







Developing an innovative model of care to address the growing mental health needs of older Australians receiving in-home aged care

Tanya Davison

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02
Executive summary

Background

Depression is common among older people who receive in-home aged care, yet the mental health needs of older Australians are not a focus of aged care providers. This Fellowship aimed to gain insights from international experts to inform an innovative approach to detect and manage depression that is effective and feasible to embed into the Australian aged care sector.

Dr Davison, a Clinical Psychologist and experienced researcher, engaged in a twelve-month fellowship commencing June 2023, where she attended key international conferences in the UK and met with leading practitioners with expertise in late-life depression and in-home aged care.

Dr Davison collated a set of recommendations for the Australian aged care sector signed to address the growing rates of depression among older people living at home, and developed a new model of care that will be implemented and evaluated within a large, national aged care service provider.

Fellowship learnings

Late-life depression can be effectively treated using psychological therapy – even in older people with complex medical and physical needs. Behavioural activation is a simple, brief therapeutic approach that may be particularly suitable for the aged care setting, given its high acceptability to older people and demonstrated effectiveness even when delivered by non-specialists. However, like all psychological therapies, behavioural activation programs need to be carefully tailored to meet older people's specific needs and preferences and account for the stigma of mental illness in this cohort.

Telehealth and other digital approaches may be used to facilitate older people's access to depression care. There is growing evidence that these approaches are effective and acceptable to older people, as older people increasingly use technologies, such as smart phones and tablets, in their day-to-day lives. Careful planning when using technologies is required to ensure accessibility, including specifically designed training and support programs to optimise the uptake of these programs. The role of the aged care workforce to support their clients using these technologies also needs consideration.

Aged care workers often develop close relationships with older people and visit them regularly at home, and so are ideally situated to detect signs of depression and help older people to access early interventions. In the UK several programs have trained non-specialists – e.g., hairdressers, postal workers – to detect symptoms and direct people to care. In some programs, support workers and other non-specialist health providers – e.g., community pharmacy assistants – have been successfully trained to deliver psychological treatments to older people. These kinds of programs appear suitable for the aged care sector in Australia, particularly given the existing funding for allied health clinicians and nurses.

Consideration needs to be given to how to effectively embed depression care into in-home aged care services. In the Fellowship, learnings were extrapolated from work across multiple teams in the UK training in-home aged care workers in dementia care. This included optimal training approaches and resources for this setting, creation of 'champion' roles, appropriate mentorship, leveraging family carers, and the importance of organisational strategy and commitment to practice change. These learnings can shape the development of effective approaches to implement a depression model of care in the Australian in-home aged care setting.

Personal, professional and sectoral impact

The Fellowship provided an opportunity for Dr Davison to engage with international leaders in aged care and mental health and attend key events. Through international travel she was also able to raise the profile of the work already underway to improve the care of older people with depression in Australia and build a new network to share ideas and innovations. These connections have already resulted in several new collaborative projects and are expected to continue to develop and grow.

Dr Davison has developed a new model of care called Enhanced Management of home-Based Elders with Depression (EMBED), which is designed to improve the detection and management of in-home aged care recipients with depression. Learnings from the Fellowship have helped Dr Davison to refine this model of care and informed the way in which it will be implemented within routine service delivery. She is currently piloting EMBED with a small group of in-home aged care recipients in Victoria with depression at Silverchain – a national aged care provider – and will also evaluate the program in a large clinical trial in other states, to gain evidence of its efficacy and cost-effectiveness.

Other initiatives to translate the learnings to the aged care sector are also in the planning stage. The dissemination strategy includes a range of opinion pieces, journal articles, conference presentations and media releases. Dr Davison is also in the process of developing a new mental health training program for the aged care workforce, to align closely with new requirements for providers to meet changing quality standards.

Recommendations

Several recommendations were made for the Australian aged care sector, based on the learnings from the Fellowship. These included:

- The current approach to managing late-life depression in Australia – whereby older people with symptoms receive high levels of antidepressant medications but have very limited access to psychological therapy and other specialist mental health services – is not working.
- In-home aged care recipients need better access to effective psychological treatments – both as a first-line treatment for clinically significant depression, and to prevent mild symptoms from developing into full-blown disorders. A 'social prescribing' approach is increasingly utilised internationally but has not yet been widely adopted for older Australians.
- Depression intervention programs should be designed to meet older people's preferences and goals, noting the stigma around mental health in this cohort. Telehealth and other digital technologies may facilitate access to depression programs and specialists, if designed specifically for (and ideally, with) older people.
- The aged care sector could – and should – play a larger role in supporting depression among ageing Australians. This includes early identification of signs of depression – including through routine depression screening – and rapid escalation to treatment. Aged care workers should support older people engaging in treatments and could be trained to apply simple psychological approaches.
- The Australian aged care workforce should receive training in detecting symptoms of depression and caring for depressed older people. Current training is inadequate, and workers are unclear how to assist clients experiencing depressive symptoms. New training programs and resources

are required to support the workforce in caring for depressed older people, specific to their role and setting.

- With an increased focus on mental health in the new Strengthened Aged Care Quality Standards, providers will be required to demonstrate they meet the needs of older people with mental health conditions. Existing governance, processes and funding models for aged care may need to be optimised to support increased requirements.
- Aged care providers should see mental health as a priority, communicate this throughout the organisation, and ensure workers have dedicated time to implement new approaches.
- While there is good evidence around the effectiveness of approaches identified in this Fellowship to address late-life depression, research is urgently required to evaluate effective ways to implement these new approaches into the Australian aged care sector.

03
Fellowship Background

Fellowship context

This Innovation in Aged Care Fellowship aimed to support the development of innovative approaches to address the mental health needs of in-home aged care recipients in Australia. The Fellowship focused on depression – an increasingly common condition among older adults who receive care at home.

Depression in the in-home aged care setting

There has been rapid growth in the provision of in-home aged care services in recent years, with a four-fold increase in the number of Australians accessing aged care at home in the past decade (Australian Institute of Health and Welfare, 2023). This funding change has enabled more older people to remain living at home and avoid or delay admission to residential aged care, in line with most peoples' preferences. However, it has also led to an increase in the clinical complexity of the population of older people receiving aged care services at home (Inacio et al., 2021). The aged care sector requires innovative approaches to meet the increasingly complex needs of these older people within the home.

The mental health of older people who receive care in the home has received little attention from researchers and policy makers. However, international literature indicates this group experiences mental health conditions at twice the rate as the broader population of older people in the community (Wang, Shang, & Kearney, 2016). Up to one half of people who receive aged care in the home experience significant symptoms of depression (Wang et al., 2016), and there are indications that depression rates have increased markedly in the past decade (Inacio et al., 2021).

In Australia, the management of depression is largely situated within the healthcare system (rather than the aged care system). There are indications that the current approach is not serving older people well. This group is prescribed antidepressant medications at very high rates, yet many continue to report depressive symptoms. Experts have raised concerns about the effectiveness of antidepressant medications for frail older people (Brown et al.., 2022). Factors that contribute to late-life depression, such as loneliness or functional disability, commonly go unaddressed in the biomedical treatment model that is predominant in Australia.

Psychological therapy is an alternative treatment approach, but very few aged care recipients have access to specialist mental health services (Cations et al., 2022; Thapaliya et al., 2024), and shortages in the mental health workforce is likely to continue. Older people are often reluctant to present to their General Practitioner or other healthcare providers for assistance with mental health conditions, due to the stigma they perceive about mental health problems or a misconception that depressive symptoms are a 'normal' or expected consequence of ageing or long-term physical conditions. As a

result, symptoms often go undetected and under-treated, and many older people continue to remain depressed and isolated at home.

The potential role of aged care providers in addressing late-life depression

The aged care system could make a significant contribution to solving the problem of rapid growth in the number of in-home aged care recipients with depression by identifying depressed older people early and facilitating access to evidence-based treatment.

The aged care workforce develops strong, trusting relationships with their clients, and staff are ideally situated to observe early indicators of deterioration, such as low mood, decline in self-care or lack of engagement in daily activities, and could escalate for assessment and early intervention. However, the current aged care workforce has received little training in mental health and most workers lack knowledge about the signs and symptoms of depression and how to support those clients who are experiencing symptoms. Aged care providers do not routinely screen for common mental health conditions and many report difficulty accessing treatment for their clients through the healthcare system.

Alternative approaches are required, leveraging the existing aged care workforce. This could include initiatives to provide older people with access to early psychological treatment directly via the aged care system. However, the Australian aged care sector lacks information on evidence-based approaches to appropriately support older peoples' mental health and wellbeing, as well as knowledge on how to implement these approaches into aged care service delivery.

The Innovation in Aged Care Fellowship

This Fellowship aimed to address gaps in knowledge and practice by providing an opportunity to engage with leading international experts and identify innovative approaches to improve mental health and wellbeing that could be applied in the in-home aged care setting.

Specific areas of focus included:

1. **Psychological therapy with older adults.** Identification of psychological therapies that are effective with older people and insights on how to effectively engage older people in these therapies to improve their mental health and wellbeing.
2. **Embedding mental health care into aged care services.** Information is required on how to effectively engage the aged care workforce to recognise signs of depression and provide support to older people, including optimal training approaches to improve their skills and knowledge.
3. **Digital approaches to support older peoples' mental health.** Digital technologies may address workforce shortages and facilitate access to treatment for people in rural and remote areas. Information is required on how to use digital approaches effectively with older people, including any training and support they may require.
4. **Integration of aged care and healthcare.** To meet the needs of aged care recipients with depression, aged care and healthcare services need to collaborate effectively. The Fellowship aimed to identify effective integrated care models and collaborative approaches that may inform an aged mental health model of care for the Australian setting.

The Fellowship was designed to gain insights and learnings through the above activities that would inform the development of a new, innovative model of care to reduce depression among in-home aged care recipients in Australia. This model was proposed to include both effective psychological treatments for aged care recipients with depression and a tailored training program to support the in-home aged care workforce. In particular, the Fellowship aimed to identify critical barriers and enablers to success that could be incorporated into Australian initiatives. It was proposed to pilot the new model of care at Silverchain – a large Australian in-home care provider – and develop evidence and resources to share with the broader aged care sector.

