Managing mental health in older Australians:

Prof Marita McCabe
and the implications for aged care

Palliative Care First:

Prof Mark Boughey
explains the problems with euthanasia and physician-assisted suicide

What Hunt Must Do:

Prof Lesley Russell
talks big picture issues the new health minister must address

Making sure there is always a nurse on-call:

Prof Lee Boyd
on the issues facing a sustainable nursing workforce

- Will the current aged care means testing arrangements fit the bill?
- Health Savings Accounts: advantages of a cost-sharing arrangement and opportunities for reform
- Bioethicists: A Conversation about the Next Generation
- Consumers will gain from embracing aged care reform
- Ministry Leadership Program - development well underway
Welcome to the first Health Matters magazine for 2017. There are unique challenges facing Catholic health, aged and community care providers in today’s world. Some of these are considered in this edition.

Catholic hospitals, clinicians and researchers have benefitted in the past from robust debate and discernment as new procedures or technologies were considered within the framework of the Code of Ethical Standards for Catholic Health and Aged Care Services in Australia by bioethicists at the various bioethics centres that work with Catholic Health Australia members.

With articles by Prof Gabrielle McMullen and Notre Dame’s Xavier Symons, we explore a matter ripe for concern – the question of where our future bioethicists will come from, having traditionally been members of the clergy with training in moral theology and bioethics.

We also consider what differentiates Catholic care from other care providers through the lens of pastoral and spiritual care, and also palliative care with articles from the pastoral care teams at St John of God Accord and Catholic Healthcare Limited, together with an insightful Q&A discussion with The Centre for Palliative Care’s A/Prof Mark Boughey.

Workforce challenges are again being highlighted as we consider sustaining our nursing workforce through the shortages that are predicted to lie ahead. Cabrini Health’s Prof Lee Boyd discusses some of the major issues around nursing workforce faced by members and offers recommendations for action.

The foundation to the response of Catholic care providers to these, and other, challenges are our values.

Our personal values and beliefs guide our behaviours and are a central part of who we are, and also who we want to be. In making the best choice in any situation, not just in response to some of life’s toughest decisions, our values equip us. So too, the core values of Catholic health, aged and community care service providers inform ‘the way we do things around here’ and help determine if the organisation is on the right path and fulfilling its goals.

The values say a lot about what is important to an organisation and form a foundation for the culture, helping to shape responses.

Not surprisingly, a quick scan of the stated core values of Catholic Health Australia members shows very strong themes coming through of compassion and respect. The values of dignity and hospitality also shine through very strongly.

Continuing the healing ministry of Jesus requires understanding of the changing sociological trends, political factors, economic influences, technological innovations, clinical environment and other external influences upon health & care services, and also the evolving faith and Church context. Our values assist those entrusted with governance and leadership of our services, as well as our staff, to navigate this complex environment to enable the mission of the Gospel entrusted to the Church to continue to flourish.

But has the modern context in which care services are delivered in Australia also heralded new challenges to our organisations? Challenges that require new or different behaviours informed by more contemporary values?

Despite the commonality of some values, such as compassion, across many Catholic providers of care services, we also see new themes coming forward in the stated values of members.

One trend is values articulated which support new ways of
thinking or new ways to address challenges. These values include innovation, excellence, creativity and teamwork. In this age of digital disruption and information overload, often now referred to as ‘infobesity’, such values give us permission to celebrate the diversity within our organisations, and particularly the workforce, to formulate new business models and ways of working to ensure excellence of service delivery to those cared for in Catholic services and their families.

Another trend is the occurrence of core personal values to shape the organisation such as honesty, trust and justice. This may be a sign of the times, a response to political scandals and community concerns raised in the media. Reframing these values into business operational language, many organisations have developed models of service delivery embedded in concepts of accountability, integrity, and courage.

Whatever the values that guide and shape an organisation, what is certain is that when your values are clear, making decisions becomes easier.1

Unfortunately, though, not many decisions are black or white. Various competing interests or needs, shifting societal norms, funding pathways, and the like, at best, place pressure on our values being a roadmap and, at worst, may in fact even erode organisational ability to act in accordance with stated values. Yet how we grow our capacities to work in tough environments, how we discern between competing interests and how we maintain authenticity of care as Catholic service providers is guided by these values.

The 2017 CHA National Conference is going to be in Hobart, 28 – 30 August. This year, delegates will explore the theme of ‘Sustaining our Values’. How do we use the compass of our values? How do we ensure they are not eroded by the daily challenges of the provision of care services in a complex world? How do we sustain our values? And how do our values sustain our service delivery and goals?

There will no doubt be powerful stories to share of the challenges faced by faith-based delivery of care services now and into the future and I invite you all to come together this August to discuss Sustaining our Values.

2  Extract from Foreword of the Catholic Health Australia Strategic Direction Statement 2020.
3  Quote from Roy E. Disney (10/01/1930 – 16/12/2009).
“Health Savings Accounts have become a popular model that works to control health care costs by turning price insensitive patients into price conscious consumers.”
Many Australian private hospitals have been experiencing weaker than normal hospital volumes and slower growth. Current trends suggest a declining satisfaction with private health insurers as consumers evaluate the costs and benefits of private health insurance coverage. Recently, Chris Rex, CEO of Ramsay Health Care, has urged for a renewed focus on how medical services are funded. Private health insurers account for the majority of revenue to private hospitals who are under increasing pressure by these insurers to cut prices. Most recently, prostheses funding came under the chopping-block. Disappointed with the results of the six-billion-dollar annual subsidy to private health insurers, Chris Rex has recommended alternative funding arrangements in the form of tax-exempt health savings accounts to increase efficiency and give patients more choice and control on how their money is spent on healthcare (Gardner, 2016).

Health Savings Accounts (HSA, also known more broadly as Medical Savings Accounts), have become a popular model that works to control health care costs by turning price insensitive patients into price conscious consumers. When an HSA is joined to a high deductible health plan, this is jointly known as a consumer-driven health plan (CDHP) (Fronstin 2015). Implemented in the USA, China, Singapore, and South Africa, HSA accounts are used to supplement catastrophic care plans with individual (and sometimes employer and government) contributions. In China and Singapore, HSA accounts are mandatory and managed by the government who also makes contributions, while in the USA and South Africa...
they are voluntary and operate within the private insurance market, or through financial institutions (Wouters et al. 2016). These accounts are tax-exempt and accept contributions up to a threshold amount that can be used to reimburse the patient’s out-of-pocket costs for qualified medical expenses. The funds can be invested, and any capital gains as well as interest earned remains untaxed when used for medical care. The accumulating funds can be used by the enrollee for family health expenses or the anticipated higher costs and utilisation of health services later in life (Gadiel and Sammut 2014). Enrollees are encouraged to save when they are most economically active in preparation for medical costs they are expected to incur in the future due to higher utilisation of services. This cost-sharing arrangement between individuals and health funds or government agencies is designed to address the potential for moral hazard by encouraging individuals to make more conscious choices when selecting health services. This, in turn, spurs competition between health providers who must respond to the price and quality sensivities of individuals (Sammut 2016).

“While there is a disparity in income-driven account contributions, this may potentially channel high income earners towards the private industry and alleviate pressure on the public sector [...]”

Disadvantages of the HSA model

Current studies into the efficacy of expanded use of the HSAs in controlling costs, sharing financial responsibility, providing financial protections, and increasing consumer choice have shown mixed results. High income earners are consistently able to make the largest contributions and reap the largest tax benefits while low income earners are less likely to contribute to their fund, and HSA tax-exempt status does not benefit the poor and unemployed (Wouters et al. 2016). While there is a disparity in income-driven account contributions, this may potentially channel high income earners towards the private industry and alleviate pressure on the public sector to make resources available for the poor, elderly, and chronically ill who tend to use a disproportionate share of services and are less likely to be able to afford out-of-pocket costs.

As for the efficacy of CDHPs, while there is evidence that these accounts reduce initial costs, some studies suggest this is because enrollees are discouraged from accessing services and treatment. One study revealed that while costs for CDHP enrollees were lower in the first few years compared to those on a more comprehensive plan, their rates of hospital admission and costs were higher after the first few years of initial savings (Fronstin et al. 2013).

There is insufficient evidence in some countries to show that HSAs control costs (Hsu 2010). For enrollees to be price-conscious consumers, information on the price and quality of services must be publicly available to them. In the USA, this data is not complete and many doctors and specialists are not able to discuss price and quality with their patients. In addition, patients are not necessarily the ones selecting the services and care they receive as these are determined by the physician. A large proportion of people lack health literacy, rendering them unable to make informed choices or engage in active purchasing. Countries with voluntary HSAs tend to have participants who earn higher incomes, are low-risk, more educated, and do not utilise services to the same extent as low-income earners who tend to use a disproportionately larger share of health services and do not have or contribute to an HSA. These factors underscore the imperfect market for healthcare which may not be capable of controlling costs based on the current evidence revealing limitations in consumer choice, price disclosure, and competition (Wouters et al. 2016).

Towards a future framework

The conflicting and incomplete evidence on the efficacy of HSAs in cost-control and reducing financial barriers to health care has challenged proposals for an Australian HSA model for implementation. Given the current trajectory of rising health expenditure and dissatisfaction with rising health insurance premiums, HSAs, if implemented to

Applications for Australia

Australia currently has the foundations in place to adopt the HSA model. In addition to the publicly funded Medicare system, consumers can purchase private health insurance to access private hospitals and care facilities. With insurance premiums currently increasing faster than wages and inflation, more consumers are opting for high-deductible, low premium plans with more exclusions. This increases the out-of-pocket costs patients face when they do access private medical services. HSAs could complement our current system by incentivising consumers through tax-exempt accounts that spread the financial risks of health costs over time, enabling them to afford medical treatment from private providers when they are in most need of it. Individuals can use these funds to cover gap payments and ancillary services like dental and optical. The HSA can be partnered to the existing superannuation framework, allowing government to make co-contributions for low income workers to ensure greater equity in access to health services and create a larger pool of individuals sharing the responsibility for healthcare costs (Sammut, 2016).
complement Australia’s health system, may prove to be a possible solution for achieving intergenerational equity and preparing individuals for higher health costs in old age.

Numerous proposals have been put forth that consider the impacts of voluntary versus compulsory accounts similar to superannuation; government subsidised accounts for low-income earners; and Medicare opt-out HSAs where individuals trade in their Medicare entitlement in exchange for an annual health voucher deposited into their HSA with which they can purchase private health insurance and cover out of pocket costs. The balance continues to roll-over into retirement and can be saved for medical costs later in life (Gadiel and Sammut 2014).

“Education strategies are integral to improving health literacy among consumers and offering low-cost measures to control the mis-utilisation and over-utilisation of services […]”

Concerns for cost shifting health expenditure into private hands stem from the public’s emphasis on social solidarity and community sharing to achieve health equity. HSAs have been considered by government agencies and supported by medical organisations that are likely to expand public interest if proposals are designed to complement the current funding frameworks, not replace them (AMA, 2009). Wouters (2016) suggests that for a successful adoption of the HSA model, a country should have the following prerequisites:

- High income per capita
- National culture of saving and taking personal responsibility for health
- Well-functioning and transparent regulatory environment

Evidence on the impacts of HSAs on long-term savings relative to health outcomes and impacts on the health system remains to be seen due to their relatively recent implementation and ongoing development in overseas jurisdictions. In the USA, health insurers have invested heavily in extensive wellness outreach programs to overcome inefficiencies caused by health illiteracy. Incentives offered to participate in health assessments, free health classes, and clinical support networks endeavour to make consumers better-informed and engaged in making smarter healthcare decisions to minimise unnecessary visits, tests, and treatments. These education strategies are integral to improving health literacy among consumers and offering low-cost measures to control the mis-utilisation and over-utilisation of services.

Developing an HSA model that corrects the weaknesses in existing approaches and acts as an interface between the current health and financial systems could be an innovative solution that improves the affordability of private health services and creates a more transparent and competitive market for consumers.

References

Aged Care means testing arrangements fit the bill? will the current

While accepting that taxpayers will inevitably meet the majority of aged care costs, successive Australian Governments have applied various forms of means testing arrangements and price controls to make aged care services affordable for taxpayers and individuals. The question is whether in their current form these arrangements are relevant for a future aged care service industry which is consumer-driven and more market-based.

The current policy context

The 2012 Living Longer Living Better (LLLB) package, drawing on principles developed by the Productivity Commission, adopted the following principles to guide policy:

- accommodation and everyday living expenses should be the responsibility of individuals, with a safety net for those with limited means; and
- individuals should contribute to the cost of their personal and nursing care according to their capacity to pay, but annual and lifetime caps should ‘insure’ consumers against excessive costs.

This policy approach has been largely accepted by recent governments.

However, determining what is an appropriate level of contribution by individuals towards their personal and nursing care costs, who should receive an accommodation subsidy and which assets and incomes are taken into account in determining capacity to pay within this policy framework, is another matter entirely. This decision is one for government having regard to social, economic and political considerations, balanced against other national priorities, current and prospective, that influence the formulation of Commonwealth Budgets. Governments will also take into account the interplay with income support for older people and health care funding arrangements, especially Medicare.

For consumers, attitudes will be influenced by perceived fairness, including views about inter-generational transfers and the role of government, and the simplicity of the arrangements (ease of comprehension). Consumer views could also be expected to be influenced by the quality of the services for which they are being asked to pay a fee, and how much choice, control and flexibility they have over services.

All told, a complex range of sensitive issues have to be weighed and balanced.

Some history

The current means testing arrangements have their roots in government policies in residential aged care that applied many decades ago, before home care packages were introduced. Because government policy at the time, and for many years, did not require a consumer contribution towards personal and nursing care costs, the means test that was developed for residential care was designed to determine only if a resident qualified for a government subsidy towards accommodation costs. The expectation was that most Australians would meet their accommodation costs using an entry contribution or accommodation bond financed through the sale of their former residence.

For everyday living expenses, on the other hand, there has been a longstanding expectation that these costs are met by residents, including through use of any age pension entitlement. However, governments have applied price controls whereby all residents (except those living in extra service facilities) contribute 85 per cent of the single age pension towards the cost of a list of services specified in legislation. Residents can agree to pay for additional or higher quality services, but there have been ongoing issues about what constitutes ‘additional’.

Thus, with a focus on who should qualify for an accommodation subsidy, an asset test was developed for residential care that did not have regard to a person’s total assets or wealth, but solely focussed on determining whether a person had the minimum level of assets considered necessary to meet their accommodation costs. In effect, to determine whether the resident had sufficient assets to be able to pay at least the same amount as the government was prepared to pay on behalf of a person with limited means. So a nexus was drawn between the Commonwealth accommodation subsidy and whether a resident was expected to look after their accommodation costs themselves.

