ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

DIVERSITY IN AGED CARE

SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

INTRODUCTION

1. This submission concerns diversity in aged care.

2. This submission is provided in response to the matters the Royal Commission will inquire into at the public hearings to be held in Melbourne between Monday 7 October 2019 and Friday 11 October 2019.

3. The Royal Commission will explore how an aged care system can be designed to meet the needs of all people, including those from diverse backgrounds such as:

   - People with culturally and linguistically diverse (CALD) backgrounds.
   - People who identify as being lesbian, gay, bisexual, transgender, or intersex (LGBTI).
   - Care leavers, being people who spent time in care as a child, including institutional and out of home care arrangements.
   - Aboriginal and/or Torres Strait Islander People (with a particular focus on people living in urban areas).
   - People who are homeless or at risk of becoming homeless.
   - Veterans.

4. This submission focuses on the above groups of people from the perspective of Australian Nursing and Midwifery Federation (ANMF) members' delivery and/or involvement in care.

THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION (ANMF)

5. The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 275,000 nurses, midwives, and care workers across the country.[1]

6. Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of

[1] Care workers can be referred to by a variety of titles, including but not limited to 'assistant in nursing', 'personal care worker' and 'aged care worker'. In Australia, these staff are unregulated in contrast to registered nurses and enrolled nurses. For the purposes of this submission, workers who provide assistance in nursing care within RACFs are referred to as care workers.

these settings, fulfil their professional goals, and achieve a healthy work/life balance.

7. Our strong and growing membership and integrated role as both a trade union and professional organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

8. Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

9. The ANMF represents almost 40,000 nurses and care workers working in the aged care sector, across both residential and home and community care settings.

10. The ANMF's position is that all people should have access to and experience safe, appropriate, best practice care regardless of their location, health conditions, personal circumstances, and background. When accessing aged care services, people must be carefully assessed in terms of their needs and preferences for care and services to ensure that they are cared for by a safe, effective, and appropriate skills mix of staff.

11. Nurses and care workers are central to the provision of care encompassing all aspects of health care as well as in providing clinical and functional assessments and assistance and support with activities of daily living. This includes health promotion, prevention of illness and injury, care of the ill, disabled and dying. Care should be evidence-based, person-centred, and holistic in addressing physical, mental, social, and emotional wellbeing and should also be delivered in a manner that is appropriate and consistent with the individual preferences, values, and beliefs of each person.

12. As with the wider Australian community and the nursing, midwifery, and carer workforce the ANMF membership is itself diverse, with members from a range of social, cultural, and language backgrounds, age groups, and gender and sexual identities. The ANMF values and celebrates Australia's and its own diversity which is enshrined in our organisational value of Fairness, Unity, and Inclusion:[2]

    - Fairness: "*We treat all people in an equal manner, regardless of their gender, ethnicity, religion, political or sexual orientation, and in a way that is free from self-interest, prejudice or favouritism. We are committed to eliminating discrimination, harassment, intimidation, and violence.*"
    - Unity: *"We work collectively and collaboratively to achieve the bet results of our members and our communities and to strengthen internal, national, and international solidarity."*

[2] Australian Nursing and Midwifery Federation (ANMF). 2018. ANMF Strategic Plan 2018-2023 [Internet]. Australian Nursing and Midwifery Federation. Melbourne, Victoria. Available at: https://anmf.org.au/pages/strategic-plan

- Inclusion: *"We recognise all individuals and provide equal access and opportunity for all to take part in our activities. We contribute to improving the ability, opportunity and dignity of those who are disadvantaged because of their identity to participate in our community."*

13. The ANMF is pleased to observe that the recently proposed Australian National Aged Care Classification (AN-ACC) model has built-in consideration of the need for additional funding for certain diverse population groups, including people experiencing homelessness, residents in regional and remote areas, and to a small extent culturally and linguistically diverse people, but highlights the need to ensure that this additional funding is sufficient for the particular needs of these groups.[3] Along this line, the proposed annual costing study to inform price will be vital and must be conducted independently and transparently to ensure that the pricing is sufficient to cover the real costs of resident care – both for mainstream and diverse residents.

14. It is the ANMF's view that along with the range of actions and improvements that are urgently necessary to address the systemic issues with Australia's aged care sector, appropriate, safe, quality care for any person will not be feasibly achieved or sustained without the gradual introduction of mandated minimum safe staffing levels and skills mix. Funding that is transparently directed towards care, diverse skills, resources, training, and capabilities are required to care for everyone in aged care, but without the minimum numbers of the right kind of staff, that care cannot be delivered effectively or appropriately.

DIVERSITY IN AGED CARE

15. The *Aged Care Act 1997* defines ten groups of 'people with special needs' for whom there should be additional consideration in the planning and delivery of aged care services.[4] These groups include:

    - people from Aboriginal and Torres Strait Islander communities;
    - people from culturally and linguistically diverse backgrounds;[5]
    - people who live in rural or remote areas;
    - people who are financially or socially disadvantaged;
    - veterans;
    - people who are homeless or at risk of becoming homeless;
    - care-leavers;
    - parents separated from their children by forced adoption or removal;
    - lesbian, gay, bisexual, transgender and intersex people;

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[3] University of Wollongong. 2019. Resource Utilisation and Classification Study – RUCS Overview and Reports [Internet]. Australian Government Department of Health. Available online: https://agedcare.health.gov.au/reform/resource-utilisation-and-classification-study-rucs-overview-and-reports

[4] Australian Government. Aged Care Act 1997. No. 112. Section 11.3. Federal Register of Legislation. Available online: https://www.legislation.gov.au/Details/C2017C00047

[5] According to the *Aged Care Act 1997*, people from CALD backgrounds are defined as those born overseas from countries other than the United Kingdom, Ireland, New Zealand, Canada, South Africa, and the United States of America.

- people of a kind (if any) specified in the Allocation Principles.

16. One important initial point is that an individual person, their family members, and/or loved ones may belong to more than one category of diversity. This increases the importance of ensuring that each person receives individualised person-centred care that is sensitive to their unique preferences and needs. This level of care cannot be assured when there is an insufficient number and skills mix of staff.