One goal of the Fellowship was active dissemination of the learnings across the aged care and related industries, using existing and newly established networks. The Fellowship also aimed to demonstrate that aged care providers can effectively manage mental health systems under existing or developing funding and governance models. A model of care developed for depression could act as an exemplar of an integrated health and aged care approach and could be applied to address other common medical issues in the aged care population, such as falls, palliative care and management of chronic diseases. With the Australian aged care sector currently undergoing major reforms, the Fellowship offers a key opportunity to have broad impact on the sector.

Fellowship methodology

The Fellowship was conducted via face-to-face engagement and workshops with knowledge leaders internationally in aged mental health and in-home aged care, through attendance at international aged care industry conferences that focused on sharing innovative approaches to care, and through online meeting after the international travel. A focus was on identification of practical strategies to successfully implement new approaches, through the experiences of the international experts interviewed. In addition, published literature, websites and other online resources were reviewed.

Conferences attended included:

- **Global Ageing Conference.** Hosted by the Global Ageing Network in Glasgow, Scotland from 7 to 9 September 2023. This conference brought together industry leaders in aged care to identify solutions to the challenges facing the aged care sector. This conference showcased innovative programmes and approaches from around the world and offered a stimulating forum for the exchange of practical knowledge and new strategies focused on the provision of high-quality care and support.
- **Social Care International Workforce Summit.** Held in Glasgow, Scotland on 6 September 2023. This summit addressed the workforce challenges facing the social care sector throughout the world. Global experts discussed workforce solutions, including the role of technology, immigration and migration, training, and professionalization.
- **Curiosity Partnership – Adult Social Care Research Festival.** Invited to present a keynote presentation at an industry event held in Hull, England, 14 September 2023. This event brought together aged care providers, funding bodies, policy makers, and researchers.

International knowledge leaders were identified through a review of published literature, scan of keynote presenters from industry events, and through recommendations from industry and academic networks. Meetings were held with senior leaders of the following organisations:

- **Ageing and Health Unit, World Health Organisation, Geneva, Switzerland:** Dr Matteo Cesari and Dr Yuka Sumi (Chief Medical Officer). This unit is leading a program of work called Integrated Care for Older People (ICOPE), supporting several pilot studies implemented worldwide. The aim of this meeting was to explore models for integrating mental health care into aged care.
- **Institute of Mental Health Research, University of York, UK:** Dr David Ekers (Honorary Visiting Professor and Clinical Director Research and Development, Tees Esk and Wear Valleys NHS Foundation Trust, and), and Dr Liz Littlewood (Research Fellow, Department of Health Sciences). This team has led multiple internationally regarded trials of psychological interventions for older people with depression and long-term health conditions, including interventions delivered by non-specialists. The focus of this meeting was on designing a suitable treatment program for depressed aged care recipients and engaging older people.
- **Social Policy Research Unit, University of York, UK:** Professor Yvonne Birks (Director), and Dr Mark Wilberforce (Senior Research Fellow), and other team members. Invited to present at a seminar.
- **NIHR Policy Research Unit in Health and Social Care Workforce, King's College London:** Dr Monica Leverton (Research Associate), Dr

Kritika Sami (Senior Research Fellow), Dr Olivia Luijnenburg (Research Associate), and Dr Tiffeny James (Research Associate). The group has substantial research experience in home care, with particular expertise around dementia care and the home care workforce. The focus of the meeting was on translation of research initiatives to implement new initiatives in home care into routine practice.

- **The King's Fund, UK** – an independent charitable organisation working to improve health and care in England. Simon Bottery (Senior Fellow, Social Care) from the Policy Team.
- **Institute of Mental Health, University of Nottingham, UK:** Professor Martin Orrell (Institute Director and Head of the Division of Psychiatry and Applied Psychology).
- **School of Medicine, Keele University, UK:** Professor Carolyn Chew-Graham (Head, School of Primary, Community and Social Care), Dr Tom Kingston (Senior Research Fellow) and Professor Krysia Dziedzic (Director, Impact Accelerator Unit). Invited to present a symposium to the broader team as part of the Fellowship visit.
- **eHealth Living & Learning Lab, Amsterdam UMC, the Netherlands:** Assistant Professor David Neal. The aim of this online meeting was to determine how best to support older people to use technology to access psychological care. This resulted in a new collaborative project to design and test a new protocol to implement technology within in-home aged care.

Fellowship period

The twelve-month Fellowship commenced on 6 June 2023. This included a period of international travel undertaken between 25 August and 15 September 2023.

Fellow biography

Dr Tanya Davison DPsych(Clin) BSc(Hons) is a Clinical Psychologist and Fellow of the College of Clinical Psychologists. She is an internationally regarded research leader with 20 years of experience in research in the health, aged care, and academic sectors. She is currently Director of Research Discovery at Silverchain – a large home care provider – where she is responsible for the development of a world-class program of research to inform the future of aged care in the home. She also holds adjunct professorial roles at Swinburne University of Technology, Federation University Australia, Curtin University, and Monash University, and is involved in multiple partnerships with leading researchers across Australia. She is a member of several groups that aim to improve the care provided to older Australians, including the Australian Association of Gerontology and is a committee member of the Australian Psychological Society Psychology and Ageing Interest Group.

Dr Davison implements applied, translational research that aims to demonstrate a sustainable impact on health and aged care policy and practice. She is passionate about improving the mental health of older Australians, through designing, implementing, and evaluating programs to address the high prevalence of depression and anxiety among older people receiving care. For several years her research has focused on residential aged care, but since joining Silverchain, has begun to address gaps in our understanding of the mental health needs of Australians who receive aged care services at home.

Abbreviations / Acronyms / Definitions

In-home aged care: Also referred to as Aged Community Care or more generally as 'home care'. This refers to a range of services provided to older people to support them in managing activities of daily living and to remain living within their home. Services include personal care, allied health, nursing, social support, meals, transport, and home and garden maintenance. These services are funded by the Australian government, under schemes such as the Commonwealth Home Support Program or Home Care Packages. In the UK, aged care services are under the umbrella term 'adult social care' (which also includes disability care and other care for people aged under 65 years).

Depression: Within this report, the term 'depression' is used to refer to either diagnosed mental health disorders, such as Major Depressive Disorder, or the presence of symptoms of depression (also referred to as subthreshold depression or minor depression), which also have a significant negative impact on older peoples' quality of life and functioning.

04
Fellowship Learnings

Research theme 1. Psychological therapy with older adults

A key aim of the fellowship was to develop strategies to effectively engage older people in psychological therapy to improve their health and wellbeing. Recognising that older people experiencing symptoms of depression often do not present to health professionals for treatment of their condition, it is critical to consider how the aged care sector can help older people with depression to engage in psychological therapy. Family and other informal carers may also play a role in facilitating engagement.

To ensure that psychological therapies are suitable for widespread use in aged care, they must be effective and cost-effective, acceptable to older people and feasible for implementation within routine service provision.

To address this aim, two interviews were conducted with mental health researchers at the University of York in the UK. The first was with Professor David Ekers, Honorary Visiting Professor at the Institute of Mental Health Research, University of York, and Clinical Director for Research and Development in a large Mental Health NHS Trust, who leads a program of research into psychological therapy with older adults. A second interview was conducted with Dr Elizabeth Littlewood, Program Manager, Della Bailey, Research Fellow, and Kate Bosanquet, Research Fellow, who are responsible for the day-to-day implementation and evaluation of several projects implementing psychological therapies with older people, to learn from their experiences.

Figure 1. Meeting at the Institute of Mental Health Research, University of York

The Institute of Mental Health Research at the University of York focuses on the development, implementation, and evaluation of interventions to reduce symptoms of late-life depression and improve people's wellbeing as they age. This group has a strong commitment to improving access to effective interventions and have developed an impressive evidence base to support the dissemination of interventions that are cost-effective to implement at scale. They have led several large trials of psychological therapies for depression with older adults in the UK, collaborated with colleagues in other countries, and are internationally recognised as leaders in this field.

Another group with expertise in the implementation of psychological treatments with community-based

older adults, particularly those delivered by non-specialists, is based at the School of Medicine, Keele University. A seminar session was conducted with several members of the research group, including Professor Carolyn Chew-Graham, Head of School of Primary, Community and Social Care, Dr Tom Kingston, Senior Research Fellow, and Professor Krysia Dziedniz, Director of the Impact Accelerator Unit, which was established to accelerate translation of research findings into healthcare.

Figure 2. Fellow at Keele University

The trials implemented by these two leading research groups have demonstrated strong benefits of psychological therapy for depression in older adults, and established therapeutic approaches that are effective, feasible for use with older people living in the community, and acceptable to older people as well as those facilitating the programs. Key learnings from the interviews are summarised below.

Which kinds of psychological therapies are effective for late-life depression?

There is well established evidence that psychological therapies are effective in treating depression among older people (Davison et al., 2024; Orgeta et al., 2022). These types of therapies are typically delivered by mental health clinicians. For example, clinicians commonly use cognitive behavioural therapy to help people to change negative patterns of thinking and behaviours associated with depression. However, the UK research teams suggested that simpler interventions that can be delivered by non-specialised health providers may be a more feasible and cost-effective approach for the in-home care setting, given the difficulty this group faces accessing mental health clinicians. One such approach – behavioural activation – shows substantial promise. Behavioural activation is a therapy that focuses on supporting people to engage in more meaningful or pleasurable daily activities, and addresses the withdrawal that often accompanies depression. This psychological therapy has been demonstrated to be effective in treating late-life depression in trials led by mental health researchers at the University of York and others (Gilbody et al., 2024; Janssen et al., 2023).

Behavioural activation appears to be highly acceptable to older people and simple to implement, including by non-specialists (Shearsmith et al., 2023). Older people, including those with multiple health conditions and depression, have demonstrated strong engagement with this approach, with excellent retention in programs (Chew-Graham et al., 2022). Behavioural activation can be usefully adapted to manage the loss of function and lack of positive reinforcement which can commonly occur in later life, including poor mobility, long-term health problems or changes in role following retirement or bereavement.