When home care packages were introduced in the early 1990s, the assets test in residential care was not considered relevant because personal and nursing care is delivered in a person’s own home, and therefore no changes were made to the existing accommodation-focussed means testing arrangements. Instead, borrowing from the policy applying to the former hostels (whose level of care the Community Aged Care Packages delivered in a person’s home were the equivalent of), the government gave home care providers discretion to charge a fee linked to the age pension. However, this arrangement did not enable fees received by providers to be deducted from the Commonwealth subsidy. Fees for home support services, when eventually introduced under the former Home and Community Care Program, were similarly set and charged at the discretion of each provider operating under loose government guidelines.
In 1998 the government extended fees to personal and nursing care in residential care. In doing so, it introduced a separate income test in order to offset fees against its care subsidy. However, the government kept the separate assets test dedicated to determining each resident’s capacity to pay for their accommodation costs.

**The Living Longer Living Better package**

The use of separate tests for accommodation and personal and nursing care costs in residential care created the situation where income-rich, asset poor residents contributed to their care costs but nothing towards their accommodation costs, whereas asset-rich, income poor residents paid for all their accommodation and nothing towards their care.

The LLLB package introduced in 2012 addressed this inequity by introducing a combined income and assets test for care and accommodation, which is the means test used currently. This was achieved by grafting an income test on to the assets test that was originally designed to establish whether a resident had sufficient assets to pay for their accommodation.

The combined operation of the income and assets tests generates a ‘means tested amount’ for each resident, and maintains a nexus with the accommodation supplement.

A resident qualifies for a full or partial accommodation subsidy (ie. becomes a supported resident) if the ‘means tested amount’ is less than $54.39, which equates to the maximum daily subsidy that the government will pay for a person who does not have the capacity to pay for all of their accommodation costs. The new combined test was calibrated to result in no change in the proportion of supported residents.

The means test then assumes that anyone who cannot afford to meet their accommodation costs also cannot afford to contribute to their personal and nursing care costs. Any amount in excess of the ‘means tested amount’ becomes the care fee, subject to the fee not exceeding the cost of the resident’s care as determined by the ACFI assessment. The LLLB package also introduced a formal income tested fee for home care packages administered by the government which enabled the government to reduce the subsidy payable by the amount of any income tested fee.

To this day, means testing and fee arrangements across residential care and home care packages remain quite separate, as do fees for home support services which remain at the discretion of each provider operating within recently promulgated national fees policy guidelines.

How much funding do the current means testing arrangements contribute to aged care?

In 2014-15, consumers contributed $4.2 billion (or 27 per cent) of total residential provider revenue of $15.8 billion. The bulk of this amount ($3.6 billion) was for everyday living expenses and only $377 million was for personal and nursing care fees (3.8 per cent of Commonwealth care subsidies and care supplements paid to providers on behalf of residents).

Under market-based accommodation prices that now apply across all residential care, consumers meet the bulk of accommodation costs. Refundable lump sum accommodation deposits contributed by consumers totalled $22 billion as at December 2015 and consumers contributed $660 million in daily accommodation payments in 2014-15. The accommodation subsidy paid by government on behalf of supported residents in 2014-15 was $827 million.

Home care recipients contribute about 10 per cent of total home care provider revenue, as do home support recipients.

Where do these arrangements leave us?

Compared with the principles outlined earlier, the upshot of the above is that consumers are contributing the bulk of accommodation costs and everyday living expenses, but are contributing relatively modest amounts towards personal care and nursing costs in either residential or home care settings.

The following sets out sustainability and equity issues that arise from the current arrangements.

**Sustainability issues**

The 2015 Intergenerational Report projected, based on current policy, that Australian Government aged care expenditure will almost double as a share of the economy by 2055, from 0.9 per cent to 1.7 per cent of GDP. This projection does not take into account the cost of removing the rationing of services under a more consumer-driven market-based aged care system envisaged under the Roadmap.

In part, the legislated review of the LLLB reforms currently in progress will go some way towards estimating the extent of unmet need and the potential cost of removing service rationing. However, the fact remains that there is a big question mark over the affordability of a consumer-driven market-based aged care system.
Affordability for taxpayers will not only depend on the level of unmet need, but also on other factors such as the extent of savings by having more care provided in people’s own homes, the effectiveness of the eligibility assessment processes, productivity gains through increased competition, greater attention to early intervention and reablement services and service quality expectations. Affordability will also depend on increased contributions by those who can afford to pay in return for greater choice and control of services in a more consumer-driven system.

Any significant policy change to increase affordability for taxpayers by increasing consumer contributions would need to target personal and nursing care. Accommodation costs are already substantially met by consumers, as are everyday living expenses, and any additional revenue from ‘additional services’, assuming the vexed issue of what constitutes ‘additional’ services can be sorted out, will not improve taxpayer affordability as there is no scope to use this revenue to offset Australian Government subsidies. Currently, some 75 per cent of households aged 75 and over rely on government pensions and allowances as their main source of income. On the other hand, 80 per cent of 75-plus households own their homes outright, and home equity per household in the population is highest for households aged 65-74 years, averaging $480,000 in 2011-12 (considerably more in 2017), but with values varying considerably by region. This indicates that the main scope for increasing contributions for personal and nursing care is to draw on the wealth represented by the equity in the former principal residence, noting that all but $159,163 of the value of the former residence currently is excluded from the means test in residential care, and only an income test applies in home care.

Equity issues

The current treatment of the former residence, which excludes all but $159,163 of its value, results in considerable inequity in contributions towards personal and nursing care costs when considered in the context of capacity to pay when total wealth and the operation of lifetime care contribution caps are not taken into account.

As the Productivity Commission points out, if a primary motivation of individuals is to preserve the value of the former residence for a bequest, it should not be at the expense of shifting the cost of their aged care to taxpayers. In effect, this amounts to taxpayers subsidising the bequests of those holding wealth (noting that the value of homes and bequests vary widely).

Treating all residents with a ‘protected person’ living in the former residence as supported residents also raises equity issues, noting how aged care needs present differently across households due to differences in each person’s frailty trajectory. There is also no discernible policy basis for the different means testing and care fee arrangements that apply in home care and residential care for individuals with the same assessed care needs, nor the level of government subsidy paid on their behalf. Similarly, the means testing and fee arrangements in home care bare no relationship to those that apply in home support where a set of policy guidelines exist to guide fee policies developed and administered by each provider.

The conclusion to be drawn from the above is that, from both a sustainability and equity point of view, there is scope to increase care contributions by those who can afford to pay, in return for choice and control over the services they purchase, while still leaving the vast majority of personal and nursing care funded by taxpayers. Such a move would go a long way towards making consumer-driven market-based services more affordable for taxpayers.

Where to from here?

One option to help address these sustainability and equity matters is to increase the proportion of the value of the former residence that is assessable under the current combined means test in residential care. The deeming of the first $159,163 in value as assessable under the current test seems to give precedence to the nexus with the maximum amount of the accommodation subsidy as a means of determining residents with the capacity to meet their own accommodation costs, rather than establishing a resident’s capacity to contribute to their care costs based on their total wealth.

“Consumer views could be expected to be influenced by the quality of the services for which they are being asked to pay a fee, and how much choice, control and flexibility they have over services.”

It is also relevant in this context that the value of bequests grew from $18 billion to $24 billion between 2003 and 2013 (in 2013 dollars) and continue to grow. This compares with estimated Australian Government funding of $17.4 billion in 2016-17 and care fees paid in 2014-15 of $377 million, though it is expected that this amount will increase a little more as the impact of grand-parented arrangements reduces. There is no data available as yet on how many consumers have paid care fees that have reached the annual and lifetime caps on care contributions. However, a very rough calculation suggests that on average, the 125,900 non-supported residents who received permanent residential care in 2015-16 paid on average about $3,000 each in care fees (compared with a lifetime cap of $60,000).
This approach, however, would not deal with equity issues concerning care contributions across residential care, home care and home support. These service types would continue to be subject to separate program-specific means testing and fee arrangements.

The Productivity Commission sought to address these issues in its report Caring for Older Australians by proposing an alternative approach based on the following:

- Consumer contributions towards personal and nursing care costs and support costs, whether delivered in a person’s home or in a residential setting, would be determined by a comprehensive means test that incorporates income and assets.
- The definition of income would be consistent with the age care pension income test, but only assets excluded from the age pension test would be included in each resident’s share of equity in the principal residence and any lump sum contributions paid.
- Contributions would be proportional to the actual cost of the care being provided, and contributions would be subject to annual and lifetime caps.
- The eligibility of a resident for an accommodation subsidy would be determined by an assets test which includes all of a resident’s share of total assets.

More comprehensive means testing arrangements along the lines suggested by the Productivity Commission that would apply across all aged care services, and which would take account of total wealth as an indicator of capacity to pay, would require most consumers to monetise equity in their former residence, either through sale or use of an equity release product.

However, the vast majority of older Australians are highly reluctant for a variety of reasons to monetise equity by tapping into the wealth in their homes. The reasons include not wishing to dilute the value of their bequest, debt aversion especially in older age, attachment to the security of the family home, perceptions of equity release being exploitative and high cost, and low awareness of equity release products. There is also a reluctance on the part of many financial institutions to offer equity release products. This being the case, any policy changes designed to increase consumer contributions for personal and nursing care for those that can afford to pay would need to address this reluctance if sale of the house (perceived as forced) and use of drawdowns from a lump sum deposit is not to be the only option for consumers.

**Conclusion**

A rational analysis of the current means testing arrangements and what reforms are required to achieve an aged care service industry which is consumer-driven and more market-based, and yet be affordable for taxpayers, can only lead to the conclusion on sustainability and equity grounds that reform of the current means testing arrangements has to be one of the key reform steps.

Without reform in this area, the quality of personal and nursing services and availability of aged care services will remain completely hostage to government budgetary constraints and priorities, the consequences of which we have already experienced. These consequences will be amplified in future as Australia confronts the trifecta of more modest economic growth in the post resource boom era, rapidly increasing aged care needs as the population ages and rising community expectations for quality and choice in aged care services.

Of course, the policy choices become considerably more complex if ever proposals to include the residence in the age pension assets test gain any traction, especially with regard to home care.

**Disclosure statement:** The author of this article, Nick Mersiades, is a member of the Aged Care Financing Authority. The opinions in this article should not be read as being an expression of the views of the Aged Care Financing Authority.

**References**

1. First introduced as Community Aged Care Packages or CACPs (equivalent to former hostel or low level residential care) and subsequently expanded to Extended Aged Care at Home or EACH (equivalent to nursing care or high level residential care).
2. This amount (which is indexed) is considered sufficient to encourage investment in renewing and expanding services.
3. Provider discretion to charge a basic daily fee up to 17.5% of the single pension was continued.
4. The Aged Care Reform Roadmap prepared by the Minister for Aged Care’s Aged Care Sector Committee.
5. Productivity Commission Housing Decisions of Older Australians December 2015
6. Ibid
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CONSUMERS WILL gain from

by Richard Gray AM
Senior Aged Care Advisor
February 27 2017 was a watershed moment in the history of aged care reform in Australia. From that date, for the first time, consumers assessed as needing and allocated a home care package level of services actually assumed control of the package instead of the package being controlled by an approved provider.

Since the late 1980s when the rationing and distribution of aged care places was introduced and controlled by the Commonwealth government, aged care places (initially nursing home and hostel beds and subsequently home care packages) were allocated according to a planning ratio of places per thousand people aged 70 plus. Based on this formula, the places were allocated through a competitive application process to approved providers in specific geographic locations. Basic home support services such as meals on wheels and domestic assistance through the Home and Community Care (HACC) Program remained under the province of the states and territories.

Demand for places in most locations outstripped the supply, meaning that residential aged care facilities were full and providers operated waiting lists. Home care packages were rationed according to three levels and not all providers could deliver all three levels of care. This meant that in some geographic locations there were waiting lists for some care levels whilst in neighbouring regions there were package vacancies. The provider held the package and controlled how it was used and the services and hours of services provided to the package consumer. The concept of individuals having control and choice over their aged care services and the providers that deliver them was not considered.

The Productivity Commission’s 2011 report Caring for Older Australians stated that recipients of aged care, the consumers, should have control over the services they receive. The Commission concluded that a more consumer-driven and market-based system was needed if consumers were to have greater choice and control.
The April 2012 release of the Labor Government’s Living Longer Living Better Package of reform measures became the first step in a ten-year process of increasing consumer choice and creating the basis for a national aged care system by consolidating home care and home support and the Commonwealth’s aged care programs under the policy of the one level of government.

The package also included increasing consumer choice by lifting the rationed service provision target to 125 places per 1,000 people aged 70 and over, allowing more services to be delivered in the home, introducing consumer directed care and individual budgets in home care, and improving consumer information to support choice through the myagedcare website and contact centre gateway.

“Consumers should welcome this ‘fair bargain’ as they hold the cards of choice and exercise market power through that choice.”

However, realising the full potential of consumer choice and control and service provider flexibility to be responsive to consumer needs and preferences requires the removal of service rationing.

The next step in the building blocks of reform came with the Abbott Government’s endorsement of an Aged Care Statement of Principles to guide the thinking. The then Assistant Minister for Social Services invited the Aged Care Sector Committee to develop a ‘roadmap’ setting out the short, medium and long-term actions required to achieve aged care services based on these Principles.

The Principles envisage a system architecture where:
- funding follows the consumer;
- consumers and informal carers are empowered to exercise choice and control;
- services are demand-driven;
- providers compete on quality, value and performance;
- provider revenues are market-based;
- consumers make an equitable contribution to their care costs according to their means; and
- there are safety nets to protect consumers.

The system would then meet the assessed care needs of the consumer and empower them to use their means tested care subsidy to choose where their care and support services should be delivered, in their own home in whatever form or in residential aged care, and which provider(s) delivers those services. Providers would be empowered to make business decisions on the forms of aged care they wish to deliver, where they choose to deliver it and the size and complexity of those services. In the case of residential aged care, providers would decide how many beds they should build and where these should be located. This would then be no different to any other service sector where the owners decide size and location.

In exchange for having choice and control, the consumer makes a contribution to their care from their assessed income and assets. Consumers should welcome this ‘fair bargain’ as they hold the cards of choice and exercise market power through that choice. Providers need to ‘win’ consumers to their services by providing innovative and better quality services and accommodation.

This freed up market for residential aged care would lead to new types of aged care services. Instead of large 60 to 80 bed complexes, smaller boutique styles will emerge. Families could get together, invest in a property that suits their preferred location and size for their frail aged relatives, supported by the assessed and funded care services needed. Families could form into corporate entities and become approved service providers or contract care to existing providers.

The flexibility that’s unleashed by freeing up the system would benefit generations of consumers. This consumer focused approach is supported by the National Aged Care Alliance (the Alliance) a unique sector organisation of 48 members comprising national peak organisations representing consumers, aged care providers, unions and professional groups.

The Alliance envisages that the new reformed single care and support service system would be consumer-led and demand-driven, with access based on assessed need. Consumers assessed as having care needs will be able to access care appropriate to their needs and preferences. The market will determine the nature, location and quantity of services. Government will no longer regulate the number or distribution of services, but will take other action if necessary to ensure provision in circumstances where services might otherwise not be provided and continue to regulate for quality.

Consumers will be able to choose the setting (e.g. in their home or in a variety of other residential settings); and type of care and support they will access. Providers will have greater flexibility and incentive to develop innovative and responsive services that respond to consumer needs and expectations including episodic, early intervention and restorative care programs.