17. Person-centred care is vital to the provision of safe, appropriate, quality aged care to people with diverse backgrounds, identities, and/or life experiences. Nurses' responsibilities regarding person-centred care and the related practices of shared decision-making and informed consent are clearly described in the Nursing and Midwifery Board of Australia's (NMBA) Code of Conduct for Nurses.[6] As the ANMF have submitted to a previous hearing that partly focussed on person-centred care,[7] person-centred care is about focussing care on the needs of the individual person as opposed to the needs of the service. At the core of person-centred care is the aim of enabling individuals to be equal partners with staff in the planning of their care and to always feel that their opinions and preferences are listened to and important.

18. Person-centred care is integral to the delivery of good practice aged care and is the responsibility of all staff and organisations. Here, we further emphasise that person-centred care is also about moving away from overly generalised assumptions regarding people's needs and preferences. Indeed, as detailed by the NMBA's Code of Conduct for Nurses in relation to culturally safe and respectful practice;

> *"Nurses engage with people as individuals in a culturally safe and respectful way, foster open, honest and compassionate professional relationships, and adhere to their obligations about privacy and confidentiality."*

19. Person-centred care acknowledges that each individual has their own unique and often changing needs, preferences, priorities, beliefs, and views of how they would like (or not like) to be cared for.[8] While people from different groups may have different preferences and needs regarding care, experiences, and services relevant to aged care, an individual person's unique needs and preferences must be recognised as being their own and not necessarily consistent or dependent upon their belonging or connection to a particular group or background. Here is where the concept of holistic, person-centred care is important, as beyond any association with a social, cultural, linguistic, or experiential background or identity, a person's preferences and needs regarding their care may be unique and individual and may contradict or concur with those which might be understood to be commonly linked

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[6] Nursing and Midwifery Board of Australia (NMBA). Code of Conduct for Nurses [Internet]. Nursing and Midwifery Board of Australia. Available online: https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

[7] ANM.0004.0001.0003.

[8] McCormack, B., and McCane, T. (Eds). 2016. Person-centred practice in nursing and health care: Theory and Practice. John Wiley and Sons. Chichester, West Sussex.

with their background or identity. For example, an individual male from a cultural background where it is not considered appropriate for a woman to engage in particular intimate discussions or activities required in the provision of personal or health care in a residential aged care facility (RACF) may not personally subscribe to that particular cultural convention and may themselves personally prefer to engage in care with a female health care professional as opposed to a man. It is the health care providers' responsibility to ensure that these unique, individual preferences for care are known and acted upon to the best of their ability.

20. The ANMF and its members acknowledge, respect, and uphold in their behaviour and practice the universal right that people have to receive safe, appropriate, quality care regardless of identity, background, belief, or life experience whilst ensuring a safe environment for workers and consumers.[9]

21. In Australia, the NMBA requires all nurses to practice and behave in line with the International Council of Nurses' Code of Ethics for Nurses.[10] The Code is broadly concerned with the nurse's fundamental responsibility to promote and restore health, prevent illness, and alleviate suffering while respecting considerations of age, colour, creed, culture, disability or illness, gender, sexual orientation, nationality, politics, race or social status.[11]

22. Consistent with the first element of the Code, the ANMF and its members promote an environment – in this instance, the Australian aged care sector - within which the human rights, values, customs, and spiritual beliefs of the individual, family, and community are respected. The Code enshrines the requirement upon nurses to ensure that individuals receive information in a culturally appropriate manner and to support action that meets the health and social needs of all members of society, and particularly those of diverse and vulnerable groups.[12]

23. A challenge within the Australian aged care sector that faces many members of our diverse community is accessing information, resources and services that are appropriate, understandable, and sensitive to peoples' backgrounds, identities, and personal circumstances. The ANMF is aware of and supports the Australian Government's Aged Care Diversity Framework as well as the series of Action Plans developed for providers, consumers, and government stakeholders to address challenges faced by Aboriginal and Torres Strait Islander people, people from CALD backgrounds, and lesbian, gay, bisexual, transgender and intersex people.[13,14]

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[9] Ibid. [2]

[10] International Council of Nurses (ICN). 2012. The ICN Code of Ethics for Nurses (Revised 2012). Geneva. Available online: https://www.icn.ch/sites/default/files/inline-files/2012_ICN_Codeofethicsfornurses_%20eng.pdf

[11] Ibid.

[12] Ibid.

[13] Australian Government Department of Health - Aged Care Diversity Sub-group. 2017. Aged Care Diversity Framework [Internet]. Australian Government Department of Health. Available online: https://agedcare.health.gov.au/support-services/people-from-diverse-backgrounds/aged-care-diversity-framework

[14] Australian Government Department of Health - Aged Care Diversity Sub-group. 2017. Aged Care Diversity Framework action plans [Internet]. Australian Government Department of Health. Available online:

Beyond this Framework and the Action Plans, however, more needs to be done to ensure that the Aged Care sector, which is systematically failing many people – diverse and 'mainstream', including both consumers and its own workforce – is supported and equipped to provide safe, appropriate, quality, best-practice care to all people.

PEOPLE WITH CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

24. People from CALD communities may have different needs and preferences relevant to care and services provided in the context of aged care.

25. Australia is home to people from a great variety of cultural and linguistic backgrounds. One in four people living in Australia were born overseas, almost half has at least one parent born abroad, and nearly a quarter of people speak a language other than English at home.[15]

26. There have been significant changes in the profile of languages other than English spoken at home as immigration patterns have changed; Mandarin is the most common language spoken at home (1.6% of people) followed by Italian (1.5%), Arabic (1.4%), Cantonese (1.3%), Greek (1.2%), and Vietnamese (1.1%).[16]

27. As people from CALD backgrounds grow older (37% of people aged 65 or older were born overseas), they are accessing aged care services in greater numbers; approximately one-third of people using aged care in Australia were born overseas.

28. People from CALD backgrounds may have varying levels of ability and confidence speaking, reading, and understanding spoken English and English language abilities may be further impacted upon by advancing age, dementia, and declines in hearing and vision. One of the most fundamental challenges faced by people from CALD backgrounds in relation to the aged care sector is accessing relevant, understandable information as well as in effectively communicating with and understanding others who cannot speak the same language. This challenge may appear in the form of older CALD people and their families having difficulty understanding written and spoken information as well as in the form of staff with CALD backgrounds having difficulty being understood by English speaking older people, families, and other staff.

