therefore making sure that they understand what this program is about is important. The communication back to the GP [after a resident has completed an episode of care] is also important. As such, one of the key things we have in the contract is that the providers are required to provide feedback the GP.
>
> *PHN representative*

Most service providers support a team-based approach to care by sharing care plans, regular progress updates, and discharge summaries with RACF staff and the GP. These processes are in place regardless of who initiated the resident's referral.

> Every time we do an assessment, we advise the GP in writing of the fact that the assessment has occurred and we invite them to our case conference meeting, which is attended by psychiatrist. We also send them a letter after the case conference meeting telling them what the treatment plan is, and then we communicate with them prior to discharge and seek their input. We also send them a discharge summary. It's very, very formalised.
>
> *Service provider representative*

Often, these updates include advice for RACF staff on how to support the resident to manage their symptoms and put the skills learned during sessions into practice. For example, one staff member reported that 'the service provider would suggest some techniques and strategies like breathing exercises and if we happen to come in and find [the resident] in an anxious state then we would guide them through some of these exercises.'

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[17] While there is no hard limit on the number of sessions that residents can access, the initiative is primarily intended to provide short-term rather than ongoing support.

[18] Provisional psychologists have completed an accredited psychology course in Australia, trained as a psychologist overseas, or are returning to the workforce after an extended break, and are completing a mandatory period of supervised 'on-the-job' training before they can register as a psychologist.

Service providers noted that updates are only shared with the client's consent, and that 'about 98% do consent for that information to be shared'. In line with good clinical governance, providers will also share information *without* consent when they have concerns about the immediate health or safety of the resident or someone else (e.g. due to suicidal ideation, family violence, or delirium).

RACF capacity building

> Something that has come out of this program is that the training of the RACF staff has been really important.
>
> *PHN representative*

The expectation that funding be allocated primarily to service delivery appears to have been interpreted differently by different PHNs. As a result, capacity building is incorporated into service models to varying degrees. Of note, representatives of one PHN commented that they were 'told at the beginning we weren't allowed to use the funding to implement mental health training in the RACFs as it is the responsibility of the RACF', and reflected that 'this is a real miss'. Most PHNs, however, have understood that improving RACF staff knowledge of mental illness is encouraged and as such have included responsibility for the delivery of capacity-building activities in their service provider contracts.

Service providers undertook a range of capacity-building activities, including formal workshops, brief 'toolbox sessions', ad hoc conversations, and provision of written resources including manuals and posters. One service provider also discussed the planned development of brief online psychoeducation modules, including quizzes.

Typically, capacity-building activities aimed to improve recognition of mental illness, ensure staff understand referral pathways (including but not limited to those available under the initiative) and develop skills in supporting residents with mental illness (including delivering mental health first aid). Some service providers (typically larger organisations working across multiple PHNs) delivered or arranged training on broader issues such as pain, staff resilience and self-care, use of telehealth, legal issues, and other topics of interest identified in consultation with RACF management.

Crucially, the capacity-building element of current service models is highly valued by RACF staff.

> [The service provider] conducted trauma training with our staff. We had a resident who was experiencing a lot of challenges and had gone through trauma; staff were not really understanding them and were finding the behaviour of the resident very challenging, so training was organised. This was the most well-attended training [we have had], with about 40 attendees. The feedback from staff was that this training was very helpful.
>
> *RACF staff member*

Service monitoring

PHNs report monitoring the effectiveness of their service model and its implementation across multiple domains, aligning with the *PHN Program Performance and Quality Framework* (Department of Health 2018b) and/or the *Quadruple Aim Framework* (Bodenheimer & Sinsky 2014). Their approach to understanding the initiative's progress and performance is consistent with that employed in their other primary mental health care activities, with service providers required to submit PMHC MDS data, provide regular reports (typically, including both qualitative and quantitative data) and attend regular meetings to discuss progress and address any challenges encountered. However, some modifications to standard reporting requirements have been made, for example to remove the expectation that data on substance use is collected and reported, or to introduce systems to track RACF participation.

Similarly, KPIs for initiative-funded services align with PHNs' standard practice and relate to the volume of services delivered, value for money, K10 completion rates, improved client outcomes and experiences, staff supervision and training (including completion of cultural awareness training). Initiative-specific KPIs include targets for the number of RACFs participating in the initiative, delivery of education and training for RACF staff, and provision of information to both the RACF and GP at the completion of treatment. In many cases, KPIs have been developed in partnership with service providers, informed by the initiative's pilot phase and revised to reflect evolving service models and contextual factors (e.g. an initial target of daily client numbers in one region proved too ambitious during COVID-19 restrictions). However, we also heard that there is some uncertainty over how performance should be benchmarked, for example in terms of the proportion of RACFs participating, or what constitutes an improvement in client outcomes. As such, some PHNs felt it is difficult to understand how their service model is tracking, compared to other regions and the department's expectations.

We also heard that monitoring is made difficult in some regions by a paucity of data and incomplete record keeping, with one PHN staff member new to the initiative lamenting that this has made it difficult to 'gather information on the procurement and commissioning and continue the roll out of the program'. Further, not all PHNs have formal requirements in place to routinely collect feedback from residents, their families, or RACF staff. Instead, these perspectives are often captured on an ad hoc basis and/or will be collected in formal evaluations planned in several regions.

Finally, service providers often engage in monitoring activities over and above those required by their PHNs, to inform and improve service delivery at the individual client level. Despite widespread concerns about assessing resident outcomes (see section 4.1.7), several service providers reported finding such data beneficial for understanding progress and adapting treatment plans as necessary. They suggested that outcome measures can be more effectively administered using creative or conversational approaches and being flexible in the timing of administration (e.g. asking questions over a period of time rather than in a block).

4.1.2 What are the characteristics of effective service models?

Based on implementation of the initiative to date, and peak body perspectives of what is needed to effectively support aged care residents' mental health, we identified 4 characteristics of effective service models (Figure 4-1). Underpinning these characteristics is a commitment to data collection and monitoring, enabling PHNs and service providers to understand what is working and implement changes to address areas in need of improvement.

Figure 4-1: Characteristics of effective service models
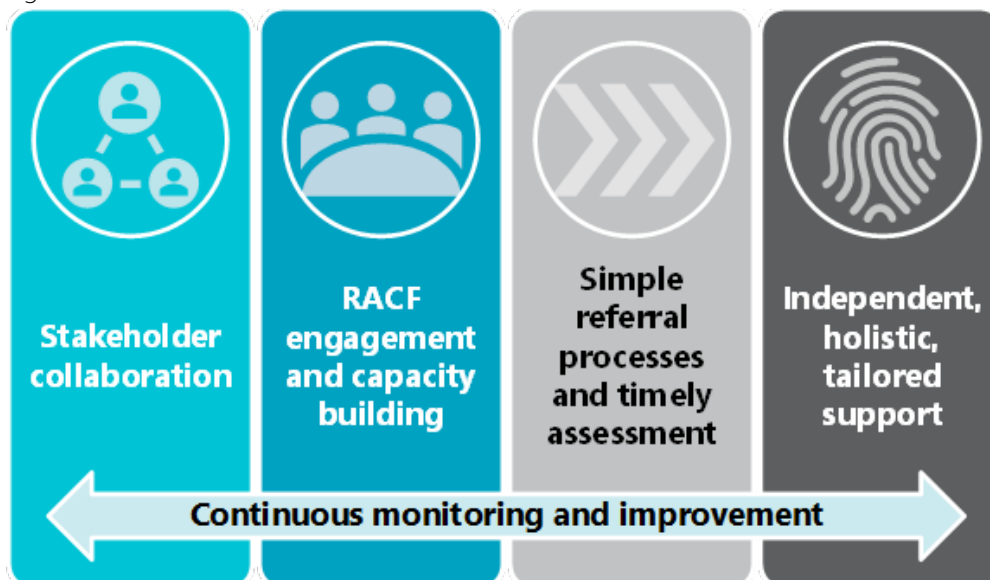
Each of these characteristics is briefly described below, with further detail provided in section 6 of the technical supplement.

Stakeholders work collaboratively, with partnerships between PHNs and service providers, and service providers and RACFs supporting appropriate service design, smooth implementation, and a mutually agreed approach to addressing challenges as they arise.

RACF engagement and capacity building are prioritised, with a commitment to ensuring that service providers and RACFs have a shared understanding of service arrangements and that responsibility for initial and ongoing engagement is clearly defined (e.g. through establishing a dedicated RACF engagement role, supporting identification of RACF staff champions). Taken together, feedback from PHNs, service providers, RACF staff and peak bodies suggests that effective capacity building includes training for staff at all levels, delivered in small, face-to-face group sessions that fit into the RACF schedule. Activities address mental health literacy, services available under the initiative and related supports, cultural awareness, and trauma-informed care.

Simple referral processes facilitate timely assessment of a resident's appropriateness for the service, removing unnecessary delays to service commencement while ensuring that the individual's treatment needs are appropriately considered. Given that service providers are primarily responsible for determining whether the resident is a good candidate for the initiative, effective service models are those with minimal barriers to this assessment. Arrangements to help streamline the referral process include direct-to-provider pathways, few restrictions on referral sources, RACF staff champions who can lead referrals, and minimal administrative burden for referrers.

Residents have access to independent, holistic, and support, enabling them to speak confidentially with someone not involved in their day-to-day care. At the same time, mental health practitioners should be highly visible within the RACF, to build trust among staff and residents alike. Effective services offer appropriately tailored, multidisciplinary care, and adopt a holistic approach to care that goes beyond formal psychological therapy for diagnosable psychiatric disorders. Both individual and group programs are important in meeting residents needs and preferences; group programs may be more important for services delivered under the initiative than those delivered in other contexts as they align with the format of lifestyle programs routinely provided by RACFs and may therefore be less stigmatising, can address issues such as loneliness without requiring residents to confront them directly, and provide options (e.g. music therapy) that are accessible to people with cognitive impairment or limited English language proficiency.

It is important to note that while these characteristics are essential in optimising program success, they are not sufficient. Effective services cannot be created overnight, and will require time to gain traction, iron out teething issues, and address local needs and idiosyncrasies.

4.1.3 Are residents being referred appropriately?

Overall, PMHC MDS data indicate that referrals are being made appropriately, with most people referred for psychological services in residential aged care falling within the initiative's target population. For example, the average K10 score at the beginning of an episode of care is 24.2, indicating mild mental disorder; the most common primary diagnosis at service commencement is depressive symptoms (27% of clients),[19] and 3% of referrals include a suicide flag. Moreover, the appropriateness of referrals appears to be improving slightly over time, with clients more likely to report mild to moderate mental disorder – and less likely to report no or severe disorder – in 2020-21 than 2018-19 (Figure 4-2).

Figure 4-2: Proportion of aged care clients likely to have no, mild, moderate, or severe mental disorder at service commencement (assessed using the K10)
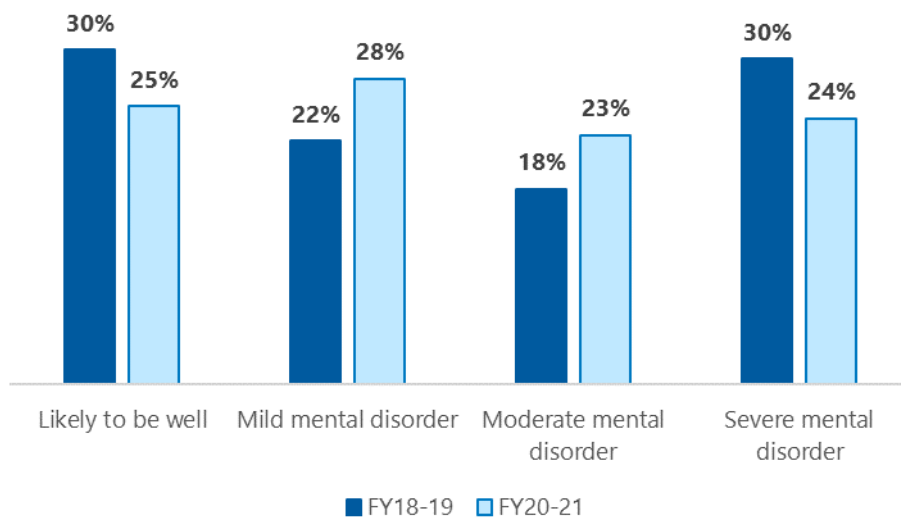
As discussed in section 4.1.1, RACF staff are the primary referrers to the initiative, and are likely captured within the category of 'other' referrers in the PMHC MDS. Residents referred by someone in an 'other' profession have similar levels of psychological distress at service commencement to those referred by a GP, suggesting that these different referral sources result in equally appropriate referrals. That said, stakeholders identified 2 types of referral error (inappropriate referral and non-referral), as shown in Figure 4-3 and discussed in turn below.

Figure 4-3: Appropriate and inappropriate referral matrix

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[19] Compared to just 4% for whom the primary diagnosis is the more severe category of major depressive disorder.

Inappropriate referrals

There was general agreement that inappropriate referrals are rare; one service provider commented that 'we have refused very few referrals because we know the resident isn't going to be suitable for this particular service; generally we have to go in and assess anyway'. When a referred resident is not suitable for the initiative-funded service, providers typically suggest more appropriate supports (see section 4.1.4).

The main reason referrals are deemed inappropriate is that the resident is more suitable for dementia services. However, many stakeholders reflected that it can be extremely challenging to identify degrees of cognitive impairment and the extent to which it may prevent the resident from participating in or benefiting from the care available through the initiative. We heard that this judgment is particularly difficult for RACF staff to make, although service providers also felt ill-equipped to determine whether residents with cognitive impairment were appropriate for their service.