While interventions with more sessions tend to produce stronger outcomes, researchers interviewed during the Fellowship noted that depressive symptoms can be reduced following as few as 6-8 sessions of behavioural activation. This ‘dose’ is lower than that typically recommended for psychological therapy, and so may be a more cost-effective therapeutic approach. There is also evidence that behavioural activation can be successfully implemented with older people using self-help manuals (Gilbody et al., 2022). In some trials, behavioural activation has also reduced symptoms of loneliness and anxiety, and improved quality of life (Gilbody et al., 2024), which are key concerns for older adults living in the community. Treatment outcomes are typically maintained for several months following therapy. However, few studies have tracked older people over the longer term to determine whether relapse is prevented.

Which older people can benefit from psychological therapy?

Behavioural activation is effective for those with subthreshold depression ('mild' symptoms), as well as more severe conditions, such as Major Depressive Disorder.

Experts indicated that older people should have at least one 'core' symptom of depression – low mood and/or loss of interest or pleasure in day-to-day life – to maximise the likelihood that they will engage in therapy. It is difficult for those without low mood to see the link between mood and daily activities, which is a core component of behavioural activation.

Who can deliver psychological therapy for late-life depression?

Substantial specialist mental health training is required for traditional psychological therapies, such as cognitive behavioural therapy. However, the shortage of trained and registered mental health clinicians limits the potential for older people to access therapy – particularly the high number of in-home aged care recipients with mild symptoms of depression. This is particularly problematic within Australia, where there are long waiting lists and few clinicians specialise in working with older people.

However, the UK experience suggests that non-specialists without a background in mental health and psychotherapy can be trained to deliver simple therapies, such as behavioural activation, to people with less severe conditions, with clinical support. These interventions can be delivered within their existing roles, and there is the advantage that these non-specialists may already have established relationships with the clients. However, while mental health qualifications are not required, workers do need core skills of being able to talk to older people and provide support.

Mental health researchers at the University of York have trained a broad range of healthcare workers to implement behavioural activation, including junior nurses, community psychiatric nurses, health support workers, primary care practice nurses, midwives, physiotherapists, and community pharmacy assistants. Healthcare workers have responded positively to the opportunity to implement behavioural activation. Although appearing nervous at first, these workers have reported observing strong benefits with older people and feeling a sense of satisfaction seeing older people achieve their goals.

Similarly positive outcomes were reported by the Keele University group, who tested the feasibility of training third sector workers to deliver a psychological intervention to older people with anxiety and depression. Support Workers from a UK-based charity called Age UK – which provides assistance to older people in the community – successfully implemented behavioural activation to older people at home. This approach was acceptable to both the Support Workers and older people, who welcomed the one-to-one support they received and the opportunity for someone to listen to them and take an interest in their lives. Interestingly, the interventions offered by the Support Workers extended beyond traditional psychological therapy ('talking therapy') to include practical supports, such as organising mobility aides for the older person, and they commonly engaged older peoples' family members in interventions. Support Workers reported that supervision was important, particularly when first implementing interventions, given the complexity of the problems many of their older clients faced.

In Australia, unlike the UK, allied health services are funded as part of aged care. A range of allied health clinicians work within aged care providers, including social workers, occupational therapists, and nurses, who could potentially be trained to implement these kinds of simple therapies. This offers an opportunity for Australia to lead the way internationally in embedding psychological therapies for depression into aged care service delivery.

How can we encourage older people to take part in psychological therapy?

Several insights were provided by clinicians and researchers with long experience working with older people with mental health conditions. Language is important, given the strong stigma of mental illness in this cohort of older people. We should avoid terms

like ‘depression’ and ‘mental health’ and instead use ‘low mood,’ and avoid providing a mental health diagnosis (or other forms of ‘labelling’). Older adults are more likely to self-identify as experiencing low mood, stress or distress and so these terms are typically more acceptable. Adopting the terminology used by individual older people themselves can be helpful – for example, some people use terms such as ‘my nerves.’

Many older people do not feel they need professional help, especially those with subthreshold depression. In part, this is because they may not identify as having a problem with their mood. To address this, interventions should be framed around prevention or maintenance of their wellbeing (e.g., ‘a program to help you to stay well’ or ‘helping you to maintain your health’) rather than addressing symptoms related to low mood or depression. Alternatively, the program may be framed around factors that are contributing to their depression, such as managing loneliness, bereavement, and loss, rather than symptoms of depression. And rather than ‘intervention’, ‘treatment’, or ‘therapy’, use of the term ‘support’ may be more acceptable to older people.

Researchers from Keele University suggested that the current cohort of older people often feel responsible for managing their own mental health problems, rather than relying on others for help. Many older people have experienced symptoms of depression or anxiety over many years but never sought out help. Effort may be required to encourage this group to recognise that they have the right to access services now. Those recruiting older people into programs may need to address the commonly expressed concern that somebody else may be more worthy of the support. This may include normalising both the experience of low mood and engaging in strategies to improve wellbeing. In the research context, we may engage older people in trial of psychological therapy by framing this as an opportunity to help others through gathering information on what works, with several researchers interviewed suggesting that older people often value this opportunity to contribute in this way.

Other providers, for example, the person’s General Practitioner (GP), may be a good first contact when attempting to engage older people in psychological therapy, with some people likely to respond to a suggestion from their doctor to take part.

An interview was also held with Professor Martin Orrell, Director, Institute of Mental Health and Head of the Division of Psychiatry and Applied Psychology at the University of Nottingham. Professor Orrell is an Old Age Psychiatrist and international leader in aged mental health. He shared his expertise around working effectively with older people, with insights detailed below.

Figure 3. University of Institute of Mental Health (top) and Martin Orrell (right)

Professor Orrell suggested asking older people directly what might make their lives better. It may be possible to address at least some part of their goals or desires, for example, restoring some function or activity they enjoyed, or a role they previously held. Clinicians should consider how the older person constructs their identity and the kinds of activities that fit with their identity and interests. Social activities, such as weekly groups, provide the important benefit of interacting with others. The opportunity to engage in conversation and see others taking an interest in them can be validating to older people.

Older people – like younger people – need to feel they are participating in and contributing to their communities and societies. People often become disempowered in later life and may have limited opportunities to contribute meaningfully. Interventions for depressed older people at home should consider positive and meaningful activities that are feasible for them to do, particularly those activities that build a sense of reciprocity, like volunteering. This approach is highly consistent with behavioural activation.

What factors are critical to successfully implement psychological therapies?

Those interviewed talked about the importance of the clinician or worker building a trusting relationship with the client. They should demonstrate care for the client – e.g., remember important things happening in the client's life.

Continuity of care is also critical – i.e., the same clinician or worker should take the client through the program. This helps in building a strong therapeutic relationship during the program, which is a key success factor.

Those delivering the therapy should be enthusiastic about the therapy, inspire older people to try strategies, and motivate them to engage in activities. Some older people are more likely to engage in strategies when they know that the clinician or worker will follow up – this can be a helpful prompt to begin engaging in activities. Hopefully, once they have started to engage in some activities, they will notice the benefits, which will facilitate their motivation to continue.

Mental health researchers at the University of York developed a client booklet which included case studies – these were examples that were designed to be relatable to older people. For example, cases included older people who felt lonely or who had experienced bereavement. This approach helps older people to identify with the cases and see parallels with their own situation, which clinicians found motivated them to try the strategies.

Psychological interventions should be tailored to meet clients' needs, preferences and goals. Clinicians noted that interventions don't need to follow a set order, and not all components need to be delivered. A collaborative approach between the client and the clinician or worker is preferable. Behavioural activation is suitable for older people with significant comorbidity and complex needs. However, older people may need help in modifying preferred activities, to account for any physical, sensory, or cognitive limitations, to achieve the expected benefit.

Clinicians recommended older people keep a diary of mood and activities, to help them to understand how their mood and activities are linked ('what I do impacts on how I feel'), and to notice the benefits of engaging in activities on their low mood. In addition, brief telephone check-in calls from the project team are helpful, to remind older people about the program and address any problems they might be experiencing when attempting to implement strategies.

Research theme 2. Digital approaches to support older peoples' mental health

In designing approaches for the aged care sector to support older peoples' mental health, it is important to recognise the current workforce shortages across the care economy – in both the aged care and mental health systems. Digital technologies may help to address these workforce shortages and enable people in rural and remote areas to access effective treatments. Technologies may also facilitate autonomy in older people as they engage with digital resources in personalised ways to support their mental health and wellbeing.

However, information is required on how to use digital approaches effectively with older people, including any support they require to use technologies to engage with psychological interventions.

During the Fellowship interviews, information was sought on the use of digital approaches to support mental health initiatives. The following learnings were obtained from interviews with mental health researchers at the University of York and dementia researchers at King's College London and the University of Nottingham.

In addition, learnings were obtained from an online resource produced by international Interdisciplinary Network for Dementia Using Technology (INDUCT), a collaboration of ten research organisations across 7 countries in Europe, coordinated by Professor Martin Orrell at the University of Nottingham. This network has produced guidelines for the use of technology in people with dementia and their family carers, much of which is also applicable to the in-home aged care population (with or without dementia). This guidance looks at how to improve the usability of technology and provides recommendations on how to successfully implement technology-based interventions and evaluate their effectiveness.

A follow-up interview was conducted with one of the INDUCT members, Dr David Neal, Assistant Professor at the eHealth Living & Learning Lab, at Amsterdam UMC in the Netherlands. Dr Neal has piloted several initiatives to support older people using digital technologies.

Can we use telehealth to deliver psychological therapies to older people?

Traditionally, clinicians have considered it important to deliver at least some therapy sessions face-to-face. However, the requirement to transition face-to-face programs to telehealth during periods of COVID-19-related social isolation demonstrated that telehealth is a viable and acceptable alternative. The experience of mental health researchers at the University of York indicated that older people preferred telephone calls to video calls, although those who opted for video calls appeared to like this approach. Some older people taking part in therapy in the UK project reported they found it easier to talk and share their feelings with people over the phone rather than face-to-face.

The need for support and guidance to access videocalls should be considered. Researchers from the INDUCT collaboration with experience implementing video-based programs reported that most older people taking part in their programs experienced difficulty accessing sessions at some point. Therefore, these problems should be anticipated and planned for, for example, through provision of a step-by-step guide on how to install and use the software, sending links on the day of the session, and providing telephone-based support.

Do older people engage with digital technologies?

Researchers at King's College London asserted that "we need to stop assuming that older people can't use technology," noting that most older people have ready access to the Internet. They gave an example of the Forward in Dementia program, which aimed to make information on dementia available to clients, family members, and in-home care workers. All groups taking part in the study expressed a preference for online materials, despite researchers being concerned about the 'digital divide' and

excluding many older people. This program found excellent access and uptake of online materials by older people.