CULTURALLY AND LINGUISTICALLY DIVERSE PEOPLE IN AGED CARE

29. The Productivity Commissions' annual Report on Government Services 2019 reports that people from CALD backgrounds are over-represented among population groups

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https://agedcare.health.gov.au/support-services/people-from-diverse-backgrounds/aged-care-diversity-framework-action-plans

[15] Australian Bureau of Statistics. 4102.0 – Australian Social Trends (April 2013). Available online: https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features30April+2013

[16] Ibid.

accessing both low- and high-level home care packages but are under-represented in all other service types including residential aged care.[17]

30. Older CALD people may have a history of negative experiences with the healthcare sector and other mainstream services in Australia or abroad, and may also have a personal social, health and wellness history that is different from many older non-CALD people. Some older CALD people may not have had extensive experience with mainstream services in Australia due to having relocated to Australia late in life or having lived within their own sociocultural community within Australia for some time. People from CALD backgrounds in aged care can face many challenges including, but not limited to:

    - Accessing aged care services.
    - Availability of understandable resources and information.
    - Understanding English-language or inadequately translated/interpreted resources and information.
    - Using technology (e.g. online-, telephone-based services).
    - Preference for face-to-face communication.
    - Lack of trust in mainstream services including health, aged care, mental health, and social services.
    - Cultural/social expectations regarding the role of elders and/or caring for elders.
    - Cultural beliefs/customs regarding health and illness, including disease, physical conditions, mental health, sexual health, palliation, and death and dying.
    - Social isolation within and outside residential aged care where other members of the same CALD community are rare or not present.
    - English language ability (which can also decline due to dementia).
    - Spiritual or religious care.
    - Food, nutrition, and food customs.

31. Despite these challenges and the importance of promoting the need to improve cultural awareness and understanding, as well as cross-cultural care and access to high-quality education resources for appropriate care for CALD people,[18] a recent Australian study found that many staff are already sympathetic and sensitive to cross-cultural issues, and that CALD staff themselves add value to the workforce and are often supported organisations.[19]

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[17] Australian Productivity Commission. 2019. Report on Government Services 2019: part f, chapter 14, aged care services report and attachment tables [Internet]. Productivity Commission. Available online: https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2019/January/Report-on-Government-Services-2019-part-f,-chapte

[18] Xiao LD. et al. 2018. Improving socially constructed cross-cultural communication in aged care homes: A critical perspective [Internet]. *Nursing Inquiry*. 21(1):e12208. Available online: https://doi-org.access.library.unisa.edu.au/10.1111/nin.12208

[19] Gillham D, et al. 2018. Using research evidence to inform staff learning needs in cross-cultural communication in aged care homes [Internet]. *Nurse Education Today*. 63:18-23. Available online: https://doi-org.access.library.unisa.edu.au/10.1016/j.nedt.2018.01.007

32. To support appropriate, safe, and effective care for CALD people in aged care, workforce interventions are required along with clear policies, criteria, and procedures in cross-cultural communication and provide ongoing education and training for staff to improve their cross-cultural communication skills and abilities.[20]

33. Residential aged care facilities and services that focus specifically on providing care to members of specific CALD groups can be an effective approach for supporting appropriate care for members of particular diverse communities.

34. Cultural safety training is a valuable and effective way for staff in aged care to begin to gain and to improve their skills and knowledge in the delivery of safe, appropriate person-centred care for older CALD people and in communicating to other people from CALD backgrounds. Every staff member in aged care including management and non-direct care staff should be provided with opportunities to undertake high quality cultural safety training and to improve their skills and knowledge through additional training opportunities throughout their careers.

35. A greater number and diversity of quality resources, policies, and evidence-based interventions such as cultural awareness and safety training are required to underpin the effective, safe provision of aged care services to people from CALD backgrounds. Having an aged care workforce which is itself characterised by cultural and linguistic diversity is one way that can help to ensure that older people from CALD backgrounds receive appropriate care.

THE CULTURALLY AND LINGUISTICALLY DIVERSE AGED CARE WORKFORCE

36. In 2016, the Aged Care Workforce Survey reported that almost a third of the residential aged care workforce were born overseas, 40% of recent hires in residential aged care were migrant workers, and that 23% of Pay As You Go (PAYG) home care and home support direct workforce were born overseas.[21] The majority of residential aged care workers appear to be from Indian or Filipino backgrounds.

37. The increasing number of overseas-born staff in aged care should be seen as a valuable asset, however as Goel and Penman have highlighted,[22] the employment positions these workers fill have repeatedly been labelled as low-paying and low-status. It is important that overseas-born workers are not exploited by aged care providers, such as by enforcing individual flexibility arrangements, and are not subject to unlawful workplace discrimination.

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[20] Ibid. [14]

[21] National Institute of Labour Studies, Flinders University. 2016. National Aged Care Workforce Census and Survey – The Aged Care Workforce, 2016 [Internet]. Department of Health. Available online: https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2017/March/The-aged-care-workforce,-2016

[22] Goel K, Penman J. Employment experiences of immigrant workers in aged care in regional South Australia. *Rural and Remote Health*. 15(1):2693.

38. The negative experiences faced by overseas-born aged care workers mirrors those of the broader aged care workforces,[23] and included constraints with time, workload, staffing, and poor peer relations. Discriminatory practices and lack of a strong support structure were also causes of dissatisfaction.[24] Workplace reforms are necessary to ensure that overseas-born and CALD staff are effectively and appropriately supported in the aged care sector.

39. The ANMF is supportive of and values Australia's CALD health and aged care workforce and considers cultural and linguistic diversity to be a strength. Indeed, a health and aged care workforce that closely corresponds in terms of its degree and nature of diversity to the general population profile is an asset and one way of enabling appropriate, effective, and culturally safe care. Internationally-born aged care staff are valuable resources in RACFs and they require organisational support and understanding including cultural awareness from the management, English language support, a sense of family, and appropriate job responsibility. Aged care policy makers and service providers should understand the range of individual staffs' positive and negative perceptions, and their employment intentions within the context of their roles and their cultural backgrounds.[25]

40. Almost 40% of participants in the survey reported that they spoke a language other than English at work.[26] This rose from 31% of participants in the 2011 workforce survey and indicates the increasing number of CALD people in the aged care workforce. The survey found that most participants reported that they were most fluent in English or reported being equally fluent in both English and a language other than English. Residential aged care facilities reported that employing care workers from CALD backgrounds was beneficial in terms of enhancing cross-cultural understandings and language other than English skills, enabling offerings of different cultural activities, linking residents to ethnic communities, and linking facilities to ethnic communities.