> We have that task of trying to differentiate between those who present [with dementia] and a secondary mental health condition … Something needs to be done because it is confusing for us, for recipients of the service and for RACFs. What level of dementia, regardless of whether it is a secondary illness, remains in scope?
>
> *Service provider representative*

A second, and often related, reason that service providers would consider a referral to be inappropriate is if it appeared to have been made without appropriate resident consent. We heard of several examples, including from residents themselves, of residents being unaware of their referral until their first meeting with the mental health practitioner. However, in some cases this may reflect problems with recall due to the way the initiative was explained (see section 4.3.1), rather than an actual lack of consent.

Some stakeholders reflected on the challenges of obtaining informed consent from residents with cognitive impairment. Referrers must not only determine residents' cognitive capacity to consent (which can change over time), but also identify who is *legally* responsible for providing consent, noting that even if an enduring power of attorney (EPOA) has been appointed, their powers may not relate to health care decisions.

Inappropriate non-referrals

Along with the potential for residents to be referred inappropriately, several stakeholders also identified the potential for residents *not* to be referred to the initiative despite being eligible and suitable for the services available. Importantly, these residents are, by definition, not represented in referral data and it is therefore difficult to define the scope of this issue. Nonetheless, stakeholders noted that inappropriate non-referrals may result as a consequence of:

- **low mental health literacy**, with some stakeholders concerned that both referrers and residents themselves may view mental health problems as a natural part of ageing, or as meaning something very specific that does not reflect the resident's current issues, and that this may lead to missed referral opportunities. As one PHN representative noted, 'when staff members are more aware or better educated [about mental health] the referrals are better.' For residents, low mental health literacy can result in a sense of shame and reluctance to ask for or accept help (see section 4.1.6).
- **demanding workloads** for RACF staff and GPs, which inhibit their ability to recognise and act on psychological distress. Many service providers noted that RACF staff are time poor and task oriented, a situation exacerbated by COVID-19. One mental health practitioner explained that 'during this last delta lockdown we've been reaching out to RACFs and they were saying that they don't have the time to make the referral. They're barely covering the physical and clinical needs of the residents.'

- **limited awareness of available services** and referral processes, meaning that even if residents or referrers recognise a problem and have time to respond, they might not know what to do. According to our survey, one in 5 residents who had not accessed mental health support in their RACF indicated that this was because they did not know help was available. Further, feedback from stakeholders and residents themselves suggests that a referral may be less likely if residents or referrers perceive that the services available are not appropriate to the resident's needs; notably, one-quarter of the residents we surveyed who had not accessed mental health support held this view.

- **a perceived mismatch between available services and resident need**, with referrers potentially reluctant to refer residents experiencing subclinical issues to the clinically focussed services that were understood by some PHNs to be required by the department (see section 4.1.7: A little can go a long way in improving residents' mental health and section 6.3.4 of the technical supplement).

4.1.4 What impact has the Better Access aged care expansion had?

Not all stakeholders were able to comment on this issue; among those that did, there was consensus that the Better Access aged care expansion has had little to no impact on the initiative. Service use data supports this perspective; the initiative's trajectory of increasing service volume (see section 4.2) was uninterrupted by the introduction of the Better Access aged care expansion, and 4,561 residents accessed PHN-funded services between 10 December 2020 and 1 October 2021 (the latest date for which data were available), an average of 456 per month. By contrast, 2,098 residents accessed services under Better Access between 10 December 2020 and 31 January 2022, an average of 150 per month.[20]

That the initiative reached more clients than Better Access in 2021 may reflect its relative maturity.[21] The number of residents accessing the initiative has risen steadily since its introduction, and the Better Access aged care expansion may experience similar growth over time.[22] Greater uptake of the initiative may also reflect differences in the services available. Several stakeholders considered PHN-funded services to be more fit-for-purpose for residential aged care and therefore unlikely to be significantly impacted by the Better Access model, which was designed for community settings. We discussed these differences briefly in section 2.2 and expand on them in Table 4-2, drawing on our findings of the service models implemented by PHNs (section 4.1.1).

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[20] Data provided by the department on 2 March 2022. Note that Better Access services are recorded in Medicare Benefits Schedule (MBS) data rather than the PMHC MDS. Exploring the uptake of Better Access in detail using MBS data was out-of-scope for this evaluation

[21] It is also worth noting that the Better Access aged care expansion was introduced into a markedly different environment than the initiative. The relatively brief period between the 2 programs commencing not only saw significant upheaval in the aged care sector (see section 2.3) but a continued shift towards prioritising mental health and access to psychological services more broadly (e.g. in the wake of the Royal Commission into Victoria's Mental Health System). In this context, it is perhaps not surprising that when comparing the first year of Better Access (2020-21) against the first year of the initiative (2018-19), more residents accessed the former.

[22] Or indeed, may experience more rapid growth in light of broader reforms in the aged care sector as well as the primary care space (e.g. the GP Aged Care Access Incentive which aims to encourage GPs to provide Medicare services to aged care residents)

Table 4-2: Key characteristics of services available under Better Access and the initiative

Characteristic	Better Access	PHN initiative
Eligibility	Residents with a diagnosed mental disorder who would benefit from a structured, multi-disciplinary approach to the management of that disorder.	Residents with mild to moderate symptoms of common mental illness; those with severe mental illness who are not more appropriately managed by OPMH services and would benefit from psychological therapy; those at risk of developing mental illness in the next 12 months.
Referrals	Referrals can be made by a GP, other medical practitioner or psychiatrist who has assessed the resident as eligible (as above) and prepared either a Mental Health Treatment Plan (GPs and other medical practitioners) or a Psychiatrist Assessment and Management Plan (psychiatrists).	Referrals may be initiated by a range of sources including but not limited to GPs and other medical practitioners, RACF staff, residents or family members. Some paperwork may be required but verbal referrals may also be accepted.
Nature of services	Focused psychological strategies and psychological therapy sessions, delivered in an individual therapy format.	Varied, with a mix of low intensity services and psychological therapies (as well as case management in some regions). Support may include focused psychological strategies and more holistic interventions (e.g. music therapy) and may be delivered in an individual and/or group format.
Number of sessions	Up to 20 per calendar year (an initial course of 10, with additional sessions subject to GP review and re-referral)	Varies according to the nature of the service (e.g. fewer sessions for low intensity services) and resident needs and preferences.
Practitioner type	Psychologists and appropriately trained and registered social workers, occupational therapists, GPs and other medical practitioners	Psychologists and appropriately trained and registered social workers, occupational therapists, and mental health nurses; low intensity mental health workers (including provisional psychologists; mental health coaches; Aboriginal and Torres Strait Islander mental health workers; peer support workers; GPs and other medical practitioners

Importantly, several stakeholders reflected that the Better Access aged care expansion may not have had a noticeable impact on the initiative because, as demonstrated by usage data, both are serving to improve residents' access to psychological services. Some commented that having both referral pathways enables residents to access additional support after exhausting their allocated sessions under one funding stream. PHN-commissioned service providers indicated that in some cases they will help the GP to find a private psychologist or mental health social worker through Better Access, and (with the client's consent) provide a hand over to the new practitioner.

The Better Access aged care expansion can also promote continuity of care by offering residents the opportunity to continue seeing the mental health practitioners they had already established relationships with while living in the community. However, service providers and PHN representatives also reported some confusion among referrers about the differences between Better Access and PHN-funded services, how to determine which to use, and whether residents can access services under both initiatives.

Finally, stakeholders consistently pointed out that the impact of the Better Access aged care expansion may be limited because an additional referral pathway does not necessarily translate into the availability of additional support. They noted that mental health practitioners who are interested and trained in psychogeriatrics are in short supply (an issue that impacts both Better Access and the initiative, as discussed in section 4.1.6), and that the flag fall items available under Better Access offer insufficient remuneration for most practitioners to find it worthwhile to take on the additional work involved in travelling to and working within RACFs.[23]

> I've asked all the people in our network if they know of any private mental health providers going in [to RACFs] through Better Access and none of them do… We just know there are so many barriers.
>
> *Service provider representative*

Differences in the perceived likelihood of service delivery under Better Access and the initiative led some stakeholders to express concern that GPs receive payment for referring to the former (knowing that service delivery may be unlikely) but not the latter (where residents are more assured of receiving care). They noted that this may present an ethical dilemma in determining an appropriate referral pathway, with GPs asked to trade their own interests for those of their patients. As one RACF staff member commented, 'I am aware that some of the GPs have done mental health plans for some of our residents. But what does that mean for our residents? All I know is that the GPs are getting some funding for it. But I don't see anything for the resident.'

4.1.5 Has the initiative improved links between psychological and other support services?

Many PHNs indicated that they had explicitly considered the initiative's relationship to broader supports in the process of designing their service model. For example, we heard often that the design phase included consultation with Local Health Districts (LHDs) and OPMH services, and less often that it involved dementia services.

Subsequently, PHNs have distributed information about initiative-funded services to their existing networks, either actively (e.g. presenting at meetings of local stakeholders including hospital staff and OPMH services), or passively (e.g. including information in their service directory). They have also distributed information about other PHN-funded programs (e.g. a falls prevention program with a mental health component, and animal-assisted therapy) to providers of initiative-funded services. Indeed, one-third of managers in our service provider survey indicated that their PHN had provided information on options for stepping clients up or down to other services.

However, as discussed in section 4.1.1, PHNs have been relatively hands-off in implementing the initiative, and it is therefore not surprising that service providers take primary responsibility for actively promoting linkages and driving information exchange with other support services both within and outside of RACFs. This includes, for example, building relationships with staff responsible for RACF lifestyle programs, and presenting to OPMH services and hospital staff about the initiative specifically or as part of a broader program of information exchange. One service provider representative also noted that their organisation has an identified Aboriginal and Torres Strait Islander role which was seen as invaluable in building relationships between mental health practitioners (including but not limited to those delivering services under this initiative) and Aboriginal Health Services.

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[23] Only one mental health practitioner told us otherwise, noting that 'I have had private practitioners who specialise in aged care and want to be visiting RACFs say to me, "I'm not getting as many referrals because of your service"'.

The extent to which service providers have been able to develop connections with other support services varies. Some PHNs commented that their service providers have established good relationships with LHDs, and one service provider noted that, as a result of the initiative, they are 'certainly stepping up to the aged persons mental health team more regularly than we have been'. However, other PHNs and service providers noted that the initiative has not been successfully integrated with the broader stepped care framework. In some cases this was a function of timing, with recently-commissioned service providers still in the process of developing relationships at the time of this evaluation. In other cases, the lack of integration was seen as a reflection of more systemic problems such as a lack of services across the stepped care continuum, with acute inpatient care the only option for residents with more severe symptoms. One service provider also reported that their desire to develop stronger connections with the OPMH service has been hampered by that service's requirement that all referrals come from the resident's GP.

In this context, it makes sense that many service providers approach the need to improve service linkages as part of individual resident care by facilitating referrals to more appropriate supports when residents are not suitable for the initiative. The role of the service provider in this situation varies; in some regions, providers are required to identify and recommend appropriate services (e.g. OPMH service, a geriatrician, Dementia Services Australia) whereas in others, they are responsible only for advising that additional or alternative support is required. One PHN indicated that the service provider works with RACF staff and residents themselves to identify suitable low-intensity, including self-help, service options where more intensive services are not required. We also heard of one provider developing a list of other relevant support services (including contact information) for all RACFs in their region.

Despite these efforts, our consultations suggest that there is room to improve awareness of alternative supports among those who refer to the initiative. For example, 17% of respondents to our health professional survey were unsure whether high-intensity services were available for aged care residents in their region, and 21% were unsure about the availability of acute and specialist services. This uncertainty was echoed in interviews; for example, one nurse working in a RACF understood the initiative to offer 'lower-level intervention for mild depression', but was unsure what services are available to support residents with higher-level needs including suicidal ideation and dementia.

4.1.6 What implementation challenges have been encountered?

We heard general agreement that while implementation activities to date represent a step in the right direction, they have not always translated into an effective rollout of services. Some PHNs reflected that 'there's been a lot of effort in implementation but [we are] disappointed it has not resulted in referrals'. Although we heard of some specific barriers to referral, discussed in section 4.1.3, it is likely that failure to convert a planned service model into actual service delivery reflects a complex interplay of internal and contextual factors, many of which PHNs have limited ability to control. For example, one PHN noted that low uptake has also been a challenge in the rollout of other psychological services, suggesting a broader need to address regional issues around stigma and the acceptability of mental health care.

In considering the multifaceted influences on the initiative's success (or otherwise), we have identified a hierarchy of individual implementation components (Figure 4-4). Each level of this hierarchy presents its own challenges to service access and delivery, and is affected by those encountered at each level above it. In the sections that follow, we consider each level in turn, exploring the sticking points that PHNs and service providers have encountered in designing, establishing, and delivering services, and those that residents have faced in accessing support.

In addition, as all stakeholder groups noted, the COVID-19 pandemic has been a *significant* contextual barrier to program delivery, creating new challenges and exacerbating existing ones at each level of the implementation hierarchy. COVID-19-related challenges were particularly evident in regions with less mature services; we heard that it was easier, as a general rule, to continue an existing service than commence a new one.

Figure 4-4: Hierarchy of implementation components

PHNs have the knowledge and resources to design and commission appropriate services

A suitably sized and trained workforce of practitioners is established

RACFs are engaged in and support the initiative

Staff have the knowledge and resources to support service access and delivery

Residents are willing, able, and have the capacity to participate in mental health care

PHNs' knowledge, experience, and resources for designing and commissioning appropriate services

Peak bodies generally agreed that PHNs are the appropriate organisations to lead the initiative's design and implementation. However, several peak body representatives were concerned that some PHNs may not be adequately equipped to make informed commissioning decisions, due to a lack of understanding of mental health and aged care needs, their intersection, and how they can be appropriately addressed. Both peak bodies and PHNs themselves noted that residential aged care is a new environment for some PHNs, requiring time to cultivate new relationships with RACFs and develop a realistic understanding of the services required.