Researchers at Keele University similarly cautioned "don't make assumptions that older people will struggle with technology." Even when a person has not used a piece of technology, they often develop competence when provided with support in how to use it: "Sometimes it's just equipping people with the confidence … having somebody who can spend a bit of time and walk them through it." They recommended building on existing comfort with devices – for example, using a tablet rather than a personal computer, and remaining flexible about how technologies might be utilised. Another strategy is to consider bringing in additional supports, such as peers or family members.

Accessibility is important when using technologies. For example, those with hearing and visual impairments may need support in accessing a hearing device or materials with enlarged text and images. By addressing barriers such as these, researchers have found that many older people will engage with technology.

An earlier paper published by the Keele University group (Moult et al., 2018) reported that while older adults in the study all had access to the Internet, most did not use it to obtain information, and did not see the Internet as a suitable source of information about distress or mood problems or a way to access social support. Such attitudes may have changed since the start of the COVID-19 pandemic, which facilitated uptake of online social interactions, but should be assessed when working with individuals. Many older people are likely to still prefer face-to-face communication.

Professor Orrell at the University of Nottingham, who has experience employing technologies with people with dementia and their family carers, noted the importance of considering which types of technology are most acceptability to older people. He gave an example of a digital call button for older people to wear to enable them to contact someone for help in case of a fall. This device had poor acceptability to many users: "it's ugly, it's stigmatising, I don't want to wear it." However, older people have been more willing to wear a smart watch, which was seen as an exciting piece of technology.

Professor Orrell co-led a recent survey of people with dementia, which found that the majority of people used the Internet daily (Lee et al., 2023). Most were interested in and enjoyed using new technology, but many expressed apprehension due to the complex nature of some technologies. Older people were commonly concerned about issues related to data protection and privacy, security, fraudulent activity, lack of knowledge and the fear of making a mistake.

How can we improve the usability of digital technologies for use with older people?

A focus on the characteristics of the user population, including the specific needs and expectations of older people, is critical during the development of technologies. This will influence the user's experience and their motivation to continue to engage with the program. Considerations include aligning with users' visual, auditory, and cognitive capabilities. This may require an ability to change the lighting, contrast, font, and image size within digital programs, lower the background noise and deliver the content more slowly. Other suggestions include the use of personal links to access programs, rather than the need to remember a username and password, the use of images and videos to accompany text, and the use of simple language. Content should be clearly aimed at adults, rather than children.

Researchers and clinicians working in this area emphasised the importance of "user-centred design" – engaging older people from the beginning to the end of the development process, including usability testing. This engagement and testing should involve diverse groups of older people, as well as those who care for them. Consultations with end users are important not only for the intervention content, but also its mode of delivery, to ensure it is appropriate for those who are intended to use the program.

It was also highlighted that technological interventions should be valued by the older people and provide benefits in their daily lives. They also need to be feasible for the older person's context, for example, their ability to access devices and the Internet (including WiFi speed in their home), and their level of digital literacy. Those with previous experience using a particular device will be more likely to engage with a new intervention using that device.

When developing new digital applications, the user experience should be optimised, for example with clear signposting and an easy and intuitive navigation. All those using the technology – including in-home aged care workers, volunteers and family carers – should be involved in its development, to ensure it is used in practice.

As a group, older people may use a range of devices with various software versions (e.g., smartphones, touch-screen tablets, and personal computers) to access apps and digital platforms. New technology should be compatible with all of these different devices, to enable the person to access using their preferred mode, to ensure successful implementation. However, it should be noted that not all older people will want or be able to engage with all technologies, and non-technology options should be available to avoid excluding them from services and interventions.

How can we improve the uptake of digital interventions by older people?

Several studies have examined factors that are associated with successful implementation of digital interventions, including those conducted by members of the INDUCT collaboration. The adoption of a digital intervention is reliant on older people accepting it and feeling engaged. When introducing a new App or other technology, it was recommended to focus on aspects that are likely to encourage their interest, such as video calls with friends or family, music, games, or family photographs. Inclusion of social interaction elements in digital interventions may prove beneficial. Research has indicated that technology-based programs that facilitate social interactions – for example, phone calls, text messages or group programs – have been effective in promoting social participation among older adults.

The types of training and support older people require is important for consideration. Dr David Neal from Amsterdam UMC shared work he has conducted to determine the appropriate level of training and support that is required by older people with dementia to use tablet-based Apps in the Netherlands. Training in the use of the program should align with the person's prior experience in working with digital devices. An opportunity to practise regularly and access to family carers has also facilitated engagement with some programs. In addition, it should be easy for people to access support for help with problems using the technology. This includes informational support (e.g., guidance and instructions) and emotional support (e.g., coaching, encouragement, peer support). Both types of support have been found to increase engagement and satisfaction in various psychological interventions. Face-to-face training and support may be required for those older people without prior experience using a particular device. Dr Neal observed few older people spontaneously called telephone helpdesks and recommended support should be offered proactively to those who need it. Interviewing users who have commenced a digital intervention may also uncover additional factors important for continued engagement with that particular intervention.

What are the considerations for the in-home aged care workforce when technologies are implemented?

Experts in this area noted that prior to implementing a digital intervention within in-home aged care, providers should consider the role of the in-home aged care workforce in supporting their clients to use the technology. Providers should clearly communicate roles and responsibilities of the workforce, so that all involved know what is expected of them and how much time is allocated for them to participate.

If care workers are required to use or support the digital intervention, their needs should be considered during the development process, to ensure that the intervention will be used in practice. In this situation,

it is important to ensure that managers support the use of the digital programs and are engaged and updated regularly, given they need to approve the time and other resources required for staff to participate in the new program. The program needs to be designed to fit in with existing ways of working and the organisational culture.

Concerns were raised by researchers at King's College London about the potential barrier of aged care workers (and other involved in implementing and supporting digital programs) themselves having poor digital literacy. Those implementing staff-led programs need to account for staff knowledge and skills. Interestingly, researchers at the Social Policy Unit at the University of York reported that the use of technology to support the delivery of home care continues to be regarded as a low priority by older people, family members, and home care workers (O'Rourke & Beresford, 2022).

Figure 4. Meeting at the Social Policy Unit, University of York

Research theme 3. Embedding depression care into in-home aged care services

Few aged care providers at present proactively manage depression among older people. To address this, information is required on how to effectively engage the workforce to recognise signs of depression and provide support to their clients experiencing depressive symptoms.

With limited knowledge about mental health, the Australian in-home aged care workforce (direct care staff and managers) would benefit from specific training in depression. However, there is little local information about optimal approaches to improve their skills and knowledge in this area.

In the UK, it has been recommended that all health and aged care staff working with older adults receive awareness training to help identify and respond to signs and symptoms of mental health problems (Age UK, 2019). However, few aged care workers receive such training – in either the UK or Australia.

During the Fellowship, no international examples were found where in-home aged care workers were provided with training in detecting or caring for older people with symptoms of depression. However, there was strong support among all those interviewed for routine mental health training for the aged care workforce.

Embedding mental health care into aged care was widely considered a valuable approach to improve outcomes for older people, despite the lack of available examples where this has previously taken place. Insights and opinions from international leaders are reported below.

What are the benefits of implementing depression care into in-home aged care services?

The current approach to restricting depression care to healthcare providers is not working well, with only a very small proportion of community-dwelling older Australians consulting a healthcare professional for help with symptoms of depression. Older adults in

many countries have poor access to psychological treatments, with health systems experiencing difficulty meeting the demand for mental health services in the general community.

Researchers at the Institute of Mental Health Research at the University of York identified several potential benefits to in-home aged care workers being involved in depression care. The pre-existing relationships between these workers and clients was seen as a strong advantage. Few other professionals visit older people at home, where there is the opportunity to observe the person's day-to-day function and pick up on early signs of decline. In addition, interventions delivered by aged care providers may be seen as less stigmatising than 'mental health services'.

Older people may require additional supports to implement preferred new activities recommended as part of therapy, particularly behavioural activation. This may include additional services to address unmet psychological or physical needs, transport, help from family members, home, or mobility aides. In-home aged care workers are well-situated to organise and implement these additional supports. As noted by Professor Orrell at the University of Nottingham, in-home aged care workers can assist older people to engage (or re-engage) in meaningful activities available within their local communities. This workforce has awareness of local groups and activities on offer and can assist to link older people, along with any transport requirements. This holistic approach – integrating care of mental and physical health conditions – is highly beneficial for those experiencing depression in the context of multiple health conditions or frailty.

Which Australian in-home aged care staff groups could implement depression care?

In many countries, including the UK, health professionals with training in mental health and delivery of psychological treatments are rarely employed in the aged care system. While this is also largely true in Australia, allied health clinicians, such as social workers and occupational therapists, and nurses are commonly employed by home care providers in Australia to provide clinical services. These health professionals could be trained to conduct screening and assessment of depression, and support clients with depression to access interventions. They could also potentially deliver interventions to older people, in a similar way to the programs led by healthcare-based Support Workers in the UK.

Direct carers may be able to support these initiatives through training in early detection of depression, and escalation of clients at potential risk for additional assessment, support, and treatment. Direct carers may also be able to provide support to older people experiencing symptoms of depression and encourage their clients to engage in treatment strategies recommended by clinicians.

Professor Orrell suggested that programs training in-home aged care workers to deliver and support psychological therapies should avoid clinical terminology, for example calling it the 'get up and go program' rather than 'behavioural activation'. Strategies employed by care workers should fit within their existing role and their perception of what they do as an in-home care worker – for example, helping the older person to do more activities and interact with others, rather than treatment of depression. The term 'social health' may provide a more positive framework for these kinds of programs than 'mental health'. Social health is an aspect of overall wellbeing that stems from connection and community, distinct to physical and mental health, and may align well with current aged care frameworks.

Drawing on learnings from related initiatives

While no examples of depression care were found in the in-home care setting during the Fellowship, several programs in the UK, including those led by mental health researchers at the University of York and Keele University, have embedded psychological interventions for late-life depression into routine care in healthcare settings outside of formal mental health programs. In these programs, a range of non-specialist healthcare providers have been successfully trained to implement behavioural activation as part of their regular role, with protected time to implement the program. Those involved

as facilitators have reported positive outcomes – observing positive benefits for older people and finding the role highly rewarding (Shearsmith et al., 2023).

