People who are 'socially disadvantaged' and the role of the aged care assessment team: a case example

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The role of Aged Care Assessment Teams

Aged Care Assessment Teams (ACAT) were developed as part of the aged care reforms that have been implemented in Australia over the last twenty years (Howe1997). Their role includes completion of comprehensive assessments, clarification of client needs, identification of care options to meet needs and assistance to access to services (CDH&AC 2000). They are described as having a coordinating role for clients with complex care or special needs (McCallum et al 1992, Gray 2001) and it is people with special needs, specifically those with social disadvantage, that are the focus of this paper.

People who are socially disadvantaged

People who are socially disadvantaged are included in the Aged Care Act 1997 as a special needs group (Office Legislative Drafting 2001 p 32). However, the Act lacks a definition of their characteristics and needs. The following definition is proposed. People who are socially disadvantaged are those who have an inability to relate effectively and appropriately with others, who lack an informal support network, who have a tendency for self-isolation and who display challenging behaviours. They are described as having a long-standing history of social estrangement including estrangement from family and friends and they have limited social and informal supports. Social estrangement relates to the person's social and interpersonal skills where they can be belligerent, uncompromising, unrelenting, contentious and unappreciative. Challenging behaviours can include intrusiveness, verbal and physical hostility. The characteristics described here limit a person's ability to access, or maintain access to, services.

A case example of ACAT intervention for people who are socially disadvantaged

The role that ACATs would assume to assist clients who are socially disadvantaged is best illustrated by a case example of an actual client of the Gold Coast Aged Care Assessment Team (GCACAT). The client described is a 79 year old male whose medical diagnoses include congestive cardiac failure, chronic renal failure, non-insulin dependent diabetes, low vision, obesity and a personality disorder with paranoid features. He is alert and orientated with an intact memory. His Mini-Mental State Examination is 29/30. He does have limited education. He is known to Integrated Mental Health Services but declines any ongoing support services. He has had previous assistance from occupational therapy, physiotherapy and podiatry. He has no informal support network as he has no contact with family and has no close friends. He moves house often and does not have

positive relationships with his neighbours. He does not participate in church or community activities. Functionally, he requires assistance with both personal and instrumental activities of daily living.

This client has been assessed twelve times by GCACAT and his original assessment, in 1995, approved him for hostel level care and a community aged care package (CCP). His most recent assessment, in 2002, indicates the need for nursing home level care. Between 1995 and 2002, he has lived in six hostels. He has lived in his own homes in the community with the support of Home and Community Care (HACC) services and he has had a CCP. The problems that relate to service provision for this client include his inability to relate appropriately to other hostel residents and staff, self-isolation, hostile demeanor, challenging behaviours, poor personal hygiene and refusal to accept care. His challenging behaviours include verbal aggression, intrusiveness, noisiness and being physically threatening. He has insight into these behaviours.

It is believed that the difficulties in sustaining services for this client occurred as a result of a lack of recognition of his special needs which should have been incorporated into care planning. This lack of recognition meant that the GCACAT has had difficulty assisting the client to access and maintain access to services and so satisfactory assessment outcomes have been short lived. When the client recently re-referred himself for another CCP approval, a different approach was taken to facilitate the client's access to services. At the time of the referral the client was receiving HACC services (six hours per week through two agencies) for showering, shopping, housework and meal preparation. The client was requesting further hours of care for socialisation and transport and was unable to receive these from existing services. Based on his care needs he was deemed by the GCACAT to be eligible for a CCP. However, the question was 'would any CCP provider be willing to take on the care of this client?' To facilitate a resolution for the client, a home visit and case meeting was arranged by the GCACAT with the client, the HACC Coordinator, current HACC service providers and all the CCP providers in his geographical location. The outcome of the case conference determined that the CCP could not improve on existing services and that no provider was willing to accept the client into their program. The HACC Coordinator was able to offer brokered funds through a Community Options Program to support the existing HACC agencies to provide daily services. This increased care by two hours per week. The client expressed satisfaction with this outcome initially and on review after three months. At a follow-up review after six months, the service providers reported that the level of service had been maintained and that the client remained satisfied with the outcome.

Issues and challenges for ACATs and community service providers

The outcome described for this client seems elementary, however, prior to this intervention the client had never expressed satisfaction with his services. The challenges in this case were to develop a care plan that would meet the client's needs and ensure his satisfaction with the services. It was essential that the care plan be sustained over time as well as meet service provider (funding) guidelines. The successful outcome achieved here was underpinned by a comprehensive assessment, which enabled the client to articulate his needs, and an excellent knowledge of the client and his previous care plans. The approach was open and incorporated a high degree of communication between service providers, and among the service providers and the client. There was also a commitment from service providers to work together to formulate an acceptable care plan for both the client and their agency.

The client's stated needs were that he wished to retain existing services and service providers while increasing the level and frequency of care. It was essential that the service providers be acceptable to the client and that he felt that he could communicate and negotiate with them regarding the levels and type of service and changes to care plans. In turn, the service providers needed to be flexible and willing to meet his changing needs while managing his often unrealistic expectations and demands. He needed to have a regular routine of services, funded on an ongoing basis, with understood service limits. Interim care options were not suitable. Services were required to manage challenging behaviours with limits placed on unacceptable behaviours. It was necessary for behaviour management strategies to be implemented and this required coordination among all staff and their agencies. Action and care planning incorporated the client's need to be fully informed of the assessment process.

This was achieved through the provision of written documentation of all meetings, phone calls, care plans, decisions, procedures and processes.

The issues highlighted by this case are that clients with special needs can alienate themselves from service providers and so limit their access to care. Service providers may lack flexibility in their funding guidelines and eligibility criteria and services can be limited by these restrictions. Clients may need to access a combination of services that are normally mutually exclusive such as HACC services and CCPs. It is also acknowledged that not all health regions have access to brokerage services to allow greater flexibility with service provision and so alternate forms of assistance would have to be devised. Clients may be eligible for services that are not available in their Health Districts. In this case example, the client would have benefited from an Extended Care at Home (EACH) package (nursing home level of care at home) but this was not yet available in his geographical location.

In spite of these issues, a successful outcome has been achieved for the client for now, although it is acknowledged that, as needs change, the GCACAT will be requested to complete further assessments. Further challenges will arise as the client's care needs increase.

Conclusion

This paper describes the primary role that Aged Care Assessment Teams (ACATs) have in assessing needs and assisting clients to receive the services that they require. It focuses on people with special needs, specifically, those described here as socially disadvantaged. This paper proposes a definition of people who are socially disadvantaged. People who are socially disadvantaged provide a challenge for ACATs in ensuring access to and maintenance of services. Due to the person's inability to relate to others, residential care options are not always appropriate and so appropriately provided community care becomes essential. This paper advocates for formal identification of client's special needs and argues for individually devised, flexible program targeted to their needs. With recognition of a client's special needs, ACATs can be confident in their efforts to assist older people who are socially disadvantaged to access the care they need.

References

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