PHNs discussed the importance of co-design and consultation activities in developing an effective service model, but some felt they had insufficient time to conduct these activities (due to pressure to commence service delivery soon after receipt of funding). PHNs with limited experience in the aged

care sector found this narrow window particularly challenging; others addressed it by rapidly implementing a small pilot of service delivery and embedding consultation within this trial phase (see also section 4.2.2: Facilitators of efficient resource use).

Several PHNs identified that a lack of appropriate service providers has been a barrier to them to fulfilling their commissioning responsibilities. For example, some reported engaging in multiple rounds of commissioning before a suitable service provider could be identified. We heard that in some cases, this reflects a thin market that is at or approaching saturation, in part due to the PHN's overlapping mental health activities. As noted in section 4.1.1, most PHNs have commissioned service providers for this initiative that are also delivering community-based psychological services; many therefore have limited capacity to take on additional service delivery (and are unable to boost capacity by expanding their workforce, as discussed below).

As a general rule, PHNs with a large rural or remote footprint have found it particularly difficult to appoint service providers and some have only partial coverage of their region, due to a shortage of candidates with suitable experience and capacity, and a mismatch between available funding and the costs inherent in designing, commissioning, and implementing an effective service model in their region. They identified a number of factors driving up the cost of service delivery, such as travel requirements given vast geographic distances between RACFs, and the higher-than-average salaries required to attract mental health practitioners to these regions.

> The biggest problem for us in the country area is that the funding does not reflect remote dispersion.
>
> *PHN representative*

Recruitment and retention of a suitably sized and trained workforce

PHNs and service providers noted that challenges with recruitment and retention have led to waitlists and delays in service delivery in some regions. They discussed 2 factors that create unfavourable conditions for establishing the workforce required to deliver services under the initiative. First, they pointed to an overall shortage of mental health practitioners, especially in rural and remote areas, that is not unique to this initiative. Second, they noted that this shortage is particularly pronounced in the aged care sector due to a lack of financial incentives, interest, and relevant training for mental health practitioners (with these issues also affecting the Better Access aged care expansion, as noted in section 4.1.4).

> One of the issues is that we don't have a workforce for this. Certainly, residential aged care is not something that psychologists traditionally learn or want to learn and are actually involved in.
>
> *Service provider representative*

Having flexibility to recruit from across the spectrum of mental health practitioners (in terms of both practitioner type and level of experience) was seen as beneficial in establishing a workforce, although peak bodies expressed concern that this may result in residents receiving services from practitioners without appropriate skills or experience.

The uncertainty of ongoing funding and subsequent short-term nature of contracts available under the initiative were also identified as barriers to recruitment, with COVID-19 and the associated border closures introducing additional hurdles to appointing interstate candidates.

In terms of retention, we heard that a key challenge has been a discrepancy between mental health practitioners' expectations of their role (delivering services to aged care residents) and the reality (engaging RACFs and negotiating access to deliver services). For example, mental health practitioners in some regions have reportedly resigned shortly after being recruited by the service provider because they found the process of trying to get into RACFs too overwhelming.

> There was feedback that practitioners did not want to take on this [engagement] role and this was perhaps impacting on retention. There have been recruitment and retention challenges because people weren't having the referrals come in as they had expected, and they weren't undertaking the work that they were expecting to undertake.
>
> *PHN representative*

RACF engagement in and support of the initiative

As noted in section 4.1.2, RACF engagement was viewed as one of the most important components of an effective service. Unfortunately, PHNs and service providers also considered it to be fraught with some of the most significant challenges they have faced to date. They discussed, for example:

- difficulties in finding the appropriate person to talk to in the first instance
- high staff turnover creating a need to continually engage with and re-educate new staff
- a need to address RACF concerns about their capacity to support the initiative's implementation and the demands it could place on staff
- a perception among some RACFs that their residents are well served by existing programs and therefore do not require additional support
- challenges managing RACF reluctance to have external people onsite due to fear of scrutiny following the royal commission.

These challenges were heightened for service providers without an existing presence within the aged care sector (see section 4.2.2: Facilitators of efficient resource use). COVID-19 added another layer of complexity to engaging and securing support from RACFs, with psychological services not being a priority for a depleted workforce managing acute threats to residents' (and their own) physical health while ensuring basic care needs are met. PHNs and service providers noted that confusion and inconsistencies in RACF visitor policies made access to facilities difficult. We heard, for example, that some RACFs 'just shut the door', while others allowed mental health practitioners onsite only if they were not working in other RACFs (the subsequent need to establish a 1:1 ratio of practitioners and RACFs creating further workforce challenges for service providers).

We also heard that there are practical and logistical barriers to service delivery in RACFs. For example, many lack the infrastructure and resources to make telehealth a feasible alternative to face-to-face support. Others lack appropriately rooms for service delivery (whether in person or via telehealth), with sessions conducted either in a public space or the resident's room. While the latter may be preferable in terms of privacy (assuming the resident has their own room), service providers noted that internet access is likely to be problematic and that some residents may prefer to separate their mental health appointments from their usual environment. Further, RACF timetables – including personal care activities (e.g. set meal and shower times), appointments with other health professionals, and family visits – can mean there is only a small window in which psychological service providers can schedule appointments. Once scheduled, these appointments may be interrupted or cancelled at short notice because of these other commitments. As one service provider representative noted, practical challenges such as these can discourage mental health practitioners from working in RACFs, compounding the recruitment and retention challenges discussed above.

RACF staff knowledge and capacity to support service access and delivery

> " There is nothing worse than a resident wanting to vent and a talk about feelings and you have a staff member in there who is basically watching the clock because they have numerous things to do in that hour. They try to not let that on, but that can be difficult
>
> *RACF staff member*

Representatives of all stakeholder groups commented that RACF staff are integral to effective service delivery. Time and again, however, we heard that there are significant barriers to staff members fulfilling the supporting role that is required or expected of them. Chief among these are time constraints, encompassing and accounting for all other challenges encountered at the RACF staff level and impacting their ability to:

- identify and refer residents in need of support (see section 4.1.3)
- take care of practical arrangements for service provider visits such as organising interpreter services,[24] setting up telehealth devices, and transporting residents to and from onsite appointments
- supplement residents' sessions with mental health practitioners by managing psychosocial needs on a day-to-day basis and supporting residents to implement self-management strategies
- facilitate effective communication with and between the resident's multidisciplinary treatment team.

In addition to directly affecting staff members' ability to carry out the activities listed above, stakeholders also consistently highlighted that a lack of time has an upstream impact by presenting a major obstacle to staff participation in capacity-building activities. Specifically, stakeholders noted a lack of *funded* time to attend relevant training, with uptake instead often relying on staff attending these activities unpaid, in their own time. Some stakeholders also highlighted characteristics of the direct care workforce as a further challenge to their participation in capacity-building activities. For example, these staff often do not have reliable internet access, making it difficult for them to complete online training, and frequently come from CALD backgrounds, meaning that available training may not be delivered in a way that is meaningful to them.

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[24] As explained by one service provider representative, 'accessing interpretive services in the aged care space is problematic. Accessing the service has to come by an RACF provider number. It can often end up in the too hard bucket ... when you start asking RACF clinical teams for a provider number for a service that you have responsibility for they don't quite get it.'

Residents' willingness, capacity and ability to participate in mental health care

Most stakeholders highlighted that the older generation can be reluctant to ask for or accept help in general, and more so when it comes to mental health. For example, one-third of respondents to our resident survey who had not accessed mental health care indicated that this was because they prefer to manage things on their own. We heard frequently that this attitude may reflect high levels of mental health stigma among the RACF population; as one service provider explained:

> We are dealing with a generation who do have huge stigma associated with mental health, and may have seen family members or friends locked up in asylums. That is the association with words such as 'mental illness' or 'mental health disorders'.
>
> *Service provider representative*

Alternatively, or additionally, a reluctance to ask for help may reflect a lack of mental health literacy preventing residents from recognising their concerns as valid and requiring intervention. Some health professionals and RACF staff reflected that one of the greatest challenges to supporting service access is residents' struggle to understand the potential benefits of the support available.

Reluctance to access services can be compounded by cognitive and physical decline, with some residents (18% of those we surveyed who had not accessed mental health care) prioritising physical health over mental health. Additionally, those that do decide to access mental health care might have their scheduled appointments disrupted for example, due to last minute appointments with other services or hospitalisations. Further, cognition and health can change over the course of an episode of care (see also section 4.1.3) so that residents who initially have capacity to participate are unable to complete their allocated sessions.

> If I could see [the mental health practitioner] more, especially when the COVID lockdown happened and she could not come and visit. I could not talk over the phone as English is hard to understand for me.
>
> *RACF resident*

There were further reported challenges in engaging residents and ensuring continuity of care when telehealth services were necessitated due to COVID-19 restrictions, due to factors such as residents' limited IT literacy and reluctance to engage in the service through this means. Sight or hearing impairments and requirements for interpreter services were identified as presenting additional challenges to accessing appropriate mental health care, over and above those experienced by the general resident population.

4.1.7 What impact has the initiative had for participating aged care residents?

> " Coming into aged care is a difficult transition, knowing that it is likely 'the last port of call'. Being able to talk about it has made me re-think; I am not dead yet and still have a lot of living to do and friends to gather and have around me … It's really good to talk about things with someone and not to worry family.
>
> *Aged care resident*

Overwhelmingly, the evidence to date suggests that residents who receive initiative-funded services experience improved mental health. The 1,248 clients with a start- and end-point K10 recorded in the PMHC MDS showed 17.5% improvement on average, from 24.2 to 20.0. Moreover, fewer people meet criteria for moderate to severe distress at the end (23%) than at the start (47%) of care (Figure 4-5). The likelihood of improvement increases with increasing severity of psychological distress at service commencement, reflecting the fact that those with already low levels of distress have less room to improve (i.e. a floor effect; see technical supplement section 5.5).

Figure 4-5: Level of psychological distress among aged care clients at commencement and completion of an episode of care
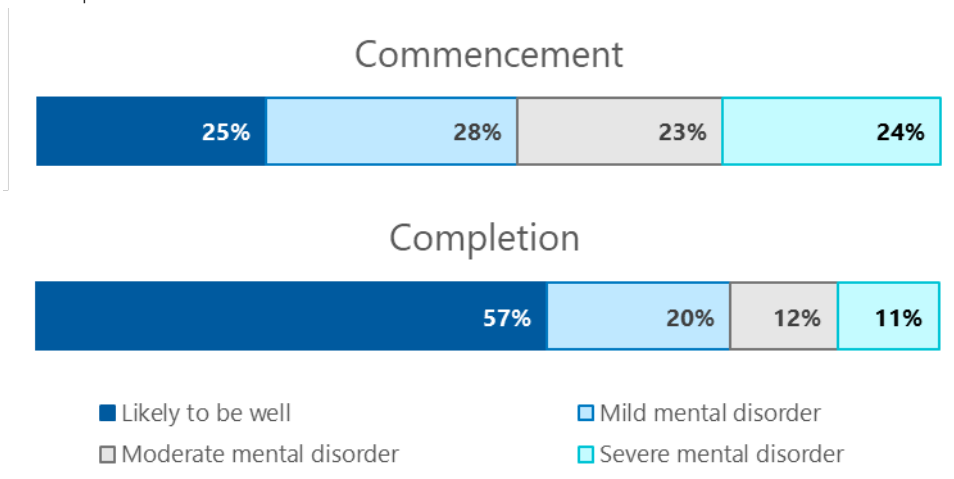
These PMHC MDS data are supported by the experiences of participants in this evaluation. Two-thirds of health professionals, mental health practitioners, and service provider managers we surveyed, and 78% of residents, indicated that the initiative has improved residents' mental health. Further, 93% of residents were satisfied or very satisfied with the service they received.

In interviews, stakeholders expanded on the initiative's positive impact for participating residents. They cited quantitative improvements on measures of anxiety and depression, adjustment, loneliness, and quality of life. Across the board, however, interviewees were strongly of the opinion that it is difficult to establish the true impact of the initiative through quantitative data. The K10 was viewed particularly negatively in this regard, with service providers reporting that it is unsuitable for the resident population due to its length and the inclusion of items that can be problematic for older people (e.g. those related to tiredness, worthlessness).[25] Some reported using alternative measures (in addition to or instead of the K10) and felt that, administered appropriately, they can provide meaningful data to inform service delivery.[26] However, we heard consistent requests for further guidance on which tools are appropriate or recommended for the RACF cohort, noting that Australian norms for the K10 relate to community-

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[25] Real or perceived difficulties with administering the K10 may go some way to explaining the low proportion (14.5%) of PMHC MDS clients with completed outcome data

[26] Examples include the K5, Assessment of Quality of Life instrument, Brief Adjustment Scale, Cornell Scale for Depression in Dementia, Generalised Anxiety Disorder scale, Geriatric Depression Scale, Health of the Nation Outcome Scales (65+ version), Montgomery-Asberg Depression Scale, Pain Intensity Measure, Patient Health Questionnaire (4-item or 9-item version), Psychogeriatric Assessment Scale, Session Rating Scale, UCLA Loneliness Scale, and WHO-5 Wellbeing Index.

dwelling individuals aged 85 or younger (Slade et al. 2011).[27] Some PHN and service provider representatives also discussed the issue of benchmarking and what 'effective' means in the aged care population, noting that symptom improvement may not always be an appropriate goal. In some cases, preventing deterioration may be more apt, and as one service provider commented, 'when we talk about benefits, we need to understand that this is not a recovery program, this is a quality-of-life program'.

It is clear, then, that K10 and other structured assessments (including experience measures such as the Your Experience of Service survey) tell only part of the story. Interviewees provided feedback from residents, family members, GPs and RACF staff to support a richer understanding of the initiative's impact, and highlight meaningful impacts such as residents:

- experiencing decreased stigma and more willingness to discuss emotional issues with those around them
- participating more actively in RACF life, for example spending more time out of their room and joining in group activities
- displaying fewer disruptive behaviours
- having improved relationships and less conflict with other residents and staff
- being happier
- being able to reduce their use of psychotropic medications
- resolving issues and concerns before they pass away.