Other programs have integrated early detection of people with depression into the standard role for non-health professionals and trades, including hairdressers, Police, postal workers and workers from Fire and Rescue Services (Kingstone, Chew-Graham, & Corp, 2022). In many of these programs, non-health workers are trained to ask older people about their mood and provide 'sign-posting' – i.e., direct people to primary care and other sources of support and information for mental health symptoms. Researchers at Keele University trained a community-based organisation called AgeUK to deliver a brief intervention for older people with depression and/or anxiety. This program was acceptable to the older participants, GPs and the Support Workers (Kingstone et al., 2019).

In considering how to implement depression care into in-home aged care, we can also gain insights from previous initiatives focused on care of older people with dementia within the home. Several groups have focused on this area, including dementia researchers at King's College London, including Dr Monica Leverton, Dr Olivia Luijnenburg and Dr Tiffeny James, Research Associates, and Dr Kritika Sami, Research Fellow at the National Institute of Health Research Policy Unit in Health and Social Care Workforce. This research group has strong knowledge about engaging with the home-care workforce to change their day-to-day practice. These researchers shared substantial experience implementing new dementia initiatives into in-home aged care during a Fellowship interview, which could be translated to depression care are summarised below. This included practical strategies to ensure that new care approaches become embedded into routine practices.

Figure 5. Fellow at King's College London

Learnings obtained from dementia initiatives within in-home care and mental health initiatives in other settings that may apply to the development of suitable approaches for a depression program that could be successfully implemented into in-home aged care are detailed below.

Consider the role of 'depression champions' within in-home aged care

Researchers at King's College London have successfully improved the management of in-home aged care clients with dementia through the creation of 'dementia champion' roles. This approach was designed to address the lack of opportunities for career progression in dementia specialisation in the UK. In this model, a small group of in-home aged care workers receive specialised training and become the 'experts' within their group. The aim is that these champions share their new knowledge with their colleagues and support them in caring for clients with dementia. This approach is likely to be more cost-effective than providing specialist training to the whole in-home aged care workforce. The researchers reported strong interest among care workers in the UK in taking on dementia champion roles and building their competencies. With a growing need for mental health care within the broader 'care economy', aged care workers may welcome an opportunity to become a 'depression champion' and develop specialised skills.

Aged care workers holding champion roles should be properly rewarded and recognised for their new skills. In the UK, aged care providers have expressed concern about the difficulty of retaining newly skilled dementia champions, who may leave for better paid and higher status roles in other organisations.

Consider the role of family carers in supporting older adults with depression

Several programs in the UK utilise family carers to support new initiatives. For example, researchers at King's College London shared an example of a program training family carers to deliver cognitive stimulation therapy to people with dementia at home. Another recent project in the UK successfully implemented a psychosocial intervention to support independence in dementia (NIDUS-family), which provided guidance to people living with dementia and their families in how to achieve their goals, using a manual and support from non-clinical facilitators (Cooper et al., 2024). It may be useful to explore whether a similar approach could be applied to the care of older people with depression, for example, supporting family carers of older people with depression to implement simple strategies to improve the older person's mood. However, engaging family members to support mental health initiatives may be more challenging. Mental health researchers at the University of York attempted to engage older peoples' family members (and other people who support them day-to-day) to support the older people in implementing new activities designed to improve their mood. However, the researchers found this difficult in practice, reporting that many older people did not want to ask others for help.

To help family members (and other carers) in supporting an older person to implement new psychological strategies into their daily lives, the team at Keele University recommended offering an additional package of support and resources. They noted that family carers commonly experience depression themselves, as well as anxiety and burnout, resulting from strained relationships and difficulty caring for the person with depression. While there is good awareness of the impact of caring for a person with dementia on family carers, society does not recognise the negative impact of caring for a person with depression – a group that often presents with complex problems and multiple long-term conditions, in addition to depressive symptoms.

How can we effectively train in-home aged care workers in new practices?

Training aged care workers in new skills in critical. The behaviour activation programs for depression run by the Institute of Mental Health Research at the University of York included 2-5 days of training, with competency assessments conducted.

Based on substantial experience training in-home aged care workers, researchers at King's College London noted that one of the key enablers to training uptake was support and encouragement from managers. If managers believe that mental health is important, they are more likely to ensure that their staff attend training sessions.

Staff should be paid to receive training during their regular working hours, to ensure engagement with the content. Keele University researchers stated

that training is not typically funded under aged care contracts between service providers and local authorities in the UK. The result is that in-home aged care workers commonly need to complete training in their own time. In interviews, these workers have explained that "… we want to do all this extra training, we want to have this knowledge of how to do this effectively, but we're not being paid for it … we're not treated like this is part of our job."

This suggests that if training in depression is non-mandatory, and staff are not paid to attend, update and engagement is likely to be low.

Several groups, including those at King's College London and the Institute of Mental Health Research University of York, used in-person training methods, but transitioned to online training during the COVID-19 pandemic. The NIDUS trial in the UK provided dementia training to home care workers via video calls, which was demonstrated to be acceptable and feasible to deliver in practice (Kelleher et al., 2022). Remote training has worked well in prior programs, reducing the need for staff to travel and increasing uptake in training. Remote training may also be easier to spread out over a period of time, allowing for consolidation of learnings and the potential to practise new skills in between sessions. However, recent Australian research providing dementia training to in-home aged care workers (the PITCH study) found that only in-person training was effective in improving workers' attitudes, knowledge, and confidence; on-line training was not effective (Dow et al., 2023). A review of published literature conducted by researchers at the Social Policy Unit at the University of York similarly found greater support for face-to-face learning over online approaches (Newbould, Samsi, & Wilberforce, 2022), but these papers pre-dated the pandemic and the results may not apply to the current context, where online training has become more common.

The researchers at King's College London shared examples of training resources that have proven successful in the UK. In-home aged care workers particularly welcome 'toolkits' – step-by-step guides or checklists that provide simple instructions in the new practices. Visual resources, such as illustrations, have been successfully employed in dementia training programs and could be modified for use in depression training. For example, a resource with illustrations depicting symptoms of depression could help aged care workers to understand how depression might present in their client group – for example, an older person refusing to eat or being reluctant to get out of bed, to supplement traditional images of someone looking sad. Researchers at the University of Nottingham developed a guide for in-home aged care workers, based on research on dementia care in the home, in the format of a graphic novel, with relatable scenarios ('Winston's World' by Tony Husband & Justine Schneider), to help care workers to think about the issues related to dementia and see examples of high-quality care.

Professor Orrell at Nottingham University shared his experience using case vignettes as way to train in-home aged care workers in depression. The researchers presented care workers with short descriptions of situations they could face when caring for a client with depression and asked them how they could deal with each situation. This provided an opportunity to assess the workers' skills and expertise, as well as provide training on new approaches, and was found to be highly effective.

Professor Orrell cautioned that care workers will have substantial experience, developed through their roles, which should be acknowledged by external trainers. Some care workers may hold negative views of 'experts' with little direct knowledge of the actual day-to-day experience of delivering care. He recommended that those designing new programs spend some time working in the carer role, to gain this 'real world' understanding and build their credibility.

What are the likely barriers to implementing depression care?

At the organisational level, Professor Orrell from the University of Nottingham noted the difficulty of engaging in-home aged care providers to take on new practices. The provider may be concerned about whether they have the appropriate governance processes in place to take on the new approach – a potential issue when considering depression

care, which has not previously been a focus of in-home aged care. Implementing industry-led initiatives – i.e., those designed by the aged care providers themselves – may be more effective than a university-led approach.

Given the high rate of suicidal ideation among the depressed older population, it is important for organisations to have structured approaches in place to assess the level of suicide risk and respond accordingly to any disclosure of suicide intent or behaviour. On-hand clinical support – whether internal or external to the aged care provider – is also required when implementing a mental health care initiative, to provide support to care staff and respond to more challenging cases.

A key barrier at the level of individual aged care worker is a concern about 'opening up Pandora's box' when asking older people about depression. This has been observed in several programs where non-specialists have been asked to detect older people at risk of depression, for example when members of a Fire and Rescue Service were asked to incorporate detection of mental ill-health during routine in-home visits conducted to identify members of the community at risk of a home fire. Researchers at Keele University noted that while these workers were open to this aspect being included in their role, they found asking questions about mental health challenging and required specific training.

This barrier may be addressed through the use of clear, structured approaches for the aged care workforce and training in how to have conversations with older people about their feelings and wellbeing. Researchers at King's College London recommended the use of visual resources for aged care workers, for example, using illustrations to depict older people with depression. These visual tools may be used instead of traditional screening tools for depression – which care workers may see as 'too clinical' and may not feel confident using – to help them have conversations with clients about their symptoms.

What are the key success factors for implementation of depression care?

Mental health needs to be part of the organisation's vision and strategy, with a clear commitment to changing practice. Interviewees noted that for depression care to be successfully implemented, it must be appropriately funded and prioritised, with clear roles around who provides which kinds of activities related to the care of an aged care client with depression (e.g., assessment, intervention, and support). Researchers at King's College London cautioned that the skills provided should be within the worker's scope of practice. For example, care workers are not expected to diagnose or treat depression in older people, but may be trained to recognise symptoms, have conversations about mood with older people, and escalate to others. During the initial stage of implementation, where possible, clinicians and workers should self-nominate for depression care, to ensure they are enthusiastic and motivated.

Depression care must be considered by the care workers and their managers as a core part of the workers' role, rather than additional tasks to be completed on top of routine duties. They require dedicated time (and funding) to take part in training programs and implement new tasks within existing roles, as well as clear support from their manager. If there are no benefits to busy workers engaging in the depression-related activities– whether financial or recognition by managers – they will likely prioritise their other 'essential' tasks. Problems were observed in UK-based studies where workers left their primary role and were no longer able to continue in the program, or where workers reported difficulty committing the time to the depression program.

Researchers at Kings College London recommended that strategies to support in-home aged care clients with depression should be included in the client care plan. This may facilitate the transition to depression care being considered a core part of aged care service delivery.