41. Based upon the results of the National Institute of Labour Studies' 2016 survey, most aged care staff from CALD backgrounds do not report difficulties with speaking, reading, or writing English and the benefits of employing workers from CALD backgrounds are recognised by providers.[27] It is important however that all aged care staff are able to effectively communicate with everyone they care for, their families or loved ones, and other staff and managers. Residential aged care provider survey participants noted that the most common difficulty regarding providing and managing care services at facilities with CALD care workers was with

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[23] Australian Nursing and Midwifery Federation (ANMF). 2019. ANMF National Aged Care Survey 2019 - Final Report [Internet]. Australian Nursing and Midwifery Federation (Federal Office), Melbourne, Victoria. Available online: http://anmf.org.au/documents/reports/ANMF_Aged_Care_Survey_Report_2019.pdf

[24] Ibid. [22]

[25] Gao F, Tilse C, Wilson J, Tuckett A, Newcombe P. 2015. Perceptions and employment intentions among aged care nurses and nursing assistants from diverse cultural backgrounds: A qualitative interview study [Internet]. *Journal of Aging Studies.* 35(Dec):111-122. Available online: https://doi-org.access.library.unisa.edu.au/10.1016/j.jaging.2015.08.006

[26] Ibid. [21]

[27] Ibid. [21]

communication – either between staff and residents, staff and families, and staff and management/other staff.[28]

42. The ANMF's National Aged Care Survey 2019 also revealed challenges with communication involving CALD staff – particularly care workers - who spoke languages other than English and highlighted how difficulties speaking and/or understanding English could result in perceived or actual problems in the provision of safe, quality care.[29]

43. The self-reported fluency in English among aged care staff in the 2016 workforce survey was most similar between registered nurses and care workers with close to 32% of participants in both groups reporting that they spoke English most fluently and close to 50% reporting that they spoke both English and a language other than English equally well.[30]

44. The NMBA has a specific registration standard for the English language skills for all nurses applying for initial registration for both enrolled and registered nurses.[31] Similar standards do not currently apply to care workers in aged care who are unregulated, and while many care workers appear to be fluent or proficient in English language communication, because a specific requirement/standard does not exist, some may be disadvantaged in the provision of safe, appropriate, quality care by language and communication difficulties. Indeed, as highlighted in the Final Report of the Council of Australian Governments (COAG) Health Council - A National Code of Conduct for Health Care Workers, low levels of English language literacy and skills may create barriers to awareness and comprehension of the National Code.[32]

45. As well as the NMBA's registration standards, the NMBA's Code of Conduct for Nurses further explicates the individual nurse's responsibilities regarding effective communication.[33] Nurses must be aware of and act upon differences in health literacy between individuals and also must wherever possible meet the specific language, cultural, and communication needs of people and their families by making arrangements for translation and or interpreting services. Nurses must endeavour to confirm that a person understands any information communicated to them and must also clearly and accurately communicate clear, relevant information in a timely manner about the person to colleagues within the bounds of relevant privacy requirements. While these details do not explicitly refer to the importance of ensuring appropriate levels of language proficiency (English or otherwise), it is

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[28] Ibid. [21]
[29] Ibid. [23]
[30] Ibid. [21]
[31] Nursing and Midwifery Board of Australia (NMBA). 2019. English Language Skills – Registration Standard [Internet]. Nursing and Midwifery Board of Australia. Available online: https://www.nursingmidwiferyboard.gov.au/Registration-Standards/English-language-skills.aspx
[32] Council of Australian Governments (COAG) Health Council. 2014. Final Report - A National Code of Conduct for Health Care Workers [Internet]. Victorian Department of Health on behalf of the Australian Ministers' Advisory Council. Available online: http://www.coaghealthcouncil.gov.au/NationalCodeOfConductForHealthCareWorkers/ArtMID/529/ArticleID/40/A-National-Code-of-Conduct-for-health-care-workers
[33] Ibid. [10]

clearly implied that if communication is impeded (through for example, lack of sufficient ability to communicate either in English when required or in a language other than English – i.e. to a person who is not themselves proficient in English) difficulties in meeting the requirements of the Code, and therefore the professional standards required to practice as a nurse may be present.

46. If a nurse is found to have acted in breach of the NMBAs professional standards, then there are official processes that are to be followed to ensure that their conduct is improved. An appropriate performance and/or education/training plan should be put in place to ensure that the nurse is supported and monitored to improve. Where no improvement is noted, then the NMBA can be notified.

47. As care workers are an unregulated workforce, there is currently no such formal process in place for carers. While a national Code of Conduct does exist, it has been argued to be worded in an ambiguous manner and difficult to apply in practice.[34]

48. The ANMF supports the Aged Care Workforce Strategy Taskforce recommendation that aged care workers should be regulated in a similar way to nurses covered under the National Registration and Accreditation Scheme.[35] The standardisation or harmonisation of education requirements, clearly defined competencies including language and communication, clear requirements regarding continuing professional development and recency of practice would afford a better degree of confidence in care workers ability to provide safe, quality care.

GENDER AND SEXUALLY DIVERSE PEOPLE (LGBTI+)

49. In this submission, we use the broad and inclusive term 'gender and sexually diverse' to refer to people who may be or identify as lesbian, gay, bisexual, transgender, and intersex (LGBTI) as well as any other diverse gender or sexuality not specifically incorporated within the common LGBTI acronym (+). The term gender and sexually diverse is also used with the recognition that some people may not choose to identify themselves as such and may or may not have their own chosen term, descriptor, or identity. In any case, the ANMF is inclusive, respectful, and accepting of people regardless of their sexual and/or gender identity and affirms that all people have the right to safe and appropriate, quality person-centred care.