We also heard that seeing these benefits provides positive reinforcement for GPs and RACF staff, who are then more likely to refer other residents to the service, enabling further benefits to be realised, and so on.

The initiative has had a positive impact for residents with different personal and situational characteristics

RACF staff and service providers recounted stories of positive effects for residents from different groups such as those from Aboriginal and/or Torres Strait Islander or CALD backgrounds, and those in palliative care. One service provider reflected that the positive impacts of the service for men had come as a surprise given 'the stereotype of the older male not wanting to talk'. Many PHNs and service providers also commented that the initiative has been especially helpful in supporting older people who have recently moved into residential care, while others felt it has been invaluable for those isolated from friends and family during to COVID-19 restrictions.

Stakeholders highlighted that, as with any service, there are individual differences in the degree to which residents experience benefits from the initiative. We only heard of 2 groups who may experience systematically different, and, specifically, time-limited outcomes; namely, residents with cognitive impairment, and those living in an RACF where staff are unable or unwilling to support them between sessions or after they finish an episode of care. PHNs and service providers felt that residents from these groups are likely to experience benefits in the short term that are not maintained.

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[27] This age cut off is also the average age of clients receiving psychological services in aged care; see technical supplement section 5.1.

A little can go a long way in improving residents' mental health

> We have heard generally that people have felt a lot better and just being listened to is helpful. One lady just didn't want to be in the RACF and just being able to talk about that was very helpful.

Service provider representative

Stakeholders identified that the reason residents benefit from the initiative is service providers' ability to consider residents' overall wellbeing and deliver supports that are appropriate to their needs. As discussed in section 4.1.2, this does not always mean providing psychological therapy in the traditional sense, although some residents did comment that they had learned strategies to address sleep, anxiety, and grief. More often, however, we heard that the initiative's impact comes from simply providing residents with someone to talk to. Many stories highlighted how tailored low-intensity approaches can result in meaningful improvements in mental health and quality of life, even for residents with long-term illness or high levels of distress. Examples include conducting 'walk and talk' sessions for restless residents, supporting residents to reconnect with family, and in one case, organising a tablet so an Indigenous resident could stay in touch with their culture by listening to Indigenous music.

> We had an individual in our dementia facility, while his wife was at another facility. She never came out of her room and was losing weight. Then I arranged for her to come over here when a bed became available … every day the service provider is here she takes the wife to see him and [there has been such a positive difference] just from getting them back together.

RACF staff member

> If you looked at [this resident] clinically you would have thought that they were clinically depressed, but the change which happened by just introducing that regular contact with their family overseas… they were a completely different person as a result of this.

RACF staff member

Some residents – especially those from special needs groups – are not benefiting from the initiative due to inequitable service availability

While residents who have had the opportunity to participate in the initiative have experienced a wide range of benefits, it is also true that many residents have not had this opportunity. For most stakeholders, issues of equitable access to care are more apparent *across* RACFs rather than *within* them. That is, assuming an RACF has enrolled in the initiative, there was a belief that most residents will have the opportunity to access and benefit from support.

However, as highlighted in section 4.1, the initiative has not yet been rolled out to all RACFs. In an important technicality, some PHNs have refined their eligibility criteria to specify that residents must live in a 'participating RACF'. It is likely that there are some systematic differences between participating and non-participating RACFs meaning that this criterion disproportionately affects residents from aged care special needs groups.[28] For instance, several PHNs and service providers noted that they had either not targeted, faced difficulties engaging, or specifically excluded RACFs in

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[28] There are 9 special needs groups specified in the *Aged Care Act 1997*: Aboriginal and Torres Strait Islander people; people from culturally and linguistically diverse backgrounds; people who live in rural and remote Australia; people who are financially or socially disadvantaged; veterans; people who are homeless or at risk of becoming homeless; care leavers; parents separated from their children by forced adoption or removal; and lesbian, gay, bisexual, transgender and intersex people. In this evaluation we expanded this list to include older people with disabilities, reflecting their status as a special needs group within the My Aged Care system.

rural or remote areas or those that have a high proportion of residents from Aboriginal and/or Torres Strait Islander, CALD, or low socioeconomic backgrounds. On the other hand, a forthcoming telehealth-only model in one PHN is designed to ensure RACFs and residents have equitable access to the initiative regardless of their geographic location.

While inequities in service availability *within* participating RACFs were generally seen to be less of a concern, some stakeholders did express unease about the extent to which members of special needs groups have the opportunity to access initiative-funded services:

- People from CALD backgrounds were consistently identified as being the most likely to miss out on initiative-funded care,[29] due to many the challenges discussed in section 4.1.6. To improve the availability of services for these residents, some service providers have recruited bilingual mental health practitioners to specifically target CALD communities in their region (and in fact, are contractually obligated to do so in some regions).
- Aboriginal and/or Torres Strait Islander people and veterans were less likely to be referred for support available under the initiative, due to a preference or perceived requirement among referrers to direct these residents to Aboriginal mental health and DVA-funded services, respectively.[30]
- People with disabilities were seen to potentially fall through the cracks, particularly those who are younger than other aged care residents and may therefore be ineligible for or unsuited to care available under the initiative.

Peak bodies in particular noted that special needs groups tend to be disproportionately affected by mental illness and have unique needs that are not well recognised in aged care. As such, they may be differentially impacted by problems of low mental health literacy, demanding referrer workloads, and limited awareness and understanding of the services available under the initiative (discussed in section 4.1.3) and therefore at risk of higher than average rates of inappropriate non-referrals.

Even if a referral is made, mental health practitioners with an understanding of or specialisation in topics pertinent to the care of members of special needs groups may not be available, resulting in inequitable access to **appropriate** services. We heard repeatedly of the impact of trauma on the groups above as well as care leavers and members of the LGBTIQ+ community, and the need to ensure that both aged and mental health care are trauma-informed.

> Some groups of residents would have challenges [accessing care under the initiative]. But it is true of all psychological services in general; the issue is that there aren't many providers in the whole country that specialise in CALD issues.
>
> *Health professional*

Of course, while it is critical that all initiative stakeholders address service gaps to the extent possible, it is important to note that their ability to ensure all residents can access mental health supports is constrained by the limitations of the health and aged care sectors more broadly. People living in rural and remote areas of Australia, for example, have disproportionately poor access to and outcomes of health care across the board. As such, residents' need for improved access to psychological services cannot be realised through initiative funding alone.

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[29] PMHC MDS data provides some support for this; see Figure 5-4 and Table 5-11 in the technical supplement.

[30] While this may reflect resident preferences and/or a desire to connect these residents with more specialised support (as discussed below), in some cases it appears to reflect a misunderstanding of these residents' eligibility for PHN-funded services.

4.2 Has the initiative been implemented efficiently?

Feedback from PHNs and service providers suggests that the initiative has not been implemented as efficiently as may have been hoped, with service provision delayed and/or disrupted in many regions due to mental health workforce shortages, challenges with engaging RACFs (see section 4.2.2), and of course COVID-19. After a slow start, however, services are gaining momentum and delivering more services to more residents as time goes on (Figure 4-6). As one PHN representative noted, the number of service contacts per client 'is [now] relatively consistent with our other mild to moderate mental health services. It has just taken a long time to get there.'

Figure 4-6: Number of residential aged care clients and service contacts across all PHNs, from 2018 to 2021
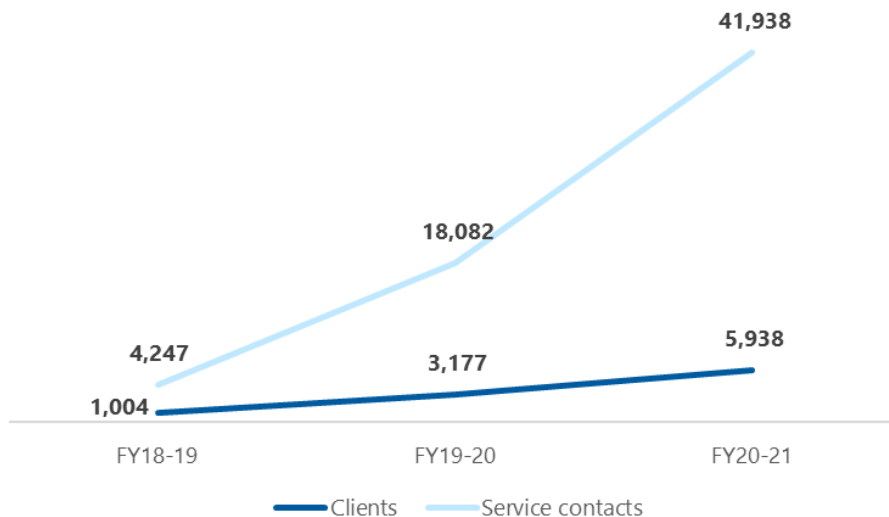
4.2.1 Which approaches are cost-effective?

Between 1 July 2018 and 30 June 2021, PHNs received a total of $48.2 million in initiative funding. During that time, 10,119 aged care residents received 10,551 episodes of care, delivered over 64,627 service contacts; an average spend of $5,027 per client, $4,833 per episode of care, and $944 per service contact. These averages, however, mask steady improvements in the cost of service delivery as the volume of services grows, as demonstrated in Figure 4-7. Note that this is a relatively blunt analysis that likely overestimates the true cost of delivering support to aged care residents as it includes all funding (i.e. planning, establishment and operational costs as well as those associated with service delivery) but only a subset of residents receiving services (as not all clients provide consent for their PMHC MDS data to be released).

Figure 4-7: Number of, and average cost per, service contact, across all PHNs from 2018 to 2021
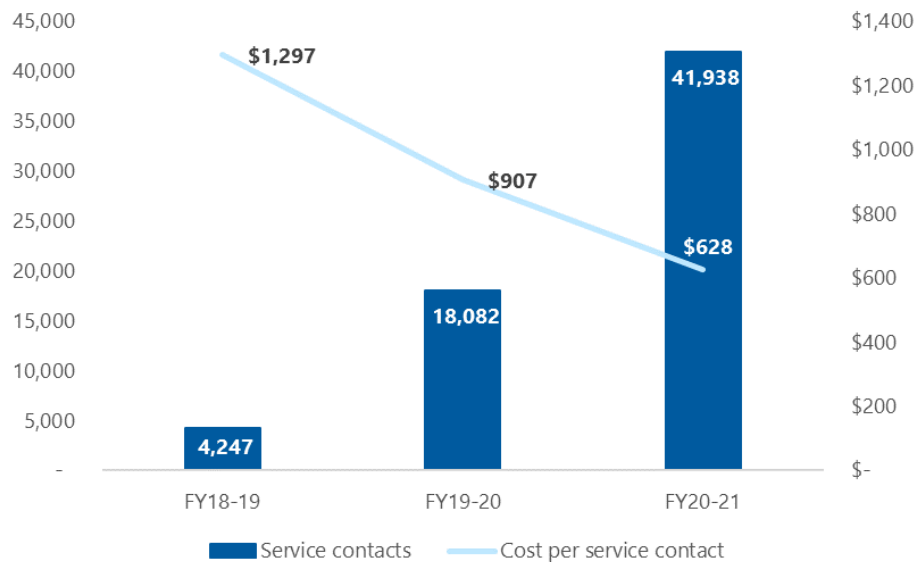
Given the similarity of service models across most PHNs and limited available data, it is difficult to determine whether one approach is more cost-effective than another.[31] However, it is worth noting that the 4 PHNs with the lowest cost per service contact share a service provider (for details, see technical supplement section 5.6). Services in these regions may be more cost-effective for 2 key reasons. First, there are likely economies of scale being realised through reduced duplication of resource development, communications and marketing, clinical governance and supervision arrangements, and administrative burden associated with meetings and reporting. Second, services in these regions are delivered primarily by provisional psychologists who are likely to be on lower salaries than their fully registered counterparts, enabling more practitioners to be engaged for the same cost. At the same time, these regions also tend to demonstrate lower than average improvements in psychological distress (ranging from 0.1 to 3.8 points on the K10, compared to the national average of 4.2 points), suggesting there may be a trade-off between efficient and effective service delivery.[32]

The relationship between volume and cost-effectiveness was picked up in interviews, with PHN representatives and service providers commenting that not only is it important that the service provider can cater to multiple RACFs, but that these facilities have a sufficient number of eligible residents to make doing so worthwhile. Of course, economies of scale are a luxury not available to all PHNs, and it is not surprising that those with a higher cost per service contact are those with a large rural footprint. Given that several PHNs with large rural footprints that are yet to record any RACF-based services within the PMHC MDS are taking different approaches to implementation (e.g. telehealth-only model versus engaging local providers), it will be interesting to explore the costs and benefits of these in future.

> The only way that this service model was ever going to work was ... on volume. If you have 7 clients booked in for a day to make it financially viable to go to the facility and deliver the service, and then you find that 3 or 4 are out of scope ... there is a significant financial loss to the service delivery company.
>
> *Service provider representative*

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[31] Although one GP felt that low-intensity services may represent poor value for money if they are available through other channels.

[32] Note that we are unable to explore this issue in depth due to the structure of the PMHC MDS meaning that it is not possible to compare K10 outcomes across different practitioner types. Of course, change in K10 scores is only one measure of effectiveness, and may be an artefact of the different client groups served and interventions provided by different practitioner types. Thus, this metric should not be interpreted to mean that one practitioner type is universally more or less efficient or effective than others; rather, the key consideration is that service models incorporate the type and volume of practitioners that is required to meet resident need.