When introducing new initiatives, program developers should consider how to support staff in implementing new practice. The review conducted at the Social Policy Unit at the University of York also noted the importance of making information and guidance easy to access (Newbould et al., 2022). Well-designed resources may increase the confidence of in-home aged care workers in conducting new activities. This review also highlighted the importance of providing appropriate mentorship, as well as opportunities for trained staff to share their new learnings within the team.

When asked about how they would like to access informational resources that would be helpful to use in their day-to-day work, in-home aged care workers have expressed a preference for an app-based portal. This allows workers to access information on the road, for example, between clients, rather than having to wait until they have returned to their office or home.

How do we 'scale up' depression care across the in-home aged care sector?

King's College London researchers recommended that screening for depression be a mandatory part of the aged care assessment. This is easier to implement in Australia, where assessment forms are standardised, compared to the UK, where local authorities each use different processes. Unfortunately, older people with depression are often provided with antidepressant medication only and have limited access to effective psychological therapies (Thapaliya et al., 2024). International experts suggested that nonpharmacological options be made available as the first line treatment. In the UK, 'social prescribing' is growing in momentum – where the person's GP 'prescribes' social or other activities, rather than medication for people showing early signs of depression. This approach does not appear to have been widely adopted for older Australians.

Researchers at King's College London suggested a two-process to 'scale up' and embed depression care broadly across the in-home aged care sector. Gaining evidence around what works is a critical first step in reforming aged care service delivery. This includes research to demonstrate that models are efficacious and cost-effective for routine use, as well as implementation research, to understand how to effectively embed new programs. This kind of evidence is not yet available and requires urgent funding. Aged care research is chronically under-funded in Australia, with very few trials conducted in the in-home aged care setting.

The next step is to engage with policy makers and government, to advocate for change, based on the evidence. Translation of evidence into practice change at scale is often difficult and requires a clear plan. Keele University researchers recommended building relationships with policymakers with an interest in the area, for example through informal coffee invitations, noting that policymakers "trust a credible opinion-leader." These engagements can allow for new initiatives to be flagged and findings shared, and also help to understand government priorities and agendas. As noted by King's College London researchers, engagement with policymakers requires specific communication skills, for example preparing short briefs with clear takeaway messages and explicit recommendations. Visual communication methods are highly engaging and capture attention. These researchers suggested that many policymakers look for information on social media platforms, such as Twitter/X and LinkedIn – those seeking to implement change should connect with key stakeholders using these platforms and maintain a good online presence. Linking new initiatives to a particular national policy and ensuring that recommendations are included in the guidelines reviewed by policymakers (e.g., NICE Guidelines) were also recommended.

Research theme 4. Integration of aged care and healthcare

To meet the needs of aged care recipients with depression, aged care and healthcare services need to collaborate effectively. The Fellowship aimed to identify effective integrated care models and approaches to collaboration that may inform aged mental health care approaches for the Australian in-home aged care setting.

Integrated health and aged care in the UK

Efforts were made during the Fellowship to identify international programs where aged care and healthcare services had been successfully integrated, particularly to better manage the mental health of older people. Researchers at the Social Policy Unit at the University of York noted the difficulty of coordinating health and social care organisations. They reported a finding that "joint working between home care and healthcare services" was considered a top priority for home care recipients, family members, home care workers and providers, and policy leads (O'Rourke & Beresford, 2022). However, while there was consensus on the importance of integrated approaches to care by all interviewed as part of the Fellowship, few examples were identified, whether regarding mental health or other health-related conditions.

According to Simon Bottery at the King's Fund – an independent UK-based charity working to improve health and care – the promise of integrated care has not yet been realised, despite a considerable focus of policy makers over many years. Integrated care systems were established in England in July 2022, designed to encourage health and care organisations to work together to integrate services but outcomes have yet to be determined from this relatively new approach.

Researchers at King's College London suggested that mental health nurses and others with mental health expertise could be brought into in-home aged care. These researchers have explored the potential to work with 'Admiral Nurses' employed by a charity called Dementia UK who work across both the National Health Service (NHS) in the UK and within in-home aged care, many of whom have specialist training and clinical skills. They suggest that this under-utilised resource could help to "bridge the gap between health and social [aged] care." The UK also has 'Healthcare Assistants' and 'Support Workers' who are employed by the NHS to assist with tasks such as measuring blood pressure and administering medications to older people at home. This is another workforce that could potentially support mental health initiatives within in-home aged care, and facilitate the linkages between aged care and healthcare services. As described above, Support Workers have been successfully trained to implement psychological therapy for late-life depression.

Integrating mental health care in other healthcare settings

Mental health researchers at the University of York and Keele University have successfully integrated mental health care into non-specialist healthcare settings, most notably primary healthcare, where General Practitioners (GPs) refer patients with depression to the program. Of particular interest, Keele University established a depression treatment program in community pharmacies. In this project, pharmacy assistants were trained to identify older people who may benefit from therapy and recruit them into the program. However, in practice, few clients were recruited, and the researchers proposed that a program led by primary healthcare with linked pharmacies may be more successful in recruiting older people to take part in the program. Regardless of who leads the program, practitioners noted the importance of ensuring that depressed clients were able to access the care they needed and any gaps in care were addressed, for example encouraging the client to follow up with their GP around any physical health issues.

Within the UK, there is increasing interest in using non-traditional providers to support people's mental health. Simple informational resources on mental health are increasingly available for use by all levels of health and aged care professionals, including resources funded by the NHS. These resources

provide information on symptoms of depression and the kinds of treatments available. They may be particularly useful in 'signposting' – directing older people towards more information and treatment providers. The NHS initiative 'making every contact count' utilises the millions of day-to-day interactions that organisations and individuals have with older people to support them in making changes to their physical and mental health and wellbeing. This approach leverages conversations that are already taking place, to detect and escalate people who may benefit from mental health support.

How can we engage with General Practitioners in depression care for in-home aged care clients?

Programs addressing depression among in-home aged care recipients should ensure good communication with GPs and other health professionals and set up processes to collaborate effectively. To develop optimal processes for collaborative care approaches, researchers at Keele University and Nottingham University, with substantial experience implementing new initiatives into primary healthcare, noted the importance of developing strategies to engage with GPs through inclusion of a well-regarded GP in the project team. This adds credibility to the program and also provides an insight within the broader team on how GPs work. GPs are under substantial time pressures in the UK and are only paid for certain patient-related activities. Requests for GP input into the development of new programs should be fully funded to facilitate GP involvement.

Another suggestion to involve GPs in new initiatives was to offer them specialist training in mental health in return – a strategy used successfully to engage GPs in physical health projects. Key to this approach is to engage a well-regarded specialist in the field, who is available to answer any questions the GPs have about managing the mental health of their patients.

Integrated healthcare for healthy ageing - ICOPE

A meeting to discuss international standards for best practice in integrated care was held with leaders at the World Health Organisation (WHO) Ageing and Health Unit – Dr Matteo Cesari and Dr Yuka Sumi. This unit has developed a novel model called Integrated Care for Older People (ICOPE), which aims to help people maintain a high level of functional ability as they age – a healthy ageing approach. This model calls for screening to identify early markers of decline in older adults – loss of capacity in domains that are known to strongly predict mortality and care dependency – one of which is depression. Once loss of intrinsic capacity is identified, health providers conduct a comprehensive assessment of multiple domains and develop a tailored care plan to delay, slow or prevent the process of becoming frail or care dependent, including treatment of depressive symptoms.

Figure 6. World Health Organisation

Dr Cesari and Dr Yumi stressed the importance of considering depression within the person's broader context and multiple capacity domains, such as mobility loss, malnutrition, cognitive impairment, and sensory impairment, noting that there are strong links between these conditions and depression, and treatments may need to address multiple domains to ensure benefits.

WHO advocates for a whole-of-community approach, where healthcare providers collaborate in delivering a comprehensive care plan to support healthy ageing in place. It is based primarily within the primary care setting, but the unit notes the importance for healthcare providers to connect with the aged care sector, to ensure that the services required to address the older person's needs are activated as they age at home. The Ageing and Health Unit is currently exploring how the ICOPE model may be adapted for older people who currently receive aged care services – in terms of the screening, assessment and interventions that are recommended. There was discussion around the potential for in-home aged care providers to implement the ICOPE model, by screening and assessing older peoples' capacities and function, and potentially contributing to interventions to support healthy ageing. Further work is required to consider how aged care and healthcare could be effectively integrated to deliver care using this kind of model.

05

Personal, Professional, and Sectorial Impact

Personal impact

The Fellowship provided an opportunity for Dr Davison to engage with international leaders in aged care and mental health and build her international network. Over the past twenty years, Dr Davison has developed a strong national reputation as a research leader in aged mental health in Australia. However, with significant caring commitments throughout her career, she has had limited opportunities to travel internationally – a situation compounded by the COVID-19 pandemic in recent years. The Fellowship helped to establish Dr Davison's international profile in aged care and aged mental health. It enhanced her credibility in the international arena and allowed her dedicated time to engage in activities outside of her professional role.

Dr Davison has been employed in research-specific positions for most of her career but has a strong desire to develop skills and networks to enable her research to be disseminated outside of academia and translated into policy and practice. The prestigious nature of the Fellowship allowed her to focus on this goal and begin to build her reputation as an international expert in mental health in aged care and one of Australia's leaders in innovation. This should strengthen Dr Davison success in advocating for positive changes to improve the lives of older Australians.

During the Fellowship, Dr Davison was invited to present at the following events:

- Symposia at Keele University and the University of York, UK, September 2023.
- Keynote speaker at the Curiosity Partnership – Adult Social Care Research Festival in Hull, UK, September 2023.
- Member of a panel discussion on innovation in aged care, at Victorian Healthcare Week, Melbourne, October 2023.
- Invited to present her approach to depression care within in-home aged care as an innovative case study at the aged care stage at Victorian Healthcare Week, Melbourne, November 2024.

Figure 7. Curiosity Partnership – Adult Social Care Research Festival

Figure 8. Fellow presenting at the Curiosity Partnership – Adult Social Care Research Festival

Dr Davison was also offered several new opportunities during the Fellowship including:

- Editorial role on one of the leading international journals in the field Ageing and Mental Health, and an opportunity to write an article describing in-home aged care for this journal, with introductions to potential co-authors.
- Opportunity to author a book on a topic of her choice.

