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An evaluation of the impacts of the C2bMe program delivered at Residential Aged-Care Facilities on residents' wellbeing

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RESEARCH REPORT PREPARED TO UNITING NSW.ACT

June 2022

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ACKNOWLEDGMENTS

We wish to acknowledge Uniting NSW.ACT for being proactive in seeking an independent evaluation of their C2bMe program – this demonstrates care and an intent to always provide the best possible services to their (often vulnerable) clients. We wish to thank, in particular, South Eastern NSW staff involved in the C2bMe program for wholeheartedly supporting this evaluation and being open to receiving feedback. Again, it demonstrates their professionalism and great care for the wellbeing of their clients. We are grateful also to all participants in this study who shared their experiences and knowledge with us during the course of the project; this evaluation would not have been possible without them.

ABOUT THE AUTHORS

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EXECUTIVE SUMMARY

The project aimed to evaluate the impact of the Continuing to Be Me program in improving wellbeing of elderly participants who live in Residential Aged-Care Facilities (RACFs). The study involved a qualitative approach to data collection, involving interviews with C2bMe program clients, family members and RACFs care managers. In total, 17 interviews were conducted, with 9 program clients, 4 family members and 4 care managers, covering 10 different facilities where the program has been offered. Main findings and recommendations are summarised below:

- Without prompting, the majority of interviewees compared C2bMe to other services available and reported that C2bMe was either equal or superior to other services.
- The cost-free nature of C2bMe is absolutely vital to the program's success.
- The flexibility and adaptability of the program was a major strength and should be encouraged.
- The personality and character traits of clinicians were vital for the success of the program.
- Social interaction was the most common and effective method of treating depression and anxiety, and was additionally effective when clinicians would employ traditional counselling methods.
- A stylistic difference was detected between C2bMe staff and other clinicians who supported residents – other clinicians would focus on diagnosing the resident and providing medical intervention, while C2bMe clinicians focused on recovery without labels. This recovery was conversation-focused and individualised, and was highly praised by all participants in this evaluation.
- Clinicians should continue to act as an advocate for residents.
- Whenever possible, family members should be presented with the option to engage with the program. This may include involving the family member in meetings or informing them of progress.
- An information booklet and website should be designed with information about C2bMe. These should be distributed primarily to family members.
- Despite C2bMe staff efforts, RACFs staff training was reported as limited due to their heavy workloads. RACFs' staff feedback highlighted that there is appetite for more training and that RACF staff are eager to be given the opportunity to allocate appropriate time to engage in training. However, they reported they must have their duties covered and this is not something that is currently happening in most RACFs.
- Group sessions were met with mixed reactions, but should continue to be an option for those who are interested. These group sessions were most successful when they utilised also local resources and personnel.
- Efforts should be made to expand group sessions. Advertising within the RACF and making activities more visible may assist in this.
- Mixed methods of contact should be considered when available. Certain residents react differently to in-person and phone conversations; therefore, a variety of contact methods can provide opportunities for the residents' engagement and development.

INTRODUCTION

The World Health Organization (WHO) (2021) define healthy ageing as developing and maintaining functional ability that enables wellbeing in older age. WHO (2021) also highlight that the outdated and ageist stereotypes of older people being frail and dependent need to be eliminated, and a focus on aligning health systems that promote healthy ageing holistically and empowering individuals needs to prevail. Although aging looks different for each person, it is vital that aged care has a focus on healthy aging and helping continue "a meaningful and dignified life" (Royal Commission into Aged Care Quality and Safety, 2021). Mental activity and social engagement are both important features of an elderly person's life and should be encouraged and supported by carers (Australian Institute of Health and Welfare, 2018).

By the year 2050, it is anticipated that approximately 3.5 million people will be accessing aged care, with 80% of people choosing to receive their care at home (Visvanathan et al., 2019). Living longer can have both positive and negative impacts; however, focusing on recovery strategies, adaptation and psychosocial health can lead to healthy ageing (World Health Organization, 2021) and improved quality of life. According to the Australian Institute of Health and Welfare (AIHW, 2013), most older people prefer to "age in place"; they prefer to remain in their own living arrangements rather than move to Residential Aged Care Facilities (RACFs), but health concerns and social reasons are major reasons for moving.

Uniting NSW.ACT provides mental health and other services across New South Wales and the Australian Capital Territory. It provides support to vulnerable and disadvantaged individuals through a number of initiatives and programs that have the overall aim of assisting people in transforming their lives. Continuing to be Me is a relatively new initiative offered by Uniting NSW.ACT that provides free support programs for older people living in aged care facilities (C2bMe) or living alone (C2bMe@home). The C2bMe and C2bMe@home program follows a person-centred model of care designed to support wellbeing and optimise functioning of older persons in residential aged care facilities or at home in the community so that they can continue to live well. Working either with older persons in RACFs or in their home, the C2bMe program offers in-reach services, psychological support, psychosocial education for the older person and their family and carers, and work in collaborative partnership with RACF staff and families and carers to deliver holistic service. Clients from the C2bMe program in RACFs are involved in both group and individual sessions, whereas the @home program is focused on individual sessions only, although sessions involving family members and carers are also occasionally conducted. Outcomes and strategies are, nonetheless, very similar in both versions of the program.