4.2.2 What are the key factors that impact efficiency?

From our consultations, it is clear that resources have primarily been directed towards implementation activities such as service design, commissioning, and establishment, including RACF engagement. Direct service provision has represented only a proportion (perhaps even a minority) of initiative-funded activities to date, and a small number of PHNs noted that delays in service delivery have led to an underspend of funds. As services become established and PHNs and service providers learn more about what works and what does not, efficiency is likely to improve over time. In the context of this learning curve, we heard of both challenges and facilitators to the efficient use of resources within the initiative, as outlined below.

Challenges to efficient resource use

> Maintaining engagement with facilities is a massive part of our job. It takes up, for a team leader, around 60% of their time.
>
> *Service provider representative*

While RACF engagement and capacity building are critical components of effective service models (see section 4.1.2), stakeholders identified that these activities are also highly resource intensive, with potential inefficiencies associated with:

- staff turnover, meaning these activities frequently need to be repeated
- RACFs' corporate structures, which can mean that memoranda of understanding (MoUs) take several weeks to work their way through the approval process
- the ease with which the service provider's mixed workforce (e.g. a psychologist, social worker, and peer worker) can be incorporated into RACFs' understanding of (and presumably, processes for working with) allied health staff.
- the development of resources and training for RACF staff on issues such as how to book interpreters and use telehealth. While there is no doubt these resources are essential to the effective delivery of services under the initiative, knowledge and skills in these areas are also integral to resident care more broadly and may be more appropriately addressed through the implementation of broader aged care reforms.

Also contributing to the potential inefficient use of resources is the substantial duplication of effort associated with PHNs or service providers in different regions independently developing staff and client resources that are doing 'the same thing in different ways'. This includes developing an initiative 'brand', with several stakeholders noting that the title 'Improved Access to Psychological Services in Aged Care Facilities initiative' is not meaningful or memorable for participants. As one PHN representative put it, re-branding has been 'a painful process … the Commonwealth is paying for our time to do this, and if they'd just given us a simple name, we could have just gotten on with it'. Not only does the development of region-specific brands represent an inefficient use of resources in and of itself, but it also risks additional inefficiencies associated with challenges in promotion and awareness raising (as discussed in section 4.3).

The efficient implementation of the initiative has been further impacted by recruitment and retention challenges within PHNs themselves, in addition to those experienced at the RACF and mental health practitioner levels (see section 4.1.6). Several of the PHN representatives we spoke to were relatively new to the initiative and not only required time to familiarise with themselves with the service model and build relationships with key stakeholders, but were often unfamiliar with activities conducted early in the initiative's lifespan suggesting the potential for inefficiencies associated with revisiting old ground.

Facilitators of efficient resource use

" The initial set up of getting the services established was quite quick. We were lucky to have interested providers and providers with capacity to deliver those pilots, as well as pre-existing relationships with RACFs. As such, we could establish that pilot program quickly which then gave us additional time to go through the commissioning process.

PHN representative

While sources of potential inefficiencies were common, we also heard examples of factors that have contributed to a more efficient use of resources. Chief among these is PHNs' re-commissioning of existing psychological service providers, affording significant efficiencies through established local networks and service linkages, familiarity with PHN reporting requirements, and in many cases, capacity to deliver higher or lower intensity care if required. Some PHNs noted that their service provider had already delivered similar services in RACFs and was able to leverage this experience to rapidly establish a workforce and roll out the initiative in RACFs, whether as part of a small scale pilot or region-wide solution. Others confirmed this from the other direction, noting that the rollout and uptake of the service was delayed where providers lacked existing relationships and trust within the aged care sector. Similarly, PHNs that had more aged care experience felt that this enabled them to quickly develop their approach to the initiative, for example by drawing on existing RACF relationships and co-design information, and adapting existing aged care programs to include more of a mental health focus.

4.3 Has the initiative been communicated effectively?

" I'd say that there's 80% of facilities and GPs that don't know about the service.

Service provider representative

Overall, it appears that awareness of the initiative's introduction and the services available remains relatively low across the health and aged care sectors. Indeed, a number of peak body representatives we spoke to had not heard of the initiative prior to being invited to contribute to this evaluation, while others had discovered it through their own research. None had received communication directly from a PHN. Feedback from both peak bodies and PHNs indicated that raising awareness of the initiative in a meaningful way on a national scale is made difficult by the lack of a recognisable name or singular brand (see also section 4.2.2). It is known, for example, in different regions as the *Continuing to Be Me*, *Supporting Emotional Wellness in Aged Care*, *Emotional Wellbeing for Older Persons*, and *Psychology in Aged Care Well-being* programs, to name just a few. Tellingly, one peak body representative indicated they were unaware of the initiative, but went on to discuss their involvement in one of the programs named above. Thus, apparently low awareness of the initiative may simply reflect the fact that stakeholders know it by different names.

We also heard that in several regions, communication about the initiative has been restricted to the RACFs that the service provider has capacity to serve, with several PHNs and service providers indicating that they do not actively promote the service as they are concerned about creating demand that cannot be met. Limited awareness of the initiative among sector stakeholders and the community at large may therefore be an artefact of this more targeted promotional approach. On the other hand, several PHNs and service providers reflected that they have engaged in, as one representative put it, 'an exceptional amount of marketing', but have not seen this translate into RACF or resident participation (due to some of the barriers outlined in section 4.1.6). On this point, it is worth noting

that more than 40% of the residents we surveyed were unaware of a program to support mental health in their RACF, despite, by definition, their RACF being involved in the initiative.

> " This service should be advertised better and more clearly because I didn't know about it before.
>
> *Aged care resident*

It appears there is also room to improve communication to residents who are referred to initiative-funded services, with half indicating that they received insufficient information about what to expect from being referred to the service. Importantly, members of special needs groups were less likely to feel they had all the information they required. Of course, it may be that residents receive information about the service but cannot recall doing so, due to memory lapses or differences in how the service is referred to or explained. Either way, the evidence suggests that communication is often not meeting residents' needs.

4.3.1 How has awareness of the initiative been raised, and what has worked well?

> " The marketing is something that we assist the provider with, however, it is not something that the PHN takes carriage of.
>
> *PHN representative*

We found that service providers are primarily responsible for actively raising awareness of the initiative, with their communication strategies and materials subject to PHN approval. Although the department's guidance outlines the expectation that PHNs communicate with RACFs about the initiative, in practice PHNs are unlikely to have direct contact with RACFs after the initial pilot phase. Rather, they contribute to awareness raising primarily by distributing information to GPs and health professionals. PHNs' co-design workshops in the early stages of the initiative were also seen to be extremely useful in distributing information to all relevant stakeholders and facilitating inter-agency channels of communication.

While not common, we did hear from some PHNs that they had attempted to raise the profile of the initiative among the general community through traditional media, including appearances on local radio and a public launch event at an RACF. It is also worth noting that both PHNs and service providers have made information about the initiative available on their website and social media pages. However, direct contact with relevant stakeholders was seen to be a more effective means of raising awareness of the service than these broad-brush approaches, at least initially. PHNs and service providers noted that as services gain traction, the need for active promotion decreases and RACFs and GPs play a greater role in raising awareness of the initiative through their networks.

Below we consider common pathways by which health professionals, RACF staff, and residents and their families and friends are made aware of the support available under the initiative, and the effectiveness of these. Communication with other key stakeholders including OPMH services is discussed in section 4.1.4.

Communication with health professionals who visit RACFs

About half of the health professionals that responded to our survey indicated that they first became aware of the initiative via communication from their PHN; others tended to learn of it through an RACF or a service provider, although there were some reports that GPs found out about it through their own research.

To raise awareness of available services among health professionals, and particularly GPs, PHNs typically provide information via the regular (e-)newsletters they distribute to health professionals in their region, and adding information about initiative-funded services to HealthPathways (an online information portal for GPs and other primary care clinicians). In addition, some PHNs indicated that they take the opportunity to introduce the initiative when presenting to GP meetings, and that GPs on their clinical council assist by promoting the service to their colleagues and networks.

Service providers considered that activities that work best are those that involve direct contact: presenting at regular meetings of local GPs and other health professionals, collating a list of GPs and contacting them individually, talking to GPs that are already known to the provider through other programs, or taking the opportunity to meet new GPs while onsite at participating RACFs. The effectiveness of less direct approaches such as distributing written resources (e.g. posters or pamphlets outlining the service and referral process) to general practices, was unclear.

Communication with RACFs

When thinking about how best to promote services to RACFs, PHN and service providers noted success with highlighting the value of the service to residents, the minimal impact on staff workloads, and the support available to staff to develop knowledge and skills to manage their own mental health as well as that of their residents.

As noted above, service providers, rather than PHNs, have been largely responsible for communication with RACFs. Indeed, all RACF staff we spoke to indicated they had only had contact with the service provider and some commented they were unaware what other services a PHN might offer. However, some PHN representatives noted that they had taken the opportunity to promote the initiative during regular meetings with aged care providers or communication with RACFs about other PHN programs (e.g. flu or COVID-19 vaccination rollout, RACF staff wellbeing program).

Consistent with their approach to raising GP awareness of the support available, service providers reported contacting RACFs individually, either building on their existing relationships with RACFs, introducing themselves to new sites via phone or email, or seeking GP support to facilitate these introductions. Most service providers indicated that their organisation provides RACFs with both verbal and written communication about the initiative. Although they are initially likely to establish a single point of contact with an RACF (typically someone in a management role), both they and RACF staff noted that this leaves the service vulnerable to staff turnover.

As noted in section 4.1.2, identifying a staff champion to take responsibility for awareness raising within participating RACFs can be highly effective, but is not a strategy in widespread use. Instead, service providers conduct the majority of this work. They do so through tailored approaches including meetings and training sessions, ad hoc conversations with staff on the floor, and provision of posters, flyers, and/or brochures similar to (or the same as) those distributed to general practices. Service providers also reported a range of creative approaches to promoting their service to and within RACFs, including developing an informational video, and doing 'small promotional things like stress balls, water bottles with our name on them, [or] self-care cards that we hand out to staff'. Importantly, although one PHN reflected that the CALD background of RACF staff is a key consideration when delivering training and education, we did not hear any specific examples of how communications are adapted as a result.

Communication with RACF residents and their families

The residents we surveyed were most likely to have been told about the availability of mental health support by a member of RACF staff (n=60; 46%), with GPs and health professionals playing a relatively minor role despite being the next most common source of information (n=19; 15%). This finding highlights the importance of ensuring staff understand their role in promoting the service, with several PHNs commenting that it can be helpful for MoUs to define awareness raising responsibilities[33] and expectations for these to be addressed in new staff training.

It is also evident that staff must have the information they need to communicate effectively and consistently with residents and their families. However, this information may not always be available; one nurse commented that 'I don't have any pamphlets or any of the old-fashioned communication tools that I would have liked to give to residents'. Residents also indicated a need for more information about the service they are referred to, and few were aware of printed information about the initiative in their RACF. Thus, effective communication requires not only the existence of written resources, but their availability in ways and locations that people normally access information within the RACF. Some PHNs also reported that their service providers have developed newsletters and run face-to-face information sessions for residents and family members, and found these to be effective ways of raising awareness of the initiative.

Among respondents to our resident survey, awareness of available mental health supports was similar in those who identified as a member of a CALD community (53%) and those who did not (57%). A small number of PHNs, service providers, and RACF staff commented on whether and how available supports were promoted to residents from diverse backgrounds. Some noted that this has not been a major consideration as RACF residents in their region tend to be less culturally diverse than the general population. In regions with greater diversity, approaches to communication most commonly involved advising RACF staff on how to access translation services, or utilising bilingual mental health practitioners where possible. We also heard isolated examples of strategies such as utilising Aboriginal artwork designs on information sheets to engage residents from Aboriginal and Torres Strait Islander communities, connecting with local community groups when residents from different backgrounds arrive at an RACF, and developing fact sheets in different languages.

RACF staff, service providers, and PHN representatives alike commented that to communicate effectively with residents and their families, it is important to promote the initiative as an emotional support program, rather than a psychological or mental health service, to address the barrier of stigma (as discussed in section 4.1.6). This was perceived to be particularly important for residents from CALD backgrounds, with several peak bodies highlighting that the words and concepts used to describe mental health may not translate well for residents from other cultures.

> The mental health care ladies were very sympathetic and understanding. They did not use verbal expressions that I couldn't understand.
>
> *Aged care resident*

Finally, clearly communicating that services are free may also help to improve engagement with the initiative, with one provider commenting that residents and families are often surprised to hear that there is no payment required, and some residents who had not accessed mental health care reporting that this was because they were worried about the cost.

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[33] In one region, MoUs contain a requirement that RACF newsletters include information about the initiative.

4.4 Has the initiative resulted in any unintended consequences?

Few stakeholders identified any potential or actual unintended consequences of the initiative. Those that did raised both positive and negative consequences for the different stakeholder groups involved in the initiative's implementation.

For many PHNs and service providers, there is a concern that the initiative has created an unsustainable workload and funding model, with some service providers running the program at a financial loss. One peak body also suggested that there is a potential risk to residents' psychological safety should the funding be discontinued. In areas where demand outstrips the capacity to deliver services, PHNs were concerned that RACFs' expectation that services would be equitably available nationally could result in reputational damage to PHNs and negatively impact their relationships with RACFs. On the other hand, several PHNs reported that the initiative has had a positive effect on their relationships with service providers and RACFs, and for some, has provided an opportunity to establish new relationships and better understand the service landscape in which they operate.

Some stakeholders discussed the potential consequences of services under the initiative being delivered by an inexperienced mental health workforce. For example, peak body representatives noted that residents may not benefit from the care provided by mental health practitioners lacking appropriate training in older people's mental health; leading residents and practitioners alike to believe that psychological services are not relevant or appropriate for the RACF population. One representative commented that mental health practitioners may abandon the initiative as a result. We also heard from some service providers that high client mortality rates can be confronting for mental health practitioners who are new to the RACF space, presenting an additional threat to job satisfaction and practitioner wellbeing. On a more encouraging note, stakeholders cited positive outcomes for the mental health workforce such as the introduction of new pathways for workforce development, particularly in rural areas, including expanded opportunities for student placements and provisional psychologists.