50. It is conservatively estimated that around 11% of the overall population is gender and sexually diverse.[36] Despite increasingly inclusive legislation in Australia and

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[34] Martyn JA, Zanella S, Wilkinson A. 2019. Perspectives from practice: Complexities of personal care workers' education, regulation and practice. *Australian Health Review* [Internet]. 43(2):238-239. Available online: https://doi.org/10.1071/AH17035

[35] Aged Care Workforce Strategy Taskforce. 2018. A Matter of Care Australia's Aged Care Workforce Strategy [Internet]. Department of Health, Commonwealth of Australia. Available online: https://agedcare.health.gov.au/aged-care-workforce-strategy-resources

[36] National LGBTI Health Alliance. 2016. National Lesbian, Gay, Bisexual, Transgender, and Intersex mental health and suicide prevention strategy: a new strategy for inclusion and action [Internet]. National LGBTI Health Alliance. Newtown, New South Wales. Available online: http://lgbtihealth.org.au/wp-content/uploads/2016/12/LGBTI_Report_MentalHealthandSuicidePrevention_Final_Low-Res-WEB.pdf

internationally, equity for people who are gender and sexually diverse is not yet a reality, with many people still experiencing inequitable, discriminatory, and even aggressive attitudes and treatment based upon their sexuality or gender.

51. Gender and sexually diverse people may have needs and preferences for care, as well as characteristics based upon past experience and perceptions that are different from those of the mainstream populations.[37] Past discrimination, abuse, harassment, violence, and persecution experienced by gender and sexually diverse people may mean that these people do not feel safe or included in an aged care system that is largely not set up with the potentially specific needs and preferences of this diverse community. Gender and sexually diverse people may be more likely to experience:[38,39]

    - Higher risk of cancer.
    - Higher rates of tobacco and alcohol use.
    - Higher likelihood of sexually risky behaviours.
    - Worse cancer-related outcomes.
    - Poorer physical and mental health.
    - Higher risk of suicide, suicidal ideation, and self-harm.
    - Disability (older GSD people).
    - Higher levels of mental distress.
    - More health risk behaviours post-cancer.
    - Less access to care/health service engagement.
    - Less satisfaction with treatment.
    - Less frequent inclusion of partners in treatment.
    - Lower levels of traditional family and social support.
    - Less access to relevant information and support service.

52. Older gender and sexually diverse people may have a history of negative experiences with the healthcare sector and other mainstream services and may also have a personal social, health and wellness history that is different from many older people with mainstream gender and sexual identities.

53. As the ANMF raised in its previous submission regarding younger people in aged care, intimacy and sexual health needs are at risk of being ignored among people in RACFs as generally, older peoples' sexuality and sex lives are overlooked.[40] This may be especially true for older gender and sexually diverse people who may have

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[37] World Health Organization (WHO). 2016. Gender, Equity, and Human Rights – Health and Sexual Diversity [Internet]. World Health Organization. Geneva, Switzerland. Available online: https://www.who.int/gender-equity-rights/news/health-sexual-diversity/en/

[38] Galea S. 2019. LGBT Health Is Inseparable from LGBT Rights: More equality means better health [Internet]. *Psychology today*. Jun 19. 2019. Available online: https://www.psychologytoday.com/au/blog/talking-about-health/201906/lgbt-health-is-inseparable-lgbt-rights

[39] National LGBTI Health Alliance. 2016. The Statistics at a Glance: the mental health of lesbian, gat, bisexual, transgender, and intersex people in Australia [Internet]. National LGBTI Health Alliance. Newtown, New South Wales. Available online: https://lgbtihealth.org.au/statistics/

[40] Doll GM. 2013. Sexuality in nursing homes: practice and policy. *J Gerontol Nurs.* 39(7):30-7. Available online: https://doi.org/10.3928/00989134-20130418-01

experienced a lifetime of negative experiences or invisibility due to the prevalence of sexual and gender discrimination, judgement, and abuse both within health and aged care as well as in the broader community.

54. Sexuality and sexual health of people in RACFs is a topic that has been frequently overlooked but which is now gaining greater attention and interest. The needs, preferences, and attitudes to sex and sexuality for both older and younger people in RACFs deserves attention and consideration and can be a common area where care can fall short.[41] A recent survey found that most residential aged care staff do not have access to policies on sexuality or sexual health even among mainstream populations to guide their practice.[42] Nurses can play a key role in ensuring RACFs provide an environment that is supportive of residents' rights, needs, and desires regarding sex, sexuality, and sexual health.[43] By including recognition of diverse genders, sex and sexuality in overall understandings of life satisfaction and care planning, the holistic care needs and preferences of residents is better able to be met. There must be an understanding that each resident, regardless of age, may have different and unique gender identities, as well as needs and preferences regarding sex and sexuality. Aged care providers must include a thorough assessment of sexual health of residents in routine practice and include sexual health in care planning with the understanding that gender and sexually diverse residents may have both unique and dissimilar needs, preferences, and concerns regarding how they would or would not like their gender, sexuality, and sexual health to be addressed or included in their care.

55. Research evidence regarding the needs, experiences, and perspectives of older gender and sexually diverse people is limited, but increasing in volume and scope. As described by Putney and colleagues; (gender and sexually diverse) adults are a vulnerable yet resilient population who face unique stressors as they foresee health decline.[44] Their study found that older gender and sexually diverse adults tend to seek inclusive residential care settings that encompass two related aspects of LBGT-affirmative care: culturally competent skills and knowledge of practitioners, and the the values and mission of the organisation as a whole.

56. While there has been a gradual, general increase in broad social acceptance of gender and sexually diverse people, discrimination is ongoing, and many gender and sexually diverse people believe that older gender and sexually diverse people continue to face discrimination.[45] Some studies have found generally tolerant and

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[41] Aguilar RA. 2017. Sexual expression of nursing home residents: systematic review of the literature. *J Nurs Scholarship.* 49(5):470-7. Available online: https://doi.org/10.1111/jnu.12315

[42] McAuliffe L, Featherstone D, Bauer M. 2018. Sexuality and sexual health: Policy in Australian residential aged care. *Australas J Aging*. [E-Pub ahead of print]. Available online: https://doi.org/10.1111/ajag.12602

[43] Roach SM. 2004. Sexual Behaviour of nursing home residents: staff perceptions and responses. *J Adv Nurs.* 48(4): 371-9. Available online: https://doi.org/10.1111/j.1365-2648.2004.03206.x

[44] Putney JM, Keary S, Hebert N, Krinsky L, Halmo R. "Fear Runs Deep:" The Anticipated Needs of LGBT Older Adults in Long-Term Care. *Journal of Gerontological Social Work*. 61(8):887-907.