Research Objective

The aim of this project is to evaluate the impact of the Continuing to Be Me program in improving wellbeing of elderly participants living at Residential Aged-Care Facilities in the South Eastern region of NSW. In order to do this, the views of residents (i.e. program clients), family members and RACFs' care managers were gathered and analysed.

METHODOLOGY

This is the second of two small, inter-related projects that aim to evaluate the impact of the C2bMe program in improving the wellbeing of elderly residents. The first one, finalised in November 2021, focused on clients of the C2bMe program who were living at home (C2bMe@home program) and used a mixed method approach, where clients were interviewed and referrers were surveyed about their experiences of the program. Given the characteristics of the C2bMe program being delivered in RACFs, it was felt that for this second project a purely qualitative approach would be more appropriate in eliciting meaningful data and feedback. The study was again cross-sectional but focused this time on older adults residing in the South Eastern region of NSW, Australia who were receiving support from C2bMe staff in RACFs, as well as family members of elderly clients of the program and care managers of RACFs where the program was being delivered.

Data Collection

An interview design was chosen as the data collection method for this evaluation as it would best enable a description of participants' experiences, using open-ended questions so that in-depth information could be collected. Also, given participants include older individuals who usually do not engage as readily with surveys and who are more likely to appreciate a more personal approach, an interview method was deemed more appropriate.

Recruitment of elderly residents and family members was facilitated by C2bMe staff who work directly with clients and are therefore familiar with their abilities and medical history. Staff were advised on how to proceed with recruitment of program users in an ethical manner, including only inviting clients who do not present a medical condition that impacts on their ability to participate in an interview or to provide consent. Staff who initially recruited participants provided some general information about the study to clients and explained that participation was entirely voluntary. If the client expressed an interest in participating, they were asked if they consented for their telephone details to be shared with the research team, who then contacted them to provide more information. Clients had time to consider the invitation and were free to say no when the researcher called them. The researcher also gave them the option of calling back later if they felt they needed more time to consider their participation or were not available at the time. At the time of the interview, the clients were reminded that their C2bMe clinician[1] provided the research team with their contact details and explained again what the aim of the interview was. A total of 18 clients' and six family members' contact details were provided to the research team by the program manager and all were contacted for participation; of those, nine clients and four family members consented to and participated in an interview.

Recruitment of care managers was conducted via email messages sent by the research team directly to the care managers of each of the RACFs that receive the C2bMe program. An initial email invitation and a follow-up email were sent to the care managers of 25 RACFs. Individual care managers were also approached by the program manager to encourage their participation. Four care managers consented to and participated in an interview.

[1] We are aware that staff working in the C2bMe program come from different professional backgrounds, including social work, counselling, psychology and mental health nursing, among others. Given the similar role played by all staff in the program, we have chosen to use the term clinician as a proxy for all staff who work supporting C2bMe clients.

A semi-structured interview schedule was prepared prior to the interviews. This technique is based on open questions that allow researchers to provide context for understanding the participants' perspectives. The interview guide was developed to address issues identified as relevant to the research aim and consisted of simple questions regarding participants' experiences in the C2bMe program.

Interviews were conducted between March and June 2022 and ranged in duration from 18 to 77 minutes.

Data Analysis

In common with the majority of qualitative research, all interviews were digitally audio-recorded (Puchta, Potter, & Wolff, 2004) with the permission of each participant involved. This process enabled the collection of an accurate and unbiased record of the interviews and allowed for the use of direct quotes in the interpretation of the qualitative material. Also, this permitted the researchers to focus on the participants rather than on writing down each of the subjects' responses.

The analysis involved the transcripts being read thoroughly by the researcher who also conducted the interviews, annotating it in order to identify main topics emerging from the data. The principal researcher reviewed all transcripts and notes as part of a triangulation process to ensure identified topics were accurate and provided a rigorous representation of the experiences shared by participants.

FINDINGS

17	66%	10	5
interviews with clients, family members and RACFs care managers	of clients were **females**	participating **RACFs** covered	different **C2bMe staff** provide care to client participants

Results are presented into six main themes that emerged from interviews and surveys, and provide insights into matters related to the effectiveness of the C2bMe program as well as identifying its strengths and weaknesses. They are: Program Establishment; Clinician Attributes; Group Sessions; Challenges; Collaboration and Training; and Overall Effectiveness.