For RACF staff, unintended consequences of the initiative were generally perceived to be positive; they include increased job satisfaction knowing that residents have someone to speak with about their mental health concerns, and broader organisational change brought about by mental health practitioners supporting residents to provide feedback on issues of concern. We also heard that the initiative has prompted greater use and awareness of telehealth, with some service providers commenting that they have been able to support this in tangible ways:

> RACFs are renowned for poor IT infrastructure. We have been able to help move this along because we have wanted to use telehealth. In [one region] we have 13 computers on wheels located in facilities and we have 6 in [another] … an unintended consequence is that the facilities have these [computers] to use for relatives and clients.
>
> *Service provider representative*

Finally, although several staff members and other stakeholders identified that the initiative has reduced staff workloads (e.g. with less time required to manage challenging behaviours), we also heard that there is the potential for additional work associated with supporting access to and delivery of services, as discussed in section 4.1.6.

5 Recommendations

This chapter addresses evaluation question 5, providing broad recommendations and specific actions to enhance the initiative and better support aged care residents' mental health.

Key points

- Our findings present clear opportunities to enhance the initiative and improve access to and delivery of psychological services that meet RACF residents' mental health needs.

- Drawing on the wealth of data available for this evaluation, we have identified 9 overarching recommendations for future development and provide specific actions within each for the department, PHNs, and service providers.

- Out of scope for this evaluation, but no less important in shaping the future design and delivery of psychological services in aged care, is the need to address systemic challenges facing the mental health and aged care sectors (e.g. those related to workforce recruitment and retention, and training).

In highlighting the importance of improving access to timely and appropriate mental health care for aged care residents, this evaluation gives rise to the following recommendations:

1. Extend and expand funding to enable the initiative to realise its objectives
2. Foster integration and collaboration among all relevant stakeholders
3. Publicise the availability of psychological services in aged care
4. Encourage and support RACF participation
5. Build RACF staff capacity to support service delivery and residents' mental health
6. Clarify eligibility criteria and referral and assessment protocols
7. Match service offerings and the workforce that delivers them to resident need
8. Generate evidence of the impact of psychological services in RACFs
9. Share information to reduce inefficiencies and support continuous improvement.

Below, we discuss each of these recommendations in turn and define the specific actions that will support their implementation. The full list of recommendations and actions is also provided in Appendix A for ease of reference. Our recommendations are designed to capitalise on the progress made towards achieving the initiative's objectives, and overcome some of the challenges encountered to date. Importantly, they are intended to be feasible for those directly involved with the initiative to accomplish. As such, we recognise that these recommendations represent only part of the puzzle of optimising mental health care in RACFs. Aligning this initiative with broader efforts to improve other health and basic care needs will not only generate efficiencies, but will also prevent mental health from being siloed and de-prioritised. We note, for example, that stakeholders' requests for a greater emphasis on (and paid and mandated) training for RACF staff may be addressed, at least in part, by the forthcoming aged care skills development program (Department of Health 2020).[34]

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[34] Other measures introduced in response to the royal commission's recommendations may go some way to addressing other suggestions for sector reform such as the need for RACFs to: be adequately resourced; have appropriate infrastructure in place to support telehealth; provide an environment that is conducive to good mental health; and better utilise allied health professionals to deliver holistic care.

Stakeholders also identified a number of areas of development for the mental health sector that are beyond the scope of this initiative or evaluation to address. For example, they suggested that:

- universities should be encouraged to build a pipeline of mental health practitioners able and willing to work in RACFs
- professional colleges could introduce continuing professional development activities to encourage their members to undertake extra training in psychogeriatrics and working in RACFs
- rural workforce initiatives (e.g. the Allied Health Rural Generalist Pathway) should place a greater emphasis on retaining experienced mental health practitioners in rural areas
- the department should explore options to enable PHNs funding to be used to cover Better Access gap fees. We note also that the current evaluation of Better Access may deliver recommendations that have implications for the future design and delivery of this initiative.

5.1 Extend and expand funding to enable the initiative to realise its objectives

> Due to challenges in 2020, the true implementation of the program has only been able to commence in 2021.
>
> *PHN representative*

First and foremost, the evidence collected in this evaluation suggests that support for the initiative's introduction and continued operation is ubiquitous. It is clear too that improving residents' access to psychological services is a complex, multifaceted activity, and that PHNs' and service providers' ability to meet this objective has been significantly hampered by circumstances beyond their control. As a result, it has had less time to mature than the 4 calendar years since its introduction would suggest. As one PHN representative reflected, 'the full benefits of the program will only start to be achieved by 2022 and therefore, there is a need for funding to continue beyond this date.' Residents and RACF staff indicated high levels of satisfaction with the services currently available; their most common suggestion for the future was to scale them up so that more residents can access support more often.

Actions for the department:

- Commit to extending the initiative beyond June 2022.
- Consider expanding funding to enable PHNs to scale up the services available, in terms of the number of RACFs and residents that can take part and the geographic areas serviced.
- Consider expanding funding and clarifying funding rules to accommodate the varied activities required to implement the initiative, beyond direct service delivery.
- Consider increasing rural loadings to account for costs involved with engaging and servicing highly dispersed RACFs, and to attract and retain mental health practitioners.

Actions for PHNs:

- Extend service provider contracts to support workforce retention and provide RACFs with confidence in service continuity.
- Explore block funding or other alternatives to fee-for-service funding arrangements (if not already in place) to ensure service providers are remunerated for all aspects of the initiative, including but not limited to direct service delivery.

5.2 Foster integration and collaboration among all relevant stakeholders

> " I think that it is a missed opportunity for this initiative not to be connecting with advocacy organisations, both in terms of shaping [the initiative] to be something useful and beneficial, but also in terms of linking people to the service.
>
> *Peak body representative*

There was general consensus that PHNs are the appropriate organisations to implement the initiative, given the importance of ensuring regional capacity to understand and respond to local needs and services. At the same time, stakeholders identified that PHNs cannot fulfil this role alone, and that there is a need for greater integration and collaboration between and across key stakeholders including Commonwealth and state and territory governments, the aged care and mental health sectors, GPs and other health professionals, dementia services, and services for and representatives of special needs groups. We heard that PHNs vary in their awareness of and relationships with these stakeholder groups (particularly those representing special needs groups) and that there may be a role for the department in facilitating their engagement.

Actions for the department:

- Liaise with other relevant government departments (e.g. Department of Veterans' Affairs, Department of Social Services) and organisations with a national footprint (e.g. peak bodies) to discuss how the initiative might link with other services available for the groups they represent.
- Support or encourage PHNs to develop new partnerships with key stakeholders known to the department (e.g. members of sub-committees).

Actions for PHNs:

- Foster a culture of internal collaboration, to prevent the initiative being siloed from the PHN's other aged care activities and the organisational expertise they generate.
- Ensure that local service mapping takes into account non-mainstream services that residents from special needs group may prefer or be more appropriately served by (e.g. Aboriginal or LGBTIQ+ community-controlled organisations).
- Seek to maintain stakeholder engagement in the initiative and seek input into implementation and communication on an ongoing basis, rather than as a once-off start-up activity.
- Seek opportunities to embed the initiative within the local service landscape by actively supporting networking between service providers, other relevant services, and GPs.

5.3 Publicise the availability of psychological services in aged care

> At the beginning, service providers came back to us saying that they couldn't get their foot in the [RACF] door, but then we also couldn't get our foot in the door as the RACFs didn't know what a PHN was. That was an interesting dynamic and I wondered if the initial communications should have come from the Department of Health.
>
> *PHN representative*

To date, efforts to raise awareness of the initiative have been relatively small scale, with PHNs and service providers investing significant energy in direct communication with individual stakeholders, many of whom were unfamiliar with their organisation and its relationship to aged care. They noted that in contrast, the department has established channels of communication with all aged care stakeholders including RACFs and could use these to promote the initiative nationally. Although challenges with a lack of nationally consistent branding were identified, abandoning regional solutions at this stage may create further inefficiencies and confusion; instead, it may be desirable to ensure that both nationally consistent and regionally specific information are easily found online. Further, some stakeholders highlighted that low awareness of psychological services for aged care residents is not limited to the initiative. We heard several calls for wider promotion of the Better Access aged care expansion, more information about its relationship to the initiative, and clarification of whether individual residents can access support under both funding streams.

Actions for the department:

- Work with aged care team(s) within the department to develop and implement a communications strategy for the aged care sector, using established channels of communication (e.g. Bulk Information Distribution Service).
- Liaise with other government departments and organisations with a national footprint to discuss how best to raise awareness of the initiative among the groups they represent, including health professionals and aged care residents and their families.
- Consider developing and promoting a central website for the initiative, potentially including a directory of services (or links to PHN websites) to enable interested parties to quickly find information relevant to their region.
- Develop information explaining the similarities and differences between the initiative and the Better Access aged care expansion, to support RACF staff, GPs, and residents and their families to understand why and how each may be utilised.
- Consider making centralised information and resources about the initiative available in multiple languages, using culturally appropriate terminology.
- Explore options to support PHNs to develop culturally and linguistically appropriate information and resources.

Actions for PHNs and/or service providers:

- Ensure information about the initiative can be easily found on PHN and service provider websites.
- Engage with local representatives of special needs groups (including residents themselves) to co-design regionally appropriate promotional and information materials.

5.4 Encourage and support RACF participation

It is evident from this evaluation that the availability of psychological services for aged care residents does not, in and of itself, translate into improved access to these services. The importance of ensuring RACF buy-in to the initiative, and the resources required to achieve this, are potentially understated in current guidance. There is also a need to better understand the initiative's reach across different regions; at present this is difficult due to inconsistency in how PHNs define 'participating' and 'eligible' RACFs differently. However, regardless of how the numerator or denominator are defined, PHNs and service providers have experienced significant challenges in making inroads to RACFs. Department-led communications could go some way to addressing these by clarifying expectations of participation (in addition to raising awareness of the initiative more broadly, as suggested in section 5.3).

It is important too to ensure that PHNs and service providers are adequately resourced to for both the initial work involved in engaging RACFs in their region, and the ongoing support required to ensure smooth and effective service delivery. Discussing solutions to structural barriers to service access for residents from special needs groups at the time of RACF engagement may help to encourage active participation. We heard that establishing a dedicated engagement role within service provider organisations is a useful approach, but recognise that in some regions it may be more feasible or appropriate for the PHN to take on engagement responsibilities (e.g. where several smaller organisations or sole practitioners are commissioned to deliver services).

Actions for the department:

- Define key terms and expectations, including when an RACF should be considered to be 'participating' in the initiative, target participation rates, and whether there are eligibility criteria for RACFs (e.g. only those that are Commonwealth-funded or those with under a specified proportion of dementia beds). If eligibility criteria are defined, support PHNs to understand which RACFs in their region meet these.
- As part of the broader communications strategy for the aged care sector, promote the role of initiative in supporting RACFs to meet their obligations under the Aged Care Quality Standards.
- As part of the broader communications strategy for the aged care sector, communicate the status of mental health practitioners as essential services and therefore allowed onsite during periods of visitor restrictions.
- Consider expanding funding and revising funding rules to provide PHNs and/or service providers with protected time for RACF engagement.
- Consider providing guidance or resources to PHNs to assist with developing and implementing an effective RACF engagement strategy.

Actions for PHNs and/or service providers:

- Review staffing arrangements to consider where RACF engagement responsibilities best sit and how to ensure sufficient time is available for their completion.
- Discuss, agree, and clearly document roles and expectations of both parties when onboarding new RACFs to the initiative. This process should address arrangements in place to support residents from special needs groups (e.g. how and when interpreter bookings are made) and how mental health practitioners can best integrate with RACF operations and resident care.
- Work with RACFs to explore options that facilitate cultural change and RACF buy-in to the initiative. One example may be nominating a member of staff to act as a 'wellbeing champion' and provide ongoing support to raise awareness of mental health problems and use of available supports.

- Ensure reporting processes capture the nature and volume of RACF engagement activities, including the time and resources involved and challenges and successes experienced.

5.5 Build RACF staff capacity to support service delivery and residents' mental health

Across all stakeholder groups there were consistent calls for greater emphasis on improving mental health literacy and awareness of the initiative among RACF staff. We heard of the critical role this plays in ensuring timely and appropriate referral, facilitating service delivery, and providing ongoing support after the conclusion of formal psychological services. However, several PHNs understood that RACF staff training is not permitted under the initiative's funding rules, suggesting a need for greater clarification on this issue.

As well as psychoeducation to improve staff capacity to recognise and support residents with mental illness, stakeholders also expressed a desire for RACF staff to be trained in broader topics such as cultural awareness, trauma-informed care, navigating consent processes and working with EPOAs, dementia care, medication management, communication, and managing grief and loss. Some peak bodies felt they could play a useful role in delivering or supporting capacity building, but had not been approached to do so. However, we understand that the department is currently funding the Australian Psychological Society (APS) to deliver an online training project to support aged care staff to understand and support residents' mental health, which may help address some of the gaps identified in this evaluation.

Actions for the department:

- Clarify funding rules to ensure PHNs can include capacity building in their service model.
- Review and promote existing training and educational resources, including those available through the forthcoming aged care skills development program and APS online training project, to support RACF staff develop skills and knowledge in mental health and broader topics relevant to the initiative.
- Consider whether additional training or resources are required to supplement those that already available (e.g. to address mental health in more detail or cover initiative-specific topics). If so, seek input from peak bodies and PHNs to develop a set of nationally consistent materials that all service providers can use.
- As part of the broader communications strategy for the aged care sector, encourage RACFs to release staff from regular duties to participate in capacity-building activities.

