The Cost of Hope: 
Prof Suresh Sundram
and Understanding the mental health of asylum seekers in Australia

Bringing Health into Culture:
How the CHA-Apunipima partnership is promoting workforce exchange

Marcus Riley
speaks on
Calling for a UN Convention of the Rights of Older Persons

Annette Panzera
on Informing user choice in the provision of selected health services – what reforms could work?

• Fr Cormac Nagle OFM on the question of autonomy • Heads, Hearts and Hands: Catholic Social Teaching in Workplace Health and Safety • The Value of a Research Culture in Health Services • The Status of Australia’s Aged Care Workforce • Mission leadership - supporting today’s ‘specialist’ leaders • Putting media focus on aged care quality into perspective
The health, aged care and community services sectors are in an era of considerable challenge and opportunity. The Federal Government’s reform processes have been underpinned by a strengthened agenda to consult with stakeholders towards achieving the Department of Health’s vision for “better health and wellbeing for all Australians, now and for future generations”. Yet much debate continues in the public policy arena as various institutions and stakeholders jockey for their positions to gain traction with our legislators.

Against this backdrop, and in an age of short media cycles, a disrupted government and increasingly complex social problems, Catholic Health Australia works to be the credible, ethical and influential voice of Catholic care providers.

Understanding the human person in all of our dimensions is a foundation for the concept of health encapsulating the broader well-being and welfare of the person. It is the person who is at the center of the care journey offered by Catholic Health Australia members.

Yet it is not just those receiving person-centered care for whom CHA gives voice, as not everyone who needs help has the ability to ask. Not every Australian who needs improved access to quality and affordable health care and aged care services has a voice.

Open your mouth for the dumb, for the rights of all who are left desolate. Open your mouth, judge righteously, maintain the rights of the poor and needy.

Proverbs 31: 8-9

Catholic Health Australia is a fierce advocate for accessible and affordable health and aged care. When engaging in public policy concerns, Catholic Health Australia bases its advocacy and policy development on the following foundational principles.

**Dignity of the Human Person**
Each person has an intrinsic value and dignity. Within the context of health and aged care in Australia, this means everyone has a right to essential, comprehensive and affordable care.

**Service**
The provision of care is conducted out of a spirit of service and solidarity with those in need. Health care is a social good. The degree to which health care is driven by a genuine compassionate concern for others and a selfless commitment to the well-being of people will be the measure by which a community can gauge its maturity and sense of integrity.

**Common Good**
Our commitment to the dignity of every individual leads us to an appreciation and dedication to the community at large. Catholic care providers are an active partner in the ongoing development of the health and care of the community.

**Preference for the Poor and Under-Served**
Catholic social teaching has embraced a ‘preferential option for the poor’. This stresses our concern for the provision of adequate, timely health care for all, especially those who have little choice, opportunity or capacity to pay. Structural reforms need to identify ‘poverty gaps’ in the system and move to eradicate areas which leave people vulnerable and isolated from care. Broader economic reforms must enable all people to receive dignified care at all times.

**Stewardship of Resources**
Creation and human life are divine gifts. We are called to treat them responsibly and to manage them wisely. Health resources must likewise be prudently developed, maintained and shared in the interests of all. Economic discipline and realistic control on expenditure characterise sound health management.

**Subsidiarity**
The needs of individuals and communities are best understood and satisfied by those closest to them within a spirit of solidarity and service. Applied to health, this has implications for the extent of choice and the devolution of responsibility that exists within a system. Where at all possible, individual autonomy and the freedom to determine one’s mode of health care need to be encouraged.

**Setting the Policy Agenda**
During the last few years, Catholic Health Australia has placed increased focus on policy and advocacy work as we have kept in step with the Federal Government’s strengthened...
agenda to consult with stakeholders. The volume of submissions lodged with government has increased three-fold, and CHA members are represented on more government committees and working groups than ever before.

Our framework for advocating expanded access to health care for all people, for seeking reform in the aged care sector, for making policy recommendations for improved funding or for any of the myriad of important issues, all starts with the work of the Catholic health, aged and community care service providers. CHA members engage on what needs and challenges are encountered as they serve communities across this nation, paying special attention to those persons who are poor and vulnerable.

CHA practices a model of policymaking process that forms a cycle. This cycle begins with an assessment of the issue or problem, often as identified by the work of one of the numerous CHA committees, particularly including the Hospital Senior Executives Forum (HSEF), the Mission and Identity Committee or the Aged Care Committee.

Working collaboratively with members, the CHA team researches and engages in wider consultation with Catholic service providers and other relevant stakeholders as to preferred evidence-based positions or interventions to be implemented. In preparing a position statement, response to a government discussion paper, or policy submission, draft versions are prepared, based on the Foundational Principles, and are circulated and settled through collaborative engagement with all interested members.

Where the issue which is sought to be addressed is sensitive or, for example, has wide ranging ramifications, the policy position determined through this consultation process will also require CHA Board endorsement before it goes public. The policymaking cycle concludes with a systematic evaluation, position-shaping and eventual advocacy.

However, the reality of the policymaking process is rarely that simple or straightforward.

CHA needs to remain agile to respond to what is often a fast-paced policy environment, resources need to be effectively allocated to respond meaningfully, and many who we need to engage with are already over-burdened with other priorities. Yet CHA members also have a great wealth of knowledge in this country, particularly with respect to maternity services, end-of-life care, and consumer-driven aged care. Bringing the depth and breadth of wisdom together is a happy dilemma to have.

CHA is optimistic about the future of health, aged care and community services and the positive role our members play in people’s lives. The voice of Catholic care providers is an important voice in the public square, as we reach out for people in need and speak out for those who are not being heard, especially those experiencing poor health outcomes.
The Productivity Commission (PC) is the Australian Government’s independent research and advisory body on a range of economic, social and environmental issues affecting the welfare of Australians. Its role is to inform governments on how to make better policies, in the long-term interest of the Australian community.

On 2 June 2017, the PC released its latest draft report that examines how the people that use human services (healthcare, social housing, and family and community services) can be placed truly at the heart of service provision. This is of utmost importance as all Australians will access human services at some point in their lifetime, and the public must have a voice in shaping the services that they receive.

There is significant expenditure in Australia on these services, both public and private (exceeded $300 billion in 2014-15), and with ageing demographics, this amount is predicted to keep growing. This is why delivering these services effectively and efficiently is essential. This report had to concentrate on a specific selection of those services, and in this inquiry the PC chose to focus on proposing reforms to six services where greater user choice, competition and contestability could improve their effectiveness. These services were:

- end-of-life care services;
- social housing;
- government-commissioned family and community services;
- services in remote Indigenous communities;
- public hospitals, and;
- public dental services.

by Annette Panzera A/Director of Health Policy
Governments need to play the role of system stewards, ensuring that service provision is effective in meeting its objectives. This includes policy design, regulation, oversight of service delivery, monitoring provider performance, and developing ways for the system to continuously improve. These arrangements are difficult to get right – functions need to be tailored to each service and the unique settings in which they are delivered.

Overall, this report highlights three key topics where governments could improve service delivery. These include greater coordination between governments, agencies, and providers to eradicate duplication and detraction of services, in addition to breaking down government silos so that policy does not lead to competing objectives, or losing sight of the ‘bigger picture’.

More transparency and provision of information is proposed in order to improve accountability and to assess performance of service provision. It is of course impossible for governments to evaluate efficacy of systems and provider performance without real transparency.

Lastly, when the decision to implement major policy reform is taken, smoother transitions would ensure that users are not disrupted, and continuity of outcomes is preserved. This necessitates better planning and preparation up-front for change, and at the same time better clarity of information made available for users as part of the system reform process.

Of the six areas outlined above, three have direct consequence to Catholic health and aged care service providers; these are public hospital services, services in remote Indigenous communities and end-of-life care services, including palliative care. Since the inquiry began in 2016, CHA has liaised with its members in order to fully participate in the submission process, whilst the PC prepared this draft report and its recommendations. CHA will next coordinate another response by mid-July 2017, with the final report due for release in November 2017.

In terms of policy reform, the draft recommendations in the area of public hospital service provision – if successfully implemented – could be of huge benefit to consumers in
enabling informed choices regarding choosing where and how to receive care. Overall, the PC recommends more reporting transparency from public hospitals and their employees and asks that both levels of government strengthen and expand their commitment to public reporting in the National Health Reform Agreement. This should result in enhanced performance improvement by hospitals and specialists.

The report further proposes that jurisdictions commit to provide data and other assistance to the Australian Institute of Health and Welfare (AIHW) in order to strengthen the MyHospitals website. This would enable the website to be a tool to inform patients as well as monitor provider self-improvement. It also suggests that a general policy be embraced to publicly release any data that a jurisdiction holds unless it can be clearly demonstrated that releasing data would harm the interests of patients.

Finally, extensive recommendations are outlined in the report regarding providing better end-of-life care for Australians. The report recognises that people who have a preference to die at home need to be able to access support from community-based palliative care services. This will require state and territory governments to assess the need for additional community-based palliative care services, and then design services that address those identified gaps. It also recommends that the Commonwealth Government remove current restrictions on the duration and availability of palliative care funding in residential aged care, and provide sufficient additional funding, so that people can receive end-of-life care that aligns with the quality of that available to other Australians.

“It is of course impossible for governments to evaluate efficacy of systems and provider performance without real transparency.”

In addition to better information provision, the report also encourages more choice for patients in being able to attend either public outpatient clinics or private specialists for their initial consultation. In return, specialists can accept any referrals, irrespective of whether another person is named as the specialist in the referral. In order to facilitate this, the Government should develop with general practitioners (GPs) best-practice guidelines on how to best support patient choice.

In relation to the delivery of services to remote Indigenous communities, the report focuses on better integration of services and agencies so that delivery is co-ordinated before point-of-delivery at the community level. The PC recommends that longer contract periods would allow service providers to establish their operations and improve stability in service delivery and handover before contracts end. It also states that provider selection processes allow sufficient time for providers to prepare considered responses; that providers be notified in a timely manner of tender processes, and; that enough time is allowed for transition in the case of new providers being selected.

It is also encouraging to note that the report recommends strongly that human service providers be selected on their ability to provide culturally-appropriate services; proven engagement with the community; collaboration with existing service providers, and; those that put a high priority on training and employing local and/or Indigenous staff. It states clearly that the commissioning processes in this area should have a strong focus on transferring skills and capacity to people and organisations in those communities, thereby moving away from the ‘seagull’ type mentality that has characterised service delivery behaviour in the past to many remote Indigenous communities.

In summary, the PC is urging governments to legislate better data transparency in public hospitals and aged care with the dual benefit of enabling consumers to make an informed choice, as well as being able to measure and compare provider performance. Providers delivering services to remote Indigenous communities are asked to work together in order to ensure continuity with a focus on transferring skills to local staff. Finally, governments are requested to invest significantly in better end-of-life care. These principles are practical and admirable, and will hopefully be realised in the not too distant future. Successful implementation (if achievable) will significantly strengthen service delivery in these important areas of human service provision in Australia.

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Performing research is vital to the process of generating new knowledge that advances our current understanding of our world. Mankind has had to adapt to new challenges in order to survive, but has had to discover new realms of knowledge in order to advance. How health providers adopt research into their service model is a necessary consideration in the multidisciplinary approach to delivering evidence-based practice (EBP) that integrates the best scientific knowledge with clinical expertise and patient choice. This practice can be achieved by fostering a culture of research where evidence is valued, clinician participation is encouraged and rewarded, professional development and training opportunities are adequately resourced, and investment in research capital is a priority.

Research culture reflects the shared meaning of knowledge, experience, values, and attitudes in the systematic generation of new ideas and information to devise new applications that can be put into practice. To cultivate a research culture, a health organisation must have an environment that is willing to embark on the search for new information and embrace EBP as it evolves. Undertaking research is key to enhancing models of care across multiple levels of academia, practice, and policy. Rather than relying on industry silos that approach research and practice separately, organisations that can bridge these two areas acquire the capacity to provide improved health outcomes and organisational benefits that support the health system as a whole.

The organisational benefits of a strong research culture create value for patients, staff, and the greater health system. In 2015-16, health expenditure exceeded $147 billion nationally, reaching 10 per cent of GDP. The rate of increase in cost of health care continues to be greater than the growth in GDP as the proportion of health expenditure continues to rise at an unsustainable rate. Meanwhile, in 2013-14, $5.9 billion was spent on health and medical research (H&MR) or only 0.37 per cent of GDP. One third of all R&D expenditure occurs in higher education institutions, and of the 19 per cent of H&MR expenditure that occurs in the private sector, the majority is in pharmaceutical R&D. Continuing to funnel money into the health system at the current rate is not guaranteeing value or sustainability of the system. Harnessing research strategies from the point-of-

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by Stephanie Panchision Health Policy Officer
care can reduce unnecessary clinical interventions through better EBP and can also generate economic benefits through increasing productivity in the healthcare system and the formation of partnerships to translate new evidence into practice. Pushing research initiatives in the delivery of health services can drive new efficiencies that generate economic and organisational benefits.

**What a research culture can offer health services**

Investment and participation in research has been shown to provide a range of benefits to providers. Direct investment in H&MR has shown to have added value for the health system. For every dollar invested in health research and development in 1992-2005, $2.17 was returned in health benefits (Harding 2017). The mechanisms by which a research culture impacts care are complex, but there is a growing body of evidence to show that investing in a research culture has been shown to benefit patient outcomes and organisational performance.