Before we move to the next section, where the abovementioned themes are detailed, a caveat needs to be presented. The Royal Commission into Aged Care Quality and Safety (2021) has highlighted in recent years the poor quality of care and living conditions prevalent in RACFs across the country. This is largely due to staffing shortages and poor funding (Royal Commission into Aged Care Quality and Safety, 2021). Many participants in this study have reinforced this perspective and reflected upon the services provided by their C2BMe clinician in comparison. One resident, in particular, initially mistook the evaluation being conducted as an assessment of the RACF as a whole. Until prompted about her C2BMe clinician, she made entirely negative comments about RACF staff.

"They think that we don't have a mind of our own [...] There's no listening... they think that they're more superior than what we are." (Resident)

Similar negative comments were made by other residents (though not always with such intensity) about doctors, psychologists, nurses, and other RACF staff. This was sharply contrasted with perspectives on their C2bMe clinician, with an immediate tonal shift. Comments made by one resident below highlights this shift:

"Oh, she's lovely. She's really, really lovely, [clinician's name]. I cannot wish for a better person than [clinician's name]. She has been absolutely wonderful. And I mean she's wonderful. And I hope she'll be continuing what she's doing, because she's good at her job." (Resident)

Other residents had more sympathetic views of RACF staff, but still identified that there were major structural issues with aged care that resulted in poorer care for residents:

"The only thing I've got against here is... now everyone's blaming the coronavirus. They were understaffed when I'd first come here. I have nothing but admiration for the empathy of the staff... These people have true empathy. They're underpaid and they're [over]worked." (Resident)

The findings of this report should be interpreted in light of this context.

1. Program Establishment

Clinicians typically introduced themselves to RACF staff and residents, explained the program, and built rapport. Setting up the program was considered straight-forward, and both RACF and C2bMe worked well together.

"It was really easy." (Care Manager)

Residents were typically aware that they had been referred to a C2bMe clinician due to some problem in their mental health or personal life. This ranged from mental health issues such as anxiety, depression or suicidality, to relational problems with family or a physical disability. Some residents, however, simply saw their C2bMe clinician as "*someone to chat with*" and who would provide them with some basic assistance. One resident with a physical disability reported that their clinician assisted them with setting up a phone and would engage them in casual conversation from time to time but did not accept that their clinician was part of a particular mental health or support program offered to residents in need. This raises issues around program awareness and even the 'brand' awareness of the C2bMe program, which C2bMe program managers may want to consider to strengthen their 'brand'.

Relational issues would often strip residents of their few confidants. Without anyone with whom to discuss issues, their mental health would often decline rapidly. One resident noted that his wife began to cognitively decline and relationally distance herself. He felt he had lost a major support in his life and had nobody to talk to about the issue. When support structures suddenly shift, C2BMe can be a vital backup and help residents build resilience.

"We've come to a point where she's like, 'I don't want you to come home.' It was very hard." (Resident)

Clients reported that referrals to the program were typically done by RACF staff, but clients were also recommended by other program participants. This was occasionally family members who were also part of the program, or other clients in the same facility.

Although a rare occurrence, some clinicians maintain connection with clients as they transfer between RACFs, which was seen in a positive light and can provide extra comfort for residents in need of mental health support. More broadly, residents felt confident that they could reconnect with their clinician if they needed further assistance.

"I have her business card and telephone numbers, etc, and in that any event of having to reconsider and say let's get back to Melissa. We would contact her." (Resident)

When asked about the referral process, care managers found it to be quick, effective, and simple. After a quick period of learning, care managers were able to determine which residents would benefit from the program and had very few residents rejected.

"Once we learnt exactly what criteria the resident needs [to meet…] we know who to refer." (Care Manager)

One resident reported becoming aware of C2bMe through a flyer. She was aware of her own mental health needs and so reached out to the program for assistance. She found that more people than expected participated in C2bMe and this made her feel less isolated. This finding suggests that self-referral should be encouraged, as it represents a willingness to improve and normalises mental health care.

"I'm at the position where you either just give up and become a recluse or you venture on." (Resident)

Clinicians had an effective strategy for meeting residents for the first time. The clinician would approach the resident in a friendly, informal manner that often contrasted with other RACF staff. The clinician would engage in casual conversation with the resident and quickly establish a rapport. Even when residents were initially hesitant, this approach quickly set them at ease. Other residents reported taking a quick liking to the clinician. Having a non-clinical first meeting is important for a long-term relationship.