Actions for PHNs:

- In service provider contracts, include provision for the time required to deliver ongoing capacity-building activities.
- Ensure reporting processes capture the nature and volume of capacity-building activities delivered, the time and resources involved, and challenges and successes experienced.
- Work with service providers to develop locally specific materials, such as those outlining available services and referral pathways, and discussing aspects of mental health that are particularly important to the local resident population (e.g. raising awareness of culturally specific presentations of mental illness).

Actions for service providers:

- Ensure that RACFs understand the capacity-building activities available, and discuss expectations and benefits of participation.
- Explore options to integrate capacity building into routine resident care (e.g. include care staff in case conferences or family meetings) or facility operations (e.g. include information about the initiative in training for new staff).

5.6 Clarify eligibility criteria and referral and assessment protocols

Overall, we found that the initiative's target population – residents with mild to moderate mental illness – has good access to the initiative. However, it is clear that some residents in need are missing out due to uncertainty over resident eligibility and permitted referral pathways, or inconsistency in how current guidance is interpreted and applied. We heard that residents with more severe mental illness and/or cognitive impairment can and do benefit from initiative-funded services and should not be excluded from accessing them, but that referrers and service providers alike can find it difficult to determine where the line between appropriate and inappropriate referrals lies. All stakeholder groups identified gaps in mental health support in the lead-up to and at the point of transition into residential care; a time when many residents feel a sense of grief, loss or failure and could benefit from early intervention. Deteriorating physical health and the death of other residents were also considered useful indicators of 'at risk' residents who should be considered within scope for the initiative. In addition, we heard strong and consistent feedback that services should be expanded to support families, particularly during the transition period; as one RACF staff member explained, 'family members are often a silent client who can go through guilt sending loved ones into aged care.'

Service providers' calls for greater consistency in referral protocols and removal of barriers to self and family referrals carry some weight, given that they are ultimately responsible for determining residents' eligibility for the initiative and the appropriateness of the services they provide. One representative noted that while PHNs are supportive of self and family referrals on paper, in practice referrals still require sign-off by a GP or registered nurse. For some residents, this requirement may introduce unnecessary delays in the service provider's assessment of the resident and the subsequent commencement of services under the initiative or referral to more suitable supports. Regardless of the eligibility criteria and referral processes in place, ensuring that RACF staff, GPs, and residents and their families are provided with clear, written information is paramount to support a shared understanding of how and why the initiative can be accessed and by whom.

> We are following the referral pathway we believe has been set down by the department… But in [another region] they don't follow that because their PHN said they didn't have to.
>
> *Service provider representative*

Actions for the department:

- Clarify eligibility criteria, for example to specify whether the initiative is open to younger people living in residential aged care and veterans and war widow(ers).
- Provide further guidance to operationalise the 'at risk' criterion, for example to include all new residents, residents experiencing a marked change in physical health, or those affected by the death of another resident.

- Consider expanding the initiative or introducing complementary funding to improve access to psychological services prior to or during the transition to residential care, and to family members of current or future residents.
- Clarify expectations around who can refer to the initiative and how. Consideration may be given to removing the current distinction between 'request for service' and 'referral'.
- Seek advice from peak bodies and academic experts on how referrers and mental health practitioners can effectively and efficiently assess residents' capacity to participate in and benefit from psychological support.
- Encourage RACFs to incorporate mental health assessment during or soon after the intake process in order to facilitate timely referral and provision of appropriate care.

Actions for PHNs and/or service providers:

- Review and, if necessary, update eligibility criteria and referral and assessment protocols to ensure that they are consistent with guidance (particularly in light of any updated advice from the department) and that eligible residents have access to timely and appropriate care.
- Provide RACF staff, GPs, and other potential referrers with written resources outlining the services available, to whom, and how.
- Work with RACF staff and GPs to determine how and where information on referral and assessment, including consent, is documented and shared.
- Ensure that residents and their family members or other informal supports, including their EPOA if relevant, are provided with written information about the services that are available or that they have been referred to.

5.7 Match service offerings and the workforce that delivers them to resident need

> A lot of people are referred at a point in their life where … they aren't really motivated to do intensive psychological work. These people are lonely and isolated, so often what they want from us is to have a meaningful conversation with a caring and empathic person. This is a potential sticking point; we are charged with delivering psychological interventions, but often what people want is more of a wellbeing approach.
>
> *Service provider representative*

PHNs, peak bodies, and service providers perceived a gap between the initiative's current focus and resident needs, with the former seen to be much narrower than the latter. They expressed strong opinions that this gap must be closed in order to better support residents' mental health. We heard consistently that one size does not fit all, that complex needs do not necessarily require complex intervention, and that a multidisciplinary approach (including RACF staff) is critical. Common requests were for services to be expanded to address elder abuse, loneliness, grief, trauma, and adjustment, and to incorporate group and music, art, and animal therapies. One peak body representative also suggested that faith-based approaches should also be considered within scope given that older people are more likely than most to practise a religion.

Consistent with a more holistic intervention approach, stakeholders highlighted that, 'we need to get away from the assumption that if there is a mental health issue, we need to call in a psychologist or a psychiatrist'. Workforce flexibility was seen to be especially important in rural areas, and social workers, peer workers, and students were specifically named as providing good options for diversification. However, we also heard that mental health practitioners have limited access to support and

development in some regions, and several PHNs were uncertain about the degree to which they are able to expand their service offerings and associated workforce beyond traditional psychological therapy and therapists.

Actions for the department:

- Consider expanding the initiative beyond 'psychological services', in name and scope, to encompass the broad array of mental health needs experienced by RACF residents.
- Allow flexibility to commission and deliver services to within this expanded scope, with the principal goal being the provision of holistic, person-centred care.
- Clarify the types of practitioners that can deliver services under the initiative, allowing for flexible workforce models while ensuring practitioners' scope of practice is suitable for the type of services required.
- Seek advice from peak bodies on relevant professional development activities and resources and encourage PHNs to distribute these to their service providers. This may include, for example, activities to build knowledge and skills in working in residential aged care, cultural awareness, trauma-informed care, and LGBTIQ+ inclusive practice.
- Consider expanding eligibility for free access to translation and interpreting services (including sign language interpreting services) to commissioned providers of psychological services.
- Clarify the extent to which the service model can be adapted to different cultural constructs of mental health and appropriate interventions; for example, supporting residents to build social and cultural connections may be preferable to individual therapy.

Actions for PHNs:

- Work with service providers to review current service models and identify any unmet need; consider extending existing contracts or re-commissioning to address gaps as required.
- Continue to encourage and support service providers to work flexibly and trial innovative approaches to supporting residents' mental health.

Actions for service providers:

- Work with RACFs to identify opportunities for residents to access wellbeing support through new or existing lifestyle programs.
- Explore options to facilitate effective partnerships with and between GPs, RACF staff, and others involved in a resident's care, including agreeing on communication pathways.
- Seek to engage a workforce appropriate to local resident population; bilingual or peer support workers may be particularly important for RACFs with a high proportion of residents from CALD backgrounds.
- Provide mental health practitioners with, or support them to access, clinical supervision and relevant resources and professional development opportunities. This may include, for example, training on working in residential aged care, cultural awareness, trauma-informed care, and LGBTIQ+ inclusive practice.

5.8 Generate evidence of the impact of psychological services in RACFs

Despite growing awareness of the importance of addressing aged care residents' mental health needs, evidence for acceptable and effective interventions remains limited. PHNs and service providers now have a unique opportunity to build this evidence base and contribute to future service improvements. However, to do so, some limitations of current data collection and reporting processes must be addressed. PHNs and service providers were unequivocal in their view that the K10 is not suitable for the resident population; this lack of support has clear implications for collection of outcome data and may feed into a lack of compliance with PMHC MDS reporting more broadly. Acknowledging that there may not be an appetite, at least in the short term, for deviating significantly from the current data specifications, adopting the 5-item version of the Kessler psychological distress scale (K5; Australian Institute of Health and Welfare 2009) as the mandated outcome measure for this initiative may offer a reasonable compromise. Indeed, this measure has already been adopted in some regions, leading to some confusion in others:

> In [another region] they can use a K5 for their clients, but our PHN has said that it needs to be a K10. We don't understand if this is coming from the PHN or the government.
>
> *Service provider representative*

Underreporting to the PMHC MDS may be further hampered by a combination of service provider concerns about data sovereignty, and client reluctance, particularly in the presence of cultural or language barriers, to consent to data release.

Actions for the department:

- Clarify PMHC MDS reporting requirements to support more consistent outcome measurement across the initiative. Specifically, consider revising PMHC MDS guidance to permit the use of the K5 as the core outcome measure for people living in residential aged care.

- Seek guidance from mental health peak bodies and academic experts on suitable outcome and experience measures – and approaches to their administration – for aged care residents, including those with cognitive impairment or from different cultural backgrounds. This guidance should be released to PHNs and, in turn, service providers, to support data-informed treatment planning and local monitoring, if desired.

- Consider expanding the referrer profession categories within the PMHC MDS to include 'registered nurse'. An option of 'aged care worker (not otherwise specified)' could also be considered to capture referrals made by other staff within RACFs and, as service offerings for older people expand, those working elsewhere in the aged care sector (e.g. Aged Care Assessment Team members).

- Consider options to incorporate flags within the PMHC MDS for initiatives such as this, to generate more robust evidence of the uptake and outcomes of specific budget measures.

- Develop guidance on common concerns about data collection, management, and privacy and how these can be addressed, while respecting residents' right not to provide data or consent to its release.

Actions for PHNs:

- Work with service providers to ensure reporting requirements are understood and barriers to compliance are addressed.
- Work with service providers to identify and address residents' concerns about data collection or release, and develop tailored, locally-relevant communication strategies to address these.
- Ensure that reporting requirements include flexibility for service providers to provide qualitative feedback (including case studies, if desired) in addition to quantitative data on activities and outcomes.
- Be flexible and allow for innovation in service delivery, which may mean accepting KPIs are not met in the short term or need to be revised to better reflect the service and/or environment it is operating in.

5.9 Share information to reduce inefficiencies and support continuous improvement

It is clear that PHNs are committed to understanding how psychological services can be effectively and efficiently delivered in RACFs to improve residents' mental health. We heard repeated requests for increased sharing within and between their respective networks, through dissemination of evaluation findings, and establishment of regular communities of practice. We understand that these forums may already be in place to varying degrees, with some service providers reporting taking it upon themselves to meet and share experiences, and the department helping to establish a PHN community of practice that was disrupted during the COVID-19 pandemic. It appears the timing may be right to reinstate and embed these networks into routine operations. As a starting point, focused discussions on specific topics of interest (such as those discussed in the recommendations above) may assist PHNs and service providers to plan their approach to the next phase of the initiative. Inefficiencies associated with duplication of effort across regions could be reduced through PHNs and service providers sharing the resources they have developed (e.g. information manuals for RACF staff) or the lessons learned through the development process, or establishing working groups to source or generate new material.

Actions for the department:

- Explore how PHNs would like to interact and share information about their implementation of initiative.
- Consider options to facilitate communities of practice and continuous improvement without taking ownership from PHNs (e.g. providing administrative support).
- Consider facilitating invitations to peak bodies to support a nationally consistent understanding of key topics.
- Consider sharing this evaluation report, or a summary thereof, with PHNs.

Actions for PHNs:

- Actively participate in community of practice meetings and out-of-session discussions.
- Explore options to facilitate service provider communities of practice.

Actions for service providers:

- Actively participate in community of practice meetings and out-of-session discussions.

6 Conclusion

In this final section of the report, we consider the limitations and strengths that may influence our findings and recommendations, and reflect on the evaluation's activities and outcomes overall

6.1 Limitations

The methodology we used to address the evaluation questions comes with a number of limitations, and the findings presented in this report should be interpreted accordingly.

First, despite our best efforts, we received input from only a small number of RACF staff and GPs. While this is disappointing, it is not entirely unexpected; our own experience and published literature demonstrate that these are difficult populations to engage. We are confident, however, that relatively low representation of these groups does not adversely affect the evaluation's outcomes; the feedback from those that did participate was consistent with that provided by other stakeholder groups and received in our other recent evaluations conducted in RACFs. It therefore seems unlikely that additional participants would have offered a significantly different perspective. Further, participation in the evaluation is contingent on awareness of and engagement with the initiative; thus, limited involvement from RACF staff and GPs supports findings reported by other stakeholders, and highlights the importance of further promotion of the initiative and its potential benefits not only to RACF residents but those that care for them.

Second, the service provider managers and mental health practitioners that took part in interviews generally represented large organisations; it is possible that consultations with smaller business or sole practitioners would have yielded different results. It is worth noting, however, that respondents to the service provider survey did include small business representatives and sole practitioners, and thus their perspectives are not entirely absent from the evaluation.

Third, there are several limitations of our resident survey worth noting. We relied on other stakeholders to distribute information on our behalf and, although all materials stated that the survey was open to all residents in participating RACFs, it is possible that service providers or RACF staff were selective in who they invited to complete it in order to elicit more favourable feedback. Further, we cannot validate survey responses so cannot rule out the possibility that resident perspectives were influenced or misrepresented. Because of the regional differences in branding, we were unable to ask about the initiative specifically, although the frequency with which residents named service providers responsible for delivering services under the initiative provides confidence that their responses relate to the initiative. The relatively low number of respondents within each PHN region and from outside major cities limited our ability to explore the impact of geographic differences on residents' experiences of the initiative, and we were unable to provide translated materials, presenting a potential barrier to participation for residents from CALD backgrounds.

Findings related to PMHC MDS data should also be interpreted in the context of several caveats. For example, it is not possible to discriminate services delivered under the initiative from those delivered as part of other PHN activities. Given the vanishingly small number of services delivered in RACFs prior to the initiative's introduction, it seems unlikely that the volume of non-initiative-funded services would be sufficient to influence our results. As discussed elsewhere in this report, not all service providers comply with data collection and reporting requirements, and not all clients consent to their

data being released to the department. Further, the PMHC MDS is subject to change, especially the data relating to more recently delivered services, as PHNs can revise these data. Minimising the impact of these changes on evaluation findings was one reason we opted to focus our analysis on services delivered prior to July 2021, allowing time for corrections to be made before the data were extracted in early November.