Studies in the UK have confirmed an increased likelihood of mortality for patients treated at the NHS trusts in the lowest quartile of research activity when compared to the highest quartile of research activity. A study in the US on substance abuse treatment facilities found science-based innovativeness was also associated with a greater range of comprehensive services. The proven outcomes of lower mortality rates, higher patient satisfaction, and the range of deliverable services create better value for consumers.

Staff personnel have also been shown to benefit from strengthening research capacity. Training in EBP has been tied to a reduction of staff turnover with greater staff satisfaction that has improved professional recruitment and retention (Harding 2017). When operating in an environment that values research, organisations that are shown to be investing in research also appear to encourage the uptake and implementation of EBP in the delivery of services.

The benefits from the accelerated adoption of EBP are multilayered, including providing improved outcomes for patients, greater efficiencies for the provider, and better value for the health system. Better innovation that results from a research culture has been shown to increase the number of patients treated, reduce patient length of stay, and generate greater income per patient (Harding 2017).

**How to foster a research culture**

One of the greatest challenges expressed by researchers is the ability to translate the results of research from clinical studies into clinical practice. Cultivating a research culture requires a multidisciplinary approach to developing skills and techniques that can be used to conduct research that translates those results into EBP. Leadership and engagement from senior management is crucial to establishing a research culture. Commitment from higher management is vital in order to secure the necessary funding support, expand partnership arrangements, and sustain the research agenda. Ensuring that clinician and administrative goals are aligned is important for stakeholders to realise the value of the research enterprise.

Cooperation among stakeholders brings together various tools that contribute to the infrastructure supports needed for conducting research. Developing clinical research networks (CRN’s) and forging partnerships helps to facilitate research by pooling resources and expertise needed to conduct clinical research. Having a multidisciplinary approach to research promotes EBP across departments that generate efficiencies by streamlining work drawn on best practices that avoid duplication.

**Barriers to developing a research culture**

Overcoming barriers in the establishment of a research culture requires strategies that consider multiple perspectives across stakeholders. Studying barriers to trial enrolment, researchers from the Cancer Research Network in the USA recognised that one of the greatest obstacles to participation in clinical trials in a non-academic healthcare system was the disparity in the perceived value of clinical research by clinicians and senior leadership.

Organisational factors that included misaligned goals between administrative staff and clinicians as well as miscommunication on the financial and human costs of clinical trials presented barriers to research implementation (Somkin 2005). Evaluating the economic benefits of research is an area that deserves further exploration.

A primary challenge for clinicians responsible for conducting research in health services involves the amount of time required. Often, research is ancillary to their clinical role and the numerous priorities can limit clinician involvement in research activities. Allocating suitable backfill for clinical
roles and a tedious regulatory environment also feeds into this time intensive process. Adequate resourcing and support from administrative levels and across other disciplines can relieve some of these pressures experienced by researchers.

One of the most challenging aspects of research is the translation of clinical findings into clinical practice. Strategies to adapt new knowledge and techniques gained from research are necessary to implement EBP. Institutions and providers who have a strong research culture are more likely to value EBP and to more easily adapt to new treatments and procedures based on new evidence (Harding 2017). A recent report by the Australia Council of Learned Academies (ACOLA) reviewed research translation across many developed countries with a strong record of performance in research.

ACOLA found that translating research in Australia could be improved through a more efficient distribution of incentives, repairing fragmentation in research participation, and the establishment of a national strategy that incorporates innovation. This review also indicated that international research participation was associated with economic and societal value where, “[…] stable, well-designed and funded measures in other countries have created jobs, increased business turnover and provided other benefits.” (ACOLA, 2015).

Conclusion

Philosophical shifts to making research a priority evolve slowly, and require a mutual trust between the providers and institutions who conduct the research and the communities they serve. This process can be challenging and can vary according to regional dynamics, social determinants of the community, and clinical engagement. The multifaceted nature of research culture demonstrates there is no single approach to enhancing research engagement. Participation occurs across multiple levels of institutional and individual involvement, but with combined commitment and a shared responsibility, a culture of research can generate significant benefits.

Research is not a linear process and cannot be approached as such. Innovation is dynamic and complex, involving the culmination of ideas from many people over time and across disciplines. Our health delivery systems are based on the technologies and practices that have been refined over time through research. It is the analysis and application of this knowledge that bridges the divide between research and practice and that will ultimately improve service delivery and patient outcomes.
The status of the aged care workforce

by Nick Mersiades
Director of Aged Care

Get a group of stakeholders in a room to discuss the future of aged care and the conversation will turn quickly to workforce issues, and then to the need for an aged care workforce strategy.

Of concern will be the four-fold increase in the aged care workforce that the Productivity Commission estimated will be required by 2050, how Australia will train such a large increase in the workforce, and how to ensure that the sector will be able to compete successfully in the labour market for quality staff.

The recently released report, The Aged Care Workforce 2016, provides useful data on workforce trends in the sector to help inform a response to the workforce issues facing the sector.

The 2016 report was prepared by the National Institute of Labour Studies. The Institute also prepared the three previous workforce reports – 2003, 2007 and 2012. It is based on a census of aged care providers and a structured sample survey of aged care employees that the Institute conducted in the second half of 2016.

Sector participation in the census and survey disappoints

Participation in the workforce census is a requirement for aged care providers receiving funding from the Commonwealth.

The Accountability Principles 2014 require approved providers of residential care and home care packages to return a completed workforce census. The Commonwealth Home Support Manual 2015 places a similar requirement on all CHSP grant recipients. A legal requirement to participate in the workforce census has been in place from the outset for residential providers, but participation by home care and home support providers had been voluntary prior to the 2016 census.

Disappointingly, valid responses were received from only 76 per cent of residential care providers and from even fewer home care and home support providers (42 per cent). The residential care response was a significant reduction on the 2012 response (96 per cent) when receipt of the since discontinued Conditional Adjustment Payment was conditional on participation. The home care and home...
support response in 2016 was a marginal improvement on the 2012 voluntary response rate (33 per cent).

As a result, the NILS researchers have had to extrapolate the responses received to make them relevant to the entire aged care workforce.

Despite the inherent risks of extrapolation based on returns from providers who self-selected, the workforce census and employee survey are still the best information available about trends in the aged care workforce.

What does the 2016 census and survey reveal?

The following draws together ten major trends and ‘take-aways’ from the report.

1. The home care and home support workforce has declined

Surprisingly, the 2016 report found a significant reduction in the full time equivalent (FTE) direct care workforce in home care and home support since 2012, from 54,537 in 2012 to 44,087 in 2016 (−19 per cent). One would be forgiven for taking this extrapolated finding with a grain of salt given that the number of operational home care packages increased by 30 per cent over that period. Moreover, over much of this period, home support funding was growing at 6 per cent real per annum.

On the other hand, direct care FTE employees in residential care over that period grew by 3 per cent (from 94,823 to 97,920), in line with the 4 per cent growth in the number of operational residential places.

The total head count of employees in the aged care sector in 2016 was an estimated 366,000, of whom about 240,000 were direct care employees. The overwhelming majority (about 76 per cent) of direct care employees are permanent part-time.

2. The gradual decline in the number of RNs in residential care evident before 2012 has not continued

The number of RNs (FTE) in residential care increased by 625 (4.5 per cent) since 2012 to 14,564, reversing the previous trend which saw a decline from 16,265 in 2003. However, their share of total direct care staff has remained at 15 per cent (21 per cent in 2003).

The number of nurse practitioners (FTE) has also increased, from 190 in 2012 to 293 in 2016.

However, residential care continues to rely increasingly on Personal Care Attendants (PCAs), with PCAs increasing as a proportion of direct care employees from 68 per cent in 2012 to 72 per cent in 2016 (57 per cent in 2003).

In home care and home support:

- The estimated RN FTE count as a proportion of total direct care employees has declined from 14 per cent in 2007 (6,079 FTE) to 11 per cent in 2016 (4,651 FTE).
- Allied health employees increased from 6 per cent to 8 per cent (3,540 FTE), with allied health professional employees growing faster than allied health assistants.
- Community Care Workers (CCWs), whose composition of the direct care workforce remained relatively stable at 78 per cent, provide the bulk of the direct care in home care and home support.

3. The skill level of the residential aged care workforce continues to improve gradually

The increasing reliance on PCAs in residential care is matched by a gradual improvement in the qualifications held.

- The proportion of PCAs with a Certificate IV in Aged Care has steadily increased from 8 per cent in 2003 to 23 per cent in 2016.
- The proportion of PCAs with a Certificate III in Aged Care in 2016 was 67 per cent, the same proportion as in 2012.
- The proportion of aged care homes with more than three quarters of PCAs holding a Certificate III has increased from 62 per cent in 2012 to 66 per cent in 2016 (47 per cent in 2007).

However, the majority of RNs (71 per cent), Care Leaders (79 per cent) and Care Managers (63 per cent) do not have specialised qualifications in ageing and aged care such as gerontology, palliative care and psychogeriatrics. This is largely unchanged since 2012.

In home care and home support:

- Direct care workers with post-secondary school qualifications in 2016 has increased to 88 percent, almost the same as in residential care (90 per cent).
- However, the proportion holding certificate level qualifications is lower than in residential care, with 51 per cent and 12 per cent of CCW's holding a Certificate III and Certificate IV in Aged Care, compared with 67 per cent and 23 per cent respectively for PCAs.
- As expected, more CCWs hold a Certificate III in Home Care (27 per cent) compared with PCAs (3 per cent).

A majority of direct care workers in residential care had participated in continuous professional development (58 per cent) and on-the-job training (80 per cent) in the past 12 months, with mandatory training being the most common form. These figures differ little from those reported in 2012.
There has not been an improvement in the proportion of home care and home support direct care employees participating in continuous professional development (48 per cent) and on-the-job training (75 per cent).

While most PCAs and CCWs were overall positive about the quality of their training, concerns were raised regarding the inadequate length of courses and placements, the use of online training methods and gaps in course content.

4. The aged care workforce is relatively stable

In residential care in 2016:

- 42 per cent of direct care employees had worked in the sector more than nine years, and approximately 25 per cent had worked in the sector more than 14 years;
- 54 per cent of direct care employees had worked in their current job more than four years and 26 per cent more than ten years;
- ten per cent were actively seeking new employment;
- 82 per cent expected to be with the current employer in 12 months; and
- the most common reason for leaving the previous job related to personal circumstances, such as moving house, fulfilling care responsibilities and wanting a job closer to home (45 per cent). Other reasons included seeking work that is more challenging or to get the shift or hours desired.

A similar picture applies in home care and home support:

- a majority of RNs and ENs (64 per cent and 71 percent respectively) had been working in home care and support for more than nine years. The lower proportion of CCWs who have worked in aged care more than nine years (39 per cent) partly reflects their older starting age (25 per cent were over 50 years when they started in aged care);
- nine per cent of direct care employees were actively seeking alternative employment;
- 81 per cent expected to be with their current employer in 12 months; and
- 33 per cent cited personal reasons for leaving their previous job, and just over 40 per cent named higher pay, getting preferred hours and more challenging work.

Employees, similar to 2012, reported relatively high levels of job satisfaction. The lowest satisfaction level recorded related to pay.

5. Aged care is still not a career of first choice

A large proportion of new direct care hires in residential care and home care and support have held jobs in other sectors prior to aged care. Aged care is the first occupation for very few direct care employees – about nine per cent in residential care and six per cent in home care and home support.

Apart from nursing, where a large number have come from the acute or other community care settings, there is no clear pathway into aged care for the other occupations. PCAs come from a very wide variety of previous occupations including sales, hospitality, cleaning, clerical work, managerial and or other professional (non-nurse), to name a few. A similar situation applies for CCWs in home care and home support.

At this stage at least, disability is rarely the previous employment sector for direct care employees for both residential care (about two per cent) and home care and home support (between two and six per cent, depending on the occupation).

6. Providers are still reporting skill shortages; however, there is some evidence of under-utilisation

Two-thirds of residential facilities with direct care employees reported skill shortages in at least one direct care occupation, with RNs being the most common. Skill shortages are most common in remote and very remote areas.

In home care and home support, 49 per cent of services with direct care staff reported skill shortages, with shortages of CCWs being the most common.

In both residential care and home care and support, most reported no suitable applicants as the cause of the skill shortages, with ‘suitable’ defined as skill level, qualifications, experience and values.

Notwithstanding the above, the survey found that many existing employees would like to work more hours and many hold more than one job.
• 30 per cent of direct care employees would prefer to work more hours.
• The equivalent figure in home care and support is 40 per cent.
• The preference for longer hours relates mainly to PCAs and CCWs.
• Nine per cent of direct care employees in residential care and home care and home support had more than one job.
• Almost half had another job in aged care, while the rest had jobs in other sectors.
• Multiple job holding is more common in aged care than for the Australian workforce (five per cent).

Taken together, these figures suggest that there is a degree of under-utilisation of the available labour force, though it would be wrong to suggest that this applies universally. Under-utilisation was also evident in the 2012 report.

Turning to vacancies:
• In residential care, 26 per cent took less than one week to fill, and 76 per cent were filled within four weeks.
• The medium vacancy duration was 2 weeks for PCAs and 3.5 weeks for RNs.
• In home care and home support, 71 per cent of vacancies were filled within four weeks.

Time taken to fill vacancies is an indicator of the tightness of the labour market. The above average vacancy duration figures are not considered indicative of a tight labour market. That said, as noted above, there are important regional variations such as in remote and very remote areas regarding certain occupations, and there are concerns about the suitability of many potential employees.

7. Home care and support makes greater use of Australian born direct care employees than residential care

There has been a slight decline in the proportion of direct care employees in residential care born overseas, from 35 per cent in 2012 to 32 per cent in 2016. On the other hand, the proportion of overseas born new hire employees has been increasing, from 34 per cent in 2007 to 40 per cent in 2016, suggesting a higher turnover rate for overseas born employees.