"The first time she was suspicious of it but after a couple of times she couldn't care less, she'd just chat away there, which was great. It takes a special person to be able to do that… I could see in her body language she was slowly relaxing." (Family Member)

"He was a bit apprehensive because he hates the place. It's not that they're bad to him, his mind… he believed that the facility was just doing it to him, he didn't realise that the whole world was going through a pandemic." (Family Member)

"The first meeting, it took about two words and I couldn't believe how lovely she was… a lovely calmness in the voice and the smile." (Resident)

Stigma surrounding mental health concerns and counselling services are a barrier to residents accessing care. Informality was considered a great tool for engaging with residents that otherwise would be unlikely to participate in a counselling service. Description of the C2bMe program made participants more likely to connect with a counsellor/clinician. One care manager made the following observation.

"If you say this is a mental health service, it doesn't come across very well and they'll just shut down, but we can say that someone else who you can talk to who can support you, they're not a psychologist, they do have a background in mental health, but they're all about working with you to find things that work for you, and being guided by you, then they've actually been really, really open to it." (Care Manager)

2. Clinician Attributes

One of the key attributes of C2bMe clinicians that was cited by residents was their willingness to engage in conversation. Residents regularly felt socially isolated, and problems with mental or physical health typically exacerbated their isolation.

"The advantage is that she would simply have the patience and time to simply listen to what my bellyache was all about. Now that might sound, oh well, wouldn't anybody do that? No, they don't." (Resident)

Conversational skills were often praised as a strength of the clinician. Reminiscing with the resident was commonly reported, and active listening skills such as asking questions and showing understanding

made residents feel both heard and understood. Residents were often surprised with how well they enjoyed the company of their C2bMe clinician. One family member noted that the clinician would use decorations to initiate conversation naturally and engage with the resident.

"She would ask, 'oh, where'd you get this one?'. So that initiated a half-hour discussion all about where they came from. So that was another good move… It's all those past things that she likes to talk about." (Family Member)

"She's got some magic thing. We just start talking." (Resident)

"To be able to communicate with somebody is watching their body language and understanding body language, and therefore knowing how to ask that question, or when to ask that question. And she seemed to know that very well." (Care Manager)

Patience with residents who were experiencing cognitive decline was also praised. One family member appreciated the clinician's willingness to repeat misunderstood phrases and allow the resident to speak despite difficulties in doing so.

"I think she was patient. That was the most important thing… The ability to listen." (Family Member)

"She's very approachable too, very, very able to adapt her articulation to the residents that she's seeing." (Care Manager)

Residents reported feeling that their clinician *"felt genuine"*. This was reinforced by care managers and cited as a major factor for the program's success. When considering a clinician for this position, personality and values should be considered highly.

"She gives me her honest opinion." (Resident)

"I think a lot of it comes down to the actual person, like the person the clinician is as well, whether or not they want to be there, whether they're genuine." (Care Manager)

As determined in a previous report on the efficacy of C2bMe outside RACFs, one major strength of the program is the ability of clinicians to engage with the personal interests of the resident. In RACFs however, this has less of a focus on hobbies such as gardening or artwork, and more of a focus on reminiscing with the resident on events in their past. The adaptability of C2bMe staff and flexibility of the program were highly praised in this regard. This allowed clinicians to develop genuine relationships with residents and helped foster trust.

"If a resident doesn't want to see them this week, that's fine. If they can't come on site, they'll offer another way of communicating. And just hearing about the different things they're doing with different residents, it's completely different depending on what trying to work for that resident and what role they've made for themselves… It's a really individualised approach, which we really appreciate." (Care Manager)

3. Group Sessions

Residents cited several group activities that were being run by C2bMe, though it was not always clear which activities were actually organised by the RACF. Coffee and conversation was the most common form of group activity, though yoga, mindfulness sessions, and card-making were also identified. The coffee and conversation groups were either gently guided by the clinician or allowed to run independently. Residents who participated in these conversations reported enjoying them as a source of social recreation.

"Sometimes residents are a bit sceptical, they say no, I don't want to participate. Then they see the groups that have been going on, and then they'll re-approach them and say, 'hey, I want to join.'" (Care Manager)

Many residents reported feeling unable to connect with other residents in their RACF, either due to differences in cognitive function or due to physical disability keeping them in their room. Some residents would initially reject the group sessions, but reconsider when seeing the activities take place.

"A lot of the people here are a little beyond me talking to them." (Resident)

"You let them know they we need to come up with some ideas for how we're gonna attract other people… There are people here who never leave their rooms. Never talk to anybody. But there must be some people that are in that undecided… we need a hook. That's what we need." (Resident)

When the RACF had organised their own activities for residents, C2bMe group sessions were occasionally considered unnecessary, as residents already had things to do. This opinion should not prevent the development of groups, as it is one of a range of opinions.