Since returning to Australia, Dr Davison has engaged in media training and actively promoted a previous program of research in the residential aged care sector. This led to several interviews on radio stations, including ABC Radio National Life Matters, ABC News Radio, and multiple regional ABC radio stations in March to April 2024, and published media articles on ABC online and The Conversation, which were picked up by multiple media outlets. Dr Davison will build on these experiences and her growing reputation to promote the learnings of the Fellowship broadly in the media.

06
Professional impact

Through the Fellowship, Dr Davison developed new connections with leading international experts, which are expected to continue to grow over time.

The following UK-based practitioners have sought out an opportunity to engage with Dr Davison in Australia as a result of the Fellowship:

- Professor David Ekers at the University of York, who is an internationally renowned expert in behavioural activation with older people is visiting Australia in late 2024. He offered to present at any suitable forum and also offered to train staff in Dr Davison's programs in the use of behavioural activation.
- Professor Yvonne Birks and Dr Martin Wilberforce – experts in home care from the Social Policy Unit at the University of York were inspired by Dr Davison's Fellowship activities and initiatives underway in Australia and announced a plan to visit Australia later in 2024.
- Dr Monica Leverton from King's College London – an expert in home care, particularly training staff in new initiatives – similarly applied for funding to visit Australia. Dr Davison supported her application and organised for support from other colleagues.

As a result of new connections made through the Fellowship, Dr Davison has engaged in several new collaborative projects. These include:

- Application for research funding led by Keele University to evaluate a program training non-specialists to detect depression and anxiety among older people and escalate for treatment.
- New project on the implementation of digital technologies in the in-home aged care setting. Following the travel, Dr Davison was connected to a research group at Amsterdam University Medical Centers, who agreed to collaborate in a new study to determine how to tailor technology-based interventions to meet the needs of in-home aged care recipients. This will have wide-ranging applications within the Australian aged care system.
- Dr Davison was invited to be an investigator on a new project led by Swinburne University of Technology that explores how to facilitate access to psychological services in the Australian aged care sector. This 5-year project received funding from the Ian Potter Foundation.

Several other collaborative projects have been discussed and are in various stages of development:

- New models of care for dementia care in the home. There is strong interest from King's College London and University of Nottingham researchers in collaborating in international research. Both groups have well established programs and a wealth of expertise to draw upon. This would enable the best practices from the UK to be applied in the Australian setting. Funding opportunities are being explored to support this work.
- A new program of work to develop approaches to support in-home aged care workers caring for older people with complex mental health issues (such as schizophrenia, drug and alcohol problems, and self-harm). This is a strong

identified need within Australia, with in-home aged care staff noting the difficulty of providing care to older people with complex needs and barriers to care, such as care refusal. Existing work by the Social Policy Unit at the University of York could inform new ways to train and support Australian care staff in managing clients with complex mental health issues. Dr Davison will submit research grant applications in partnership with leading international experts to support this work.

- WHO Ageing and Health Unit members expressed an interest in collaborating in a pilot of the ICOPE program in the home care setting. This would be a new area of work to support healthy ageing and potentially extend the role of aged care providers in preventative health.

These initial steps are in line with Dr Davison's goal to collaborate with knowledge leaders in significant international research, for example, determining the efficacy and cost-effectiveness of models of care for the aged care sector across different settings. A collaborative, international approach provides an ideal opportunity to learn from the best practices worldwide and implement within Australia, as well as to share the innovative work currently underway in Australia. In addition, these international collaborations will enhance Dr Davison's academic track record, and likely improve her success in applying for highly competitive funding opportunities.

Organisational impact

Dr Davison is Director of Research Discovery at Silverchain – a leading national home care provider in Australia. Silverchain has a strong interest in developing new approaches to support in-home aged care recipients with depression and expressed a commitment to implement Dr Davison's recommendations.

The collective learnings from the Fellowship informed the development of a new model of care to address depression, which is designed to be suitable for broad implementation across the in-home aged care sector. This model of care is called Enhancing the Management of home-Based Elders with Depression (EMBED) and includes training in depression for the aged care workforce, and access to psychological treatments for older people experiencing symptoms of depression (see Figure 1). The EMBED model of care was initially developed by Dr Davison at Silverchain using a co-design method with frontline staff, managers and consumer representatives. Dr Davison received funding to implement and evaluate this model of care.

The Fellowship provided the practical insights to refine this model of care, building on learnings from the international expertise. It helped to inform the development of the staff training program as well as the psychological treatment components provided to older people – drawing upon the positive findings from trials of behavioural activation to treat late-life depression in the UK. In the pilot, the psychological treatments are delivered by experienced mental health clinicians via telephone (telephone or video call), and aged care workers are asked to support and encourage their clients to implement the selected strategies into their day to day lives. An optional digital platform was also developed for older people to use, to engage with the program, building on the learnings from the Fellowship on how to implement technologies with older people.

In addition to refining the model of care, Fellowship interviews were also critical to consider how to most effectively implement the EMBED model of care, to ensure that in-home aged care staff and aged care recipients engaged optimally with the program materials.

Following the international travel, Dr Davison finalised all program materials and commenced a pilot of the EMBED model of care with a group of aged care recipients and their care workers in Victoria, to determine its feasibility and acceptability. At the time of writing, Dr Davison and her team have recruited 19 aged care recipients with depression into the program and are on track to meet their goal of 24 participants. Participants will each be tracked for 3 months and outcomes collected, including any changes in their level of depressive symptoms and their satisfaction with the treatment program. The staff training component will be separately evaluated, to determine if it increased the knowledge and self-

efficacy of aged care workers, and reduced stigma about mental health.

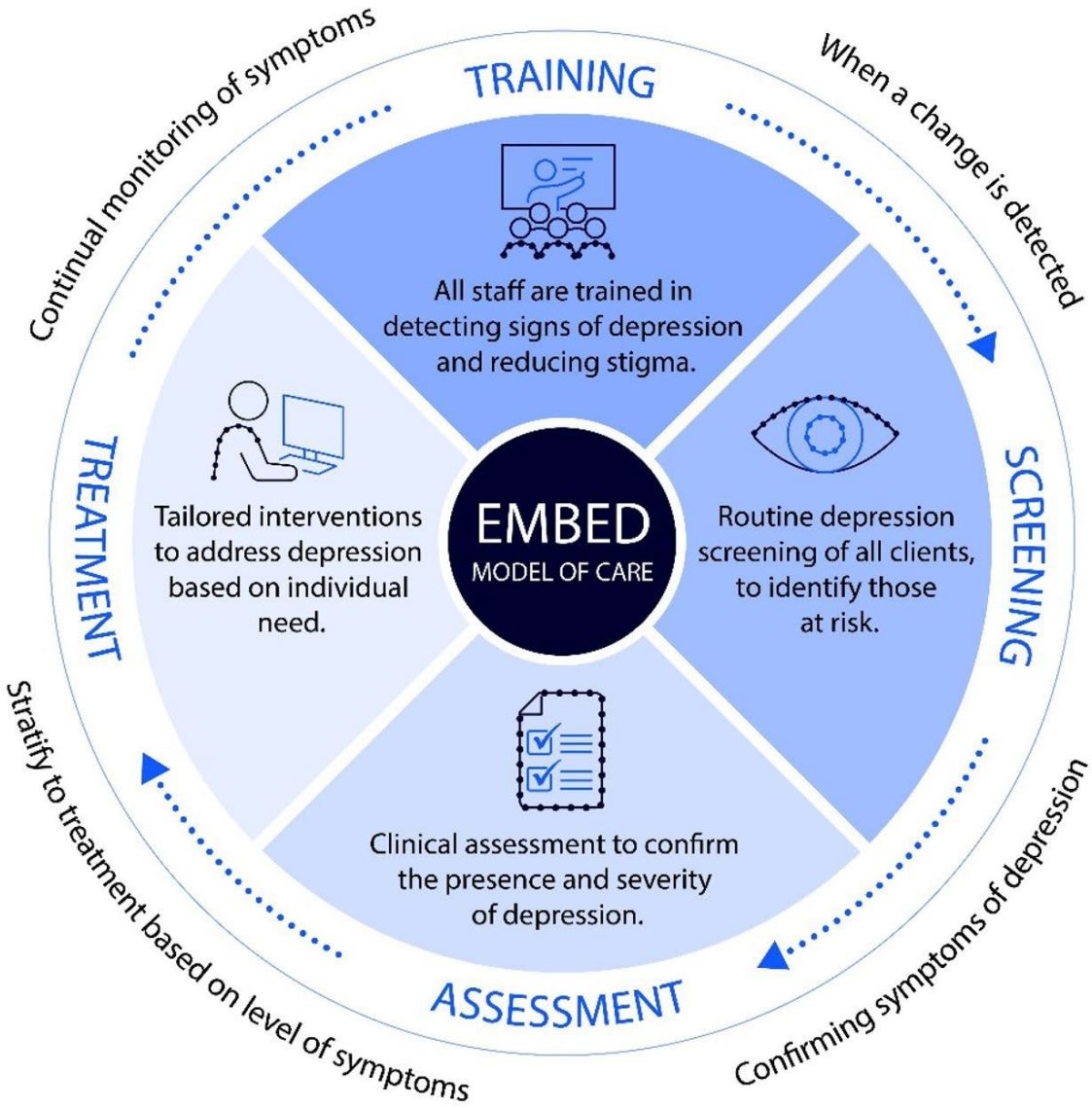

Figure 9. Enhancing the management of home-based elders with depression

Upon completion of the pilot, Dr Davison will make any changes required and implement the EMBED model of care in other Silverchain services, in Western Australian and South Australia, and evaluate its efficacy and cost-effectiveness in a large clinical trial. Silverchain has demonstrated strong commitment to implementing this new model of care widely across all its services, if effective.

Silverchain has actively promoted Dr Davison's work within the media and plans to use this work to advocate for alternative approaches to support older Australians with depression. This is in line with Silverchain's mission to create a better home care system for all Australians and consistent with its goal to be an industry leader in aged mental health.