[45] Mahieu L, Cavolo A, Gastmans C. 2019. How do community-dwelling LGBT people perceive sexuality in residential aged care? A systematic literature review. *Aging and Mental Health.* 23(5):529-540.

open attitudes towards gender and sexual diversity in aged care,[46] further improvements are still necessary to ensure that discrimination and marginalisation never occurs.

57. A systematic review of provider and gender and sexually diverse (LGBT) peoples' perspectives on issues regarding long term care (both residential and home care) in the United States located 19 studies.[47] Findings from the perspectives of providers revealed that there is a lack of training and knowledge regarding LGBT issues and health and that there are generally negative attitudes toward same-sex relationships among older adults however accepting attitudes were also noted in some studies. Negative attitudes towards gender and sexually diverse people in long term care may discourage residents from expressing their sexuality and be at risk of impaired sexual health. Findings from the perspectives of gender and sexually diverse people highlighted concerns regarding long term care planning for gender and sexually diverse people, fear of discrimination from providers, and also revealed several strategies for improving care for older gender and sexually diverse people in long term care. Overall, the systematic review revealed a need for long term care providers such as RACFs to receive training in gender and sexually diverse peoples' health and be reflective regarding potential biases toward gender and sexually diverse people. This is a finding of other similar studies, for example; mental health providers in long term care would benefit from more training in gender and sexually diverse-specific mental health problems and evidence-based treatments, and efforts to destigmatise gender and sexually diverse people in these settings might improve access to mental health care.[48] Suggestions for improvements included; publicised sensitivity training on gender and sexually diverse peoples' health, gender and sexually diverse-friendly long term care facilities with visible and inclusive language on resources and mission statements, and visibility of gender and sexually diverse staff.

58. There have been considerable accomplishments in legal and human rights for gender and sexually diverse people. Their visibility in health and social care has also increased. These appear however, to have surpassed the ability of many care services to meet the needs of this population given documented concerns about the accessibility, inclusiveness, and safety of care services - particularly institutionalised or long-term care.[49] Systemic changes are necessary, but are difficult to operationalise. While it is generally well known that providers should be sensitive to the needs of gender and sexually diverse older adults, one study found that gender

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[46] Villar F, Serrat R, Celdran M, Faba J, Martinez MT. 2019. Disclosing a LGB Sexual Identity When Living in an Elderly Long-Term Care Facility: Common and Best Practices. *Journal of Homosexuality.* 66(7):970-988.

[47] Caceres BA, Travers J, Primiano JE, Luscombe RE, Dorsen C. 2019. Provider and LGBT individuals' perspectives on LGBT issues in long-term care: a systematic review. *Gerontologist.* gnz012. Available online: https://doi-org.access.library.unisa.edu.au/10.1093/geront/gnz012

[48] Smith RW, Altman JK, Meeks S, Hinrichs KL. 2019. Mental Health Care for LGBT Older Adults in Long-Term Care Settings: Competency, Training, and Barriers for Mental Health Providers. *Clinical Gerontologist.* 42(2):198-203.

[49] Hafford-Letchfield T, Simpson P, Willis PB, Almack K. 2018.
Developing inclusive residential care for older lesbian, gay, bisexual and trans (LGBT) people: An evaluation of the Care Home Challenge action research project. *Health and Social Care in the Community.* 26(2):e312-e320.

and sexually diverse-themed programming, inclusive language and symbols, or joint initiatives with gender and sexually diverse communities were sometimes not adopted by long term care homes (i.e. RACFS) because of anticipated negative resident/family reactions.[50] The authors highlighted that comprehensive strategies involving staff, residents, and family should be implemented.

59. A study conducted in Australia with 33 lesbian women and gay men investigated the perceptions and experiences of residential aged care and home care in terms of their preparedness to accessing such services.[51] Participants revealed concerns regarding accessing aged care services and were fearful of discrimination, hostility, lack of access to community and partners, the potential for elder abuse, and poor quality care. Overall, participants were hopeful of never needing to use residential aged care services and described strategies that were hoped would help them to avoid RACFs entirely including home care, renovations to their own homes, access to other out-of-home support services, and the option of voluntary euthanasia. The research paints a revealing picture that gender and sexually diverse participants held entirely negative views regarding RACFs. Overall, the participants expressed several concerns that may also be shared by mainstream counterparts, such as fears or losing personal autonomy, but that this can manifest differently, including feeling unable to express their sexuality, and maintain valued connections to the lesbian and gay community. Many concerns about utilising aged-care services, whether home or residential-care, were related to the potential impact of discrimination, which is a finding of similar studies elsewhere.[52,53]

CARE LEAVERS

60. Care leavers are defined as a person who spent time in care within foster care, residential care, or another arrangement while aged under 18 years. Care may have been provided as directed by the state, voluntarily, or by the private sector. 'Forgotten Australians' is one term used to describe members of this diverse group, however not everyone identifies with this term personally. Other terms that may be used to describe this group include; former child migrants, former wards of state, and stolen generations.[54] There are estimated to be around 500,000 care leavers in Australia; 450,000 of which are Forgotten Australians.

61. Care leavers may have experienced abuse or other traumatic experiences both prior to and within entering 'care'. As these people grow older, they may feel anxious

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[50] Sussmann T. et al. 2018. Supporting Lesbian, Gay, Bisexual, & Transgender Inclusivity in Long-Term Care Homes: A Canadian Perspective. *Canadian Journal on Aging.* 37(2):121-132.
[51] Waling A, et al. 2019. Experiences and perceptions of residential and home care services among older lesbian women and gay men in Australia. *Health and Social Care in the Community.* 27(5):1251-1259. Available online: https://doi-org.access.library.unisa.edu.au/10.1111/hsc.12760
[52] Kortes-Miller K, Boule J, Wilson K, Stinchcombe A. 2018. Dying in Long-Term Care: Perspectives from Sexual and Gender Minority Older Adults about Their Fears and Hopes for End of Life. *Journal Of Social Work In End-Of-Life & Palliative Care*. 14(2-3):209-224.
[53] Higgins A, Hynes G. 2019. Meeting the Needs of People Who Identify as Lesbian, Gay, Bisexual, Transgender, and Queer in Palliative Care Settings. *Journal of Hospice & Palliative Nursing*. 21(4):286-290.
[54] Helping Hand. 2018. Acknowledging Forgotten Australians [Internet]. Helping Hand. Available online: https://plan.helpinghand.org.au/acknowledging-forgotten-australians/

regarding the possibility of needing to re-enter care. Issues around trust, aversion to authority, fear of loss of control and personal independence are common concerns for Forgotten Australians who may require aged care services. These are similar to, but distinct from the concerns of other mainstream groups, as there are also legitimate fears of abuse and the triggering of past traumatic experienced based on past experiences.[55] Indeed, the words used to describe the environments that many care leavers and Forgotten Australians grew up in (large institutions; isolated, forbidding, impenetrable, poorly maintained, beyond the reach of the law or other authority) echo the perceptions, fears, and sadly, the lived experiences of many people in relation to Australians residential aged care sector.[56]