Where there is insufficient market response, government will take other steps to ensure the system delivers services to all people assessed as in need of support and care. It’s in the interests of the community and the future consumers of aged care services that the pressure for continuing the reform journey must not slacken or pause.
Language at the Heart of Mission

On a daily basis I like the fact that words such as love, joy, formation, sacred and hope are always welcome at the table right there alongside quality reports, budget negotiations and patient care.

Tony Doherty, So You’re Working For the Catholic Church

For further information, or to order your copy, please contact CHA at secretariat@cha.org.au
It is exciting to be able to report significant progress over the summer months in tackling the process of implementing the ground-breaking Ministry Leadership Program (MLP), ready for commencement in July 2017.

The background and history to the development of this program in Australia was recounted in some detail in the December edition of Health Matters. This edition’s update will provide some insights into how the Australian program is now being shaped and developed to meet the high expectations that were set when the US Ministry Leadership Centre (MLC) team visited Australia in January 2016 to present a ‘taster’ of their program.

The Ministry Leadership Program coming into its own

We are delighted to have a finalised design of the program logo. The circle captures the sense of community and growth the program is striving to foster. The crosses in the shape of stars reference the constellation of the Southern Cross signifying the Australian context. The US Ministry Leadership Centre will soon be sharing their program resources through a website transfer which will also be branded and designed for the Australian program and then migrated to a local platform.
The Ministry Leadership Program - A work needing many hands

The Formation Team

A team of uniquely equipped people will play a crucial role in engaging participants with the content and process of the program. Interviews were conducted in mid-December and a team of six formators has been appointed. These are: Kerry Brettell, Gerard Smith, David Beaver, Ruth Morgan, Sr Karon Donnellon rsm, and Sr Rachel McLoughlin ibvm. Many of these people will already be known to and well respected by CHA members. They each bring a range of skills and experience across the disciplines needed in a team that will support the transformation of the leaders who will attend the program. From strong theological backgrounds, expertise in formation of leaders and on the ground knowledge of what it is like to lead others in the complex health, social services and aged care environments, these six people will be immersed in a specially designed training process under the guidance of the US MLC team.

We have been blessed to recruit such a richly skilled and diverse team who will complement the wider network of expert presenters, as well as coaches and mentors, each supporting program delivery in a variety of ways.

Program Integration Team

The relationship between the program, the organisation and the participant is critical to ensure that all of the outcomes of the program are realised and it meets all of the desired goals, those of participants, organisations and the wider Catholic community. A program integration team of representatives from the organisations sending participants is being brought together. The formator and program integration teams met and began working together at a workshop held in Sydney in March. This two-day workshop commenced the formal training and orientation to the program for both teams. It was also an opportunity to gather the people who are key to the program’s success and to build the wider community that will support the new Ministry Leadership Program.

Expert Presenters

We are presently in the process of identifying and engaging a team of expert presenters who will provide the core content from 2018 onwards. We are delighted to already be able to welcome to this team two people well known to members. They are Fr Frank Brennan sj, recently appointed CEO of Catholic Social Services Australia, and Dr Dan Fleming, previously of Broken Bay Institute, coordinator of the CHA Decoding the Code online ethics program, and now Director of Formation and Ethics, St Vincent’s Health Australia. Other expert presenters will be advised as they confirm their commitment.

Evaluation

A critical aspect of any new initiative or program is the assessment of perceived value and communication of concrete outcomes achieved. Sound stewardship dictates that we ensure resources are being used effectively and achieving the intended goals. Any formation program must result in both improved leadership behaviours and organisational outcomes that serve the mission. So it is vital the new program be able to identify and communicate with key stakeholders the impact of participation across the key domains for which the program is designed.

“Any formation program must result in both improved leadership behaviours and organisational outcomes that serve the mission.”
transformational leadership development, personal impact and organisational impact and this is of relevance not only to the program itself but to the broader evolution of management and organisational academic literature.

A draft evaluation plan has been developed which articulates ways we aim to evaluate:

- Program processes to inform ongoing development and quality improvement of the administration, participant support, content and learning process;
- Impact and outcomes so we understand the difference the program makes for the participant, both personally and professionally, and the participating organisations as well as the people they serve.

We are currently in conversation with a range of academic and other people experienced in research and evaluation who may want to partner with us as we undertake this important and exciting aspect of the program.

A Country Place – The importance of the right setting

A wonderful venue for the first two cohorts was finalised just before the Christmas break. It was extremely challenging to find a space that met our wide range of requirements, not least the capacity to accommodate close to fifty people with proximity to a capital city. The Country Place on the outskirts of Melbourne offers a beautiful retreat-like setting without the sophistication of an upscale conference venue. The quiet, leafy environment is sure to provide the opportunity to unwind and re-connect, so needed by those busy executives who will be attending.

Where to from here

A busy work agenda lies ahead between now and July. Following the March workshop, and drawing on the knowledge, skills and experience of both the formator and integration teams, work will commence on adapting and contextualising the US program so its language resonates and its content relates to Australian concerns and challenges. Invoices for the first forty places have been sent to participating organisations and we will be gathering the names of people registered for the first cohort to connect with and help them prepare for this significant opportunity.

We look forward to continuing to share with members the milestones on this extraordinary journey.

“A team of uniquely equipped people will play a crucial role in engaging participants with the content and process of the program.”

References

1. A new resource to assist evaluation of formation impact will soon be published through the Pathways initiative and provides further information and guidance.

health and healthcare: what Hunt MUST DO
Malcolm Turnbull’s appointment of Greg Hunt to the vacancy created by the resignation of Sussan Ley has prompted more than the usual opinions and suggestions about the health minister’s role and priorities. The portfolio is always a key one for voters, but concerns among consumers and health organisations are more potent than usual for several reasons: a growing awareness that significant changes are needed to the delivery, integration and funding of health and healthcare services; frustration at the failure of the Abbott and Turnbull governments to propose and implement coherent policies; and suspicions that the government’s stealth agenda is to undermine the universality of Medicare through further privatisation and higher out-of-pocket costs.

Minister Hunt comes to the task with a mixed record in his previous portfolios and has already sent mixed messages about his new portfolio. He has a substantial task ahead, and little time to get up to speed on the issues. Ley left many issues in the too-hard basket, work on the 2017–18 Budget is already under way, decisions must be made about increases in private health insurance premiums for 2017, and public trust in the ability and willingness of the Turnbull Government to protect Medicare is eroding.

I have written previously that the ideal health minister is someone with enthusiasm for the task at hand who will listen to and make the effort to understand the needs and concerns of consumers and professional groups, and who recognises that investments in health and healthcare deliver returns in productivity and social equity. He or she needs to be someone who can forcibly make the case to those who control the budget and can work across portfolios and levels of government to better deal with the needs of the population. Is this a description of Greg Hunt?

His record reveals a political chameleon. As environment minister he implemented Tony Abbott’s program of eviscerating the portfolio, abolishing the Climate Council, dismantling Labor’s carbon pricing scheme and supporting the coal industry. Famously, he resorted to Wikipedia to support the government’s position on climate change. But then, as industry, innovation and science minister under Malcolm Turnbull, he was credited with pushing innovation and providing a vision for CSIRO that includes a clear focus on “pure public good” science and climate research (albeit without additional funding).

In his first statements as health minister, Hunt was pledging a “rock solid commitment to the future of Medicare” even as the media were reminding him that his 2002 maiden speech had called for the expansion of employer-provided healthcare (funded through tax breaks) to free up government funds for spending elsewhere. Do these dichotomies reflect a willingness to toe the party line, a lack of policy acumen, or a whatever-it-takes approach to the task of the day? Now, as the designated minister for damage control, he will need a consistent grip on a policy more aligned with community interests.

continued next page
Sussan Ley will be remembered primarily as the minister for incomplete actions, largely because she was unable, unwilling or not permitted by higher authorities to make decisions. She failed to deal with the consequences of the Medicare rebate freeze or to complete a deal with the pathology industry over budget cuts to that sector; her tenure saw no action on the changes recommended by the Medicare Benefits Schedule, or MBS, Review; nothing significant has been done to make sure that taxpayers, directly through their premiums and indirectly through the private health insurance rebate, get better value for private health insurance; the energy and enthusiasm that once supported the Health Care Homes proposal has dissipated as a consequence of poor consultation and an unsustainable funding mechanism; and mental health reforms are languishing.

These issues now sit on Hunt’s desk. He would do well to recognise that they are not unrelated and must be addressed as part of a strategic approach to much-needed healthcare reform. No more policy on the run, no more tinkering at the margins, no more pushing decisions off for committee review.

Mental health would be a good place to start, and here the minister’s personal experiences can serve to guide him. He and his family will know about the need for stepped care, the frustrations when the right services are not available, how important support for family and carers is, the need to integrate physical and mental health services better, and how essential it is to enable people with mental illness to preserve their rights and dignity.

The fifth National Mental Health Plan has been out for consultation and there is general agreement that it needs a lot more heft to be a useful and strategic plan for mental health reforms and services over the next five years. The next iteration is due in February, although there has been a push to delay this to deal with the large number of concerns. In the meantime, the Primary Health Networks are struggling to commission mental health services with constrained funds and little guidance, and to integrate services for those with severe and complex mental illness with the rollout of National Disability Insurance Scheme services.

On another critical issue, the Health Care Homes trial was scheduled to be up and running by July; that looks less and less likely. While the primary reason for the stalled progress is doctors’ concerns about the poor levels of reimbursement for the care of chronically ill patients, other sticking points include e-health support, and data collection and analyses. The underlying approach needs to move from that of an all-the-eggs-in-one-basket, time-limited experiment to a model or models that can be tested, refined and scaled up in a culture of continuous improvement, evaluation and expansion.

The work of the MBS Review must continue at an increased pace and its recommendations implemented quickly if Australia is to have a Medicare system that matches the medical needs of the twenty-first century. So far, despite its inherent promise, there is little to show for two years’ work by the experts engaged on this task.

This review is essential to ensuring that Medicare delivers better outcomes and better value. Its importance was highlighted by a series of papers (with substantial Australian input) published earlier this month in the Lancet revealing the extent of overuse and underuse of medical interventions and the prevalence of low-value procedures. Another set of Australian studies has recently shown that both doctors and patients do a poor job of estimating the benefits and harms of treatments, screening and tests.

The solution to this complicated dilemma must be multifaceted: linking the work of the MBS Review with that of Choosing Wisely, more patient engagement, and rewarding doctors for the time spent in communicating with their patients. The MBS Review should recommend reimbursement levels for approved MBS items commensurate with the time and skill (both technical and cognitive) involved, and look at areas where bundled payments would be appropriate. This work would help deal with the growing gaps between what Medicare pays and what doctors and allied health professionals are charging, and thus limit patients’ out-of-pocket costs.

All of this work requires greater efforts to move to a patient/consumer-centred system. It is important to listen to and consult with all stakeholders, not just the Australian Medical Association, the Pharmacy Guild and the private health insurance funds. So it was disconcerting to hear Hunt describe himself as the “minister for GPs” and laud these professional bodies, all of which are already pushing him for action on their particular priorities.

In many ways, though, these are the easiest of the issues confronting the health minister. Sooner or later the Turnbull Government must confront the realities Tony Abbott tried to
dismiss. The first is that real reforms in healthcare services and financing require federal, state and territory governments to work together. Most of the major National Partnership Agreements in health and related portfolios have lapsed, despite the fact that the Gillard and Rudd governments showed they can work to the benefit of all stakeholders.

The second reality is that Hunt must recognise and make the case forcibly to his colleagues – especially those who control the budget – that his portfolio is about health. That takes the scope of his responsibilities well beyond healthcare and hospital funding, Medicare and doctors – important though these issues are. As the individual charged with overseeing the physical and mental health and wellbeing of the Australian population and the financial sustainability of the healthcare budget, Hunt can’t ignore issues such as obesity, climate change, and health and healthcare disparities, especially for Indigenous Australians.

Improvements in health and wellbeing among all Australians will require substantial and long-term investments in prevention, and a real effort to deal with the social, economic and environmental factors that influence health. In particular, managing the obesity crisis and its consequences should be a national economic priority.

Done well, these prevention initiatives will ultimately deliver pay-offs in healthcare costs and productivity, and reductions in health disparities. It’s ironic that the argument that “treatment without prevention is simply unsustainable” needs to be made in Australia, a country that has succeeded admirably in reducing tobacco use and protecting against skin cancer. Hunt’s best ally in this work should be Ken Wyatt, the newly appointed Indigenous health minister.

Hunt, Wyatt and the government’s Expenditure Review Committee must look at the lessons to be learnt from the current funding crisis (fast becoming a political crisis) in Britain’s National Health Service. Those problems highlight perfectly how bandaid healthcare solutions that focus on waiting times in emergency departments do nothing to meet long-term demands for care or improve health outcomes. What is required are investments in community and social services and increased support for primary care.

Australia’s systems for delivering and funding health, healthcare and social services need realignment, reform and integration inside and across all levels of government. Doing policy well is hard work, and implementing it effectively is even harder. But one more report, one more committee or advisory group, and delayed responses and actions will not make these tasks any easier. Is the new health minister – and his department and colleagues – up to the task?

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“It is important to listen to and consult with all stakeholders, not just the Australian Medical Association, the Pharmacy Guild and the private health insurance funds.”
Here is a myriad of issues facing healthcare organisations that want to ensure they have a sustainable and highly skilled nursing workforce now and in the future. It is a challenge that has not been lost on Professor Lee Boyd, who holds executive responsibility for nursing, education and research at Catholic healthcare organisation, Cabrini. Her goal is to develop a resilient workforce able to cope with change and flourish in complex circumstances while delivering excellent patient centred care.

“Together with our People and Culture colleagues, we have been working hard to develop and implement a cost-efficient and team-based strategic workforce model at Cabrini,” says Professor Boyd. “Health Workforce Australia has indicated that from 2025, we would have a major shortage of nurses in Australia, particularly speciality nurses such as midwives, critical nurses, intensive care, emergency department and perioperative nurses – and we are starting to see this realised now with shortages experienced across the spectrum of nursing.”

At the same time, healthcare organisations are experiencing an increase in the complexity of care required as patients become older and increasingly frail, as well as changing patient needs and expectations. Our staff are ageing too, with a high proportion of Cabrini’s nurses in the 45 to 59-year-old age group.

“We need to determine a transition to retirement program for our ageing workforce that respects their significant contribution and makes allowance for the fact that shift work and full time employment may be more difficult for them.”

Professor Boyd says enrolled nurses (ENs) are currently in particularly short supply. Both enrolled and registered nurses have crucial roles in delivering contemporary healthcare in both the private and public sectors.

“Our enrolled nurses are valued and vital members of our clinical team,” she says. “While this is often a pathway from another non-licensed healthcare role, such as a personal care assistant, and sometimes a platform to becoming a registered nurse, our enrolled nurses are involved in a wide range of disciplines from medical and surgical care through to aged care and palliative care, meaning that they have diverse and rewarding opportunities.”