This pattern is not repeated in home care and home support. The share of overseas born new direct care hires has declined marginally to 21 per cent, as has the proportion of overseas born direct care employees (from 27 per cent in 2007 to 23 per cent in 2016).

Overall, home care and home support makes greater use of direct care employees born in Australia (77 per cent) than residential care (68 per cent). If this reflects the requirements of the different work environments, it may have implications for the expansion of home care and home support, especially the significant expansion of home care packages.

Aboriginal and Torres Strait Islander people account for about 1-2 per cent of the aged care workforce, similar to 2012.

8. There has been a further shift away from casual and agency employees

The 2016 report has revealed a further shift away from casual/contract employment for direct care employees in both residential care and home care and home support.

• The proportion employed under these arrangements in residential care has fallen from 19 per cent in 2012 to ten per cent in 2016, a trend that was evident since 2007.
• In home care and home support, the proportion of casual/contract staff has fallen from 27 per cent in 2012 to 14 per cent in 2016, mainly due to an increase in permanent part-time employment for CCWs (from 63 per cent in 2012 to 79 per cent in 2016).

Seventy-eight per cent of the residential direct care workforce is permanent part-time. The equivalent figure in home care and support is 75 per cent.

The growing percentage of permanent employees in aged care, where continuity of staff is important for consumers, is another indicator that the current labour market is not excessively tight.

9. There has been an increase in the proportion of younger employees in residential care

Reports since 2003 had indicated that the residential care workforce was ageing.

“There is also a view [...] that aged care is considered an unattractive industry by potential employees due to perceptions that aged care is a low status job which offers poor pay and few career pathways.”
The 2016 report indicates that this trend has changed, with the median age of direct care staff having declined from 48 in 2012 to 46. The main driver of this change is the age of new hires, with the proportion of new hires under 34 increasing from 29 per cent in 2003 to 46 per cent in 2016. It remains to be seen if this trend is sustained.

The trend in home care and home support is rather different. The median age of direct care employees in home care and support increased from 50 in 2012 to 52 in 2016, and the proportion of new hires under 34 (24 per cent) has changed little since 2007 (22 per cent).

10. Volunteers continue to make a large contribution, especially in home care and home support

Approximately 23,500 volunteers worked in residential care in 2016, providing about 115,000 hours of assistance with social and planned group activities and companionship (an increase of 13 per cent over 2012). Not-for-profit residential services were more likely to use volunteers (91 per cent) than for-profits, though for-profit use of volunteers was also high (89 per cent). Average hours of volunteering in 2016 per volunteer was about five hours, about the same as in 2012.

The incidence of volunteering in home care and home support, which is dominated by not-for-profit services, is greater than in residential care. About 44,900 volunteers provide assistance in home care and home support, mainly for social/group activities and transport. On average, each service had 29 volunteers with each volunteer working 4.6 hours per fortnight.

So what conclusions might be drawn from this data? The 2016 report concluded that the current aged care workforce is stable, committed and increasingly well and relevantly qualified. Employees report relatively high job satisfaction levels and a large majority wish to stay working in the sector. The retention and attraction statistics suggest that the sector overall has been competing reasonably well in the labour market.

The data and survey responses also highlight some problem areas. There are continuing skill shortages in remote and very remote areas. There are concerns about the standard of certificate level qualifications and gaps in training regarding dementia care, palliative care and mental health. There is also a view among existing employees that aged care is considered an unattractive industry by potential employees due to perceptions that aged care is a low status job which offers poor pay and few career pathways.

But what does this mean for an aged care workforce strategy?

Aged Care Update has suggested previously that the role of government in relation to the aged care workforce in many respects is the same as for other sectors of the economy i.e. pulling economy-wide levers and funding and regulating higher education and the VET system.

Employers operating within a financially viable sector are in turn responsible for determining the attractiveness of their workplaces and the reputation and standing of their sector in the community. They are also responsible for engaging with universities and training organisations to ensure that training curricula and qualifications are meeting emerging requirements.

What distinguishes aged care, however, is that government regulations and pricing policies directly impact the financial viability of the sector, and therefore the capacity of employers to compete in the labour market and to create attractive workplaces.

It is no coincidence therefore that the relatively benign workforce situation revealed in the 2016 report coincides with a period of improving financial performance in the sector (assisted in some regions by the end of the mining ‘boom’). Improved financial performance resulted from the real increase in care prices following the redirection of the workforce supplement, and significant annual real increases in per resident per day funding under ACFI.

A starting point therefore for any strategy has to be securing the financial viability and sustainability of aged care services. An immediate focus must be to take into account the impact of the reduction in real per capita growth in funding under ACFI that the government is pursuing, as well as the review of alternative funding models which may see the replacement of ACFI. What transpires here will have the biggest impact on securing the workforce needed to deliver quality care and support.

The strategy also has to prioritise funding arrangements and training incentives that support services in the bush. It also needs to develop effective consultative arrangements with the education and training sectors to ensure that entry level qualifications and staff development opportunities are responding to emerging needs, changing technology and new models of care.

Disclosure statement: The author of this article, Nick Mersiades, is a member of the Aged Care Financing Authority (ACFA). The opinions in this article should not be read as being an expression of the views of ACFA.
As I lay on my hospital bed (private, but non-Catholic) waiting to be taken to theatre for my surgical procedure, I was contemplating and anxious as to what to expect with the insertion of a pacemaker into my body. A nurse entered the ward and said she was there to shave me, ready for my surgery. Curious, I asked where she intended to shave me. “Your groin,” she responded. “Isn’t that an unusual place to insert a pacemaker?” I asked. Taken aback, she said she thought I was to have an angiogram.

As this hospital incident was not serious, I felt sure it wouldn’t have been reported and investigated as to discover the cause of the miscommunication. It does highlight that in the human services area we have humans delivering services to other humans. And humans do make mistakes.

I recalled that hospital experience on reading recent media coverage of care failures in residential care sparked by the South Australian Makk and McLeay Oakden mental health nursing home which the SA government is closing as a consequence of a report commissioned by them into its care failures.

Media descriptions of specific care failure examples have occurred under headlines such as “Hall of Shame,” “Regulator’s checks for neglect at nursing homes are failing,” and “Regulator asleep at the wheel.” These are just emotive phrases designed to capture the reader’s attention. They serve no useful purpose in explaining why we from time-to-time see care quality failures in our human services such as hospitals and nursing homes.

The media backs up their headlines with snapshot examples of care quality failures from a range of services and then links them to the Aged Care Quality Agency’s assessments of those facilities, often going back some years. Little thought is given by the journalists to analysing or even identifying the root causes of these moments in
time lapses. No thought is given to the fact that human beings are providing care and private intimate support for activities of daily living to other human beings. None of us are infallible.

The Quality Agency conducts robust audits of residential aged care facilities. Their assessors examine how the service demonstrates that it meets the 44 Standards Outcomes. In making their decisions, the assessors examine an extensive list of documents, including all the policies, procedures, continuous improvement processes, minutes of meetings, complaints handling, incident reports, and in addition, interview a random sample of staff and residents or their representatives. The Agency’s subsequent reports are based on snapshots in time. Care failures can occur at any time when the human beings delivering the care lapse from their providers’ policies, procedures, processes, and what is expected of them professionally.

“The most frequent mechanisms of death [are] falls at 81.5 per cent, choking at 7.9 per cent and suicide accounting for 4.4 per cent.”

Committees of management and boards expect that when these lapses occur they will be reported, so that root causes can be identified and corrective action taken to avoid the same mistakes happening again. Sadly, the media is not interested in this aspect. For the media it’s about blaming, and as a consequence, damaging the providers’ reputation and image in the process.

Many of the media’s so called exposes of care failure include individual cases of downright criminal actions by rogue care staff members; in many instances these are actions that the provider could not have foreseen, such as killing by administering insulin to non-diabetic residents, attempting to suffocate an 89-year-old resident, and the killing of multiple residents by setting fire to a facility to hide a drug-related crime.

Additionally, the media also includes examples where a resident dies as a result of a fall whilst going about having their right to experience the risks that go with getting out of bed each day and living life.

The majority of serious incidents in residential aged care are as a result of falls and resident-on-resident assaults. The former can be prevented by keeping residents in bed at all times, but is that a life that they would want or you would want for them? The latter is the result of increasing numbers of residents having dementia, and for many, significant cognitive dysfunction. Locking them in their rooms all day is not the answer.

Providers try to establish home-like environments with interesting indoor layouts and communal areas that encourage residents to move around freely to mix and mingle with other residents. Activities are provided indoors as well as external outings to appealing locations and events.

Facilities also have secure outdoor areas that residents can experience and enjoy, even when it can expose them to the possibility of having a fall, as has happened with a dementia resident that died after falling into a fountain in a home’s courtyard. This resident was exercising her right to experience the dignity of risk.

Recent research published in the Medical Journal of Australia by Joseph Ibrahim, Professor of Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University, found that 15.2 per cent of over 20,000 deaths of nursing home residents between 2000 and 2013 resulted from external causes, being injury, violence, or external event. The most frequent mechanisms of death were falls at 81.5 per cent, choking at 7.9 per cent and suicide accounting for 4.4 per cent. Only 1.2 per cent died from adverse events related to their clinical care such as medication errors. You wouldn’t think this was the case from reading the scare headlines and stories in the mainstream media, however.

Given that 60 per cent of falls by older people in the community occur in and around their own homes, it’s to be expected that by living the last year/s of life in a residential aged care facility (their home), not all falls risks can be eliminated.

Calls for more government regulation will not reduce the risks of adverse events. So what is or are the answers? Providers do need to have robust incident reporting and complaint management systems. All incidents need to be reported and examined. Serious incidents need to undergo a root-cause analysis and corrective action must be taken.

Boards and senior management need to demonstrate a commitment to the organisation having a compliance culture to all relevant legislation, regulatory requirements, professional standards and guidelines, and the organisations’ own policies, procedures and incident reporting processes, even where this involves staff themselves or work colleagues.

Introducing a blame-free, all incident reporting process, followed up by root-cause analysis and continuous improvement implementation and evaluation will go a long way to avoiding media scare stories that shake the community’s confidence in Australia’s aged care system – a system which is recognised as being one of the best in the world.
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mission leadership: supporting today’s ‘specialist’ leaders, looking towards the future

by Susan Sullivan
Director of Mission Strategy

Over a decade ago, with a degree of trepidation, I accepted a position as new mission leader at the local Catholic hospital. I quickly encountered from within the complex, frenetic and 24/7 world of health care service delivery. Coming from an education background, at that time I had no real, practical idea what the mission leader role actually required or entailed. But I quickly grasped the all-encompassing reach of its responsibilities.

With a mixture of excitement and apprehension, I fronted up in those early days to an experience that could best be described as discombobulating. I was encountering new language and baffling acronyms daily – racing along a steep learning curve as I encountered a vast range of interconnected committees and departments guiding service outcomes. I was challenged by the ‘connect’ between the business of service provision and the ‘real people’ at the heart of it all, and struggled with sometimes contradictory assumptions about the expectations and tasks associated with my role. At the same time, I was acutely aware of the significance, as well as the privilege, of the responsibility entrusted to me.

The evolution of the mission leader role across the past three to four decades is well articulated in the CHA resource The Role of Mission Leaders in Catholic Health and Aged Care. In brief, the role has developed and adapted in response to seismic shifts experienced by Catholic ministries. From a mission perspective, one of the most significant is the transition of leadership and management to predominantly lay people, and often people other than Catholic. At the same time, the financial challenges and complexity of health and aged care service delivery has been escalating dramatically.

The authors of The Role of Mission Leaders in Catholic Health and Aged Care chart this transition well, and in so doing acknowledge the perennial debate about the connection between the responsibility of the organisation’s CEO and the ‘specialist’ mission leader role. However, they make a convincing case for the continuance of the specialist role and for increased efforts by organisations to strengthen the skills of people holding this delegated responsibility.

“Just as the CEO delegates responsibility for finances and clinical issues to relevant specialists, so the CEO also delegates aspects of their responsibility in nurturing the Mission, entrusted to the organisation by the Catholic Church, to an officially appointed Mission Leader”. More than ever, mission leaders of today and into the future,
“In brief, the [mission leader] role has developed and adapted in response to seismic shifts experienced by Catholic ministries.”
need a sound grasp of two quite different worlds, along with the literacy to engage with both. On the one hand, they need to be articulate and proficient in “the Catholic thing” – the unique moral, social and spiritual dimensions of the Catholic approach to life, to being human and to being a service of care. On the other hand, this knowledge only has real value in this context when it is translated and made relevant to the business, clinical, and strategic challenges of the health and aged care organisation.

It is timely, then, that through the initiative of Catholic Health Australia’s Pathways Taskforce, a Mission Leader Formation Program is under development in response to this growing challenge, and to the recognition of a two-fold reality. Firstly, the new program is a response to longstanding awareness among CHA members of the potential gap emerging in the availability of people with the range of skills and expertise needed, especially in theology, Scripture and Church relations. Secondly, it recognises and responds to the fact of growing complexity in health service delivery and the sophisticated skill-set required to be effective in the role. The skills required are increasingly more diverse than in earlier decades. Development of a sector-wide succession plan is critical to address this changing environment.