62. Recognition, advocacy, and support when entering aged care, as well as education for providers and staff who work with care leavers and Forgotten Australians to provide sensitive care is necessary, but a well-articulated strategy is necessary. Access to general practitioners and good staff identification and assurances of police checks have also been noted.[57] The organisation 'Helping Hand' has received Federal Government funding to support the development of tools to help individuals and aged care providers communicate and share critical information about care delivery and to build sector capacity to provide quality care that meets the needs of care leavers, including trauma-informed care in both RAFCs and home care settings.

63. Care leavers and Forgotten Australians, like other members of the diverse groups discussed in this submission and hearing, may also be members of other diverse groups. These people may be Aboriginal or Torres Strait Islander people, gender and sexually diverse, from CALD backgrounds, and may be more likely to be or have been homeless. Indeed, a recent large study found that 46% have experienced homelessness, 48% lived in public housing, and 60% had temporary housing at some point in their lives.[58]

64. Care leavers and Forgotten Australians experience premature aging; their health declines more rapidly than mainstream populations, and manifests in disabilities, psychological distress, and physical and mental illnesses.[59]

65. The complex needs and preferences of care leavers necessitates having a suitably sized, trained, and qualified care workforce that is able to recognise and provide the required care and support this diverse group of people deserve. Care leavers and Forgotten Australians have greater needs for healthcare services including; audiology, pathology, optometry, dentistry, physiotherapy, occupational therapy,

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[55] Helping Hand. 2018. Seminar highlights needs of Forgotten Australians [Internet]. Helping Hand. Available online: https://plan.helpinghand.org.au/seminar-highlights-needs-of-forgotten-australians/

[56] Fernandez E, Lee JS, Blunden H, McNamara P, Kovacs S, Cornefert, PA. 2016. No Child Should Grow Up Like This: Identifying Long Term Outcomes of Forgotten Australians, Child Migrants and the Stolen Generations [Internet]. Kensington: University of New South Wales. Available online: http://www.forgottenaustralians.unsw.edu.au/sites/default/files/uploads/LOW%20RES%2012859_UNSW_FASS_ForgottenAustralians_Report_Nov16_LR_FA.pdf

[57] Ibid.

[58] Ibid.

[59] Ibid.

prosthetics, and orthotics. There are also greater needs for ongoing health assessment, review, and management, along with multiple medications and surgeries and counselling and/or specialist psychiatric support.[60]

ABORIGINAL AND/OR TORRES STRAIT ISLANDER PEOPLE

66. Aboriginal and Torres Strait Islander people represent around 1% of people living in RACFs and account for 3% of people in home support and 4% in home care.[61] While many Aboriginal and Torres Strait Islander people live in and around metropolitan population centres, they also make up a larger proportion of people living in regional, remote, and very remote Australia where there are fewer health and aged care services and worse access to many services overall.

67. The Commissioners have already received extensive evidence from witnesses regarding access and inclusion for Aboriginal and Torres Strait Islander people in the aged care sector at the Broome hearing (17 June – 19 June, 2019). The Commission has heard about the unique needs of Aboriginal and Torres Strait Islander people when it comes to aged care services and the nature and scope of aged care services for Aboriginal and Torres Strait Islander people living in remote areas.

68. Aboriginal and Torres Strait Islander people are disproportionally represented among younger RACF residents and appear to be the youngest group upon admission.[62] One in ten RACF residents aged under 50 are Aboriginal or Torres Strait Islander people.[63] On average, Aboriginal and Torres Strait Islander people in RACFs are younger than non-Indigenous people; over 25% of Aboriginal and Torres Strait Islander people living in RACFs are aged under 65 years of age in comparison with around 3% for non-Indigenous people.[64] At 30 June 2018, almost 7.5% of Aboriginal and Torres Strait Islander people in RACFs were aged under 55 years in comparison with 0.6% of non-Indigenous people.

69. Due to social, wellbeing, and health inequalities, Aboriginal and Torres Strait Islander people experience aging at a faster rate than non-Indigenous people. Higher rates of multiple-comorbidities, dementia in later life, and lower life expectancies mean that younger Aboriginal and Torres Strait Islander people can experience poorer health and wellbeing than much older non-Indigenous people.[65]

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[60] Ibid.

[61] Australian Institute of Health and Welfare. 2017. People using Aged Care (Internet) [Updated 2018]. Australian Government. Available online: https://www.gen-agedcaredata.gov.au/Topics/People-using-aged-care

[62] Borotkanics R, et al. 2017. Changes in the profile of Australians in 77 residential aged care facilities across New South Wales and the Australian Capital Territory. *Australian Health Review.* 41(6):613-20. Available online: https://www.publish.csiro.au/ah/Fulltext/AH16125

[63] Ibid.

[64] Ibid. [61] People using Aged Care

[65] Australian Institute of Health and Welfare. 2015. The health and welfare of Australia's Aboriginal and Torres Strait Islander peoples: 2015 [Internet]. Australian Government. Available online: https://www.aihw.gov.au/reports/ihw/147/indigenous-health-welfare-2015/contents/health-disability-key-points

70. Ensuring a strong and suitably sized Aboriginal and Torres Strait Islander workforce in the aged care sector is vital to supporting safe, effective, and appropriate care for older Aboriginal and Torres Strait Islander people and their families. Aboriginal and Torres Strait Islander nurses and care workers play a crucial and respected role in attaining health and wellbeing equality in the Australian aged care system for Aboriginal and/or Torres Strait Islander older peoples and their communities.