A registered nurse completes three years or equivalent tertiary study to gain a Bachelor of Nursing at a university while an enrolled nurse completes a two-year or equivalent Diploma of Nursing within the TAFE or vocational education training sector.

“Our enrolled nurses work alongside our registered nurses and other members of the treating team at all times, in accordance with the decision-making framework and with scope of practice for all care givers clearly articulated,” explains Prof Boyd.

Essentially, healthcare administrators need to become better at predicting community needs, which will only increase with Australia’s ageing population.

“Cabrini needs a strategic nursing workforce plan so that we understand our current workforce and all the demographic factors associated with it; we need to know when staff are likely to retire, how long they have worked with us and at which grades/levels,” says Professor Boyd. “This is so that
we can plan for the future, and ensure a stable workforce to serve the people who entrust their care to us.”

Cabrini’s goal is to develop, resource and sustain a nursing workforce that enables provision of safe, high-quality patient care and to manage the costs associated with it. A number of concurrent initiatives are planned to achieve this. One approach adopted by Cabrini is a transition-to-professional-practice program (TTPP), rather than a standard graduate year.

“One barrier is the limited number of positions for graduates in established graduate programs,” says Professor Boyd. “Our transition-to-professional-practice program enables us to employ novice practitioners throughout the year who are supported in a fully structured program, rather than relying on one annual intake in February.”

Cabrini’s TTPP provides standalone, curriculum-based study days suitable for both enrolled nurses and registered nurses. Professor Boyd highlights the value in drawing these two groups of nurses together. “This is how they work together on our wards, which are collaborative and multidisciplinary environments, so we want them to learn together too,” she says. Another strategy being implemented at Cabrini, to support novice practitioners in the workforce, is team-based nursing.

“Team-based nursing, rather than allocating patients to particular nursing staff, means novices are always supported by experienced nurses,” says Professor Boyd. “By operating in this way, novices don’t have to struggle in a new workplace environment where all nurses are busy with their own patients – both the patient experience and the nursing experience is improved.”

Questions to inform a nursing workforce plan:

1) Which postgraduate courses should we invest in?
2) How many nurses and midwives do we need to provide high quality patient care?
3) What is the mix of nursing skills we need?
4) How do we manage absenteeism?
5) How are we managing our full-time equivalent staff versus costs?
6) Do we need health assistant or personal care assistant roles? If so, how many and whereabouts?
7) Which roles should we employ and which should we outsource?
8) How do we reduce our usage of nursing agencies?
9) What outcomes do we want to achieve?

Professor Boyd is interested in exploring a collaborative approach among Catholic healthcare organisations. For example, a Catholic health alliance for enrolled nurses where nurses are employed according to mission, values and cultural fit, and teach what they need to know in relation to patient experience, clinical care and professional conduct.

“We need to be smarter and to stop working in isolation – we all share common problems.”

While these initiatives are promising, the challenges in developing a cost-efficient, team-based strategic workforce model are many and varied. These include:

- Data – for example, integrity, accuracy, access and understanding
- Uniqueness of each clinical ward and department – for example, how the service is delivered (operational hours and length of stay), the kinds of patients who receive care (surgical versus medical) and the complexity of their needs
- Workforce – for example, models of care, rostering practices and the mix of skills

Professor Boyd extends the notion to specialty nursing. “One of the challenges we face is the difficulty for one organisation to provide all of the experience required in specialty nursing, particularly in the private sector,” says Prof Boyd. “We could provide great experiences for our people across Catholic private and public healthcare organisations, including exchange opportunities for staff who are already qualified, as a potential retention strategy.”

Professor Boyd believes that through collaboration among CHA colleagues, and solving common problems, the sector will become “unbeatable”.

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“We need to be smarter and to stop working in isolation – we all share common problems.”
“Less than half of the people in aged care with depression are properly diagnosed and treated, despite around 50 per cent of residents suffering from this mental illness.”
With the ageing of the population, more and more people will be entering residential aged care facilities. One of the major problems experienced by residents in these facilities is that their mental health problems are undetected and not well managed. However, despite Australia’s ageing population, there has been limited research examining how organisational factors can bolster, or hinder, residential aged care workers’ ability to manage the mental health of residents, especially the behavioural and psychological symptoms associated with dementia.

Whilst the transition into care generally focuses on the physical care needs of residents, there is often a lack of attention on their psychological needs, particularly in their first six months of institutional care, which is known to be a period of critical risk.

This poses significant risk for residents and caregivers, as residents are likely to mask their mental health needs and they run the risk of not having their needs addressed. Furthermore, aged care workers are frequently presented with difficult behaviours to manage, without the adequate training or knowledge to identify or manage symptoms.

Although it can be difficult to acknowledge, the unfortunate reality is that mental health problems are rife in aged care facilities and alarmingly, less than half of the people in aged care with depression are properly diagnosed and treated, despite around 50 per cent of residents suffering from this mental illness.

Despite the prevalence of mental health issues such as dementia and depression in aged care facilities this problem is further exacerbated by the finding that many aged care staff don’t feel confident in identifying, managing or treating residents experiencing issues with their mental health.

78 per cent of patients with mental illness and dementia display difficult to manage behaviours, including violence, screaming, intrusive wandering, and sexual inhibition. Often, these conditions occur alongside other comorbid medical conditions, making it difficult for carers to detect the individual issues of depression or dementia, and so using medical interventions for these psychological problems.

These behaviours can be traumatic for both the patient and care nurse; therefore, it is vital that they are treated and managed appropriately, and in a timely fashion.

by Professor Marita McCabe
Director Institute for Health & Ageing
Australian Catholic University
However, the reality is that the management and treatment of these symptoms is often limited. Due to a technicality in the Government’s Better Access Medicare program, almost all aged care residents are excluded from receiving psychological mental health treatments and plans, as they are not considered to be “in the community”.

With a lack of Government support for the therapies and treatments that many residents require beyond medication, it remains up to their carers to manage their conditions to the best of their ability. But what happens when the carers themselves, the last line of defence, feel ill-equipped to deal with the behavioural and psychological problems associated with dementia and other mental illnesses?

Management of mental health is a significant issue for carers in aged care centres. With the prevalence of mental illness in aged care centres varying between 5 per cent – 82 per cent, and studies demonstrating the benefits of early diagnoses and interventions, it is important for carers to be equipped with a good knowledge of how to detect and respond to these mental health concerns. Yet, rigid routines and time restraints on carers, and systemic communication problems between staff, have resulted in low levels of knowledge and self-efficacy of mental health treatments.

I recently led an NHMRC-funded study with other researchers from Australian Catholic University’s Institute for Health and Ageing and Deakin University that examined the factors relating to the confidence of workers caring for aged care residents with dementia or depression. Our earlier work had indicated that the workplace was an important factor shaping the knowledge and skills of care workers. The purpose of this particular study was to determine which workplace factors, such as autonomy, supportive workplace relations, job stress, and recognition of competence and ability, contributed to the confidence of aged care workers to manage both depression and behavioural problems of residents.

255 aged care staff across 21 residential care facilities participated in the study, and helped to confirm previous findings that autonomy, support and job stress were the key factors in care workers’ confidence in managing cases of dementia and depression.

Carers felt frustrated and unsupported due to the limited level of care they feel comfortable and qualified to provide to their residents. This, combined with a lack of governmental support, is placing both our older Australians and their caregivers in a vulnerable situation.

An organisational climate that supports and fosters the autonomy of carers was found to be a significant factor in increasing carers’ confidence in identifying and managing mental illnesses in their older patients. Additionally, supportive working relationships between senior and junior nurses positively impacted respondents’ levels of confidence in managing such conditions. In fact, the findings clearly demonstrate that staff believe managing difficult patient behaviours collaboratively, but without stifling carers’ autonomy, is a huge benefit in fostering positive feelings of self-efficacy.

As expected, senior nurses reported a higher level of autonomy and knowledge of depression than their junior counterparts. However, they also reported higher levels of job stress, which contributes negatively to their self-efficacy in managing depression and dementia. Surprisingly, recognition of carers’ competence and ability was not a contributing factor to self-efficacy across both senior and junior nurses.

It’s clear from the results of our study that organisational change is crucial to improving the confidence and self-efficacy of aged care nurses in managing mental health concerns of residents. But there’s no quick fix; aged care facilities will need to look at how every level of their business can ensure staff are empowered with the confidence and self-efficacy to effectively and competently manage residents’ mental health issues.

Currently, the working environments in residential care are a major contributing factor to their lack of confidence; the rigid schedules and high job stress are compromising personal autonomy, and do not foster the supportive environment that workers need to improve self-efficacy and share collective knowledge.

Equipping staff with the knowledge and skills is an important ingredient in their management of these conditions. Equally important is the promise of a collaborative, supportive, and yet independent workplace environment, where personal autonomy is valued and supported by workplace structures. If the carers can feel supported in their workplaces, their level of support provided to their residents can improve markedly, helping to provide potentially life-saving care, and ensuring that older people live the remainder of their lives in the best possible conditions.

About Professor Marita McCabe, Director Institute for Health & Ageing

Professor Marita McCabe is a highly regarded academic who conducts theoretical and applied research in the areas of body image disorders, aging, depression, sexual health and the mental health and wellbeing of Indigenous people across the lifespan.

She has published more than 400 refereed articles in these areas. In the last 10 years she has obtained more than $12 million in Category One research funding. She is a Fellow of the Australian Psychological Society (APS) and a member of the Clinical, Health and Forensics Colleges of the APS.

Professor McCabe joined ACU’s Institute for Health & Ageing from Deakin University, where she held the position of Alfred Deakin Professor in the School of Psychology. She was also the Director of the Centre for Mental Health and Wellbeing Research at Deakin.
Decoding the Code

An online program in Catholic ethics for the health and aged care sector

“This initiative is aimed at forming leaders in ethics to strengthen the ministry of healing”.

Suzanne Greenwood
CEO, Catholic Health Australia

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Thursday, 27 July 2017, Brisbane
Course commences with an introductory seminar
Melbourne 9.30am – 11.30am
Brisbane 10am – 12pm
Brisbane twilight event 5pm – 7pm
followed by online coursework over a number of weeks

Venues
Melbourne – Cabrini Hospital, Malvern Auditorium, Level 2, 133 Wattletree Rd, Malvern VIC 3144
Brisbane day event – Mercy Community Services, Happy Haven Building, 125 Queens Road, Nudgee QLD 4014
Brisbane twilight event – Mater Misericordiae Ltd, Des O’Callaghan Auditorium, Kelly Building, Raymond Terrace, South Brisbane QLD 4101

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Pathways
Effective Governance and Leadership for Mission
The early 1980s saw the emergence of Australia’s first bioethics centre, located at St Vincent’s Hospital Melbourne with Nicholas Tonti-Filippini as its foundation research officer and Australia’s first hospital ethicist. Following the closure of the St Vincent’s Bioethics Centre (1982-1990), collaboration across Catholic healthcare systems led to the establishment of the Caroline Chisholm Centre for Health Ethics in Melbourne. Comparable centres had already emerged in other States:

- Adelaide: Southern Cross Bioethics Institute (which closed in 2012 with its resources transferred to the Adelaide Centre for Bioethics and Culture);
- Brisbane: Queensland Bioethics Centre, an initiative of the Archdiocese of Brisbane;
- Perth: L J Goody Bioethics Centre, an initiative of the Archdiocese of Perth;
- Sydney: Plunkett Centre for Ethics, a joint initiative of Australian Catholic University and St Vincent’s Hospital Sydney.

In the intervening 35 years, other eminent Australian bioethicists, who have also made a vital contribution to Catholic healthcare and research, and public advocacy and policy development, include:

- Rev Dr Walter Black MSC, former Director of the Goody Centre;
- Dr Ray Campbell who retires this year as Director of the Queensland Bioethics Centre;
- Sr Regis Mary Dunne, founding Director of the Queensland Bioethics Centre;
- Rev Professor Norman Ford SDB, foundation Director of the Caroline Chisholm Centre;
- Dr Liz Hepburn IBVM, former Director of the Queensland Bioethics Centre;
- Fr Kevin McGovern who recently concluded his term as Director of the Caroline Chisholm Centre;
- Fr Cormac Nagle OFM who has had a long association with Mercy Health;
- Rev Dr Joseph Parkinson, Director of the Goody Centre;
- Associate Professor Bernadette Tobin AO, foundation Director of the Plunkett Centre; and
- Fr Bill Uren SJ AO, foundation Director of the Goody Centre and currently Rector of Newman College at the University of Melbourne.

There were others who taught in our seminaries and theological colleges and were also involved in pioneering discussions on bioethical issues.

With Professor Tonti-Filippini’s death in 2014 and other senior leaders in bioethics relinquishing key roles, it is timely to consider succession planning so that the Australian Catholic health sector has future generations of bioethicists who continue this fine tradition. During 2016 a ‘conversation’ about succession planning commenced within Mary Aikenhead Ministries and its health ministry, St Vincent’s Health Australia. Mary Aikenhead Ministries then explored with Catholic Health Australia (CHA) if there could be an opportunity during the 2016 CHA Annual Conference held in Sydney on 29-31 August to widen the ‘conversation’.

CHA enthusiastically responded to the request and Wednesday, 29 August saw Suzanne Greenwood, CHA CEO, join some 15 conference delegates from various arms of Catholic health and higher education for the ‘conversation’ – the key questions were:

- What are we doing about bioethicist succession planning for the Catholic health sector?
- Should the sector be working collaboratively on an initiative(s)?

On the occasion the nature of the role of bioethicist was considered – it was agreed that it encompassed both pastoral and academic elements, the former requiring the appropriate disposition and the latter formal qualification. Significantly, while the conference ‘conversation’ focused...
on Catholic healthcare, it is important to note that the role of most of the current Catholic ethicists/bioethicists is to serve a much wider clientele than the members of CHA.

In relation to succession planning, the value of mentoring was highlighted, and, as noted above, the Catholic sector has eminent and highly experienced practitioners who generously foster younger colleagues. In support of future planning and younger colleagues, the Caroline Chisholm Centre has been bringing together a group of bioethicists four times per year. Highlighting another key development, the University of Notre Dame Australia advised that internationally renowned Australian ethicist Margaret Somerville had recently been appointed Professor of Bioethics at the University.

The ‘conversation’ included some discussion on the ‘pool’ from which future bioethicists might emerge. Noting that bioethics was a subset of ethics, it was highlighted that ethicists and moral theologians have made a major contribution to date, but it was desirable to have professionals from diverse backgrounds, including health specialisations, to train as prospective bioethicists. The successful partnership between CHA and Broken Bay Institute in developing and offering ‘Decoding the Code’, the online course on Catholic ethics designed for the health and aged care sector, was likely to ‘whet the appetite’ for further related study, as could experience on a Human Research Ethics Committee.

Consideration was given to the availability of postgraduate courses to prepare future bioethicists – the John Paul II Institute for Marriage and Family, Monash University and the University of Sydney currently offer Master of Bioethics programs and the University of Notre Dame Australia advised that it is developing one. Course provision and research training in bioethics could be considered as a potential area for collaboration amongst Catholic higher education providers. It was noted that the many options available in the United States of America may not be readily accessible to Australian professionals, although there are some online options – for example, Loyola University in Chicago offers an online master’s degree and a hybrid doctoral degree in bioethics and health policy, as well as other postgraduate programs for health care professionals.