"She doesn't need another group doing anything with her. They have their own exercise class, they have the physio that runs the exercise class. So, I don't think that she needs any additional group activity." (Family Member)

However, the overall impact of group sessions is reported as positive. Although not every resident will engage with the groups, group sessions are a time- and energy-efficient way to improve the mental health of participants. Having a more flexible option for C2bMe was considered beneficial, as it allowed for a wider range of participants.

"Those group sessions are just wonderful because some people don't want to be put on the spot, one on one, but they're quite happy to sit around a table." (Care Manager)

Occasionally, residents are eager to engage with group sessions. These residents should be encouraged to take initiative in organising activities for the group and working alongside the clinician. Groups worked particularly well when the residents suggested topics for discussion. One resident reported that the clinician would do background research on the suggested topics to make conversation prompts. This was met with enthusiasm by group members.

"I think it's wonderful. I think it's one of the best things that's ever happened here." (Resident)

"Oh yeah, we work together. She's a facilitator. She guides us, but I wouldn't say that she's in charge." (Resident)

4. Challenges

Many clients found that access to mental healthcare was insufficient. Clients who were veterans and had access to services provided by the Department of Veteran Affairs (DVA) were more able to access mental healthcare if they needed it but benefited from a more informal service. Rigid application processes typically delayed or denied care for clients in need. This was amplified by financial difficulties, as many non-government services were prohibitively expensive.

"I was getting to the point where I had to talk to someone. Otherwise, I probably would've taken my life." (Resident)

"It was gonna charge a non-refundable $100 booking fee, and $100 for the session, which I got, I don't know, $55 back from. So that's ridiculous, I'm on a pension. Who could afford that?" (Resident)

C2bMe clinicians were able to refer clients to other services from which they could benefit. This ranged from medical intervention to couples' counselling services. It was clear from the clients who were interviewed that they strongly felt that the clinicians looked after the residents' best interests. C2bMe filled a gap in services provided at many RACFs.

"They're not at that level of being a psychologist, because that's not what people need in a lot of the cases, just having someone able to speak with them, who's able to speak with them and to be almost a link between the staff and residents to help improve that communication" (Care Manager)

According to participants, many other services were of poor quality. C2bMe was often compared to these services, showing both the high efficacy of this program and the wide gaps in mental healthcare for elderly people.

"The Older Persons' Mental Health program from NSW Health simply does not work, it's a waste of taxpayers' money. Especially in rural, regional and remote areas. […] The process from NSW Health is that you call a central intake line with people on the other side that don't understand aged care… I have never been successful in getting a person through the mental health intake line." (Care Manger)

As previously mentioned, RACF staff are under a great deal of pressure due to unreasonable workloads and staffing shortages. Although the C2bMe program has a primary focus on improving the mental health of residents, staff members greatly benefited from being able to receive support themselves. Having someone situated outside the RACF to provide perspective and support was considered beneficial in a way that was distinct from receiving support from within the facility.

"I know staff feel frustrated, tired, exhausted, and I think being able to tell somebody else outside the organisation, and for them to listen and understand has helped a few girls." (Care Manager)

"Just having her to fall back on and have that pair of ears there. It's been really, really validating for them. It's been good just for them to be able to sit down. And that's something that we've started recently as well, support sessions for staff, which has been good." (Care Manager)

This highlights the potential for the C2bMe program to get more involved with RACFs staff, particularly through collaboration and training, as discussed next.

5. Collaboration and Training

Staff were typically very willing to collaborate with C2bMe clinicians and were grateful for their presence. The initial meeting was largely characterised by relief, as staff could see that they would be receiving more support. Some staff reported that the clinician would approach the care managers in the morning to check on referrals. This was seen as a helpful and cooperative way to simplify the referral process. When asked if there was any way to improve the referral process, one care manager stated that regular feedback had already been used to make any necessary adjustments. Other care managers found no outstanding faults in the program's structure, with the exception of wanting the clinician to visit more frequently in the week.

"I get regular feedback and updates from both [clinicians' names]... so at this stage I think it's working really well for our site." (Care Manager)

"It's really easy, there's no hassles in it. And it's not really something that many barriers come up with... email or phones are always working. So we're in contact with each other." (Care Manager)

One major strength is the integration of clinicians and staff members in their RACF to provide collaborative programs. Group activities have the greatest success when existing resources are utilised.

"The residents thoroughly enjoy it. It's been really nice to see, especially during COVID and all the isolation, it's been really nice. And we've got an amazing C2bMe staff that visit... they've linked in with our exercise physiologist, so they're also doing mindfulness exercises and discussions and coffee groups... Two floors, the residents are always asking, 'When are [clinicians' names] coming?'" (Care Manager)

One potential source of friction between C2bMe clinicians and RACF staff is scope. One staff member reported that a previous clinician would occasionally attempt to diagnose residents. Several residents have reported that a major strength of the clinicians is that they are willing to talk without labelling or providing diagnoses. RACF staff appreciated when C2bMe clinicians brought patterns of behaviour to their attention but did not appreciate when a clinician overstepped. This should be balanced with the benefits of advocating for residents in medical matters, as clinicians can end up spending more time interacting with individuals than RACF staff. As such, they are able to pick up on patterns that can be overlooked by RACF staff.