The CHA Mission Leader Formation Program currently being developed responds to the needs of two different groups. Firstly, newly appointed people in the often-turbulent throes of learning the role need support and guidance. Secondly, in light of the urgent need to encourage a new generation of mission leaders, the program targets people interested in and aspiring to the role. This distinction has led the development team to structure the content and process to three broad target groups:

1. people new to the mission leader role who are still developing their skills and knowledge;
2. people with potential who are attracted to the role, while currently working in a Catholic organisation, albeit in another capacity;
3. people with interest in the role but not currently employed by a member organisation. They may be employed in another Catholic ministry, or another faith based organisation, and have an interest in a career in mission leadership.

The CHA Mission Leader Formation Program is designed around a tailor-made framework describing a core set of capabilities required of a new mission leader. While US-based Catholic ministries have for many years been guided by a comprehensive mission leader competency framework, the work of articulating a guide to role expectations in the Australian setting has been on the table for some time. The commitment by the Pathways Taskforce to develop a formation program for new mission leaders provided the catalyst for the CHA Mission & Identity Committee to invest time in reflecting on and articulating the core elements of an Australian framework to clarify expectations of a person starting out as a mission leader.

The word ‘capability’ as opposed to ‘competency’ was chosen for the Australian framework. This is because the word ‘competency’ can lead to a perception that certain skills and knowledge need to be, and even can be, acquired in a definitive and completed sense. This contradicts the well-established notion that formation is an ongoing process, always expanding and developing. It is also important to appreciate that the new CHA Mission Leader Capability Framework attempts to describe what is particular to, or most crucial, in the role of mission leader. It is not intended to duplicate or replace the capabilities expected of each senior leader, and which is usually described in organisation-
specific executive capability frameworks developed by many CHA members.

The Australian framework is developed around three core pillars: personal and interpersonal capabilities, faith and Church capabilities, and organisational capabilities. Each of these pillars is understood to have implications across the strategic, organisational and relational dimensions of the mission leader’s contribution. Under the category, **Personal and Interpersonal Capability** new mission leaders are challenged to be growing towards being “talented, faithful and competent executives who embody holistic and healthy qualities which enable them to make a positive and lasting impact on their organisation.”

The **Faith and Church Capability** has three components: Catholic Theology, Spiritual Leadership and Ethical Leadership. Mission leaders will be expected to have or be continually developing a working knowledge of Catholic theology and be acquainted with the plurality of religions that will be encountered among staff and patients and others who are served by the organization. They will be able to articulate their lived faith experience and the meaning it brings to their lives as well as encourage and empower individuals and the organisation to do the same. They will also encourage ethical behaviour throughout the organisation with a focus on organisational ethics, clinical ethics and the Church’s social justice tradition.

Finally, but of increasingly critical importance, the **Organisational Capability** emphasises that mission leaders will need to have, or be actively developing the necessary capabilities to be recognised as productive contributors to the organisation. They will be striving to bring strategic direction, thinking and guidance, as well as a collaborative spirit to the organisation to ensure that it is faithful to its purpose, identity and values.

With this foundational work in place, of articulating the horizon towards which new mission leaders are striving, the resulting capability statement is now guiding the mission leader formation program planning, design and evaluation components.

We are delighted to have engaged Jennifer Stratton and Kerry Brettell to lead the initiative. Jennifer brings extensive experience as former Group Mission Leader for St John of God Health Care and, more recently, through consulting to CHA on leader formation programs. She is also Chair of Trustees at MercyCare and a Board Director with Little Company of Mary Health Care. Kerry has for many years worked extensively across Catholic health and aged care organisations. She has had a particular focus on processes for embedding mission and developing the competencies required by mission leaders to successfully lead this process. She is currently a Director at Integroe Partners.

The project leaders have now scoped the broad outline and approach of the new program. An important feature is the multi-modal platform through which it will be offered. This

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Promotion and recruitment to the program will take place in 2017, ahead of planned roll-out in early 2018. We are hoping you will be as excited as CHA and the Pathways Taskforce is about this important new initiative. We look forward to keeping members informed as further details become available.

1 Fr Gerard Arbuckle and Jennifer Stratton, 2015

2 ibid
“To more successfully address the continuing gaps in health experienced by Australia’s ATSI peoples, we need to incorporate health into culture, not culture into health.”
‘Close the Gap’ is the name of the government strategy that aims to achieve health and life expectation equality for Australia’s Aboriginal and Torres Strait Islander (ATSI) peoples by 2031. Real progress has been made since 2006 in some areas, but in other areas the gap is still just as wide, while some contend it is widening even further in some regions. This is particularly true for ATSI peoples living in North Queensland.

A recently released Australian Institute of Health and Welfare report indicates that “after adjusting for underidentification, Indigenous Australians were hospitalised at about 2.7 times the rate for other Australians.” The gap in life expectancy between Queensland Indigenous males and females and the Australian non-Indigenous population is now estimated to be 10.4 and 9 years respectively. It is not that they are ageing at an accelerated rate, “Rather, they face a greater burden of conditions at an earlier age that lead to the premature onset of complications typically seen with ageing in non-Indigenous Australians.”

The Prime Minister, Malcolm Turnbull, acknowledges that, “Closing the Gap is a national responsibility that belongs with every Australian. Ending the disparity is complex and challenging. This will not lessen our resolve or diminish our efforts, even when some problems seem intractable and targets elusive.”

BRINGING health into CULTURE

by Anthea Gellie
Health Project Officer
Catholic Health Australia

and

Skye Williams
CHA Intern and Student
Australian Catholic University

Policy & ADVOCACY
To more successfully address the continuing gaps in health experienced by Australia’s ATSI peoples, we need to incorporate health into culture, not culture into health. So proposes Dr Mark Wenitong, a Kabi Kabi man from the south of Queensland, and Public Health Medical Advisor for Apunipima Cape York Health Council, the Aboriginal Community Controlled Health Organisation (ACCHO) for Cape York. Dr Wenitong remarked in a recent keynote presentation that our “220-year experiment in Australia to bring culture into health” has not been successful. We need to begin addressing the health needs of ATSI peoples the other way around, by bringing health into culture. This is the aim of Apunipima Cape York Health Council (Apunipima), who deliver high-quality, culturally appropriate, comprehensive primary health care to 11 Cape York communities, with more communities in Cape York to be introduced to their service in the future.

The Apunipima-CHA Project has grown from the strategic partnership developed over the past three years between Apunipima and Catholic Health Australia (CHA), together with the support of its member organisations. The partnership is a mutually beneficial one, wherein the Catholic member organisations receive opportunities in training and upskilling of staff, gain experience in rural and remote health settings, and achieve a better understanding of Australia’s First Peoples’ culture, and the particular challenges and barriers faced by their largely remote communities. This partnership offers the Catholic member organisations the unique opportunity to work alongside ATSI leaders and community members to Close the Gap. The Apunipima-CHA Project model consists of a collaborative, three-pronged approach to better assist Apunipima to address the health gaps in Cape York, by providing workforce support and opportunities for training and education.

The first of the three prongs conceived of by the partnership was the Apunipima Workforce Exchange Program, giving CHA member employees the opportunity to participate in allied health placements in Apunipima-serviced communities in Cape York. These placements are identified by Apunipima based on current community need, or as backfill for Apunipima staff.

The second prong will provide training and upskilling opportunities for Apunipima staff, both as workshops run in Apunipima’s clinics, as well as training opportunities in member facilities nationwide.

Delivering health services to the area is challenging, as it is especially remote, under-resourced, and mainly accessible by plane. On the seventh of October 2016, Kowanyama was the site of a serious incident resulting in multiple life-threatening injuries. One woman was killed and 26 people were injured, with 14 airlifted to Cairns and Townsville hospitals for treatment for a variety of injuries, including spinal injuries, fractures, dislocations and lacerations. The injured community members were supported by two doctors and four nurses already in the community. A further two nurses drove in from Pormpuraaw, a 287km journey that takes twelve and a half hours by road. Finally, the Royal Flying Doctor Service delivered a further two doctors and four nurses. Further support was provided to the community in the form of increased police presence, in addition to grief and mental health counselling.

No allied health staff had been included in the initial response team. In fact, there had been almost no allied health services delivered in Kowanyama for over two years.
in the clinic within half an hour. It was an impressively quick turnaround.

One of the factors that makes for successful programs is the right people. “They were chosen very carefully for their professional backgrounds and experience,” recalls Cath Garner, Executive Director of Mission and Strategy at Cabrini.

James Butler is a Grade Two Occupational Therapist with experience in short stay units and an emergency department. While James had not worked in remote communities beforehand, he certainly had experience in emergency response and rapid assessment of need.

“Clinically, I wasn’t too worried about it. I also work as a professional firefighter with the CFA, so there were some similarities in regards to dealing with large-scale incidents, rapid assessment and so on,” said James. “From that perspective, and I can only speak from my experience, it was fairly familiar.”

Kathleen Withers is a Physiotherapist who, at the time, was in her first year out of university. She had previous experience teaching science to ATSI children in regional and remote settings. She felt Cabrini had prepared her for the placement quite well, as she had a background in acute orthopaedics; and both outpatient and inpatient respiratory care.

“It would help to have more years on you for sure, but regardless of how much professional experience a clinician has had, the scenario is very different,” said Kathleen. “If you are a creative person, you should be able to find a way to treat patients within very limited resources”.

Kathleen also felt her personal comfort level with the environment made a big difference, and knowing she had the ability to make a phone call back ‘home’ for clinical advice.

“There were options available to discuss problems that arose. You don’t feel as if you’re out by yourself and you have to know everything,” said Kathleen.

Arriving in Kowanyama, one of the first things to hit home for James and Kathleen was the sharp contrast with how things operate in a metropolitan hospital setting. James described it as an evolving incident, with very little information available to them, due to the emergency nature of the response. To some extent, both they and the Apunipima staff had to ‘feel out’ their role requirements as they went. Another thing that struck them was the friendliness and helpfulness of the Apunipima staff in dealing with them. “Everyone was really helpful and they pointed us in the right direction,” said James and Kathleen.
They both spent some time trying to track down clients, rather than having clients arrive at the clinic for prescheduled appointments. James described the experience of jumping in a 4x4 with the Apunipima staff to find a client. Some people in the community were “a bit nomadic”, or might change addresses often, and they may have had to visit five or six houses to find a client. James explained, “We didn’t have dedicated spaces; we saw people in their homes, on their front patios, walking down the street, as well as in the clinics, and we were flexible around that.”

Kathleen and James’ expertise in different areas proved of benefit to the community. They provided patient assessment for what the community called the ‘walking wounded’; those patients still in the community who had not been seen by anyone yet as they had not required hospitalisation. After assessing their injury and establishing whether or not they required further intervention, they worked with the doctors that had flown in to assist after the incident. James’ training in hand therapy turned out to be of great benefit to one community member whose hand had been fractured in the incident. This client was able to remain in the community for longer, and receive additional hand therapy that they would not have had otherwise.

They were both challenged to think creatively in dealing with limited resources. James had the resourcefulness to successfully repair a worn orthotics harness using cable ties. Kathleen described spending some time conducting inservices for nursing staff, on taping; setting gait aids to the correct height; and icing and heat therapy education. She was also able to advocate for a client who had initially been assessed with a leg injury that was not severe enough to require hospitalisation. On assessment, they could no longer weight bear comfortably, and were suffering night pain. Kathleen was concerned about infection, and advocated for the patient to be flown to hospital, also ensuring adequate follow-up on return to the community.

Both James and Kathleen discussed the benefit of going as a pair to Kowanyama. This allowed them to debrief and problem solve together, and to decide where their roles were best used. They also found that being associated with Apunipima and wearing their uniform engendered trust within the community, and facilitated client relationships. Importantly, responding to the Kowanyama incident provided James and Kathleen with the opportunity to work alongside and learn from Apunipima Aboriginal Health Workers, who assisted them in finding clients that needed to be seen, and performed introductions on home visits. As Kathleen explained, “There was no issue in terms of building relationship. Whenever we did a house visit there was always a health worker there, which I think was really important.” The client immediately knew they were here for their health, and no one refused to see them. In general, client relationships were very positive, as “patients were really happy to have someone to listen to them, and were very receptive,” said Kathleen.

James and Kathleen were also offered important information on cultural protocols and customs. For James, the greater challenge to the practice was in making sure he and Kathleen were being culturally appropriate. He highlighted the importance of engaging with community, “rather than trying to bend them to your style”. James and Kathleen had the opportunity to talk to some Elders that worked with Apunipima. The Elders were a fantastic resource to whom they could turn to for advice if they were concerned about being culturally inappropriate.

Kathleen described the accommodation which allowed them to share in the community life as a highlight. “Everyone was lovely. We all stayed in the same accommodation as well. Every evening we cooked meals and sat around and talked, and some people from the community came and joined in. That was really good. It was welcoming,” she said. When asked to reflect on the learning opportunities that came
for him out of the placement, James expressed a greater appreciation of rural health, and an increased knowledge of the significant barriers faced by geographically remote communities, such as not having access to the basics such as fresh fruit and vegetables. This reinforced to him the significant impact this lack of access has on the foundations of health and health development. He developed an appreciation for and an understanding of being in an almost exclusively ATSI community: their community expectations; how that community functions; and how to engage and interact with ATSI people.

There are multiple communities on Cape York, and James realised the value in learning that there can be different cultural practices between neighbouring towns and communities, feeling that the opportunity enabled him to build “a more intimate knowledge”, as opposed to a non-specific general knowledge. He also learned some of the customs around ‘sorry business’, the grieving process that the community were going through while he was there. Both James and Kathleen spoke of the benefits of having “a sound knowledge of European settlement and its impacts” before arriving in the community, and that their visit reinforced some of the barriers and challenges that are experienced by ATSI people due to colonisation. The knowledge they came with regarding the barriers to health care delivery in remote ATSI communities, and reasons for some of the health issues encountered specific to indigenous people, was very helpful for them in their practice.