Broader sector impact

Following the pilot (expected completion August 2024) and clinical trial (expected completion December 2025), Dr Davison aims to promote the EMBED model of care to broad implementation across the Australian aged care sector. It is hoped that the research will generate evidence that alternative approaches are feasible, acceptable, and effective in managing depression among older people who receive care in the home. Dr Davison will publish the findings of the research, including the effectiveness of EMBED in reducing symptoms of depression among in-home aged care recipients, and will leverage her network to actively disseminate the findings. Silverchain will assist in advocating for the model with government and aged care leaders.

While the research is ongoing, a shorter-term opportunity has been identified to translate the findings of the Fellowship within Australia. The Australian government is currently implementing major reforms in the aged care sector, including new legislation and Strengthened Aged Care Quality Standards. While still in draft form, the strengthened standards have a greater focus on mental health than existing standards. For example, aged care providers need to implement strategies for supporting workers to identify, monitor and manage high prevalence clinical care risks, including mental health. This includes actively promoting older peoples' mental health and wellbeing and responding to signs of deterioration in their mental health. Thus, aged care providers will be required to demonstrate they meet these strengthened quality standards around the care provided to older people with mental health conditions. The current context, where care providers across the country are considering how they will meet increased requirements, provides an ideal opportunity to share effective and feasible approaches to managing depression with aged care providers and policy makers.

Dr Davison is currently planning the following initiatives:

1. Develop a new mental health training program for the aged care workforce, developed specifically to assist aged care providers to meet their requirements under the Strengthened Aged Care Quality Standards. The EMBED training program can be easily adapted for this purpose. Dr Davison is exploring Silverchain's interest in supporting and promoting this initiative.
2. Author an opinion piece on the need to introduce mental health care within aged care service delivery. At the time of writing Dr Davison has drafted an article for submission to a high profile Australian medical journal.
3. Draft a report on the key learnings from the Fellowship specifically tailored for the Australian aged care sector. Findings and recommendations from this current report will be summarised and shared broadly. Dr Davison will develop a plan to disseminate the report broadly across the aged care sector, with assistance from Silverchain colleagues with expertise and connections with policy makers and from the Australian Aged and Community Care Providers Association. The dissemination plan will include media articles. Dr Davison will draw upon the expertise from the Silverchain media team, as well as personal contacts from her previous media releases at the ABC and The Conversation.
4. Investigate funding options. Dr Davison will explore the potential to provide psychological services to in-home aged care recipients with depression under existing aged care and health funding schemes. A range of treatment models will be considered, including (a) delivery by specialist mental health providers (embedded within or external to an aged care provider), and (b) training the existing aged care workforce to implement simple strategies, with clinical supervision and support.
5. Dr Davison has submitted an abstract to present at the 57th Australian Association of Gerontology conference in Hobart in November 2024. Her talk is titled 'Embedding psychological treatments for depression into in-home aged care' and is proposed for inclusion in a symposium on mental health in the in-home aged care sector.
6. Establish a forum in early 2025 with a panel of aged mental health specialists, aged care providers, policy makers, peak bodies,

consumers and carers, and researchers to review the learnings from the Fellowship, as well as evidence gained in applying the learnings in the local setting. In this forum, Dr Davison will aim to seek consensus on key directions and priorities for the aged care sector to address mental health in home care in Australia and how best to implement alternative models. At the time of writing, Dr Davison is exploring options to set up this forum, building on the success of previous initiatives.

07

Recommendations and Considerations

The following recommendations for the Australian aged care sector are provided, drawing on the findings of the Fellowship:

1. The current approach to managing late-life depression in Australia is not working; the aged care sector should play a larger role.

Up to half of older people who receive in-home aged care experience depression (Wang et al., 2016), with indications that rates are increasing (Inacio et al., 2021). This cohort is often reluctant to seek help, due to the stigma of mental illness, and symptoms often go undetected and untreated. Mental health specialists are difficult to access in Australia and few receive training in working with older people.

The aged care sector has a large existing workforce that could be leveraged to address the existing gaps in care. Aged care workers have strong relationships with older people, observe them in their homes, and so are ideally situated to identify signs of deterioration in their mental health and intervene early.

Older people's mental health needs have been largely ignored by aged care providers to date, with few providers routinely screening for depression or anxiety. However, this clinical care need has been recognised and will be addressed by the aged care sector through strengthened quality standards. A holistic approach – integrating care of mental and physical health conditions – would be highly beneficial for depressed older people experiencing multiple health conditions or frailty.

2. In-home aged care recipients should have access to psychological treatments, as well as antidepressant medications.

Less than 3% of Australians receiving a Home Care Package receive Medicare-funded specialist mental health services (Thapaliya et al., 2024). Instead, most older people with symptoms of depression are prescribed an antidepressant medication by their GP, often for many months or even years. Experts are concerned about the effectiveness of these medications with frail older people (Brown et al., 2022), and some experience side effects.

The poor access to psychological approaches by one of Australia's most vulnerable cohorts represents an equity issue that needs to be urgently addressed. The learnings from this Fellowship can be applied to encourage older people to engage in psychological therapy, for example, using appropriate language and ensuring therapies meet older people's personal goals.

3. Behavioural activation has good evidence to support its use with older people with comorbid medical conditions.

Several types of psychological therapies have proven effectiveness for depression in older people. Researchers in the UK have demonstrated that a brief approach called behavioural activation shows particular promise. It is highly acceptable to older people with complex clinical needs, and can be delivered by non-specialists in as few as 6-8 sessions. This therapy is suitable for those with subthreshold symptoms, to prevent escalation to clinically significant depression, as well as for those with more severe conditions.

Research is required in the Australian setting to determine how to effectively implement behavioural therapy with older people receiving in-home aged care. The EMBED trial currently being conducted by Dr Davison will determine if a brief form of behavioural therapy is effective when delivered by mental health clinicians embedded into aged care service delivery, plus a suite of purpose-designed self-help resources. Additional research is required to determine if the existing Australian aged care workforce (including allied health clinicians and nurses) can be trained to successfully implement behavioural activation with their clients and optimal models to support this approach in routine service delivery.

4. Digital technologies and telehealth may improve access to specialist mental health care for older people living at home.

Digital technologies offer an exciting opportunity to improve access and address workforce shortages but have been under-utilised by aged care service providers in Australia. There is good evidence to support the use of telehealth to deliver psychological therapies to older people and the assumption that older people don't use technologies should be challenged.

However, technology-based interventions need to be carefully designed to ensure they are accessible to older people and meet their needs and interests. When implementing new technologies, aged care providers should design a tailored training and support package, to ensure optimal uptake of the technology by older people. The role of in-home aged care workers in supporting their clients to use the technologies requires consideration.

5. The Australian aged care workforce should receive training in detecting symptoms and supporting older people with depression.

Few aged care workers receive any training in mental health, despite the high prevalence of conditions such as depression. They lack knowledge of signs and symptoms of depression and are not clear on how to effectively support clients experiencing symptoms. Workforce training in mental health is urgently required to enable aged care providers to meet the forthcoming strengthened quality standards.

Training in detecting signs of depression, conducting routine depression screening, and supporting clients at risk of or experiencing declines in their mental health to access appropriate health services is recommended. The aged care workforce is well situated to encourage their clients to engage in treatment plans, and may also be trained to deliver simple interventions, such as behavioural activation, with appropriate clinical support in place, drawing on learnings from similar programs in the UK.

This Fellowship identified several practical strategies to ensure that depression training programs are effective, such as the use of structured, step-by-step guides, visual resources and case vignettes. Training should address concerns commonly expressed by the aged care workforce in having conversations with older people about their mental health.

6. Initiatives to improve mental health care of older Australians require organisational support, commitment, and funding.

While gaps in the care of older Australians with mental health conditions have been recognised, more work needs to take place to determine how best to implement improved practices into the aged care system. Mental health care programs need to be designed specifically for the Australian aged care sector and align closely to existing roles and scope of practice of the workforce.

Mental health care should be included in all aged care providers' organisational strategy. Any change to existing approaches requires strong support from the executive leadership of aged care organisations, as well as 'middle managers', to ensure that training and new practices are prioritised and appropriately resourced, and are seen as 'core business'. Appropriate governance structures must be in place, with clear processes to respond to higher levels of risk, and ideally, access to clinical support and mentorship.

Providers require clear information on how activities related to mental health care are billed under existing aged care funding schemes. The current reforms being planned for in-home aged care provides an ideal opportunity to communicate this to providers, for example, in a similar way to existing allied health services or dementia services.

7. Integrated health and aged care models are long overdue.

In the UK, there are several examples of successful integration of late-life depression programs into non-specialist healthcare settings. This approach could be adopted in the Australian aged care setting, where health and aged care service providers collaborate effectively to meet older people's mental health needs using a holistic, integrated approach.

There is great interest in integrating health and aged care internationally, but an absence of effective models. The increased requirement for aged care providers in Australia to consider older people's mental health needs provides an ideal opportunity to explore how to effectively integrate health and aged services, considering appropriate funding, workforce roles, and processes. Australia could take the lead in this overdue work and provide an exemplar to share on the international stage.

08 Conclusion

There has been a major increase in the number of older Australians receiving aged care in the home who experience symptoms of depression. With the Royal Commission into Aged Care Quality and Safety concluding that “mental health conditions are not adequately identified or addressed in the aged care system” (2021, p.106), the current period of major reforms in the Australian aged care sector offers an ideal opportunity to improve the management of depression among those who receive care at home.

This Fellowship brings together insights from a range of other settings internationally to inform an alternative approach to mental health care, that can be embedded into the Australian aged care sector. A range of highly practical strategies from those with a wealth of experience in late-life depression and aged care have been collated. If implemented, these recommendations could help Australia to achieve a vision where older Australians have access to the highest quality care in the home, which meets their physical and mental health needs, and reduces the high rates of depression in this setting.

The potential benefits for Australia of more effective approaches to address depression are enormous. There is strong evidence that depression in older people is associated with a range of negative health outcomes, including increased risk of disability and mortality (Murphy et al., 2016; Agustini et al., 2022). Older people with depression have an increased rate of hospital admissions – including for non-psychiatric care – and require longer lengths of stay (Prina et al., 2015). In addition, older people with depression are at a higher risk of admission to a residential aged care facility (Viljanen et al., 2021). Embedding depression care into standard aged care services will ensure ageing Australians can remain in their own homes with optimal health.

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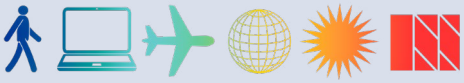

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