AUSTRALIAN INSTITUTE FOR PRIMARY CARE

Brotherhood of St Laurence
Working for an Australia free of poverty

Outcomes for older people with chronic and complex needs

A longitudinal examination of the use of community services following an aged care assessment in Victoria

Summary

While few community care services are provided to individuals solely and explicitly to delay or prevent their admission to residential care, there is evidence to suggest that receiving in-home community care services may help to delay or avoid admission to residential care. This relationship is complex, influenced by the particular characteristics of older people, carers, and the service system, but it provides encouragement for investigating ways to optimise the community care system.

Introduction to study

This is a study of older Victorians with complex or chronic needs recommended by the Aged Care Assessment Service (ACAS) to continue living in the community with the support of a range of community services. It was undertaken by the Brotherhood of St Laurence and the Australian Institute for Primary Care, La Trobe University. Participants were followed up three times, at approximately three-month intervals following their ACAS assessment.

The purpose was to examine the extent to which community services are used by older people with significant care needs and the extent to which community service recommendations are taken up. The study also aimed to identify the factors that facilitate or hinder service uptake and to explore ACAS clients' and carers' experience of the services.

The participants were recruited by clinicians from the St George's ACAS and North West ACAS at the time (or within two weeks) of the older person's ACAS assessment in mid 2005. There were:

- 33 clients who were recruited with their carer
- 28 clients who were recruited without their carer
- 18 carers who participated without the involvement of the ACAS client that they cared for.

Around three-quarters of the older people participants were aged 80 years and over and were female. They were living in a variety of housing situations, with 57 per cent living alone.

A total of 79 ACAS clients were represented in the baseline data collection, with 45 remaining throughout the study. Of these, around three-quarters were receiving a full pension.

Key findings

Frail older people used a combination of community services, privately purchased support services (if they could afford these) and informal support from family and others in the local community to assist them in their daily lives. As would be expected in a sample of people with chronic or complex care needs, use of community services increased over the period of the study. Nearly three-quarters of the study participants took up at least one new community service in the post-assessment period. The service with the lowest uptake of all recommended community services was respite.

This study found that the community care system is meeting the needs of many frail older people; however, 38 per cent of study participants reported that the older person needed more help with daily living activities. Furthermore, the community care system is working best for older people who have either family members or a case manager who help them access the required services.

For some older people, the situation was less than optimal. Three risk factors associated with difficulties in accessing community services were identified: social isolation of the older person, high carer burden and the older person reporting low mood (a rating of 'a bit down' or 'miserable').

Social isolation

Older people who had less than weekly contact with family members were less likely to access social and community participation services (such as assistance with taking part in recreational, cultural or religious activities) in the post-assessment period than those with more frequent contact with family (44% compared with 64%). This finding suggests isolation is linked with use of fewer services. For example, one older woman felt her lack of access to information about services was caused by her social isolation. She said:

> ***You see we know nothing … maybe we don't know because we don't mix, unless you ask, because other people get told by friends.***

High carer burden

While informal care may be the preferred way of supporting older people in the community for some older people and their families, it can become overly burdensome for some carers.

Carer burden amongst participants was considerable. More than 40 per cent of carers at both the first and third follow-ups rated their emotional burden/strain as high (4 or 5 on a scale 0–5). High social burden/strain was reported by around one-third of carers at both of these follow-ups.

Carer burden was significantly associated with uptake of new community services in the post-assessment period. Fifty-six per cent of those reporting medium or high carer burden took up one or more new community service, compared with 82 per cent of those whose carer reported low carer burden. There was a similar tendency for older people whose carers reported medium or high carer burden to be less likely to use social and community participation services than their counterparts.

One carer explained that she didn't have the time to read information that had been provided:

> ***I've got this much paperwork [shows bag full of services information]. It's very hard to get the time to read them.***

Older person reporting low self-rated mood

Older people who reported low mood were significantly less likely to be recommended assistance with social and community participation than those who reported their mood as high (40% compared with 73%).