Kathleen also reported the experience to be a “hugely valuable learning experience”. It brought home for her how strongly a person’s context can affect their health. The barriers Kowanyama face, including heat, were valuable for her to reflect on, and has had an impact on her clinical practice in terms of fostering creativity in how she approaches health care for people in similar areas. “I definitely learned more about the importance of liaising with other team members and…assessing risk,” said Kathleen. The importance of linking the client with other services in the community was another area of learning.

Experiences like this can assist a clinician in thinking more holistically about patient care. One of the biggest impacts on clinical outlook for Kathleen was around the benefit in considering a patient’s long-term health, and what treatment would make the most impact on that. As a clinician, she seeks to establish the key limitations that are preventing the patient from looking after their health.

James and Kathleen identified the qualities of resilience, flexibility and creativity as vital for a cultural immersion placement. They added that empathy and good communication skills - especially emphasising good listening skills – greatly enhanced a practitioner’s service provision in a remote community. A successful program for them would be one that increased the awareness of the issues faced by ATSI peoples. Kathleen emphasised the importance of being able to “implement change that could last beyond our stay there, beyond the one or two weeks.” James wanted to see a program which “provides allied health support that is driven by the needs of the community”.

“They were both challenged to think creatively in dealing with limited resources. James had the resourcefulness to successfully repair a worn orthotics harness using cable ties.”

Would they want to return? Definitely. Kathleen expressed enthusiasm for the program, “I would love to be there longer to put more things in into place, in particular, programs that would impact them the most in their health beyond the key stages.”

The next steps in developing the program are to seek expressions of interest for further placements and build a database of interested allied health clinicians. All clinicians will be given comprehensive cultural responsiveness training before being sent on placement. Apunipima and Catholic Health Australia hope that a strong partnership and good collaboration will begin to bring health back into culture, assisting Apunipima in closing the gap for the ATSI peoples of Cape York.

5 Commonwealth of Australia, Department of the Prime Minister and Cabinet, Closing the Gap Prime Minister's Report 2017.
6 Dr Mark Wenitong, Keynote address: Social accountability and remote Indigenous Health practice, 14th National Rural Health Alliance Conference, Cairns, April 30 2017.
7 Ibid.
few issues over the last two decades have so captured the Australian social and political agenda as asylum seeking. This interest has associated with similar narratives in other Western industrialised nations, and is underpinned by the greatest displacement of humans in global history. The United Nations High Commissioner for Refugees (UNHCR) estimates there are currently in excess of 65.3 million displaced persons (2015 estimate), including 21.3 million refugees. In 2015, approximately 4.9 million people sought asylum globally, 2.3 million were determined to be refugees, and a growing 3.2 million cases were still pending. These massive movements of people have been principally driven by civil war, conflict, and famine in countries such as Syria, Afghanistan, Somalia and South Sudan.¹

continued next page
“[Mental disorder] rates are many-fold higher than in the mainstream population, affecting in the order of half the adult asylum seeking population.”
In contrast to these large global flows, in 2015, Australia received 16,117 asylum applications (0.33 per cent of global cases) and recognised 2,377 claims (0.1 per cent). Additionally, with previous unresolved claims, there are over 30,000 people in Australia and in off-shore regional processing centres seeking asylum here.2 Due to geographical isolation, Australia has been comparatively protected from unsolicited claims for protection; these principally being constrained to on-shore applications from visitors, students and temporary workers and averaging 5-8,000 per annum with 9,554 lodged last year.3 An upsurge in unapproved maritime arrivals via Indonesia prompted a politically bi-partisan policy of deterrence. This has included excision of Australian land to the airport and catching a flight out of the country to any safe haven country. The migration phase may be as uncomplicated as travelling to a safe haven country in which the asylum seeker chooses to seek protection, considerations of personal safety, persecution and physical deprivation are replaced with a different set of new stressors. Asylum seekers will need to undertake the refugee determination process (RDP), adapt, acclimatise and survive in a new country, which can be mandatory and indefinite, and can be extended into community settings with curfews and restrictions on movement. The RDP evaluates the fidelity of a claim against national or UN criteria for refugee status. As such, the individual must detail the evidence that supports the claim which will include the persecution, oppression and other factors which drove the individual to seek asylum. The evidence is tested for credibility before a decision is made against protection obligations of the host nation and current conditions in the asylum seeker’s country. Such a process is experienced by most asylum seekers as extraordinarily stressful and may be protracted, especially if appeals are engaged with negative decisions. The nature of this stress erodes resilience and is associated with psychiatric morbidity. We identified that the likelihood of Post-Traumatic Stress Disorder (PTSD) increased by 1.35-fold for each rejection after the first, demonstrating a clearly traumatising effect of the RDP for asylum seekers.4

Contributory factors to mental health in asylum seekers

Those who are forced to seek asylum have experienced multiple contrasting stressors that exert distinct psychological effects. These stressors can be divided into three temporal phases: pre-migration; migration; and post-migration. The pre-migration phase is the most easily understood where the factors driving the search for asylum operate. These include war, civil conflict, persecution of all types, torture, rape, oppression and the witnessing of atrocities. The effects are multiple such as traumatic memories, grief, and long-term physical sequelae.

“The individual’s resilience when eroded by hostile, authoritarian, or rejecting host community factors, permits cumulative traumatic memories to emerge […]”

The migration phase may be as uncomplicated as travelling to the airport and catching a flight out of the country to Australia. It frequently, however, is considerably more problematic. Individuals may need to undertake significant clandestine processes that involve subterfuge, placing themselves, family and friends at great risk. Either within or outside their country, people smugglers or other agents, at considerable cost, may need to be recruited to secure passage to a safe haven country.

In contrast to individuals fleeing persecution alone or in family groups; war, civil conflict or widespread ethnic, religious or cultural persecution necessitates mass movements of people. The internal displacement of people within national boundaries, although potentially a humanitarian crisis, does not constitute a refugee issue until the national border is crossed. The rapid exodus of large groups exposes individuals to environmental and physical hardship, deprivation, including shelter, water and food, and family separation. Neighbouring countries become the focal destination, seeing the establishment of informal and formal camps. Numbers of people and conditions in such camps range vastly with starvation, violence, climatic exposure and poverty all too common. Such conditions drive people to seek refuge in safe haven countries often at great peril such as via sea or mountain crossings, imprisonment at the hands of migration and military authorities, and death at the hands of militia or vigilantes.

Having arrived in a safe haven country in which the asylum seeker chooses to seek protection, considerations of personal safety, persecution and physical deprivation are replaced with a different set of new stressors. Asylum seekers will need to undertake the refugee determination process (RDP), adapt, acclimatise and survive in a new country, and may face hostility, stigma and discrimination from the host community. Many may also experience immigration detention, which can be mandatory and indefinite, and can be extended into community settings with curfews and restrictions on movement.

There is extensive global literature on the psychological and psychiatric effects of migration,5 which is applicable to asylum seekers for the most part. In addition, though, asylum seekers may confront societal and community factors qualitatively and quantitatively different to those of mainstream migrants and assessed refugees. These could include restricted access to work rights, subsidised healthcare and social or welfare benefits, placing them in...
straitemed circumstances. Both work rights and access to public healthcare are denied to some asylum seekers in Australia, contributing to increased rates of major depression and PTSD. The converse is true, with access to work rights and public health care improving PTSD and demoralisation. The perceived reception of the host community is relevant where openness, support and acceptance contrasts with hostility, discrimination and ostracism. The zenith of the latter approach may be seen in indefinite mandatory detention. The consequences of such have been impossible to intensively study, certainly from an Australian perspective, but indicate profound deleterious effects on mental health.

In addition to the numerous factors described above, peculiar to the plight of asylum seekers are those that are relevant to psychological health and mental disorder in all people. Two of special relevance are: the presence of past mental disorders, substance use and suicidality; and the individual’s resilience, which in-turn may be enhanced by personal and social factors such as education, wealth, and host language proficiency.

The nature of mental disorders in asylum seekers

Collectively, these factors assist in understanding the nature and prevalence of mental disorders in asylum seekers. The vast majority arriving in distant countries have needed the wherewithal to undertake the hazardous and challenging journey, and, generally, are not burdened by severe mental disorders such as schizophrenia. Instead, having arrived, the impacts of the above factors overwhelm coping and adaptive mechanisms. Traumatic memories – both major and minor – kept at bay through a range of psychological strategies now recur. Disorders, in particular, major depression (MD) and PTSD, emerge both in isolation and commonly together. Rates are many-fold higher than in the mainstream population, affecting in the order of half the adult asylum seeking population. The consequences of these disorders are considerable. Very often diagnosis is delayed because people for reasons of stigma or lack of awareness do not identify illness, and because of poor mental health, screening by receiving services. Treatment services are either not accessible because of cost or availability or lack expertise in treating these conditions. Finally, the protracted nature of these stressors often means recovery is delayed, partial or incomplete, despite treatment. Thus, substantial psychiatric and psychological morbidity is present within the asylum seeking population, potentially leading to long-term adverse effects, including suicide.

“The likelihood of Post-Traumatic Stress Disorder (PTSD) increased by 1.35-fold for each rejection after the first [refugee determination process], demonstrating a clearly traumatising effect [...]”

Summary

The mental health of asylum seekers is related to pre-migration, migration and post-migration factors which act in concert with conventional psychiatric risk factors and resilienties to mediate mental disorders in this population. The individual’s resilience when eroded by hostile, authoritarian, or rejecting host community factors, permits cumulative traumatic memories to emerge, potentially contributing to the very high prevalence of mental disorder in this population. These in-turn are generally not recognised, nor adequately treated, resulting in much suffering and lost productivity. This argues for early screening of mental disorders in the asylum seeker population and referral to appropriate treatment services.

“Older people are largely undervalued, lumped together because they have reached a certain age and are assumed to be unproductive and a burden.”
As Chairman of the Global Ageing Network, I was last year honoured to be appointed as a delegate to a series of United Nations meetings in New York. As a passionate advocate for the protection of older people’s rights and inspiring the celebration of ageing in our society, I was delighted to be given the opportunity to represent Australia in the series of crucial meetings.

Worldwide, the proportion of people aged 60 years and over is growing and will continue to grow faster than any other age group due to declining fertility and rising longevity. The number of older people over 60 years is expected to increase from about 600 million in the year 2000 to over 2 billion in 2050. In developing countries this is expected to triple during the next 40 years. By 2050, over 80 per cent of older people worldwide will be living in developing countries. At the same time, the number of ‘older old’ persons (defined as 80 years and over) in the developed world will reach unprecedented levels.

Greater numbers of people will be affected directly by age discrimination and ageism, thereby increasing pressure on governments and society to respond. Strengthening older people’s human rights is the best single response. Older people need adequate income support as they age, opportunities to engage in decent employment should they wish to remain active, and access to appropriate health and social services, including long-term care.

The recent meetings included the Open-ended Working Group Sessions which report directly to the UN General Assembly – they represent the first time that a process has been set up for UN member states to specifically examine how to better protect older people’s rights.

I am – along with The Global Ageing Network - extremely privileged to be included in this very important step in advocating for a UN Convention of the Rights of Older Persons. The Global Ageing Network includes organisations that provide care and services to people as they age, and with this in mind, our statements to the UN focused on various aspects of ageism, discrimination, elder abuse, access to health services, equality, and isolation.

With a presence in over 50 countries, we are dedicated to enabling older adults to live their best lives as they age, with access to high quality services and supports. They deserve nothing less after a lifetime of making their communities vibrant.

A number of barriers exist to achieving this vision, not the least of which is the insidious ageism that permeates countries around the world. Older people are largely undervalued, lumped together because they have reached a certain age and are assumed to be unproductive and a burden. Age discrimination is widespread. Our collective attitude about ageing and the elderly remains negative and
largely unchecked. We must recognise the vulnerability of the aged and ensure their protection whilst fostering the opportunity for older people to flourish and for society to benefit accordingly.

We know, through the work of the Global Ageing Network and our members that we have not adequately tapped the energy, the experience and the wisdom that comes with age. We at the Global Ageing Network believe that all deserve respect, dignity and choice as they age. We believe that ageing is an opportunity for growth, fulfillment, and joy. Our level of services and choice for older people are generally better than many countries, however there are significant issues affecting older people which need to be addressed.

Age discrimination and elder abuse are widespread, as evidenced in Australia, where recent reports such as a report released in December by the Australian Law Reform Commission following an inquiry into elder abuse in Australia recommending: “A National Plan to address elder abuse should be developed.”

These reports are highlighting that ‘neglect’ offences against older people which include the ‘failure to provide necessities of life such as adequate food, clothing, shelter and medical care are often going unpunished because prosecuting such cases are difficult under current laws.

There are a range of reasons why prosecuting such matters may be difficult in respect of neglect of older persons, including that, in some instances, a legal duty may not exist (for example, where a person is not a legal carer); that the harm threshold is not met or, where it is met, establishing causation between the failure to provide necessities of life and the harm caused in circumstances where the victim is likely to be frail and weak as a result of their age. These circumstances often occur within family settings.

As a society, we must recognise the opportunity that our older generations provide in terms of knowledge, wisdom and capacity and acknowledge our responsibility to ensure the basic human rights of all older people are absolutely protected.

Changing attitudes takes time and a movement, however the risks to older people are ever increasing. We must lead and act. We are committed to being part of that movement. It needs to be coupled with a clear conceptual, legal and accountability framework to assist governments, the private sector and NGOs in making decisions that positively address population ageing, eliminate age discrimination and better protect older women and men’s rights. The time has come for an international convention on the rights of older people. The current silence is a blemish on our civilised societies across all regions.