6.2 Strengths

A key strength of this evaluation is the use of multiple data sources, combining information collected through document review, routinely collected service use and outcome data, and consultations with a range of stakeholders with different relationships to the initiative. Our use of the PMHC MDS enabled us to explore changes in service delivery in RACFs over time, and given these data were not collected specifically for the evaluation, they may be less subject to recall and reporting bias. We achieved high levels of engagement with all PHNs and exceeded our target of 100 resident surveys. All consultations were conducted remotely to minimise stakeholder burden and maximise participation rates, and our flexible approach meant that stakeholders could choose their preferred interview time or for residents, their preferred modality of survey completion. As a result, we were able to obtain input from stakeholders from diverse regions of Australia and with different personal and professional backgrounds, affording us an in-depth understanding of the barriers, challenges, and successes of the initiative through a national lens and from multiple perspectives. The consistency of the feedback we received gives confidence in our findings and lends weight to our recommendations.

6.3 Final reflections

> It was so exciting to have this as part of our suite of services. Everybody knows there's a need, but it needs traction.
>
> *PHN representative*

Between August and December 2021, we consulted with 386 representatives from 5 stakeholder groups, exploring their perspectives and experiences of the initiative to date, as well as their suggestions for the future. The findings from these consultations, triangulated with other available documents and data, highlight the importance of, and support for, this initiative. Despite the contextual challenges surrounding its implementation, the initiative appears to be improving aged care residents' access to services that are appropriate to their mental health and wellbeing needs.

As the initiative nears the end of its initial funding term, it is clear that there is a need to further embed and scale up the services available. It is also clear that barriers to doing so exist at multiple levels. To help address some of these, we identified 9 key recommendations and provide actions within each for the department, PHNs, and service providers. We were overwhelmed by all stakeholders' commitment to the initiative's success, and are confident that this collective buy-in will continue to improve the mental health support available to vulnerable older Australians. We will leave the final word on the subject to a current aged care resident:

> It is a good service and I think it should be there for everyone living in a nursing home.

Appendix A Recommendations and actions

1. Extend and expand funding to enable the initiative to realise its objectives

Actions for the department	Actions for PHNs
1. Commit to extending the initiative beyond June 2022. 2. Consider expanding funding to enable PHNs to scale up the services available, in terms of the number of RACFs and residents that can take part and the geographic areas serviced. 3. Consider expanding funding and clarifying funding rules to accommodate the varied activities required to implement the initiative, beyond direct service delivery. 4. Consider increasing rural loadings to account for costs involved with engaging and servicing highly dispersed RACFs, and to attract and retain mental health practitioners.	a. Extend service provider contracts to support workforce retention and provide RACFs with confidence in service continuity. b. Explore block funding or other alternatives to fee-for-service funding arrangements (if not already in place) to ensure service providers are remunerated for all aspects of the initiative, including but not limited to direct service delivery.

2. Foster integration and collaboration among all relevant stakeholders

Actions for the department	Actions for PHNs
5. Liaise with other relevant government departments (e.g. Department of Veterans' Affairs, Department of Social Services) and organisations with a national footprint (e.g. peak bodies) to discuss how the initiative might link with other services available for the groups they represent. 6. Support or encourage PHNs to develop new partnerships with key stakeholders known to the department (e.g. members of sub-committees).	c. Foster a culture of internal collaboration, to prevent the initiative being siloed from the PHN's other aged care activities and the organisational expertise they generate. d. Ensure that local service mapping takes into account non-mainstream services that residents from special needs group may prefer or be more appropriately served by (e.g. Aboriginal or LGBTIQ+ community-controlled organisations). e. Seek to maintain stakeholder engagement in the initiative and seek input into implementation and communication on an ongoing basis, rather than as a once-off start-up activity. f. Seek opportunities to embed the initiative within the local service landscape by actively supporting networking between service providers, other relevant services, and GPs.

3. Publicise the availability of psychological services in aged care

Actions for the department	Actions for PHNs and/or service providers
7. Work with aged care team(s) within the department to develop and implement a communications strategy for the aged care sector, using established channels of communication (e.g. Bulk Information Distribution Service). 8. Liaise with other government departments and organisations with a national footprint to discuss how best to raise awareness of the initiative among the groups they represent, including health professionals and aged care residents and their families. 9. Consider developing and promoting a central website for the initiative, potentially including a directory of services (or links to PHN websites) to enable interested parties to quickly find information relevant to their region. 10. Develop information explaining the similarities and differences between the initiative and the Better Access aged care expansion, to support RACF staff, GPs, and residents and their families to understand why and how each may be utilised. 11. Consider making centralised information and resources about the initiative available in multiple languages, using culturally appropriate terminology. 12. Explore options to support PHNs to develop culturally and linguistically appropriate information and resources.	g. Ensure information about the initiative can be easily found on PHN and service provider websites. h. Engage with local representatives of special needs groups (including residents themselves) to co-design regionally appropriate promotional and information materials.

4. Encourage and support RACF participation

Actions for the department	Actions for PHNs and/or service providers
13. Define key terms and expectations, including when an RACF should be considered to be 'participating' in the initiative, target participation rates, and whether there are eligibility criteria for RACFs (e.g. only those that are Commonwealth-funded or those with under a specified proportion of dementia beds). If eligibility criteria are defined, support PHNs to understand which RACFs in their region meet these.	i. Review staffing arrangements to consider where RACF engagement responsibilities best sit and how to ensure sufficient time is available for their completion.
14. As part of the broader communications strategy for the aged care sector, promote the role of initiative in supporting RACFs to meet their obligations under the Aged Care Quality Standards.	j. Discuss, agree, and clearly document roles and expectations of both parties when onboarding new RACFs to the initiative. This process should address arrangements in place to support residents from special needs groups (e.g. how and when interpreter bookings are made) and how mental health practitioners can best integrate with RACF operations and resident care.
15. As part of the broader communications strategy for the aged care sector, communicate the status of mental health practitioners as essential services and therefore allowed onsite during periods of visitor restrictions.	k. Work with RACFs to explore options that facilitate cultural change and RACF buy-in to the initiative. One example may be nominating a member of staff to act as a 'wellbeing champion' and provide ongoing support to raise awareness of mental health problems and use of available supports.
16. Consider expanding funding and revising funding rules to provide PHNs and/or service providers with protected time for RACF engagement.	l. Ensure reporting processes capture the nature and volume of RACF engagement activities, including the time and resources involved and challenges and successes experienced.
17. Consider providing guidance or resources to PHNs to assist with developing and implementing an effective RACF engagement strategy.	

5. Build RACF staff capacity to support service delivery and residents' mental health

Actions for the department	Actions for PHNs	Actions for service providers
18. Clarify funding rules to ensure PHNs can include capacity building in their service model. 19. Review and promote existing training and educational resources, including those available through the forthcoming aged care skills development program and APS online training project, to support RACF staff develop skills and knowledge in mental health and broader topics relevant to the initiative. 20. Consider whether additional training or resources are required to supplement those that already available (e.g. to address mental health in more detail or cover initiative-specific topics). If so, seek input from peak bodies and PHNs to develop a set of nationally consistent materials that all service providers can use. 21. As part of the broader communications strategy for the aged care sector, encourage RACFs to release staff from regular duties to participate in capacity-building activities.	m. In service provider contracts, include provision for the time required to deliver ongoing capacity-building activities. n. Ensure reporting processes capture the nature and volume of capacity-building activities delivered, the time and resources involved, and challenges and successes experienced. o. Work with service providers to develop locally specific materials, such as those outlining available services and referral pathways, and discussing aspects of mental health that are particularly important to the local resident population (e.g. raising awareness of culturally specific presentations of mental illness).	i. Ensure that RACFs understand the capacity-building activities available, and discuss expectations and benefits of participation. ii. Explore options to integrate capacity building into routine resident care (e.g. include care staff in case conferences or family meetings) or facility operations (e.g. include information about the initiative in training for new staff).

6. Clarify eligibility criteria and referral and assessment protocols

Actions for the department	Actions for PHNs and/or service providers
22. Clarify eligibility criteria, for example to specify whether the initiative is open to younger people living in residential aged care and veterans and war widow(ers). 23. Provide further guidance to operationalise the 'at risk' criterion, for example to include all new residents, residents experiencing a marked change in physical health, or those affected by the death of another resident. 24. Consider expanding the initiative or introducing complementary funding to improve access to psychological services prior to or during the transition to residential care, and to family members of current or future residents. 25. Clarify expectations around who can refer to the initiative and how. Consideration may be given to removing the current distinction between 'request for service' and 'referral'. 26. Seek advice from peak bodies and academic experts on how referrers and mental health practitioners can effectively and efficiently assess residents' capacity to participate in and benefit from psychological support. 27. Encourage RACFs to incorporate mental health assessment during or soon after the intake process in order to facilitate timely referral and provision of appropriate care.	p. Review and, if necessary, update eligibility criteria and referral and assessment protocols to ensure that they are consistent with guidance (particularly in light of any updated advice from the department) and that eligible residents have access to timely and appropriate care. q. Provide RACF staff, GPs, and other potential referrers with written resources outlining the services available, to whom, and how. r. Work with RACF staff and GPs to determine how and where information on referral and assessment, including consent, is documented and shared. s. Ensure that residents and their family members or other informal supports, including enduring power of attorney if relevant, are provided with written information about the services that are available or that they have been referred to.

7. Match service offerings and the workforce that delivers them to resident need

Actions for the department	Actions for PHNs	Actions for service providers
28. Consider expanding the initiative beyond 'psychological services', in name and scope, to encompass the broad array of mental health needs experienced by RACF residents. 29. Allow flexibility to commission and deliver services to within this expanded scope, with the principal goal being the provision of holistic, person-centred care. 30. Clarify the types of practitioners that can deliver services under the initiative, allowing for flexible workforce models while ensuring practitioners' scope of practice is suitable for the type of services required. 31. Seek advice from peak bodies on relevant professional development activities and resources and encourage PHNs to distribute these to their service providers. This may include, for example, activities to build knowledge and skills in working in residential aged care, cultural awareness, trauma-informed care, and LGBTIQ+ inclusive practice. 32. Consider expanding eligibility for free access to translation and interpreting services (including sign language interpreting services) to commissioned providers of psychological services. 33. Clarify the extent to which the service model can be adapted to different cultural constructs of mental health and appropriate interventions; for example, supporting residents to build social and cultural connections may be preferable to individual therapy.	t. Work with service providers to review current service models and identify any unmet need; consider extending existing contracts or re-commissioning to address gaps as required. u. Continue to encourage and support service providers to work flexibly and trial innovative approaches to supporting residents' mental health.	iii. Work with RACFs to identify opportunities for residents to access wellbeing support through new or existing lifestyle programs. iv. Explore options to facilitate effective partnerships with and between GPs, RACF staff, and others involved in a resident's care, including agreeing on communication pathways. v. Seek to engage a workforce appropriate to local resident population; bilingual or peer support workers may be particularly important for RACFs with a high proportion of residents from CALD backgrounds. vi. Provide mental health practitioners with, or support them to access, clinical supervision and relevant resources and professional development opportunities. This may include, for example, training on working in residential aged care, cultural awareness, trauma-informed care, and LGBTIQ+ inclusive practice.

8. Generate evidence of the impact of psychological services in RACFs

Actions for the department	Actions for PHNs
34. Clarify PMHC MDS reporting requirements to support more consistent outcome measurement across the initiative. Specifically, consider revising PMHC MDS guidance to permit the use of the K5 as the core outcome measure for people living in residential aged care.	v. Work with service providers to ensure reporting requirements are understood and barriers to compliance are addressed.
35. Seek guidance from mental health peak bodies and academic experts on suitable outcome and experience measures – and approaches to their administration – for aged care residents, including those with cognitive impairment or from different cultural backgrounds. This guidance should be released to PHNs and, in turn, service providers, to support data-informed treatment planning and local monitoring, if desired.	w. Work with service providers to identify and address residents' concerns about data collection or release, and develop tailored, locally-relevant communication strategies to address these. x. Ensure that reporting requirements include flexibility for service providers to provide qualitative feedback (including case studies, if desired) in addition to quantitative data on activities and outcomes.
36. Consider expanding the referrer profession categories within the PMHC MDS to include 'registered nurse'. An option of 'aged care worker (not otherwise specified)' could also be considered to capture referrals made by other staff within RACFs and, as service offerings for older people expand, those working elsewhere in the aged care sector (e.g. Aged Care Assessment Team members).	y. Be flexible and allow for innovation in service delivery, which may mean accepting KPIs are not met in the short term or need to be revised to better reflect the service and/or environment it is operating in.
37. Consider options to incorporate flags within the PMHC MDS for initiatives such as this, to generate more robust evidence of the uptake and outcomes of specific budget measures.	
38. Develop guidance on common concerns about data collection, management, and privacy and how these can be addressed, while respecting residents' right not to provide data or consent to its release.	

9. Share information to reduce inefficiencies and support continuous improvement

Actions for the department	Actions for PHNs	Actions for service providers
39. Explore how PHNs would like to interact and share information about their implementation of initiative. 40. Consider options to facilitate communities of practice and continuous improvement without taking ownership from PHNs (e.g. providing administrative support). 41. Consider facilitating invitations to peak bodies to support a nationally consistent understanding of key topics. 42. Consider sharing this evaluation report, or a summary thereof, with PHNs.	z. Actively participate in community of practice meetings and out-of-session discussions. aa. Explore options to facilitate service provider communities of practice.	vii. Actively participate in community of practice meetings and out-of-session discussions

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