This group was also significantly less likely to take up a new community service in the post-assessment period than those who reported their mood as high (37% compared with 100%).

A positive relationship was found between use of community services and improved well-being for older people. The data indicated a trend for those older people who used certain services post-assessment, such as respite and social and community participation services, to be more likely to have improved mood

scores than those who did not. Further, use of certain community services such as Community Aged Care Packages (CACPs) and respite had a positive impact on the well-being of carers.

Barriers to uptake of community services

In addition to personal factors that put older people at risk, the study found structural barriers to service uptake. These barriers included cost, lack of information, lack of availability of services and waiting lists. The study also revealed non-structural barriers to uptake of community services, including some of the attitudes and values held by the older person or their carer.

Facilitating factors

The main factor facilitating the uptake of services was having a person to assist in linking the older person to the services. This happened mainly in three ways:

- **Family support and advocacy**
  Those with more frequent contact with family tended to be more likely to take up recommended community services.
- **Shared information**
  Some participants had been able to access community services due to the information that friends or family had shared with them.
- **Assisted referral**
  Organisations, agencies or individuals (such as a case manager, ACAS clinician or a hospital social worker) often facilitated the uptake of services. They made phone calls, accompanied clients to a service or advocated for earlier access to a service. For example, a visiting occupational therapist assisted one depressed participant. As he reported:

  > ***[She] said 'How are you?' and I said 'I'm not worth a cracker' and she came in here with me and called the counsellor.***

Conclusion and recommendations

The main conclusion of this study is that achieving optimal post-assessment outcomes for most older people with complex and chronic needs will involve three key directions in the future:

- identifying and supporting older people at risk of not accessing community services
- supporting the carers of frail older people living in the community
- reducing the structural barriers to accessing community care.

In view of the importance of having a case manager or someone to link the older person to the service, special attention should be paid to enhancing the case management and the care coordination models of community care for frail older people who are socially isolated, experiencing low mood or whose carer is experiencing high carer burden.

There could be roles for ACAS and HACC providers in achieving optimal post-assessment outcomes. They could undertake client and carer risk assessments using standard scales for measuring carer burden and client mood. Risk assessment could be a trigger for targeted support for older people and their carers.

For clients who are assessed as at risk of not taking up recommended community services, post-assessment support could be improved by measures such as:

- increasing the availability of ACAS care coordination (care coordination conducted by ACAS until the required supports have been put in place)
- ongoing monitoring of client and carer well-being by HACC providers
- increasing the availability of case-managed care at diverse levels of need.

The authors acknowledge that the following recommendations have resource implications for both the ACAS and HACC workforces and that they cross state and federal program boundaries.

Identifying and supporting older people at risk of not accessing community services

Recommendation 1
A standardised assessment should be made of the older person's psychological well-being and social resources at the time of the ACAS assessment.

Recommendation 2
Respite-recommended people who have a carer should also be recommended to a Carer Respite Centre (and assisted to access the CRC where necessary).

Recommendation 3
There should be post-assessment follow-up and assistance with linking to services for older people at risk of not accessing community services.

Supporting the carers

Recommendation 4
The ACAS assessment should include assessing the capacity of carers to provide care.

Recommendation 5
The ACAS assessment should include assessing carers' burden.

Recommendation 6
There should be post-assessment follow-up of carers experiencing high carer burden.

Recommendation 7
The support (physical, emotional and financial, according to need) for carers of frail older people living in the community needs to be enhanced.

Reducing structural barriers to accessing community services

Recommendation 8
The policy and funding constraints that influence the cost, quality and quantity of community services for frail older people should be examined.

This study has demonstrated that limitations of the present community care system put certain groups of older people and their carers at risk of not taking up recommended services. The emphasis on community care solutions to enable people to remain in their homes seems likely to continue. It is therefore highly desirable that the present system is enhanced so that needs and potential risks are both effectively identified and addressed.

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The full report *Outcomes for older people with chronic or complex needs*, including data sources and bibliographic references, is available on the Brotherhood of St Laurence's website <www.bsl.org.au>.

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