Such a convention would ensure that violence against older people is prosecuted, that older people can get and keep jobs, that they have social assistance or pension access to affordable health services, and that caregivers are supported. Such a convention would level the playing field between older people and other generations, recognising that human rights are the rights people are entitled to simply because they are human, irrespective of their age, citizenship, nationality, race, ethnicity, language, gender, sexuality, HIV status or abilities.

“\n\nThe number of older people over 60 years is expected to increase from about 600 million in the year 2000 to over 2 billion in 2050.”

Following the session in December, a steering committee consisting of industry leaders from around the world has been formed (some are human rights lawyers, advocates, ageing experts, etc.) to advance the engagement with national governments, the UN and relevant bodies in the interests of achieving a UN convention. This steering group also provides the stewardship for GAROP (the Global Alliance for the Rights of Older People), which will aim to disseminate information about this cause more widely and provide a vehicle for effective engagement.

The Global Ageing Network will continue to connect and support care and service providers worldwide to enhance quality of life for ageing. We also stand ready to work with the United Nations and other NGOs to advance these vital issues. The right to choose equality and dignity doesn’t not change in old age. We need – as a community of nations – to not only believe this, but to affirm and enforce it through a convention on human rights and the elderly.
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
General approach

In today's culture there is a strong emphasis on rights, 'my rights', the individual self, the autonomous person. Witness the expansion of law suits to defend even the smallest of rights. The increasing defence of rights at law is making us a litigious society.

Those who work in health care are well aware of the autonomy of the patient to decide on the type of health care they want, and of the person who enters a research trial with the concomitant right to know the benefits and dangers. Two examples prominent in the media where autonomy is adduced as the justifying cause are euthanasia and abortion (the ZIKA virus and its possible consequences). 'This is my life and I have the right to decide when I shall die; this is my body and I therefore have the right to decide to terminate the embryo or foetus.'

Autonomy is about a person’s right to make their own decisions. To do this effectively, they need to have enough information. Patients, especially those who are stressed with illness, do not always fully understand what they have been told, or what they may not have been told. Decisions are best made without undue influence; the person making the decision should also be deemed capable of doing so.

There is no such thing as absolute autonomy for a human being. Psychologically and even physically, none of us can exist as a healthy person without other persons. The myriad of laws and other regulations governing our existence in society make it clear that 'autonomy' is a most relative term (cf. lists of do's and don'ts in every train carriage; road rules for drivers). I did not make my body or give it life; that was given to me by others.

The insistence on absolute autonomy in the question of euthanasia, for example, is really a ‘furphy’. How can one be autonomous when one closes off the possibility of all human activity? How can one live one’s life or destroy it without reference to others, the society in which one exists? Why close off all human possibilities of loving or being loved, the next opportunity to acknowledge one’s closest friend, one’s children or grandchildren or the possibility of them speaking to you or touching you? For what reason: because you may feel yourself a burden, because you fear you will not be cared for, or your pain not adequately controlled? The title of the recent movie, “Me before you”, where the paraplegic young man decided on “Death with Dignity” despite the intense love of his carer who needed his loving presence, highlights the paradox. Conversely, why do you want this person to be killed: because you are suffering over their illness, lack of independence, this person is a burden to you, or perhaps because you covert their property?

Autonomy: theological context

The greatest affront to the Creator is pride, arising from the distorted conviction that I made myself and give myself life. When Moses asked for God’s name when he was asked to go to Pharaoh to set the Israelites free from slavery in Egypt the answer came back: ‘I am’. ‘Tell the people of Israel that ‘I am’ sent you to them.’

The creation story sums up who we are: made in the image of God (who is in relationship), which implies a great personal dignity (‘The very hairs of your head are numbered’ Luke 12:7). Then, that we are created as social beings: ‘It is not good for man (adam – the human being) to be alone.’ That is, we are dependent creatures, dependent on God for continuing life and on other people to sustain this life, physically, emotionally, spiritually. Thus, the great commandment: You shall love the Lord your God and your neighbour as yourself.

Autonomy and conscience go hand in hand.

Although we are social beings we are also individuals with values we hold dear that make us the persons we are. We refer to our conscience or our conscientious decision when we act in accord with or against these values. We would feel affronted if we were asked to act against our
conscience. Nevertheless, we live with others and must also respect their conscience; and this can cause difficulties. So, basically in a democratic society we agree to respect the other’s fundamental human rights: right to life, right to property, right to the truth, right to work to live and receive a wage, etc. These are objective values respected universally, and not just my personal opinion, even though there may be degrees in which these objective values are accepted. This is why we have laws and norms to guide our autonomy and practically help keep our society peaceful. There may be matters that others hold that we do not agree with in conscience, but are not fundamental to our social democratic society or our basic rights. We have to allow others to live according to their conscience so that they will let us live according to our conscience. Take as examples for discussion same-sex marriage and abortion. Never-the-less, in a democratic society we retain the right to protest and vote against matters we do not agree with. Thus, my limited autonomy and my conscience are respected along with that of the other person.

There are some who say that there is no place for conscience in practical medical decisions. If medical decisions were based on absolute certainty that this is the best medical outcome for this patient integrally considered, and there is no room for any other decision now or in the future, this position might hold philosophically. Has this decision taken into account not only the medical, but also the psychological, spiritual, emotional, and religious beliefs of the person, or even acknowledged that there are other broader values and consequences to be considered?

And, of course, there is the paradox: it is my conscientious decision that there is no room for conscience in practical medical decisions! It seems to be born of a certain arrogance or a conception that there is no such thing as objective reality upon which decisions of conscience must be based.

Conclusion

As long as we remember that personal autonomy is quite limited in concept and in practice by the rights and needs of others to live as integrated persons it will be a supportive and positive element towards our own growth as persons, benefitting the society in which we live. Together with respect for an informed conscience respect for autonomy will help ensure the foundations of a democracy where mutual respect will allow people to live in peace. Without these two pillars, properly understood, guaranteeing individual freedom, the spectre of dictatorship will creep over us like a dark cloud. We see the results of the suppression of these two foundations in so many places today where it has given rise to civil wars and uprisings.

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1 Cf. St Francis of Assisi summing up the root cause of human unhappiness: “The Lord said to Adam ‘Eat of every tree; you may not eat, however, of the tree of the knowledge of good and evil.’ He was able to eat of every tree of paradise, because he did not sin as long as he did not go against obedience. For that person eats of the tree of the knowledge of good who makes his will his own, and in this way, exalts himself over the good things the Lord says and does in him.” Admonition II. Three key vices are listed here: disobedience, avarice and pride, all of which are inimical to the Great Commandment.

2 See Julian Savulescu. “Should doctors have the right to conscientiously object...” www.abc.net.au/radionational/programs/healthreport/doctors-have-no... Should doctors allow personal values to inform practice? Bioethicist Professor Julian Savulescu argues they shouldn’t. Schuklenk U, Smalling R. “Why medical professionals have no moral claim to conscientious objection accommodation in liberal democracies” in J Med Ethics 2016; Published Online First 22 April 2016. doi:10.1136/medethics-2016-103560. It would seem to me that such a stark and unyielding approach contradicts the very notion of modern democracy.

3 Cf. Conscience as the basis for judgements in the Nuremberg trials or the judgements of the International Court of Justice.
Focussing on Values, not Compliance

Behavioural based safety programs have been popular in Australia, as organisations seek to move health and safety from being compliance-driven to a values-based part of day-to-day management. Many large corporations have identified their own core values, and promote them accordingly.

This article seeks to explore the alignment of Catholic Social Teaching (CST) and health and safety legislative principles, and the use of the ‘See, Judge, Act’ (SJA) methodology applied to health and safety situations. St John of God Health Care (SJGHHC) considers workplace health and safety as a critically important issue, because as a Catholic organisation we do not want anyone to sustain an injury at work. Providing a safe work environment is fundamental to our SJGHJC Values, particularly Respect, Excellence and Justice.

Andrea, a Senior Health and Safety Consultant at Subiaco Hospital, had approached Keith, Director of Mission, about ways of increasing motivation and engagement with health and safety by linking in with formation. The decision was made to link health and safety with CST, and to use the SJA process in a range of activities, to ascertain if this would modify the managers’ approach to leading their teams to focus not just on compliance, but to consider CST principles in managing health and safety. Subiaco Hospital had not met lag indicator KPIs, and the need existed to trial a different approach to increase engagement.

CST provides an inclusive approach to an evaluation framework. For several years, Keith has used CST in a range of organisations, Catholic and secular. In working with leaders within Catholic health care, it has provided, without exception, an easily embraced set of principles, regardless of participants’ backgrounds. In 2016, Keith used CST as the evaluation strategy for the module on Corporate Social Responsibility, as part of the organisation’s Diploma of Leadership and Management program.

Primary to formation is the focus on increasing the engagement of participants with the Mission, Vision and Values of the organisation. This necessitates engaging ‘heads, hearts and hands’ (Sipos, Battisti & Grimm, 2008) through a process of reflection which leads to action. In this way, formation is about ‘transformational learning’ (Taylor, 2007). Health and safety in the workplace equally necessitates transformational learning for it to be embedded.
Compliance as an ineffective motivator

In Western Australia, the Occupational Safety and Health Act and subsidiary legislation has been enacted since 1984 (State Law Publisher, 1984). More recently, health and safety legislation in other states has been reviewed, however the key principles of all state health and safety legislation align to CST principles, as summarised in the table below, using the specific example of the Western Australian context:

<table>
<thead>
<tr>
<th>Western Australian Occupational Safety and Health Act 1984 – Duty of Care</th>
<th>Catholic Social Teaching</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not expose workers to hazards</td>
<td>Human dignity</td>
</tr>
<tr>
<td>Duty of employers, duty of employees</td>
<td>Solidarity</td>
</tr>
<tr>
<td>Provide adequate information, instruction, training and supervision to allow workers to perform their work safely</td>
<td>Solidarity</td>
</tr>
<tr>
<td>Consultation and cooperation between employers and employees on health and safety matters</td>
<td>Common good</td>
</tr>
<tr>
<td>Provide adequate personal protective equipment</td>
<td>Common good</td>
</tr>
<tr>
<td>Use, maintain and dispose of plant/equipment and chemicals safely.</td>
<td>Human dignity</td>
</tr>
<tr>
<td></td>
<td>Universal destination of goods</td>
</tr>
</tbody>
</table>

The importance of work is highlighted in the Laborem Exercens (On Human Work) by Pope John Paul II, issued in 1981, which describes work as “something that corresponds to man’s dignity, that expresses this dignity and increases it.” Conversely, the loss of work will have a negative effect on people’s dignity. If people are denied work through a workplace injury, the effect on them and their family can be serious. In addition to physical or psychological impact, there are financial implications for injured workers, with wages reducing after a period of time. Keeping people safe at work, to allow them to continue to work, upholds a core social teaching.

The wellbeing of people is reflected in the Mission of SJGHC, “to continue the healing mission of Jesus Christ through the provision of services that promote life to the full by enhancing the physical, emotional, intellectual, social and spiritual dimensions of being human.” The Mission is well promoted within the organisation, being included in the induction process, orientation, and ongoing activities, including mandated formation days. Mission formation for managers was identified as a potential vehicle for the promotion of health and safety within the organisation. Including health and safety into the formation program reinforces the message that this is an important requirement of the organisation, and is supported by research showing greater effectiveness of behavioural-based programs having mandatory attendance (DePasquale & Geller, 1999, p.243).

Many large organisations have sought to include behavioural-based safety programs into their overall management systems. This reflects a recognition that using punitive measures to control safety behaviour is ineffective over time. The provision of patient health care is a constantly changing environment; one in which ‘just following procedures’ may, in fact, put patients and staff at risk at times, as procedures cannot cover every situation that may arise. At such times, having CST principles incorporated into the decision-making process may provide the extra guidance required to make sound decisions.
CST and the ‘SJA’ process

The ‘SJA’ (SJA) process provides the necessary process and understandings to use CST as an evaluation tool. In identifying the issue or concern (see), one is called to make a judgement about it (judge) and to carry out actions in response to that judgement (act). The judge phase involves both social analysis and theological reflection. In working with participants who come from a diverse range of spiritual and faith backgrounds, CST provides the theological reflection which is inclusive of those backgrounds. For example, by taking a secular action (e.g. using equipment safely) and applying Human Dignity as the source of reflection, one moves from a focus on compliance to significantly increased motivation and corresponding commitment to action.

Research has clearly demonstrated that the best way to change people’s beliefs is to change their behaviour, “because people tend to re-adjust their values and beliefs to fit with the new behaviour” (Cooper, 2001, p. 187). Reinforcing behaviours, as explored through CST, is likely to influence people’s beliefs about the importance of health and safety.

Managers’ Workshop, November 2016

In November 2016, the CST-Health and Safety Workshop was conducted with 67 Subiaco Hospital leaders and managers as part of a two-day formation program. A session on CST had been provided in 2015, so managers were at least familiar with CST principles. Many had significant levels of knowledge, through other programs and experiences where CST had been a focus. The forty-minute session comprised a case study evaluation using the SJA framework. The session focused on investigating a realistic but fictional scenario where a caregiver, having arrived at work late due to caring for her sick mother, manually handled a patient (due to the hoist on the ward being out of service, and other caregivers being unavailable or absent), and injured her back, requiring surgery and a significant amount of time away from work. The patient handling risk assessment program (a ‘Red Dot’ approach) had not been maintained on the ward. The incident was investigated using SJA as a tool to identify causal factors.