An issue to consider is a career path for bioethicists – this was seen to be lacking in Australia and discouraging for qualified bioethicists who are often found working in other fields. In contrast, in America, there are many options to qualify as a bioethicist and also clearly articulated career options.

The time commitment for professionals, together with the substantial costs, of undertaking postgraduate studies in bioethics in Australia or overseas was highlighted. It would be advantageous for Catholic health providers collaboratively to offer scholarships and internships in support of succession planning to ensure future generations of bioethicists who are qualified for and committed to working in the Catholic health and aged care sectors. CHA indicated that it could play a coordinating role in this regard.

The recent conversation was lively and, in particular, timely in addressing a critical issue for future Catholic health care provision and research. It was agreed that the conversation be continued at the CHA Governance Conference on 27-28 March in Coogee.

In the meantime, CHA would welcome your comments and suggestions on succession planning for future bioethicists. Please email CHA on secretariat@cha.org.au or call (02) 6203 2777.
continuing the mission: educating Catholic bioethicists in Australia
Catholic healthcare is defined by its deep commitment to protecting human dignity and advancing the healing mission of Jesus Christ. It is widely recognised that the success of the enterprise depends upon the cultivation of an ethical sensitivity appropriate to a Christian organisation.

A significant part of this involves training of Catholic bioethicists for the next generation; bioethicists are an integral part of the Catholic healthcare enterprise, and provide vital guidance to staff and patients on a range of complex ethical issues.

Currently, there is limited scope for aspiring bioethicists in Australia to gain an education in the Catholic bioethics tradition, and many have to turn to secular institutions for a more generic ethics education, or indeed, to Catholic universities overseas.

The Institute for Ethics and Society (IES), along with several other stakeholders in Catholic Healthcare, have been studying the extant career pathways for Catholic bioethicists in Australia, and considering models of bioethics education in North America that might be usefully implemented in an Australian context. It is our wish to share certain preliminary observations with the broader Catholic healthcare community, in the hope that these can provide a guide for future strategic developments in bioethics education.

Catholic bioethics training in Australia: the lay of the land

Education in Catholic bioethics in Australia is typically carried out in smaller theological colleges attached to diocesan or religious seminaries. These institutions, such as the Catholic Theological College in Melbourne, often subsume specific courses on Catholic bioethics into broader moral theology or pastoral care programs. The Australia Catholic University formerly offered a masters qualification in applied ethics in healthcare, yet this program no longer exists. The University of Notre Dame Australia has planned to offer study in bioethics for some time, and with the recent appointment of world-renowned Australian bioethicist Margaret Somerville as Professor of Bioethics at Notre Dame’s Sydney Medical School, a bioethics program of study has been included in the Doctor of Medicine Course in 2017. A specific Master’s level course may be developed around Professor Somerville’s areas of expertise in the coming years.
The pressing issue in an Australian context is not the quality of the teaching of bioethics at our institutions; indeed, many Catholic bioethicists teaching in Australia are internationally respected. There is, however, an unfortunate prejudice among employers against qualifications from smaller institutions – and also institutions of a religious orientation – and this bias will often influence students’ decisions about whether to pursue education at a small, religious college rather than a large, secular university.

Many students will, therefore, attend secular tertiary institutions that have impressive graduate programs in bioethics and healthcare ethics. Yet these courses lack the foundation in Catholic philosophy and theology requisite for work as a Catholic bioethicist. Students from secular universities must either educate themselves through personal study, or seek internship opportunities in Catholic healthcare institutions.

This brings us to the common concern expressed by Catholic healthcare employers, namely, that it is rare to find graduates with both the sound knowledge of Catholic theology and philosophy and relevant clinical knowledge and experience.

**Models of Bioethics Education in North America**

While the American Catholic healthcare and university system is significantly different to Australia, we can nevertheless profit from considering the established educational and training pathways for bioethicists in the US.

There appear to be three features that are distinctive of the American system.

The first is that several highly regarded American Catholic universities offer prestigious graduate bioethics qualifications. Institutions ranging from Georgetown University in Washington DC to Loyola Marymount University in Los Angeles offer Master’s degrees in bioethics and healthcare ethics, and these degrees include optional moral theology units. Some of the academics in these courses were instrumental in the establishment of the discipline of modern bioethics, and others have strong links with government policy departments. Importantly, the courses are very interdisciplinary, with faculty consisting of academics from a wide range of backgrounds (law, medicine, nursing, philosophy, theology, social work, and so forth).

The second feature is that Catholic universities often have clinical ethics centres attached to hospitals and allied health institutions. These centres allow students to gain exposure to real-world ethical issues, and also serve to attract medical students and doctors already employed in the hospital to a career in bioethics. Importantly, many students will not have a science background, and therefore need opportunities to increase their clinical literacy. One example of a Catholic clinical ethics centre is the Pellegrino Center for Clinical Bioethics at Georgetown University (PCCB). The PCCB offers graduate courses in clinical ethics, and provides students with the opportunity of accompanying staff on ward rounds at Georgetown Medstar Hospital. Students can also sit in on PCCB clinical ethics consultation sessions. Through these experiences they gain a first-hand knowledge of ethical dilemmas that typically arise in a Catholic hospital setting.

The third feature of the American system is that, even where there is not necessarily an extant bioethics or healthcare ethics centre, Catholic healthcare organisations in the US tend to offer internships to graduate students. In the last five years CHA-USA has produced a list of potential internships for graduate students interested in healthcare ethics, and this list details several internships offered by hospitals, hospital networks and allied healthcare facilities across the country. In these programs, students are guided by experienced clinical ethicists who have both deep theological and philosophical understanding of ethics, as well as the pastoral skills necessary to meet the needs of the diverse patients and staff in Catholic institutions today.

**Recommendations for the Australian System**

Bearing in mind the manifest differences in the Australian and North American healthcare contexts, we can tentatively offer three recommendations for future strategic developments in bioethics education.
1. Catholic universities should seek to develop graduate courses in bioethics with a strong basis in moral theology and philosophy

Without the availability of prestigious tertiary qualifications in Catholic bioethics, we risk discouraging the next generation of ethicists from pursuing a career in the Catholic sector.

2. Australian Catholic healthcare institutions should consider establishing bioethics internship programs to educate new ethicists

Bioethics internships – particularly those in well-established Catholic healthcare institutions – offer students a vital opportunity to segue from an academic context into a clinical environment. They allow students to develop the virtues and skills necessary to translate their knowledge of the Catholic intellectual tradition into action-oriented professional virtues.

3. Catholic educational and healthcare institutions should facilitate development of clinical ethics in Australia

A broader problem facing bioethics in Australia is that the field of clinical ethics is not well established. In comparison to an American context, where clinical ethics services and committees are commonplace, Australian hospitals have limited clinical ethics infrastructure. Where clinical ethics services do exist, they are fairly ad hoc and lacking oversight. It is in the interest of Australian Catholic healthcare to consider how it might aid the development of clinical ethics consultation services and committees.

One way to ensure Catholic bioethics in Australia continues to mature is to explore the possibility of strategic partnerships. It would be mutually beneficial for Catholic healthcare providers, universities, research institutions, and diocesan leaders to work together to create impressive graduate programs, clinical ethics centres, and a culture that fosters a deep philosophical and theological engagement with healthcare ethics. This vision is ambitious, but it is not beyond the reach of a motivated and united Catholic healthcare community.

Conclusion

In this article we have offered a very brief overview of the state of Catholic bioethics education in Australia, and considered how it might be improved. While there are certain limitations to the American educational models, we do, however, believe we have much to gain from considering how a dynamic clinical ethics profession has developed there. Strategic policy development by stakeholders in Catholic healthcare help foster renewed interest in Catholic bioethics among the leaders of the next generation. For institutions concerned to preserve a Christian ethos, this is a task of paramount importance.

“A common concern expressed by Catholic healthcare employers [is], namely, that it is rare to find graduates with both the sound knowledge of Catholic theology and philosophy and relevant clinical knowledge and experience.”
holding the Heart at the centre: pastoral encounters in a disability community
The services of St John of God Accord were founded in 1953, and have evolved from support for intellectually disabled young people into support for adults living with intellectual and other disabilities. St John of God Accord merged with St John of God Health Care in 2007, and now supports over 400 clients in a variety of ways, including accommodation, day services, respite and individualised support, to assist them to live happy and fulfilled lives. As our Vision statement says, ‘we invite people to discover the richness and fullness of their lives, give them a reason to hope, and a greater sense of their own dignity’.

Professional pastoral care is a vital part of the support provided. People living with intellectual disability, and their families, have spiritual and emotional needs that are often not well understood or recognised by others. When working with our clients, we are often made aware of their deep spiritual lives and their emotional needs, even though their verbal communication may be restricted. As Pastoral Care Practitioners we are encouraged and educated to ‘Hold Space’ with the client. This is particularly important for our clients who need a safe, caring space created so that they can communicate without reservation. Pastoral care walks with them on their journey, accepting them as they are, and in no way attempting to ‘fix’ or prescribe the outcome of that journey.

Walking with the Neglected and Marginalised

‘God is a God who never forgets us, who says: ‘I will always be with you, I will always be for you, in all things at all times.’

On our journey as we walk the path of pastoral care, we walk with gentleness and openness. We pray that with each pastoral experience we will be given more strength to walk sensitively with our clients. Within each pastoral experience we have learnt that ‘Holding Space’ is important, but holding a person’s most precious organ, their ‘Heart’ is paramount. We believe that as we gently cradle their fragile, exposed ‘Heart’, we cherish this as a gift they place with us. The ‘Heart’ beats loudly within the pastoral experience, sharing its deepest emotions and feelings. In our pastoral work, two inspiring people are Mother Teresa and John Swinton. Mother Teresa’s teachings about unconditional love, empathy, and happiness for mankind contain a theology of pastoral care that, we believe, should infuse our work. John Swinton, a Scottish theologian who works with disabled people, reminds us that humanity has forgotten groups of people, and challenges his readers to value humanity in its diversity rather than valuing people on their economic value to society, and to respect the dignity of the human person.

They have inspired us to talk about the ‘Heart Feelings’ and ‘Heart Emotions’ with our clients. We find clients respond positively to this language as they immediately relate it to what they feel deep within their soul. When a client is gently prompted with the correct language and they feel safe within the space created they may share the most meaningful ‘Heart’ stories.

Working with people who have a cognitive impairment, the danger of an overly clinical model of care is that their ‘Heart’ feelings and emotions may be ignored or completely bypassed, as though they are of little importance to their everyday existence. This may also affect family members and other carers, who are often given little emotional support. Essential conversations on emotional and spiritual matters are unable to be bulk billed or be had with clinicians who are trained to deal with sicknesses of the mind and body, rather than pains of the ‘Heart’. Their ‘Hearts’ are rarely given the opportunity to be held and nurtured by someone who cares for their story.

The following case studies highlight the way in which SJGA Pastoral Care has worked to pastorally care and hold the ‘Hearts’ of our clients and their families.

Case Study One

‘G’ is a sixty-two-year-old client, living with cognitive impairment and depression/bipolar disorder, who has...
resided in SJGA shared supported accommodation (SSA) in the eastern suburbs of Melbourne for around 12 years. He lived with his parents until he was in his late 40s – and his parents were in their early 80s. In his time at the SSA he grew to like his housemates, considering them good friends. Although usually content with his life, when in a downward spiral, G would socially isolate himself from his housemates, staff and carers. The staff would work hard to keep him involved in the community – his wellbeing of paramount importance.

G’s father passed away approximately four years ago and his mother was placed in a nursing home. The staff regularly took him to visit his mum and the relationship was a loving and caring one on both parts. G understood that his mum had dementia and he watched her deteriorate over time. Staff were aware of Mum’s declining health, and noticed that G’s depression was escalating, so referred G to pastoral care. After the referral, G’s mother’s health deteriorated quickly and she passed away. The passing of his mother was a time of grief and loss – and also brought back the trauma and grief of his father’s death.

“Working with people who have a cognitive impairment, the danger of an overly clinical model of care is that their ‘Heart’ feelings and emotions may be ignored or completely bypassed.”

Fortunately, G and pastoral care had already established a trusting, sound relationship and we were able to walk with him before, during and after the funeral, at times when his ‘Heart’ was in pain. The image that comes to mind is that he was offered the support and comfort of a warm blanket being wrapped around him when his inner soul needed comfort. We were able to hold his exposed ‘Heart’ at times when he wanted to talk about the deep heart feelings he felt for his mum and dad. There were times when he needed the safe space to share what was deep within and feel supported whilst sharing.

Case Study Two

There are times at SJGA when pastoral care ‘cold calls’ a client’s family. This is important when they have recently transitioned their family member into a SJGA service, so normally after a settling-in period of around a month a call is made. Our experience is that the parents of intellectually disabled adult children seldom receive appropriate spiritual and emotional support.

One recent call was to ‘W’, a mother who transitioned her twenty-one-year-old son into one of our SSAs.

After introductions, W responded with her heart, the exposed heart of a mother who needed to be heard, comforted and cared for at that time. She was given the safe space to talk, to feel supported, and to release what was deep within.

For almost an hour W talked with pastoral care about her guilt, deep sadness, joy and pride in her son transitioning into a SJGA home. She then spoke of how grateful she was for the comfort and support the conversation gave her.

Reflection

The essence of these pastoral encounters has been ‘the spirituality of attentive presence’. As Jesus listened to the Samaritan woman at the well, he gave her comfort and respect that she had not previously received. As Pope Francis suggests, ‘Often it is better to simply slow down, to put aside our eagerness in order to see and listen to others, to stop rushing from one thing to another and to remain with someone who has faltered along the way’. Our clients at Accord need to be listened to patiently. One effect of their disabilities may be that they don’t communicate as fluently as others, or that they have been ‘marginal’ to conversations of the heart – even conversations that are about them.

In the disability field, the term ‘social role valorisation’ is used to describe the need to affirm clients in their self-worth. Where this fails, their confidence in their own dignity can be easily damaged.

Final Words

Here at Accord we have seen a clear need for pastoral care in the community of people living with intellectual disability. Although there is a lack of research in this area, the benefits of this care are clear to us and we intend undertaking proper research to refine and improve the service we offer and as a gift to the whole sector.

In the St John of God Health Care Vision Statement, as quoted in our introduction, we declare that ‘(We) invite people to discover the richness and fullness of their lives, give them a reason to hope, and a greater sense of their own dignity.’ If we are to follow the path of Jesus, we need to treat all people as possessing an intrinsic human dignity, a dignity that is not dependent on conversational fluency, or social graces.
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Often when we think of pastoral care, we think hospitals and aged care services, and it is true that the pastoral needs of patients and residents are great. There is an equal and growing need for pastoral care of clients in the community.

Not only do these clients suffer from age related conditions, physical disability, emotional and mental disease and trauma and homelessness, but they are also typically extremely isolated and lacking many of the supports needed for daily living. It is into this environment that pastoral care can speak strongly bringing comfort and hope to those in need in their homes, in day stay centres and on the streets. This is what we do when we provide pastoral care in Catholic Community Services.