Family members were also appreciative of having an ally within the RACF. Local staff were often overworked, and this led to a slower transfer of information between the RACF and families. Family members also saw the C2bMe clinician as a useful service for monitoring the health and wellbeing of the resident.

"She was the first one to tell us that she'd have to go to another facility. I think she found it out through her contacts there." (Family Member)

Some family members had a strong desire to advocate for their relatives. One resident had a requirement that no appointment should be set up without the approval of their guardian, that is, the family member interviewed. This family member was highly appreciative of the C2bMe clinician's respect. This was contrasted with other RACF staff and medical staff who would organise meetings without the family member's approval.

One resident mentioned wanting more information about C2bMe and suggested the production of a booklet containing information about the program's history and goals. Another resident expressed a desire for online information to be available. In both cases, the goal was to enable family members to better support the resident.

"What I'm looking for is something that will tell me about your program, how it began and why it began, so I could better understand why you've chosen her." (Family Member)

Many residents reported feeling as though they were often unable to speak to family members about mental health issues. Other residents greatly benefited from having family members present. For some family members, watching a resident deteriorate can cause depression or anxiety. Involvement in the counselling can be beneficial for the family member and enable them to support the resident. As such, having the option to speak with a counsellor with or without family present is important.

"For people like me, who are in a home, it does them good to talk to somebody who isn't involved. Like, isn't my family, just someone I can talk to… Sometimes I don't want to worry my family with it." (Resident)

One family member reported that too much communication from RACF staff was a stressor but appreciated quick informative contact from the C2bMe clinician. The major difference between communication was whether the information could be acted on by the family member. Calling to obtain consent for a meeting was always appreciated. When describing the unwanted communication from the RACF, one family member explained the fatigue associated with hearing constant negative updates:

"It's taken a toll on me, mentally and physically." (Family Member)

Staff shortages at RACFs are a major barrier to upskilling staff and providing training. Requiring a staff member to stop work for any period is difficult due to the constant overwork being experienced. However, when training can be provided, the C2bMe clinicians are capable of upskilling RACF staff and provide beneficial insights. Online modules were considered effective training tools, but care should be taken to avoid intruding on staff's much-needed rest.

"I think she's been able to give them some excellent tools and validation as well, because some of the residents have some interesting behaviours." (Care Manager)

To enable training in these difficult circumstances, C2bMe staff have been conducting impromptu training on site, have provided training videos accessible 24/7 to all facilities, 5-minute training bites using case studies and scenarios that Centre Educators can use with their own staff, among other initiatives. However, despite these efforts, training of staff was still reported as being rare. Given the small number of RACFs care managers who participated in the evaluation, the true efficacy of such

training cannot be properly determined through this study. It is interesting to note, however, that only a handful of care managers who were contacted to participate in the evaluation replied to the invitation, which highlights the challenges of engaging with RACFs staff in any activity that is extra to their everyday duties. These caveats notwithstanding, it is still worth noting that training was reported as being limited, which suggests that previously identified stressors within an overwhelmed system, such as understaffing, COVID-19 and cost, are limiting take up of the training opportunities being provided by C2bMe and are not being fully utilised by centres. Therefore, it is recommended that more emphasis is given to promoting the training opportunities that have been and continue to be put into place by C2bMe staff to upskill RACFs staff.

6. Overall Effectiveness

Social interaction was seen as vital for the wellbeing of the residents and cannot be understated when evaluating the effectiveness of C2bMe. Many residents are in the position of being isolated from family and friends, and feeling unable to connect with other residents in their RACF.

"Unfortunately, all her contemporary friends have passed away. That's what happens when you reach that age." (Family Member)

"The point was, having someone to talk to helped quite a bit." (Resident)

Residents had a variety of needs, which were adequately identified and addressed by their C2bMe clinician. Anxiety and depression are common among interviewed residents, and typically required a personalised response. One resident reported that her clinician would correct poor self-perceptions and recommended affirmations, which she found to be helpful at reducing symptoms of depression. Another resident would have frequent aggressive outbursts prior to counselling. A gentle and calm presence provided by the clinician was sufficient to reduce the frequency of outbursts from multiple each day to two per week.