The hospital had introduced a risk management focus for Safe Work Month, and a comparison of the steps in this was compared to the SJA process as listed below:

<table>
<thead>
<tr>
<th>SJA Process</th>
<th>Risk Management Process (S.A.F.E.)</th>
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</thead>
<tbody>
<tr>
<td>See – Knowledge, observation, facts, feelings, touch</td>
<td>Spot the hazard</td>
</tr>
<tr>
<td>Judge – Analysis, reflection</td>
<td>Assess the risk</td>
</tr>
<tr>
<td>Act - Actions, additional research, empowerment, evaluation</td>
<td>Fix the hazard Evaluate effectiveness</td>
</tr>
</tbody>
</table>

Participants were asked to consider how the SJA framework could be applied to the fictional scenario that had allowed such an incident to occur. CST is a rich tool for health and safety. For example, subsidiarity focuses on where problems should be best addressed, and solidarity stresses that health and safety remain a collective responsibility. In this task, managers were led to work through SJA as three phases:

See

The ‘See’ component of the activity asked managers how they felt about the incident, and how it might touch them personally. The personalisation of the incident was intended to create empathy with the injured caregiver, and move away from the ‘blame’ mentality which can arise during investigations.

Judge

The ‘Judge’ step of the incident analysis comprises two parts, the social analysis and reflection. The group of Managers were asked to work out why the situation existed, and from this the root causes could be identified. This aligns with ‘root cause analysis’ models which typically seek to ask ‘Why’ questions until the root cause is determined. In the next step, the group was asked to reflect on the key principles of CST, and how they could be applied to the issues identified as contributing to the incident.

Act

Participants were then asked to identify what actions were needed to change the situation, and address the root causes. This aligns with identifying corrective actions in order to prevent a recurrence of the incident.

Using CST and SJA as a framework: outcomes of the first session

The principles of CST, applied through the SJA process, to health and safety, result in increased engagement, and hopefully lead to an aspirational connection to our humanity. Feedback from the manager’s formation day demonstrated that health and safety was significantly repositioned for leaders from a focus on compliance, to a focus on deeper values that were appreciated significantly more than compliance, and thus increased motivation. At the end of
the workshop, there was positive and robust discussion from experienced organisational leaders, who noted that they had not previously seen CST applied to health and safety, and saw this as a valuable connection.

In parallel, an exploration of CST with managers provided accessible understandings of Catholic teaching, and SJA provides a useful life skill, which can be applied to a wide range of areas. Professionally, the use of CST and SJA is highly applicable to corporate, finance and human resource management areas. Personally, CST and SJA assist in providing a way of making sense of everyday life experiences and decision-making.

CST can be seen as a framework for behaviour-based safety management. Behaviour change programs have the potential to reduce incidents within an organisation (Gaustello, 1993, p.449). A key component in behaviour-based safety programs is goal setting, and the question arises as to how we can measure safety performance using CST.

Conclusion

In using CST in formation, training and professional development more broadly, it is frequently the first time that either Catholics or non-Catholics have been exposed to the principles. The inherent value of using CST as an underpinning approach to engagement with a range of programs, including an area such as health and safety, is being missed, if managers and leaders are not familiar with the principles, and do not appreciate that CST is fundamental to the Catholic faith. SJA provides an accessible and inclusive tool for reflection, which requires little training and provides both a secular and theological tool, depending on how it is later used, and on the beliefs and values of each person. The simple addition of 3-4 questions which would help some individuals reposition this work more as a theological reflection, rather than just a secular tool, has proved valuable in our experience.

Compliance is an ineffective motivator for health and safety management, and one which detracts from human dignity when rigorously applied. In our experience, people are well intentioned, with the resources they have available. While compliance to health and safety law is necessary, setting health and safety management within the context of a CST framework has the potential to add a richness and personal buy-in which will not be present with purely compliance-based systems.

With little research available on this subject, future research is merited. Whilst receiving positive feedback on the workshop, further surveying of the management group involved in the session is planned. A one-off workshop of 45 minutes is not a ‘miracle cure’, and for this approach to take root, implementation will have to be strategic and ongoing. It is early days with this approach of using CST and SJA, but it is also apparent that a focus on compliance is not achieving the desired outcomes, which warrants attempting other strategies. Development of tools which can be incorporated into the health and safety management system, such as for use in root cause analysis incident investigations, is also under consideration. Formation at SJGHC seeks to engage ‘heads, hearts and hands’, and few issues are as real to human dignity as people being safe at work.
Recruiting for Mission Fit

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Catholic Health Australia
People are your best resource, right? Well of course it is true, and even more so for organisations with a mission focus like Catholic hospitals, aged care and community care providers. However, while knowing it is important to recruit the right people for your organisation, the reality of time and budget pressures to ‘get someone into the job fast’ can often be competing forces.

The CHA Pathways Taskforce (made up of mission leaders from across various Catholic health and aged care organisations) has been grappling with the issue of how to recruit people who are ‘mission fit’ for some time. The Pathways Taskforce decided to make one of its key priorities producing a resource which would help all people involved in recruiting – whether they be recruiting for the person who works in maintenance, the canteen, the nurse manager, the pastoral practitioner, the occupational therapist, the specialist surgeon or the CEO.

At the CHA Governance Symposium held on Coogee at the end of March 2017, CHA launched the Pathways resource Recruiting for Mission Fit: Strengthening our Culture in Catholic Health and Aged Care to help everyone who works in our organisations build recruiting for mission fitness into their recruitment processes. The ‘mission’ bit of recruiting is not just a job for the Director of Mission – they have a role to play – but it is everyone’s responsibility to get the best people who can do the job and contribute positively to the mission and ministry goals of the organisation.

Recruiting for Mission Fit: Strengthening our Culture in Catholic Health and Aged Care is an easy-to-read 34-page booklet packed with useful information and tips to build the mission dynamic into recruitment. It also includes a number of photos from Catholic health and aged care providers, reflecting the Catholic mission being lived-out in our facilities.

This resource:

- Will help everyone involved in recruiting and selecting people – at all levels of the organisation.
- Reminds us that we are mission-focussed organisations and we strive to make our care distinctive. The people we employ are the people who reflect our mission - so they need to be mission fit.
- Provides guidance about how to select people who are mission fit – this does not mean being from any particular background or faith tradition, but they do need to understand the mission, vision and values of the organisation and be willing to work towards mission goals.
- Provides practical suggestions for how to determine whether a person is mission fit including providing examples of what to include in position advertisement and descriptions, possible interview questions to use and what information to check with referees.
- Takes the reader through the whole recruitment and selection process with a mission lens including post recruitment where new employees need to experience a mission driven culture and value-mission-behaviour alignment.

If you would like to purchase a copy of Recruiting for Mission Fit: Strengthening our Culture in Catholic Health and Aged Care, you can find the order form on the CHA website: www.cha.org.au or phone the CHA National Office on (02) 6203 2777.
On 21 June at Parliament House Federal Health Minister the Hon Greg Hunt MP launched Catholic Health Australia's (CHA) newest report examining how the growth of privately insured patients in public hospitals is impacting Australia's health system.

The report, titled Upsetting the Balance: How the Growth of Private Patients in Public Hospitals is Impacting Australia's Health System is the not-for-profit Catholic hospital sector’s response to concerns about the significant increase in private patients in public hospitals. It finds that the trend is having a damaging effect on patients, stakeholders, as well as the balance of Australia’s mixed model health system, and ultimately, the universality of Medicare.

The report finds growing inequity between public and private patients, with private patients receiving a number of inducements in some public hospitals that are not available to public patients. There is also evidence that, on average, public patients are waiting more than twice as long as private patients for elective surgeries in public hospitals.

“In 2011-12, annual growth nationally of private patients in public hospitals was recorded at 4.9 per cent and in 2014-15 growth rose to 18.4%. Annual growth of private patients in public hospitals in Queensland in 2014-15 was an astounding 63.9 per cent,” said CHA’s CEO, Suzanne Greenwood.

“It is particularly concerning for CHA to hear reports that the states are in some instances actively encouraging coercive behaviour to pressure patients to use their private health insurance for public care,” said Greenwood.

“Notably, while the number of private patients in public hospitals continues to grow at an alarming rate, placing increased pressure on an already stretched public health system, our private hospitals are treating an increased number of public patients,” said Greenwood.

“CHA is concerned that recently released Australian Institute of Health and Welfare data confirms bed blocking by private patients has led to public patients being pushed further down public hospital waiting lists, resulting in longer waiting times for public patients.”

“With some public patients forced to wait up to twice as long as privately insured patients for elective surgeries in a state hospital, the current system is undermining the universality of Medicare and requires immediate reform,” advised Greenwood.

SOME AVENUES FOR REFORM

• Restrict hospitals’ ability to offer inducements or unduly pressure consumers to declare their private

NEW SPECIALIST HEALTH SERVICE launched by Minister MARTIN FOLEY MP

On Wednesday 26 April, the Hon Martin Foley MP, Minister for Mental Health, launched a new specialist mental health service being introduced at the Cabrini Asylum Seeker and Refugee Health Hub in Brunswick.

Other special guests at the event included, Hon Jane Garrett MP, State Member for Brunswick; Paris Aristotle AM, 2017 Victorian Australian of the Year and CEO of Victorian Foundation for Survivors of Torture; Cr Samantha Ratnam, Deputy Mayor of Moreland; Richard Rogers, Chair of the Cabrini Health Board, and; Professor Suresh Sundram, Advisor to the Cabrini Asylum Seeker and Refugee Health Hub. A new aspect of care and services at the Cabrini
health insurance status and encourage greater data sharing between the Commonwealth and states to monitor adverse behaviours;

- Clearly identify private health insurance products for consumers (restricted cover products) that are not fit for purpose in a private hospital without attracting significant consumer out-of-pocket costs;
- Enhance the provision of information to consumers to assist with pre-admission choice of doctor and improved understanding of charges that may be incurred, in both public and private hospitals;
- Include provisions in public hospital funding agreements between the Commonwealth and states to ensure neutrality of funding for public and private patients and to address the current funding incentives for public hospitals to maximise private patient activity, such as own source revenue targets.

“This report provides a number of recommendations for reform, and we would like the next National Health Reform Agreement to take these into account,” said Greenwood.

CHA wishes to thank the CHA Health Senior Executive Forum for their extensive contributions which enabled the development of the report, and all other stakeholders who gave their time and expertise during the research consultation process.

This included hospital associations, health insurers and health insurer associations, individual hospitals both public and private, government bodies, and academics.

Printed copies of Upsetting the Balance: How the Growth of Private Patients in Public Hospitals is Impacting Australia’s Health System are available from Catholic Health Australia.

Please contact secretariat@cha.org.au to order your copy. To access the report online, please refer to www.cha.org.au

Asylum Seeker and Refugee Health Hub, the new specialist mental health service will provide a wrap-around service including case-management and community outreach.

“Our vision is to meet the significant and growing need in the community for extremely vulnerable refugees and asylum seekers who may fall through the gaps or are unable to access to mainstream services,” said Cath Garner, Cabrini’s Executive Director of Mission and Strategy.

Dr Tram Nguyen has been appointed Director of the Specialist Mental Health Service and Cabrini is currently working to recruit a mental health nurse and social worker to the team. The specialist mental health service was launched 12 months almost to the day since the opening of the Cabrini Asylum Seeker and Refugee Health Hub by then-Mayor of Moreland Cr Samantha Ratnam.

The Cabrini Asylum Seeker and Refugee Health Hub is providing a much needed service in Melbourne’s inner north filling the gap in healthcare faced by asylum seekers and refugees when they arrive in Australia without income or access to Medicare. Since June 2016, Cabrini has provided medical care to 140 asylum seekers and refugees who have come to Australia from countries such as Pakistan, Iran, Iraq, Saudi Arabia, Sudan and Ethiopia.

The Cabrini Asylum Seeker and Refugee Health Hub is a member of a number of asylum seeker and refugee health and settlement networks, both in the region and statewide. The Cabrini Asylum Seeker and Refugee Health Hub may be contacted on (03) 8388 7874.
Demolition works have begun on St John of God House, as part of the redevelopment plans for St John of God Subiaco Hospital. Executive Director WA Hospitals of St John of God Health Care and Acting Chief Executive Officer of St John of God Subiaco Hospital John Fogarty said the demolition is an exciting and significant milestone for the hospital, as it represents the first stage of the hospital's redevelopment.

“Plans for the redevelopment include extra parking, operating theatres, single rooms and consulting suites and a dedicated research and education facility, which aim to meet the future needs of the community and provide more options for our patients and doctors,” he said.

The Cambridge Street entrance and parking around SJG House will be closed until late July, to assist with the demolition works. All the other entrances to the hospital and parking access remain open as usual.

The redevelopment involves a three-stage process. Stage one includes the development of a Site Master Plan and demolition of the ageing SJG House and related works.

Located opposite the main hospital, SJG House was constructed in 1962 as nurses’ quarters. In more recent years it has been used for consulting suites, administration offices and parent education workshops. Mr Fogarty said while SJG House has served us well, its removal will unlock valuable space for the redevelopment. “We are currently finalising the Site Master Plan for the hospital and expansion plans for parking,” he said.

Stage two involves the expansion of the multi-storey car park near the main entrance to provide more parking options for patients, visitors and caregivers.

Stage three involves the refurbishment of the existing building and expansion of clinical areas, including additional operating theatres, single rooms and intensive care and coronary care beds. Mr Fogarty said we are looking at providing additional consulting suites during stage three and building a dedicated research and education facility.

“We undertake a large number of research projects and clinical trials and a dedicated facility will greatly assist with our plans to grow our research program and become a centre of excellence in this area,” he said.