Catholic Community Services is the community care arm of Catholic Healthcare Ltd, based in Sydney NSW.

A Client Story

I have no family or friends. I am isolated in my life. And I find the fact that people come in and they care about me, they are constantly checking up on me when I am in crisis - it makes me feel that someone cares and shows there is a true Christian perspective to the support and the care that Catholic Community Services provide. (Maria)

Maria (de-identified) is a woman in her 40s with cerebral palsy, a physical disability, some depression and post-traumatic stress symptoms. Maria’s older brother was an “Elder” in the family’s church. He sexually abused Maria. She found this hypocrisy alarming and devastating. She was confounded and voiceless.

When she was older Maria moved to community care facilities but due to her physical disability and emotional vulnerability, again was easy prey to predators. Maria suffered sexual assaults at the hands of the carers. Maria struggled with alcoholism and homelessness.
“The act of being held emotionally often breaks feelings of alienation and clients are reconciled with past events or people.”
Maria began receiving pastoral care visits four years ago when her Care Coordinator alerted the Pastoral Care Team of her withdrawal from community and friends. Maria would not have male carers and she never allowed herself to be in a room alone with others. She would only receive a female pastoral care support person.

The Pastoral Care Coordinator organised a visit to Maria’s house and through gentle discussion and questioning, assessed the need for ongoing pastoral care. Maria was very tentative and untrusting to begin with, however, slowly over time she built a relationship with the Pastoral Care Coordinator who was a constant presence to Maria over many months. Maria began to trust and slowly revealed her story and the pain in her life from her past.

The Pastoral Care Coordinator worked closely with the Care Coordinator to improve Maria’s situation. Due to her earlier pain and hurt, Maria did not call herself a religious person however she did believe in God as creator. She had separated her image of God from her experiences at the hands of professed ‘God-fearing people’. Maria had not blamed God for her abuse and so as the pastoral care visits continued, she gained greater insights into spirituality and the meaning of Church and understood the flawed humanity of people. She came to understand her past abuse to be antitheses to Christian beliefs.

The greatest opportunity for healing Maria’s hurt and pain arose during one session when Maria was invited to let the Pastoral Care Coordinator pray for healing, to apologise on behalf all those who hurt her in her life. Maria agreed to this prayer. This was a powerful moment creating a sense of gravity and freedom for Maria to move forward. She was able to place the pain and hurt of past years before God and receive the apology of her abusers through the words of the Pastoral Care Coordinator. The power of this act of reconciling her past with her present took place in her heart, gently held by the Pastoral Care Coordinator. Maria allowed herself to receive love and hope and as a result felt a sense of great joy.

Maria’s story reflects the powerful and positive impact the continued presence of an experienced and highly trained pastoral care coordinator can have on the life of an isolated, hurt and lonely person. It reflects how constant ‘presence’ to another can change their lives.

**Breaking Isolation & Building Links**

The Pastoral Care Coordinators work with clients to build links and stay connected with their local church communities. In this way ongoing support can be derived from the local faith community including volunteers from local church groups visiting isolated and lonely clients.

Directed by client need, links are also formed with local social groups such as the local library, book clubs, garden groups and other social groups.

Catholic Community Services provides Pastoral Care to approximately 150 clients across Sydney. The visits are usually 45-50 minutes in length. The needs of the clients are varied – there are clients with diabetes, depression, vision impairment, early dementia, Bi-Polar disorder, anxiety, agoraphobia, hoarding and squalor tendencies. There are LGBTI and amputee clients.

“Maria had not blamed God for her abuse and so as the pastoral care visits continued, she gained greater insights into spirituality and the meaning of Church and understood the flawed humanity of people.”

Following a referral, the Pastoral Care Coordinator usually visits the client to ascertain whether Pastoral Care is the best support service or if another type of service may be required. In some cases, a client may be lonely and the companionship of a volunteer would suffice. In other situations, the Pastoral Care Coordinators establish small groups of clients that meet each other socially to share prayer and discuss issues of life.

**The Program**

Unlike Pastoral Care Coordinators who work in residential or hospital settings, the community based Pastoral Care Coordinator works in a more solitary environment so systematic centralised recording of information through mobile devices is important for health professionals in cross checking clients’ overall wellbeing.

Often clients have recently lost a loved one, or have been diagnosed with terminal illness. They may be struggling emotionally or not able to find meaning in their lives. The act of being held emotionally often breaks feelings of alienation and clients are reconciled with past events or people. As in Maria’s story above, they move from being ‘stuck’ or ‘trapped’ to being liberated.

In saying the above there are exceptions to receiving clients on the Pastoral Care Program such as when they have acute mental health issues (and they are referred to a Psychologist/ Counsellor) or a current critical situation where referral to other programs is required until the client is stabilised e.g. homelessness, hoarding & squalor, alcoholism.
The Purpose

The purpose of Pastoral Care is to provide effective pastoral support with sensitivity, openness and respect and when appropriate, engaging clients and/or staff in prayer or rituals.

The client’s sense of loss is at times multifaceted as they lose their partner, children, independence and health, rendering them dependent, vulnerable, at times hurt and confused about their life direction. The Pastoral Care Coordinator begins the journey of companionship by listening and helping to lead people to find meaning, reflects on memories and to celebrate life’s milestones. It is often at this time that reconnection with family, friends, parish or community is most powerful.

The Pastoral Care Coordinator also leads reflections and liturgies with staff across the community sector. They provide prayers and help celebrate main feast days such as Christmas and Easter. At times they are invited to plan and lead funeral and memorial services.

Stress and Burn-out

Pastoral Care Coordinators can be subject to stress due to the long term and ongoing support of clients. At times clients moving into residential or hospital also need ongoing support as they settle into new surroundings and grieve the loss of their homes and living independently. Pastoral Care Coordinators often transition these clients to Pastoral Care teams within the facilities.

Pastoral care burn-out is an issue gaining more traction and concern within the sector. As a team, we discuss and highlight the importance of work-life balance and the need for flexibility in leave breaks, to ensure Pastoral Care Coordinators are themselves nourished to do their work to the best of their ability.

Resourcing

The resourcing of this rich and supportive program is an increasing challenge. The impact of an aging population with diverse cultural, social, health and financial needs of individuals, requires health providers such as Catholic Healthcare to commit to this ongoing support of people so that clients experience the spiritual healing and self-integration that then assists with the overall wellbeing of the person.

Our Pastoral Care Program seeks to provide care for the spirit and hope for the person. The words of client Helen (de-identified), who lost her only son and child gives voice to the power and presence of Pastoral Care:

“It helps me to believe in myself and to be in touch with a healthy part of myself, and not be so negative.....and to give me hope every day on this journey because it is hard. And it is easy to lose hope. So it brings a light into dark places, in your life.”

References

1 This article used the term Pastoral Care Coordinator. Some providers use other terms such as pastoral practitioner, pastoral worker etc.
can’t be what you can’t see: nurses spearhead initiative to grow Aboriginal participation in clinical workforce

Whether they’re ideas that save valuable seconds in an emergency, ease the reporting of hazards or improve the hospital experience for non-English speaking Australians, Catholic sector nurses and midwives find themselves at the forefront of innovation.

Late last year in Melbourne, Catholic sector nurses and midwives from across Australia came together for CHA’s Nursing & Midwifery Symposium. For the second year running, a session for nurses to present their ideas for innovation in health and aged care was held. The ‘Shark Tank’ session saw several finalists pitch their ideas to a panel of three judges; Patrick Tobin (CHA), Prof Michelle Campbell (ACU) and Bart Moye (HESTA).

With thanks to sponsors RogenSi, ACU and HESTA, a total of $6,000 in prize money was awarded to the winners of the three Shark Tank categories to assist the teams in the development and implementation of their innovative programs.

Deanne Riddington and Jade Murphy, from St Vincent’s Public Hospital Melbourne, won the Shark Tank category for Patient Safety & Quality. The winning initiative, a hands-on and immersive career day for Aboriginal and Torres Strait Islander high school students at St Vincent’s Public Hospital in Fitzroy, centred around Deanne and Jade’s passion for assisting Aboriginal and Torres Islander Australians to learn about and consider a career in nursing, with a view to grow Aboriginal participation in the nursing workforce.

Deanne says the $2,000 she and Jade were awarded for their Shark Tank win will be used to develop a pilot career day at the hospital – a recommendation they’ve been hoping to achieve for some time. Both Deanne and Jade aim to develop the career day program so that it can be easily appropriated to the specific requirements of any hospital.

“One of the key things I’m passionate about is that we have a number of Aboriginal patients come in to the hospital, but you don’t see many Aboriginal clinicians who identify as being Aboriginal,” said Deanne Riddington. “I’m passionate to see this change.”
“Aboriginal nurses have worked at the hospital in the past, but compared with the number of Aboriginal patients we care for, and compared to the Aboriginal and Torres Strait Islander population of Melbourne, clinician numbers have always been very low,” Jade Murphy explained.

“So we’ve taken it upon ourselves as a unit to enhance opportunities for Aboriginal people in nursing. The Aboriginal Graduate Program began in 2012 and was the first program of its kind in Australia. Now nine hospitals in Victoria have similar programs in place,” said Deanne.

Deanne Riddington, head of the Nursing Education Centre at St Vincent’s Public Melbourne, started nursing at 17 years of age and has worked in nursing for 30 years. Jade Murphy is currently Undergraduate Nurse Coordinator after holding the position of Graduate Nurse Coordinator at the hospital for nine years. Both have a passion for facilitating the training and on-going development of St Vincent’s significant nursing workforce. Jade oversees the clinical school St Vincent’s has with ACU, which is currently training its first Aboriginal students. And Deanne and Jade hope that these Aboriginal nurses will one day become the future leaders of the Aboriginal Graduate Program.

In 2015, Deanne was awarded a Winston Churchill Memorial Trust Fellowship which resulted in overseas travel in the year that followed to build upon the hospital’s pilot Aboriginal Graduate Nurse Program. She visited hospitals, universities, community groups, government and nursing organisations in New Zealand, Canada and Hawaii in 2016 to see first-hand what health services can be doing now and in the future to enable growth of employment opportunities for Aboriginal people in nursing.

“Because I’m not an Indigenous person, I travelled overseas to spend time with Indigenous nurse leaders as well as non-Indigenous nurse leaders to see first-hand how they work together to enhance opportunities for Indigenous nurses,” Deanne explained.

“It both convinced me and gave me the confidence that we have a role to play in introducing Aboriginal and Torres Strait Islander people to a career in nursing. And that hospitals have a much larger role to play in engaging high school students – to connect them with the idea of pursuing a health profession.”

In the early days of the program, Aboriginal Liaison Officer Michelle Gallagher was instrumental in connecting the hospital with a number of Aboriginal communities, both in Victoria and interstate. Communicating the goals of the program and listening to the concerns of Aboriginal communities assisted St Vincent’s to best tailor the program to provide supports specific to the needs of these communities.

“Healthcare organisations must be aware that many Aboriginal people who come in to hospital still have a fear of entering ‘the institution,’” explained Jade.

“It’s been demonstrated many times over that Indigenous people experience better clinical outcomes when Indigenous people are involved in the delivery of their care. And that’s one of the reasons why it’s so important to have greater Aboriginal & Torres Strait Islander representation in our healthcare professions.”

Deanne says St Vincent’s has been instrumental in supporting the initiative – right from the beginning – and Chief Executive, Susan O’Neill, regards the Aboriginal Employment Strategy as a priority of the hospital’s Reconciliation Action Plan.

“I’m pleased to say the program has been successful. We’ve seen a 350 per cent increase in Aboriginal nurses at the hospital since the program’s infancy in 2012, and we wouldn’t have achieved this without the support of our Indigenous Liaison Officers and the hospital’s senior leadership,” said Deanne. “It’s truly been a collaborative effort.”

“When I first came to work, I saw my gender and my culture represented throughout the hospital,” said Deanne. “I could see critical aspects of my identity reflected in the vast majority of my work mates.”

“If you can’t see your culture in an organisation, in a health service, or represented in the clinical workforce, then how on earth can you aspire to pursue nursing as a career? So the idea that ‘you can’t be what you can’t see’ has really driven us to this point in the program.”

“Importantly, when we attended CHA’s Nursing and Midwifery Symposium and presented in the Shark Tank, we had others approach us, saying they were interested in pursuing the model as well,” added Jade. “It was both affirming and extremely encouraging to have the support of our peers operating in the wider sector.”

“And this interaction is what we want – it’s our hope that this type of program will be taken up by every hospital in the country, so that there’s far more choice for Aboriginal nurses, and an increase in participation in nursing, as well as other healthcare professions, in the future.”

Both Deanne and Jade hope to share the progress of the Aboriginal Graduate Program and in particular their award-winning career day for Aboriginal and Torres Strait Islander high school students at this year’s CHA Nursing & Midwifery Symposium in November.

In the next edition of Health Matters, CHA will be speaking with Mercy Health’s Tegan Mortimer and Elizabeth Thomas, winners of the ‘Best Communications Strategy’ category with their high-tech solution to providing 24/7 real-time patient translation.
When the Truth Justice and Healing Council made its first major submission to this Royal Commission in 2013 it included a nine-point Commitment Statement by the Catholic Church leadership.

This in part said the leaders of the Church in Australia committed themselves to repairing the wrongs of the past, to listening to and hearing survivors, to putting their needs first and to doing everything the Church can to ensure a safer future for children.

Over the past four years, as the Church has been through what many would say has been the most intense and unforgiving examination of almost all aspects of its operations in Australia, the Council has worked hard to hold the Church leadership accountable to these words.

But more than that – to put these words into action.

And having been involved with this Commission from the word go I have seen the Church leadership rise to this challenge.

From the outset we have positively wanted the Commission process to help to free people to tell their stories, and we will always encourage them to do so.

We too have also engaged with survivors individually and in support groups to gain a closer and more personal appreciation of their experiences with the Church.
The general feedback from these many, many survivors ranges across a spectrum from those who found Church personnel wary and distrustful to others who expressed gratitude for the pastoral and caring response they received.

For too many the processes to gain redress and support have been protracted and stressful. Some have given up. Some remain in limbo. Others have said that they have found a more welcoming attitude from Church Authorities in recent times and a readiness to address the particular circumstances victims faced.

We want to acknowledge that it is never an even playing field when a survivor confronts the size and magnitude of an institution like the Catholic Church. Neither is it easy in the first instance to come forward and to reveal what has happened.

We admire and are grateful for the courage of those who have told their stories to us and to the Commission and on which much of the Commission's work has been based.

We acknowledge that around 40 percent of the Commission's private sessions reveal claims of abuse within a Catholic institution.

It is a history that must be told and reckoned with.

Regardless of the histories of other institutions, how the Catholic Church dealt with child sexual abuse is very much the concern and responsibility of today's leadership.

Painful though it may be, these next three weeks is the chance we all have to explore why the abuse occurred and what has been done to prevent it happening again.

Let us not forget that every person who has come forward carries with them the suffering, damage and loss, which child sexual abuse inevitably causes. They have borne the risk of further traumatisation in order to share their experiences.