"I was thinking that everything that was going on was my fault. And she said, 'you've gotta stop thinking like that.'" (Resident)

The COVID-19 pandemic seems to have reduced the overall effectiveness of the program, as clinician illness and restrictions for access to RACFs prevented clinicians from being able to interact with residents for a long period of time. RACFs that experienced outbreaks of COVID-19 kept restrictions for longer. This was a response to support the physical safety of residents, but it also increased isolation. Clinicians struggled to maintain contact with residents throughout restrictions. This was exacerbated by the difficulties residents have with technology; phones or zoom calls were unsuitable for many of them. Many systematic issues that residents faced were present prior to the COVID-19 pandemic outbreak, but were amplified during lockdowns.

"No, no, no. Don't blame the coronavirus. This problem was here in the first place. Being in the coronavirus, it has got worse." (Resident)

One resident was willing to share personal stories he had not shared with anyone, including his C2bMe clinician. When prompted, this resident stated he felt relieved to have shared the story. He stated that it was easier to be open toward someone on the phone than in an in-person meeting, even though the

interviewer was a stranger. As such, clinicians should carefully consider the type of communication that best suits the resident. Mixed methods of contact should be considered when available. A variety of contact methods can provide opportunities for the residents' development.

"It's easier to talk to a person about those types of things on the phone than face-to-face." (Resident)

The care managers that were interviewed were overwhelmingly positive about C2bMe, and frequently reported seeing major changes in residents that were part of the program. Residents would often look forward to seeing their clinician.

"Everyone mentions that the mental health of residents that want to engage and use the service has improved. We've never really had any bad reports or anything. And if people don't want to engage or participate, they don't." (Care Manager)

Additionally, several interviewees reported that the mere presence of a C2bMe clinician had an uplifting effect on residents that are uninvolved in the program. This was largely due to friendly greetings and a positive demeanour.

"You can be in the vicinity of her… and you can just feel that. It's just the vibe I get." (Resident)

CONCLUSIONS

Aged care services are becoming increasingly important as the Australian demographic becomes older, with a noticeable shift in demand from RACFs toward home care packages (Khadka et al, 2019). As such, it is important to develop and improve services that can be adapted to serve both current and future needs in aged care. The C2bMe program has proven to be an effective piece in the complex puzzle of aged care services by adopting a successful approach to providing care for seniors who are in need of mental health support beyond crisis services and who are residents of aged care facilities. It is accessible, affordable and provides evidence-based care that is compassionate, relational and individualised. C2bMe is considered an enjoyable program. The social interaction provided by C2bMe coupled with the wisdom and counsel of the clinicians has a major impact on the social and mental wellbeing of residents. Residents, family members, and care managers typically appreciate the service and would recommend it to others. Although there is always room for improvement, this independent evaluation has demonstrated that the program has so far achieved very positive outcomes.

REFERENCES

Australian Institute of Health and Welfare (2018). *Older Australia at a Glance.* Retrieved from: https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/summary

Australian Institute of Health and Welfare (2013). *The desire to age in place among older Australians.* Retrieved from: https://www.aihw.gov.au/reports/older-people/the-desire-to-age-in-place-among-older-australians/contents/summary

Cummins, R. A. (1997). Comprehensive Quality of Life Scale – Adult, Manual: Fifth Edition (School of Psychology, Deakin University, Melbourne), pp. 1–51.

Khadka, J., Lang, C., Ratcliffe, J., Corlis, M., Wasselingh, S., Whitehead, C. & Inacio, M. (2019). Trends in the utilisation of aged care services in Australia, 2008-2016. *BMC Geriatrtics, 19*(1), 1-9.

Royal Commission into Aged Care Quality and Safety (2021) Final report – Executive summary. Retrieved from: https://agedcare.royalcommission.gov.au/publications/final-report-executive-summary.pdf

Puchta, C., Potter, J., & Wolff, S. (2004). Repeat receipts: a device for generating visible data in market research focus groups. Qualitative Research, 4(3), 285-309.

Visvanathan, R., Amare, A. T., Wesselingh, S., Hearn, R., McKechnie, S., Mussared, J., & Inacio, M. C. (2019). Prolonged wait time prior to entry to home care packages increases the risk of mortality and transition to permanent residential aged care services: Findings from the registry of older South Australians (ROSA*). The Journal of Nutrition, Health & Aging, 23*(3), 271-280.

World Health Organisation (2021) Ageing. Retrieved from: https://www.who.int/health-topics/ageing#tab=tab_3

APPENDIX A – INTERVIEW GUIDE - CLIENTS

Hi [name], my name is [Interviewer], how are you?

Are you comfortable answering a few questions about your experiences with Continuing to Be Me?

Are you in a place where you feel you can talk freely?

I have a few questions to ask, but it's okay to go off topic. The purpose of this study is to hear your perspective on the program so we can improve it for others in the future. Please feel free to share as much as you like. Anything you say will only be used for the study, and your identity is completely protected.

If you have any questions at all, please feel free to ask them at any time.