The redevelopment plans require relevant approvals before they can proceed. If you have any queries on the redevelopment, please email: subiredevelopment@sjog.org.au

A new lifestyle opportunity will be offered in South-East Queensland as BallyCara CEO, Marcus Riley, was joined by Tomkins Director, Mike Tomkins, and Moreton Bay Regional Council Mayor, Allan Sutherland, turning the sod on a new three-level apartment complex within BallyCara’s retirement living and aged care community.

Mr Riley provided an insight into the exciting development taking place on the picturesque 13-hectare site at Scarborough. Construction will now officially start on the development, which will consist of a mix of 36 apartments, with a great emphasis on assisted or supported living for single people and/or couples.

Mr Riley is thrilled that BallyCara will again offer the community another opportunity to live within the ‘Village of Friends’. The apartments will offer the opportunity for residents to experience the enviable lifestyle that is on offer, while knowing they have the flexibility to accommodate for any changing needs over the years to come.

What’s more, residents at BallyCara enjoy total access to its Wellness Centre, which incorporates a stunning pool and café for residents’ enjoyment. There are various activities

BALLYCARA CREATING a new lifestyle OPPORTUNITY
Residential aged care services and models of care will be the focus of a new Catholic Healthcare research project, developed in conjunction with Macquarie University. Developed to evaluate antipsychotic medication use in residential aged care, the newly launched 12 month joint project with Catholic Healthcare is being led by Chief Investigator, Dr Lisa Pont in conjunction with several other researchers.

Dr Pont explains that the use of antipsychotics for some conditions, such as dementia, is being questioned due to the potentially harmful side effects, particularly in the older demographic of patients.

“Antipsychotic medications are often prescribed in aged care to manage behavioural and psychological symptoms associated with dementia (BPSD),” she says. “What research in the field suggests is that this method of management isn’t always appropriate.”

The suggestion that these specific medications are overprescribed isn’t unfamiliar. Alzheimer’s Australia published a white paper in 2014 that revealed “about half of people in residential aged care facilities, and up to 80% of those with dementia, are receiving psychotropic medications.” Additionally, the paper identified the serious side effects associated with antipsychotics and other psychotropics including “increased mortality for people with dementia and financial cost to the community.”

Catholic Healthcare has identified this as a challenge existing across the aged care sector and is looking to change the future for individuals demonstrating BPSD, with alternative therapies, as opposed to pharmacological intervention, if possible. “The point of the study is really to ensure we’re continuing to offer quality care to the aged community,” says Dr Pont. “With the rate of the increasing ageing population, this research is integral to ensuring we find a sustainable model for the future generations entering aged care.”

Across Catholic Healthcare, there is a significant focus from carers and staff to address each resident’s concerns, with a tailored, unique management method designed especially for them. These practices generally include holistic therapies, like exercise, sensory therapy sessions and other approaches before proposing a pharmacological solution.

“Changing the culture of medication use in residential aged care is challenging,” Dr Pont says. “Despite that, we need to ensure we put our people first. This research project demonstrates the need to expand our knowledge in this demographic.”

The project will be conducted across 38 Catholic Healthcare residential aged care services in NSW, and will explore staff and residents’ response to the use of antipsychotics. The aim is to reduce use among those residents for whom an antipsychotic may be a poor medicine choice.

“We’re looking forward to exploring the topic more,” says Dr Pont. “At the close of the project I believe we’ll feel confident in putting forward a thoroughly researched proposal to manage this effectively into the future.”

and social events on offer, including access to a 45-foot cruiser to enjoy river and bay cruises, as well as organised fishing trips.

The Village is set on completely flat ground, making it perfectly suited to morning and afternoon strolls through the 13-hectare site, or walks along the adjacent waterfront esplanade.

BallyCara’s unique location and environment, combined with a vast range of recreational facilities, offers a lifestyle to suit residents’ personal preferences. Mr Riley says BallyCara is delighted to have formed a new relationship with Tomkins, and is confident this will lead to many new and exciting opportunities for both organisations.

Mayor, Allan Sutherland, praised BallyCara for continuing to create new offerings for the region. The Mayor stressed the importance of offering residents new and continued living opportunities in their own community, allowing them to stay close to family, friends and their community, and others wanting to experience what many at BallyCara have loved for so long.
In a Queensland first, Mater Young Adult Health Centre Brisbane has introduced a kidney clinic to support the most vulnerable age group of transplant recipients from kidney loss.

The clinic provides 16 to 25-year-olds with an environment that allows young adults to feel empowered and be involved in decisions about their care, based on the world-renowned Oxford model. The evidence based model has shown that by creating a peer support network in conjunction with a multi-disciplinary medical team, the number of kidneys lost is drastically reduced.

Mater has partnered with Kidney Health Australia who established the service in Adelaide four years ago. In the young adult age group, 1-2 kidneys were being lost each year however since the clinic’s implementation, no kidneys have been lost.

Mater Director Renal and Dialysis, Dr Michael Burke, understands it is a difficult time for young adults where up to this point traditionally, their parents have guided them through the process.

“As 16-year-olds, they are required to transition towards the adult service and the risk of transplant loss is extremely high,” he said. “These specialised clinics not only provide medical support, but care for the emotional, social and educational needs of the patients.”

“We know this evidence-based model is likely to increase attendance at clinic appointments and compliance with medications which ultimately reduces the risk of losing kidney transplants to rejection,” Dr Burke said.

18-year-old Sam Hall was diagnosed with kidney disease in utero, and regular doctor’s appointments, weekly injections, and a long list of dietary requirements were part of his life on dialysis until he underwent a kidney transplant in 2013.

“Since my transplant, attending the clinics at the Mater has been a great way to meet other people my own age who are going through similar challenges,” Sam said. “I feel extremely lucky to have had my transplant and although I am on daily medication for the rest of my life, I am no longer tired, and I can eat what I want!”

“I am so happy to have started my teaching degree at Uni this year, and be just like any other 18-year-old.”

Sam received his kidney from his mother, Joanne, who always knew that if the ‘T’ word came up, she wanted to donate herself.

“Living on the Sunshine Coast, we are more than happy to travel to Mater with Sam to catch up with other families, share our news and struggles, and of course, see any specialists in-between,” Joanne said.

“Sam has been doing exceptionally well and hopes to work with other young children with kidney disease in the future,” she said.

The clinic was introduced at Mater in November 2016. Mater Young Adult Health Centre Brisbane delivers support across a board spectrum of specialities relevant to adolescent and young adults where there is an identified need and clinical benefit. It manages patients with chronic and complex conditions such as diabetes, cystic fibrosis, complex urology conditions, and inflammatory bowel disease.

Mater Young Adult Health Centre Brisbane utilises a cross-disciplinary approach to managing the care of adolescent and young adults through day programs, inpatient services and specialist consultations.
The Pastoral Care Teams at Mercy Hospital for Women in Heidelberg and Werribee Mercy Hospital were recognised in the 2017 Spiritual Care Australia Awards presented at their annual conference in Surfer’s Paradise.

The Pastoral Care Teams received the Best of Care Award in recognition for the holistic, compassionate care they provide to patients, their families and staff within the maternity and neonatal services at the two hospitals. The teams respond to a variety of pastoral needs in any one day, including pregnant women unexpectedly admitted to hospital, parents of a premature baby, or families struggling with the death of a baby. Such care requires a compassionate response to each individual, capacity to assess spiritual needs, and skills to provide appropriate spiritual care.

Werribee Mercy Hospital Pastoral Care Manager Trudy Keur said the award meant a great deal to the teams who provide support across a range of emotional and difficult situations.

“There is nothing more stark or confronting than when a mother and her partner are expecting life but instead are dealt death,” Trudy said.

“We work closely in the interdisciplinary team to provide care with the deepest respect for cultural and religious differences. We offer emotional and spiritual support while enabling mothers, partners and families to create precious memories and honour their baby in whichever way is meaningful to them.”

Pastoral Carers at Mercy Hospital for Women initiated the use of Reverie Harp as a pastoral intervention in the Neonatal Intensive Care Unit and Special Care Nursery. Nursing and medical staff often request pastoral care to play the harp when there is heightened activity or stressful medical procedures being undertaken. Some parents also borrow the harp to play for their baby – a way of active empowerment at times when they can feel quite powerless.

Families who have experienced the death of a baby frequently express their gratitude and appreciation to the multidisciplinary teams at Mercy Hospital for Women and Werribee Mercy Hospital. This appreciation often comes in the form of physical supports to enhance the care being offered to other families, such as donations of Cuddle Cots, teddy bears and quilts.

“There is such a short window of time for families to hold their little ones and honour their short lives before saying farewell,” Trudy said.

“It is a privilege to walk with these families as they seek to find meaning at this sad and difficult time.”

The Pastoral Care Team at Werribee Mercy Hospital also supports the spiritual, religious and emotional needs of patients and their families in the medical and surgical wards as well in the palliative care unit. While the Pastoral Care Team at Mercy Hospital for Women also responds the needs of gynaecology, oncology and surgical patients.
ARTS AND HEALTH: Further arts instalments for the BENEFIT OF PATIENT VIEWING

The next episodes of St John of God Murdoch Hospital’s art program for patient television will feature the life and work of photographer Frances Andrijich and sculptor Tony Jones, both celebrated Perth artists.

The episodes are part of Makers: the artists, their work, their lives, a series of 30-minute episodes that bring to life the artworks in the hospital’s art collection. Their work is currently on display in the main reception area and corridor at the hospital.

The West Australian-first dedicated arts television channel for patients was the brainchild of St John of God Health Care’s Art Curator Connie Petrillo.

“We are very excited to be able to share the significant work of these two artists throughout our hospitals,” says Ms Petrillo.

“They will provide a wonderful insight and enjoyable viewing for our patients.”

The work of Frances Andrijich has graced magazines, books and newspapers around Australia and the world, including Time Magazine, Harper’s Bazaar, Fairfax Good Weekend Magazine, Australian Geographic, Vogue, Marie Claire and Gourmet Traveller.

Amongst her many portraits, her image of an exuberant Heath Ledger is most well-known.

Frances says she is delighted to be involved in the project and looks forward to seeing patients’ reactions.

“To have artwork in such a celebrated collection, like St John of God Health Care, is an honour,” Ms Andrijich says.

“It is always fascinating for me to meet artists and to see them in their environment working…I am sure the patients will feel the same as Makers brings this experience to them.”

Tony Jones was named Western Australia’s Citizen of the Year in 2008. In 2009 he received an Order of Australia Medal for services to the visual arts as a sculptor and educator.

He continues a thriving practice in public art – after inspiring countless students over 50 years of teaching art. Often working collaboratively with other artists, many of his artworks have made their way into the public psyche, such as the regularly, and anonymously, dressed Eliza on the Swan River.

The first episode of the Makers celebrated the work of local painter, sculptor, draughtsman and printmaker Hans Arkeveld and was met with great interest by patients at the hospital. The episode gave viewers a glimpse into his fascinating studio at the University of Western Australia and the unique home he built in the Perth Hills. He talks about his work in the collection, emigrating from Holland as a child, and his father being forced to work for the Gestapo.

Makers is created by the Artist’s Chronicle and commissioned by St John of God Health Care, and on display at the Murdoch Hospital.
REFLECTION on the GOSPEL
-12th Sunday in Ordinary Time
Year A, 25 June 2017
(Matthew 10:26-33)

by Mercy Sister Veronica Lawson
Institute of Sisters of Mercy of Australia and Papua New Guinea (ISMAPNG)

Mercy Sister Veronica Lawson introduces us to the story of Najaf Mazari, an Afghani Hazara rugmaker in reflecting on this week’s gospel.

Many of those who once looked through the barbed-wire fences of Australia’s detention centres carry personal stories of fear of persecution. One such story, the story of Najaf Mazari, is beautifully narrated by Najaf and Robert Hillman in their joint work, The Rugmaker of Mazar-e-Sharif. Najaf is an Afghani Hazara who suffered persecution and torture at the hands of the Taliban. He escaped to Australia via Indonesia in 2002. After some time in detention, he established a rug making business in suburban Melbourne. He was reunited with his wife Hakeema and daughter Maria in 2008 and became an Australian citizen in June 2014.

Some of the first century Christian groups, including Matthew’s community, were a bit like the Afghani Hazaras and Syrian or Iraqi Christians in that they are persecuted simply on account of who they are vis à vis those who seek exclusive political and cultural power. They have every reason to fear bodily harm and even death, as did Jesus and his followers. The scene at Gethsemane suggests that Jesus himself experienced deep fear in the face of his impending suffering and political execution. Yet Jesus tells his disciples not to fear those who kill the body.

How are these words to be understood? To return to the story of Najaf: the Taliban had power to destroy his body, but no power over his spirit. A man of deep faith, supported by a family who sacrificed their own comfort and placed their trust in God (Allah), he survived against the most incredible odds. Even if he had died in the effort to find freedom, his faith in the fullness of life with God and the witness of his courage would remain, in stark contrast with the bullying power of the Taliban who could kill the body but not an indomitable spirit.

Trust in God is at the heart of Jesus’ response to suffering. The disciples are sent out on mission. They are to proclaim in the marketplace or from the “housetops” the gospel they have received in the security of the household. They can expect rejection and humiliation. They are not to be deterred from their mission. Above all, they are not to give up the struggle or capitulate in the face of persecution. Like all God’s creatures, they are precious in God’s eyes and will not be abandoned. On the contrary, Jesus will “acknowledge” them before God “in heaven”. Trust in the author and sustainer of life is the appropriate response to suffering endured for the sake of God’s empire. Trust in God does not take away the pain. Rather, it puts the inevitable suffering of the disciple on mission into the broader perspective of life in its fullest expression.