The fact that child sexual abuse has been perpetrated by those holding privileged positions of trust within the Church and the fact that many Church leaders then compounded the damage in various ways including in some cases covering up the truth, is a tragedy in itself.

The Royal Commission case studies have caused our Church to look deeply at its past, and confront the truth of what happened. The stark reality is that the Catholic Church should never have put itself in a position to be at the very centre and major focus of an inquiry such as this.

The Church's teaching about the sacred place of children, and about the severity with which any offending against that teaching should be met, is both famous and fundamental.

So for even one child to have been sexually abused by a Catholic priest or religious is as appalling to all faithful Catholics, as it is to all within our community.

The hypocrisy involved in these historic failures is grossly unbefitting a church which seeks to be, and should be, held to its own high standard.

As we heard outlined in Senior Counsel Assisting’s opening today, the extent of abuse within the Church spans decades and has occurred in its institutions both small and large.

We are advised that the data does not distinguish those claims that were substantiated from those that were accepted without investigation.

In an ideal world, the data would distinguish between the number of allegations where offenders made admissions, or were convicted, and those where an investigation substantiated the complaint.

Nevertheless, there can be no doubt that the proportion of priests since 1950 against whom even claims of abuse have been made undermines the image and credibility of the priesthood.

Likewise the very high proportions of religious brothers with...
claims of abuse only further corrodes the community’s trust. The data tells us that over the six decades from 1950 to 2010 some 1,265 Catholic priests and religious were the subject of a child sexual abuse claim.

These numbers are shocking, they are tragic and they are indefensible.

And each entry in this data, for the most part represents a child who suffered at the hands of someone who should have cared for and protected them.

And let’s not forget the ripples of the abuse also felt by their family, friends and carers. These secondary victims need not only to be acknowledged but to be tangibly supported and compensated for the impact on their lives.

The data is an indictment on the priests and religious who abused these children. It also reflects on the Church leaders who at the times failed to take steps to deal with the abusers, failed to call them to order and failed to deal with them in accordance with the law.

Or worse, took steps which had the effect, if not the intent, of enabling them to abuse again.

The data provides, as best it can, a public accounting of what has occurred; a public record of the number of people coming forward to say they were abused. We recognise that many have not come forward and never will.

In the interests of a broader understanding of the extent of child sexual abuse across the community it would also be helpful if this data could be seen alongside similar data from other institutions, particularly government institutions, where abuse also took place at disturbing levels.

That said, the data and the number of claims it details can only be seen as indicative of the scale of the child sexual abuse which has occurred in the Catholic Church.

This data, along with all we have heard over the past four years, can only be interpreted for what it is: a massive failure on the part the Catholic Church in Australia to protect children from abusers and predators, a misguided determination by leaders at the time to put the interests of the Church ahead of the most vulnerable and, a corruption of the Gospel the Church seeks to profess.

As Catholics we hang our heads in shame.

Part of the Council’s role has been to meet and talk with the Catholic Community in its many different settings.

Broadly speaking Catholics identify with the church not as an institution but as a community based on a shared set of beliefs and values.

What we have seen and heard over the past four years is that Catholics have been profoundly shaken, to the point of disgust, by the revelations they have heard during Commission hearings.

However it is important to understand that today’s Church is significantly different from the one that has been the focus of most of the Commission’s case studies over the past four years.

Once the role of priests and religious was dominant in the life of the Church.

In the modern era, at both governance and operational levels, the organisations that run the education, health and social services of the Church are predominantly lay led. This has brought a broader and more sophisticated and professional approach to management.

Today, due to the declining and ageing numbers in religious and priestly life, the culture and participation of lay people in key roles has changed the face of the Church.

The fact that the Church leadership chose to rely on the Truth Justice and Healing Council – a lay led advisory body – and that it has accepted all its policy recommendations is, in itself, a reflection of that change.

“Regardless of the histories of other institutions, how the Catholic Church dealt with child sexual abuse is very much the concern and responsibility of today’s leadership.”

continued next page
This Commission is not only about the past. More importantly it is about today and the future, about ensuring institutions are as safe as they possibly can be for children.

Later in this hearing the Commissioners will hear from and speak with many leaders of the Church including archbishops, bishops and leaders of religious institutes to gain a picture of what is in place today to safeguard children.

It is appropriate now to mention a few of the key changes that have been made over the past four years to address the issue of abuse and to respond to abuse survivors.

The most significant and far reaching change is the establishment in November last year of a new independent body to set standards within the Church for child safety.

This company, Catholic Professional Standards Limited, will audit and report on the compliance by bishops and religious leaders with the standards.

It is a not-for-profit public company, with its own governance structure, and with a board made up of lay professionals.

Professional standards will apply across all aspects of Catholic Church activities and will cover not only children but anyone who comes into contact with the Church.

The Company will audit the performance of bishops and religious leaders on how their services comply with the standards. The audit reports will be made public. In this way the leaders will be held accountable.

This is a dramatic change to the accountability of bishops and congregational leaders. The significance of this change will have ramifications for many years to come.

Over the past four years many dioceses and religious orders have also committed to revisiting past claims, making adjustments to payments and other compensation provided to abuse survivors.

In November 2014 the TJHC released guidelines for revisiting payments that had been settled under Towards Healing or at common law, regardless of whether or not a deed of release was entered into.

Claims and payments have now been revisited extensively by many dioceses and religious orders across Australia.

From the early days of the Royal Commission, the Church, through the Council, has been one of the most consistent voices calling for the adoption of a national, independent child sexual abuse redress scheme, similar to the one recommended by the Royal Commission in late 2015.

The Church has called for a scheme that would independently determine fair and compassionate compensation for abuse survivors regardless of where, when or in which institution they were abused.

We have said many times that the days of the Church investigating itself must be over.

A national redress scheme, organised and operated by the Commonwealth but funded by the institutions in which the abuse took place, if established, will be a lasting legacy of this Commission.

Over the past four years religious orders and dioceses across Australia have introduced many new child protection policies and procedures. They have improved their processes, taken on new staff, adopted better practices and principles, and built new child safeguarding systems, in an effort to embed a culture of child protection at all levels.

Significant changes and reviews have been made by many dioceses and religious orders across Australia. Much has changed in the Church across Australia over the past 20 years and particularly over the past four years.

Many church leaders will appear before the Commission over the coming weeks.
They will do so out of a heartfelt commitment to contribute to a reasoned discussion about better treatment of those who have been damaged in church institutions and about a better future for those who are entrusted to the care of the Church.

They will give evidence about the work they have done as a direct result of this Commission, and the initiatives they have implemented to ensure children are as safe as possible in our parishes, schools, hospitals, social services and welfare organisations.

As I mentioned earlier the Church leadership and the TJHC published at the start of this Commission in 2013 what has become known as the Catholic Church’s Commitment Statement.

In it, for the first time anywhere in the world, bishops and religious leaders, as one, made a comprehensive acknowledgement of the crimes and cover-ups of the past.

Together they offered an unqualified apology to survivors of sexual abuse.

This apology included accepting that too often victims had not been believed, that the interests of the church had been put ahead of young children and that the might of the Church had in many cases been used to silence and oppress them for many years.

Over the past four years, as the Royal Commission has gone about its work, not one religious leader has backed away from this statement.

And more significantly all of these bishops and religious leaders have actively worked to address the many issues highlighted as part of the statement.

While this is admirable still more needs to be done.

It is vital that the culture of the Church that enabled the abuse of privilege and power that led to the crimes and cover-up be confronted head on, not only by those in positions of authority but also by the Catholic Community as a whole.

Words are important, but the measure of commitment can only ever be gauged by actions.

The wrongs of the past must be repaired, survivors of abuse must be shown the compassion and justice they have been calling for, child safety must be embedded in the culture of the Church.

One measure of our success in achieving those goals will be the confinement to history of devastating abuse statistics of the kind we have heard this morning from Senior Counsel assisting the Commission.
A/Prof Mark Boughey
on the problem with euthanasia and physician-assisted suicide

As Director of Palliative Medicine at St Vincent’s Hospital Melbourne and Co-Deputy Director of the Centre for Palliative Care, A/Prof Boughey has oversight of a number of palliative care training programs and a broad range of palliative care services, as well as coordination and participation in research and education.

A/Prof Boughey is involved in the International Collaborative for Best Care of the Dying Person, and Chairs both the Victorian Palliative Care Clinical Network and the Renal Health Network Supportive Care Working Group Nationally, A/Prof Mark Boughey is the immediate past president of the Australian and New Zealand Society of Palliative Medicine, and has mentored emerging palliative medicine leaders in less developed countries through the International Palliative Medicine Leadership Development Initiative.

Health Matters recently met with A/Prof Boughey to discuss the growing momentum in Victoria around legislating euthanasia and physician-assisted suicide (EAS).

The campaign to legalise euthanasia or physician assisted suicide in Victoria has been gaining considerable momentum in the past twelve months with a bill to be tabled for debate later this year.

As a palliative care specialist and an educator, do you feel that palliative care is misunderstood or under-appreciated – not only by the broader community, but by politicians and even some healthcare professionals?

Yes, I do. And to be fair, it’s not unreasonable that we’re a bit misunderstood. As a professional discipline, palliative care is relatively new – being roughly fifty years in the making, since St Christopher’s Hospice, London, first opened its doors, spring-boarding the clinical and political momentum for the modern palliative and hospice care movement.

I think many patients and families, the general public, and also senior clinicians within hospitals misunderstand and believe that palliative care is just about dying. Although, this is important, it’s much broader than this, and is really about person-centred support for a patient and their carers that can be given across the whole trajectory of a person’s chronic or advancing illness, eventually heading towards dying.

Those who work in the area have a particular skillset to work with patients with serious illness – helping them and their families understand what their goals of care are, and to
focus on their needs and coping with the health and social impacts of being unwell. Our aim is to make palliative care a standard of care, rather than an ad-hoc process of referral. If someone’s diagnosed with diabetes, there’s no hesitation to refer them to a diabetic educator and support team, to help them to work through the impacts of their disease now and into the future, however when someone is diagnosed with a progressive serious illness, people still seem to struggle with the idea of referral to palliative care specialists and their team. It should be one of the first considerations when someone is diagnosed with a serious, life-limiting illness to assist with the physical, psychological and care issues that arise.

When of the 50,000 palliative care patients admitted to hospital in Australia each year, only 1 per cent request euthanasia or physician assisted suicide (EAS), it tells me that palliative care works, and should be attracting far more resourcing.

To begin, could you explain what are yours and the Centre for Palliative Care’s major concerns around legalising EAS?

Yes, the figure is very low. I understand that coming into hospital is often disempowering for people to express their opinion, but it has always been a relatively low number of people who request euthanasia. Interestingly, each week for many years, we ask the question, ‘has anyone requested for us to intervene to end their life?’. The very low number is certainly not reflective of how prevalent an issue the wider public seems to feel it is.

The Centre for Palliative Care is taking a very pragmatic view of the likely impacts of EAS legislation on the day-to-day clinical practice. From my point of view, when patients are facing critical points in their illness trajectory, they start to express not only their own sense of anxiety about the likelihood of dying, but also their sense of burden – whatever that means to them and their family. Now if we’re able to connect and communicate with patients at the right time, to get them to express their issues early, we give them the opportunity to focus on broader issues that are important to them, and address them. Unfortunately, I think we are ill-equipped as a healthcare system to meet people at these points. The type of therapeutic communications isn’t a fundamental competency for healthcare professionals and I think that’s an issue that needs addressing rather than focussing on interventions to intentionally end life.

And I think currently the healthcare system doesn’t have the capacity to provide that support.

I often compare the noise around euthanasia to the noise of a capacity crowd at a Melbourne Cricket Ground (MCG) football game. When you’re with the sick patient right in the centre, dealing with a deteriorating or dying patient, you’d expect the noise to be most amplified, however the reality is that most of the noise for action comes from the grandstands; with possibly some or no connection to the person with the serious illness, but these ‘spectators’ are thinking that it may be their potential future.

You’ve expressed concerns that legalising EAS could be viewed by many doctors as an additional clinical intervention – and if not educated or trained in palliative care practice, a doctor may be more likely to advise EAS.

Is there a shortage of healthcare professionals with the specialist skills to discuss end-of-life with terminally ill patients?

Appropriate communication skills are essential to be able to engage with those who are deteriorating and facing death. We’ve found so often that if you allow people to talk about their concerns around dying, simply having the conversation with the right person will dissipate many of their fears, because helping someone to understand their situation and the realities around death and dying helps to relieve a patient’s deeply held anxieties.

Unfortunately, healthcare professionals don’t recognise the need to train or retrain in communications and therefore there is a lack of suitably skilled people to work with end-of-life patient issues. From a medical perspective, doctors can inadvertently convey hopelessness to their patients. A surgeon has been trained to offer hope by means of offering a surgical intervention, so when those particular options for improvement are exhausted, you may hear a surgeon’s conversation convey a sense that there’s nothing more that can be done for the patient, and that conveys hopelessness.

So if you have healthcare professionals communicating this kind of message, the patient will say, ‘okay, I’m getting this message from my healthcare professional, so there mustn’t be any other options available to me.’ But the reality is there are a lot of options – it’s just that many clinicians aren’t necessarily accustomed to having the conversation around palliative and end-of-life care.

One of my other concerns is that the trust around the doctor-patient relationship will be shifted and eroded by legalised EAS. Every day in our palliative care services people are quite suspicious about unspoken motivations of giving appropriate medication necessary for good pain and symptom relief. Families hawkishly watch what is being prescribed for their loved ones; are we over sedating?; are we hastening death with the pain medicines?, etc. So I think it’s going to make it more difficult for people to trust the motivations of their physicians – I fear it will somehow psychologically break that trust that is so crucial to achieving good outcomes for the patient and their family.

The current proposal requires the consent of two doctors, but there is no requirement for these doctors to have experience in caring for people with advanced disease. What are the possible implications?

We’ve raised this issue on many an occasion, in several forums, and have discussed it at length with the Department of Health and Human Services in the shaping of the legislation.
So taking people at face value is problematic. If they don’t have any experience dealing with people with advanced disease, if they’re a GP who may only see a dying person once or twice a year, how do you get them to say if patients are in the real final phase of their illness and that the person’s suffering is ‘unbearable’? There is still a huge area of variability around this issue, and a great deal of unanswered questions concerning the detail of the proposed legislation.

In the Centre for Palliative Care’s submission to the Inquiry into End of Life Choices, it was raised that there are questions around EAS assessment criteria to establish the ‘unbearableness’ of a person’s suffering.

Why is it that a person not diagnosed with a terminal illness, wishing to prematurely end their own life, is automatically considered mentally ill and treated for depression etc., but a person with a terminal illness and requesting EAS will be considered free of mental illness?

Yes, you’re right that this is problematic, and it all comes down to the accuracy of the individual assessment. And again, one of my major concerns is the availability of the professionals who will be capable of making that call.