I'd like to start by asking you what your understanding is of the C2bMe program. Can you describe to me what it is?

Now I'm going to ask about your experiences more broadly with Continuing to Be Me.

- What was your initial reaction to the program?
- How did that change over time?
- And has the program changed you in any way? If so, in what way?
- Are there any highlights that you would like to share? Things that you found particularly helpful that the program provided?
- Can you tell me about a time when you used the knowledge or skills you gained from the program?
- And are you able to identify any shortcomings from the program?
- What improvements could be made?
- What did you appreciate most or least about your C2bMe clinician? Did you find the support they provided person-centred?

And have you participated in any of the group activities offered through C2bMe? [If yes, ask questions below; if no, move on to next section]

- can you tell me which group activities have you participated in?
- Was the process of joining the group easy? Was it inclusive, comfortable, safe? Can you give me examples?
- Were you able to have a say in what sort of topics you wanted to focus on? If so, can you give me some examples?
- And what do you think you learned or gained from these group activities?
- What could have been changed to make it better?

Lastly, if C2bMe was not in your centre, could you have accessed mental health support when you needed it?

Is there anything else you'd like to say about Continuing to Be Me? Any comments, criticisms, or suggestions are welcome.

Thanks for your time, I really appreciate it. I've enjoyed hearing your perspective.

APPENDIX B – INTERVIEW GUIDE – FAMILY MEMBERS

Hi [name], my name is [Interviewer], how are you?

Are you comfortable answering a few questions about your experiences with Continuing to Be Me?

Are you in a place where you feel you can talk freely?

I have a few questions to ask, but it's okay to go off topic. The purpose of this study is to hear your perspective on the program so we can improve it for others in the future. Please feel free to share as much as you like. Anything you say will only be used for the study, and your identity is completely protected.

If you have any questions at all, please feel free to ask them at any time.

I'd like to start by asking you what your understanding is of the C2bMe program. Can you describe to me what it is?

Now I'm going to ask you more broadly about the experiences of your loved one with Continuing to Be Me.

- What was their initial reaction to the program?
- How did that change over time?
- And has the program changed or affected them in any way? If so, in what way?
- Are there any highlights that you would like to share? Things that you found particularly helpful that the program provided?
- Do you feel C2bMe has made a difference in their mental wellbeing? In what way?
- And are you able to identify any shortcomings from the program?
- What improvements could be made?
- What did you appreciate most or least about the C2bMe clinician who works/ed with your loved one? Did you find the support they provided person-centered?

And has your loved one participated in any of the group activities offered through C2bMe that you know of? [If yes, ask questions below; if no, move on to next section]

- can you tell me which group activities they participated in?
- do you know if the process of joining the group easy? Was it inclusive, comfortable, safe? Can you give me examples?
- And what do you think your loved one learned or gained from these group activities?
- What could have been changed to make it better?

Lastly, if C2bMe was not in your loved one's centre, could they have accessed mental health support when they needed it?

Is there anything else you'd like to say about Continuing to Be Me? Any comments, criticisms, or suggestions are welcome.

Thanks for your time, I really appreciate it. I've enjoyed hearing your perspective.

APPENDIX C – INTERVIEW GUIDE – RACFS CARE MANAGERS

Hi [name], my name is [Interviewer], how are you?

Are you comfortable answering a few questions about your experiences with Continuing to Be Me?

Are you in a place where you feel you can talk freely?

I have a few questions to ask, but it's okay to go off topic. The purpose of this study is to hear your perspective on the program so we can improve it for others in the future. Please feel free to share as much as you like. Anything you say will only be used for the study, and your identity is completely protected.

If you have any questions at all, please feel free to ask them at any time.

I'd like to start by asking you about the establishment of the C2bMe program in your centre. Can you tell me a little bit about it?

- How easy was the C2bMe partnership? How could it be improved?
- Was/Is the referral process easy? How could it be improved?

Now referring more specifically about the support provided to the residents and your staff:

- How was mental health support accessed for residents before C2bMe?
- What has changed in your centre from before C2bMe were present to after in terms of mental health support for your clients?
- How do you feel C2bMe navigated the Covid situation and providing care to residents?
- What are your feelings around the approachability, flexibility and adaptability, and communication of C2bMe staff?
- Whether C2bMe provided formal training or more impromptu training for staff, was there a staff morale change when C2bMe were present?
- What do you feel the overall impact of having C2bMe in your centre achieved?
- Has C2bMe alleviated stress when needing mental health advice about residents?
- What are some of the areas C2bMe could be improved? How could C2bMe better support staff, the centre, the residents?
- And what are the main successful areas?

Is there anything else you'd like to say about Continuing to Be Me? Any comments, criticisms, or suggestions are welcome.

Thanks for your time, I really appreciate it. I've enjoyed hearing your perspective.