What’s remarkable is that we often see people that are expressing a wish to die, and you’re able, with expert assessment, to say that they don’t have a mental illness – they’re making a choice that doesn’t seem to be clouded by a cognitive impairment, delirium, mental illness, etc. But I think statistics from the Netherlands show that about 30 per cent of people with an advanced disease requesting euthanasia have a mental illness.

In palliative care we have the psychiatrists who can make these sorts of assessments for us, but to connect a person who is away from a hospital, particularly in regional, rural and remote Australia and expressing a wish to end their life, finding a psychiatrist or even a psychologist can be quite difficult.

And this raises questions around assessment of cognitive impairment as well. Because at the moment you may have a patient whose mood has been shifted downwards, or they become cognitively impaired, but their condition will improve – their outlook may well change from week-to-week or even day-to-day.

So taking people at face value is problematic.

Catholic Health Australia shares the Centre for Palliative Care’s view that every Victorian should have access to affordable, high-quality palliative care before consideration is given to legalising EAS.

If passed through parliament this year, what do you see as potential outcomes for some of Victoria’s most vulnerable – people such as non-English speaking Australians, those living in poverty, living with a disability, as well as the elderly and the frail?

I think anyone moving towards dying is vulnerable, but within that group of people there are other subsets of people whose vulnerability is amplified.

Some additional groups to those you’ve mentioned are prisoners and the homeless; those living alone; those without supportive families and susceptible to elder abuse; Aboriginal and Torres Strait Islanders.

Let’s take a look at people with a disability, for example. People with disability who see life as so important, yet it’s assumed that many in this group would want euthanasia.

So these groups are particularly vulnerable; they’re vulnerable to mixed messaging around treatment, and communicating hopelessness may be amplified to someone who already may view their life to be not worthy of certain treatments. Or you could have families that pressure individuals to make a certain decision.

Making sure these people are safeguarded will be of particular concern – particularly when these peoples’ state of vulnerability is amplified when acutely unwell.

We recently had an elderly patient attempt suicide before coming in to St Vincent’s. When you started to unpack the story and their treatment, they had not been given the opportunity to have an interpreter, and their family member was making all of these decisions on their behalf which they didn’t really want made for them. So it became apparent that the suicide attempt was their way of calling for attention, to be heard.

But to look outside of the cities for a moment, there are many regional, rural and remote areas around Australia that don’t have access to palliative care services whatsoever. So these people are particularly vulnerable as they have very limited choice. And so a critical concern for us is that euthanasia and physician-assisted suicide may indeed become more readily an accessible treatment option than appropriate palliative care.

It’s important to remember that the Catholic healthcare environment cannot see itself immune from the legalisation of EAS debate. Catholic health care services already see dying patients care as part of their mission of concern, but if we don’t step forward and work appropriately at care and good communications in this space, have these important discussions, then vulnerable people will be left high-and-dry.

Whatever comes of what the government decides the structure will be, we can’t ignore it – we can’t pretend that it’s not on our patch. We need to continue doing what we do so well in Catholic healthcare. We need to keep helping vulnerable people and – importantly – we need to support colleagues to continue our important work in this space, to provide excellent and timely palliative and end of life care.
Pastoral care is part of the fabric of Catholic health and aged care.

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St Vincent’s Health Australia (SVHA) has committed $450,000 to bring culturally appropriate palliative care services to five Aboriginal and Torres Strait Islander communities in the Northern Peninsula Area (NPA) of Cape York as part of an MOU with Northern Peninsula Area Family and Community Services (NPAFACS) and Apunipima Cape York Health Council (Apunipima).

People living in remote Cape York communities – in particular the five Aboriginal and Torres Strait Islander communities of Bamaga, Seisia, Injinoo, Umagico and New Mapoon – experience some of the highest levels of chronic disease and poorest health outcomes in Australia yet don’t have access to local palliative care. The nearest palliative care is more than 1000 kms away in Cairns.

St Vincent’s Health Australia – the nation’s largest not-for-profit health and aged care provider and a provider of palliative care services for more than 125 years – said it responded to a need, raised by NPAFACS through Apunipima, for expert guidance to develop a high-quality, culturally appropriate palliative care service tailored and accessible to the communities of the Cape.

The MOU outlines SVHA's commitment over five years to achieve in partnership with NPAFACS, Apunipima and the communities of the NPA, including:

- Participation in the Commonwealth Government’s palliative care education program (Program of Experience in the Palliative Approach or PEPA) which includes capacity for palliative care specialists to visit Aboriginal health services to facilitate palliative care learning;
- provision of advanced palliative care training for local staff;
- community capacity building through ongoing clinical support;
- development of a culturally appropriate model of care and a business plan to establish a permanent palliative care service, and;
- provision of specialist care and support of palliative care clients via telehealth.

The NPA palliative care project is an extension of an ongoing partnership between St Vincent’s and Apunipima that already provides primary healthcare services to 11 Cape York communities and advocates for 17 others, including those of the Northern Peninsula Area.

“With the highest levels of chronic disease in the country and an average life expectancy of 58 years, there’s considerable need for high-quality and culturally appropriate end of life care in our region,” said Ms Ugari Nona, President, NPAFACS.

“$450,000 COMMITMENT to bring palliative care to ABORIGINAL and TORRES STRAIT ISLANDER COMMUNITIES of NORTHERN CAPE YORK

St Vincent’s Hospital Melbourne’s Centre for Palliative Care, said – first and foremost – he and his colleagues would listen to the communities about their palliative care needs.

“It’s going to be a learning exercise and an exercise in trust-building. We need to listen to the people in community, and understand what they want from their palliative care service, so that it will cater to the requirements of those who will access it,” he said. “From there, an appropriate service model can be developed, and then local stories will spread about how members of the communities will die respectfully, at home, on country and with family.”

Mrs Patricia Yusia, a Board Member of Apunipima Cape York Health Council, voiced a sigh of relief about the project.

“It is great to see that St Vincent’s Health Australia is not only willing to fund this project, but is willing to walk alongside Apunipima and NPAFACS on how we can best help these communities,” said Mrs Yusia.

For the people of NPA’s five communities who have a life-limiting illness, accessing end of life care means leaving the community, leaving family and country to travel to Cairns.

“It’s hard enough for those who are dying to move away to Cairns, but it’s also very hard for the family who can’t be with them,” said Councillor Edward Newman, Mayor of the Northern Peninsula Area Regional Council.
A new partnership between Calvary and University of South Australia is thought to be the first of its kind between a private hospital and public university. Juanita Ielasi, CEO of Calvary Wakefield and Calvary Rehabilitation Hospitals, praises what she says is taking nursing and allied health training to a new level.

“For more than 20 years it has been based on university training and clinical placements, but under the collaborative partnership it will be based on information sharing” she says.

The partnership is in the planning stage for the creation of a clinical training school at the Calvary Health Group’s new Calvary Adelaide private hospital, to be opened late in 2018. The new hospital will replace the current Calvary Wakefield and Calvary Rehabilitation (Walkerville) hospitals, to more than double capacity from 180 beds at the Wakefield site and 65 at the Walkerville site to 340 beds. Its 24-hour emergency service will more than double in capacity as well.

“In the past placements have also been compartmentalised, where medical schools organised training separately from nursing and allied health. The Calvary and UniSA partnership is being coordinated across the three disciplines. There’s been a traditional approach, particularly when you look at nursing when it went into universities, and there’s always been placements,” she says.

“The key for me is the quality of the placements we can provide.”

Ielasi says that while the healthcare provider has taken nursing students for years, it has not always taken many allied health students. The partnership will create greater opportunities for those allied health students who have generally gone into the public hospital system for placements, and puts Calvary forward as a future employer of choice. “The public sector is under increasing pressure and it’s always taken the majority of students and it becomes a case of how we can help,” she says. “The key for me is the quality of the placements we can provide.”

Juanita sees UniSA graduates as passionate and engaged learners, who can successfully adapt to different clinical environments and cultures whilst still putting theory into practice. “Calvary Health Care’s partnership with UniSA allows us to influence practitioner development aligned with the core values we believe are essential to providing reliable healthcare. We look for graduates who are eager to learn, highly motivated, can work independently, and take direction, supervision and feedback.”

Juanita advises students that in order to be career-ready, you need to be self-aware and understand your limitations. “Realise the possibilities that a degree can afford you, and recognise that study requires hard work, dedication and some sacrifice.”

Disclaimer: The story above is an excerpt from The Weekend Australian 11 Feb 2017 Uni of South Australia, Calvary Health to work on clinical training.
For older people living in the southern metropolitan region of Melbourne, they can now take advantage of a unique home-based dementia advisory service which is delivered in the comfort of their own home.

Leading aged care provider Southern Cross Care (Vic) has recently launched a new Dementia Advisory Service, aimed at supporting people with dementia and their carers with information and practical day-to-day advice to help them better manage the changes that dementia brings.

Southern Cross Care (Vic) CEO, Andrew Newton, said that with the right support and care, people living with dementia can still live a fulfilling and meaningful life.

“A dementia diagnosis does not mean a person has to give up
More families suffering with perinatal illness in Western Australia are able to access St John of God (SJOG) Raphael Services as a result of the service’s growth in 2017. Staffed by a multidisciplinary team of mental health clinicians, SJOG Raphael Services provides secondary level specialised mental health services to families in the pre-conception, perinatal and infancy stages, up to the child’s fourth birthday.

SJOG Raphael Services are available to all members of the community, not just St John of God Health Care patients, and are provided free of charge or at minimal cost. The central site for all Raphael Services in WA is located in Wembley, which is connected to satellite locations in Fremantle, Cockburn and Midland.

Helen McAllister, Director Raphael Services said the service was proud of the unique care it provided to its clients and that it would continue to expand in 2017 to help meet the needs of more parents and families.

“We’ve changed our model of care by introducing a hub, satellite and spoke delivery structure. We established the hub in Wembley late in 2016 and recently expanded our services in Midland and started a new outreach service in Cockburn,” she said.

“This approach to service delivery means that rather than expecting our clients to travel to access care, we are and will continue to take our services into the areas of greatest need, to where people are disadvantaged, by geography, economic circumstances and where limited health services may exist.”

Over the past six months Raphael Services WA delivered 2,170 individual counselling sessions, providing perinatal mental health care to more than 350 parents in WA. In addition, more than 100 group therapy sessions were held. “Raphael Services are dedicated to early intervention, prevention, mental health treatment and health promotion. We focus on helping parents to understand and manage their emotional health as well as providing tools to improve and sustain a healthy relationship with their infant/s and partners,” Helen said.

“Our service is underpinned by Attachment Theory and to deliver this approach all of our clinical caregivers are trained in the core competencies in attachment theory and practice. “We are working steadily to expand our service to include further outer metropolitan, regional and rural areas in WA. Our objective is to make Raphael Services as accessible as possible for West Australian parents and families that are struggling to maintain their emotional wellbeing.”

Funded by the Australian Government Department of Social Services, Southern Cross Care (Vic)'s Dementia Advisory Service is currently available in the southern metropolitan region of Melbourne covering the municipalities of Kingston, Bayside, Frankston and Mornington Peninsula. People living with dementia are eligible for the service if they live in the region, and are aged 65 years or above.

“Dementia is today the single biggest health issue facing older people in Australia. Our Dementia Advisory Service is part of our three-year dementia strategic plan to help us achieve the best outcomes for people living with dementia and their carers,” said Mr Newton.

For more information on Southern Cross Care (Vic)’s responsive and unique home-based Dementia Advisory Service, please call 1800 508 008 or email mail@sccv.org.au
In November last year, the Australian Catholic Bishops Conference recommended the publication, A Ritual for Laypersons: Rites for Holy Communion and the Pastoral Care of the Sick and Dying (Collegeville, MN: Liturgical Press, 1993, 2013) for use by those engaged in pastoral care ministry in Catholic health facilities and aged care homes.

While the Bishops noted that other quality and approved publications from local and overseas publishers exist, the value of A Ritual for Laypersons is that it brings together a range of scriptural and liturgical prayers under the one cover. The publication is well laid out according to the approved ritual forms, and published in a convenient size.

One difference to note is that the Scriptural translation is from the New American Bible translation, which will be different from the Jerusalem Bible translation or the New Revised Standard Version translation used in the Australian (1981) and Canadian Lectionaries (1992ff, 2009, 2014) respectively. The publication has also received approval by the United States Conference of Catholic Bishops.

In our Catholic hospitals and aged care facilities, lay pastoral practitioners work side-by-side with Catholic chaplains. In some facilities it is not always possible for pastoral care teams to be able to obtain the services of a Catholic priest to provide communion regularly and to be available at times when patients are very sick or dying.

The recommendation from the Australian Catholic Bishops Conference for this publication recognises that lay pastoral practitioners are called to provide ministry through rituals and rites for our patients and residents in many different circumstances. In using this publication, pastoral practitioners can be assured that the rites and rituals included are liturgically sound.

The publication is structured as follows:

Part I: HOLY COMMUNION OUTSIDE MASS
Chapter 1: Holy Communion Outside Mass
A. The Long Rite with the Celebration of the Word
B. The Short Rite with the Celebration of the Word

Chapter 2: Administration of Communion and Viaticum to the Sick
A. The Ordinary Rite of Communion of the Sick
B. The Short Rite of Communion of the Sick
C. Viaticum Outside Mass

PART II: PASTORAL CARE OF THE SICK
Chapter 3: Visits to the Sick
Chapter 4: Visits to a Sick Child

PART III: PASTORAL CARE OF THE DYING
Chapter 5: Commendation of the Dying
Chapter 6: Prayers After Death

PART IV: A SELECTION OF READINGS, RESPONSES AND VERSES FROM SACRED SCRIPTURE

PART V: PRAYERS AND TEXTS IN PARTICULAR CIRCUMSTANCES
A. Prayers for the Dead
B. Prayers for the Mourners

BIBLICAL INDEX

The book should be available (or ordered) through Catholic bookshops and some online retailers. If you would like assistance in sourcing a copy, please contact Margaret Deerain, CHA’s Mission Manager, at margaretd@cha.org.au
How did a Health Promoting Palliative Care project grow out of a car-park salvage operation? Joni Mitchell sang “They paved paradise and put up a parking lot”— and Nature seems to have replied by encouraging hundreds of Japanese Maples to germinate out of the Bethlehem Hospital parking lot.

A “ground swell” of seedlings emerged this year, inspiring a rescue operation that required volunteers donning boots and shovels. The project this year quickly grew to involve patients, families, staff, volunteers, as well as a local gardening business.

Trees have been shared and replanted in a growing radius around Melbourne and we are tracking and collecting the stories that they have inspired.

Stories that may help others with the journey they have before them.

Much more than just a ‘salvage operation’, the project has provided – for some patients – a sense of purpose, occupation and meaning. For others, it has become a means of leaving a legacy in nature and via the written word.

For some families and friends, it has provided an avenue of honouring a life. Still, for others in the community, it has been a gesture of solidarity with that positive life force that seems to be trying to Re-seed Paradise-out of the Parking lot.

If you would like to plant a tree in honour of someone and wish to share the story behind it, or would like more information about the project, please contact either:

Mary Hocking
mary.hocking@calvarycare.org.au

or

Sam Kelly
sam.kelly@calvarycare.org.au
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