71. In line with the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023,[66] priorities for the aged care sector should be around developing and supporting effective recruitment and retention strategies for Aboriginal and Torres Strait Islander nurses, managers, and care workers across the aged care sector and to ensure that non-Indigenous staff have access to high-quality cultural safety training to support their work with Aboriginal and Torres Strait Islander clients and their families.

72. The current Australian Government benchmark is to achieve representation in the heath workforce equivalent to population parity, which is 2.8% according to the 2016 census. As the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) states, Aboriginal and/or Torres Strait Islander Australians experience a burden of disease 2.3 times greater than non-Indigenous Australians.[67] CATSINaM has calculated that national benchmarks of 5% or greater representation in the nursing and midwifery workforce, combined with dedicated strategies, are required to adequately address this elevated burden of disease. This could also be extended to apply to the aged care workforce, where it would be ideal to ensure population parity between the Aboriginal and Torres Strait Islander aged care workforce and Aboriginal and Torres Strait Islander people who receive aged care services.

PEOPLE WHO ARE HOMELESS OR AR RISK OF BECOMING HOMELESS

73. As the population of people experiencing homelessness ages, an increasing number of these people require care, some may enter RACFs.[68] In one study from the United States, veterans who were homeless in the year prior to entry into an RACF were younger (62.5 years/Standard Deviation (SD) = 10.3 years) than stably housed residents (75.3 years/SD = 11.9 years).[69] Residents who were homeless have different characteristics to stably-housed residents and were also more likely to

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[66] Aboriginal and Torres Strait Islander Health Workforce Working Group. 2016. National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016-2023 [Internet]. Australian Health Ministers' Advisory Council, Aboriginal and Torres Strait Islander Health Workforce Working Group. Available online: https://www1.health.gov.au/internet/main/publishing.nsf/Content/work-pubs-natsihwsf

[67] Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM). 2018. Strategic Plan 2018-2023 [Internet]. CATSINaM. Available online: https://www.catsinam.org.au/static/uploads/files/strategic-plan-20182023-v6-print-wfvgxtdpjxcs.pdf

[68] Homelessness Australia. 2016. Homelessness and older people. Homelessness Australia. Available online: https://www.homelessnessaustralia.org.au/sites/homelessnessaus/files/2017-07/Homelessness_and_Older_People.pdf

[69] Jutkowitz E, Halladay C, McGeary J, O'Toole T, Rudolph JL. 2019. *Journal of the American Geriatrics Society*. 67(8):1707-1712. Available online: https://onlinelibrary-wiley-com.access.library.unisa.edu.au/doi/full/10.1111/jgs.15993

have a diagnosis of alcohol abuse, drug abuse, mental health conditions, dementia, liver disease, and tri-morbidity. These complex conditions can be challenging for RACF staff, especially where staffing and skills-mixes are poor, leading to too few staff with the clinical and specialist expertise to provide safe, quality care or adequate integration with and handover to medical, allied health, and social services specialists.

74. There is currently a "homelessness supplement" for RACFs that specialise in caring for people with a history of, or who are at risk of, homelessness.[70] Currently, providers must have more than 50% of all residents meeting the viability expansion component and homeless supplement assessment criteria in order to be eligible for the supplement. While this supplement is necessary to support the additional care requirements that many people who experience homelessness/ unstable housing and other commonly associated co-occurring conditions, limiting the supplement to RACFs with 50% or more eligible residents may not adequately incentivise the provision of care to these people, who are also likely to be younger than the general RACF population, in facilities where there are fewer than 50% of residents with a history of, or who are at risk of, homelessness. This may be a particular problem in areas with limited availability of RACFs, such as in regional and remote areas where homelessness is rising.[71]

75. Further, it is unlikely that the additional supplement is sufficient to adequately fund the necessary care that people with a history of homelessness or who are at risk of homelessness require. The ANMF is pleased to observe that the recently proposed Australian National Aged Care Classification (AN-ACC) model has built-in consideration of the need for additional funding for certain diverse population groups, including people experiencing homelessness, residents in regional and remote areas, and to a small extent culturally and linguistically diverse people, but highlights the need to ensure that this additional funding is sufficient for the particular needs of these groups.

VETERANS

76. Veterans - people who have experienced active military service can experience premature affects of aging in comparison to non-veterans. Chronic health issues, pain, injury, and psycho-emotional issues can be significant challenges for veterans as well as their families and loved ones. As veterans age, these problems may be magnified. While veterans aged 55 or older have similar rates of chronic disease,

[70] Department of Health. 2016. Aging and Aged Care: Homeless Supplement. Australian Government. Available online: https://agedcare.health.gov.au/aged-care-funding/residential-care-subsidy/supplements/homeless-supplement

[71] Parkinson S, Batterham D, Reynolds M, Wood G. 2016. The Changing geography of homelessness: a spatial analysis from 2001 to 2016. Australian Housing and Research Institute. Available online: https://www.ahuri.edu.au/__data/assets/pdf_file/0010/40402/The-changing-geography-of-homelessness-a-spatial-analysis-from-2001-to-2016-Executive-Summary.pdf

higher rates (1.8 times that of non-veterans) of mental health and behavioural problems can be experienced by veterans.[72]

77. Older veterans and war widows/widowers are able to receive aged care services from the Department of Veterans' Affairs (DVA) and Australia's My Aged Care as long as the same services are not provided by both services. Services can be provided via the DVA through their home care program as well as the Community Nursing Program.

78. While some studies have found similarities between older veterans and non-veterans in terms of indices of health and aging, there are some differences. Veterans appear to smoke more and have more chronic conditions which in turn is associated with lower subjective wellbeing.[73] Interventions and resources that address peoples' sense of purpose in life, support one's capability to achieve, and strengthening social and physical environment through social connectedness, may serve as protective factors for poor wellbeing in veterans.

79. Falls are one of the most important causes of injuries and accidental deaths among people aged greater than 65 years. In Taiwan, veterans' risk of falls and recurrent falls have both been found to be greater than those of non-veterans.[74] Age level, comorbidities/complications, and level of low urbanisation are also all important factors affecting veterans' falls.

80. It is well-established that post-traumatic stress disorder (PTSD) and major depressive disorder (MDD) are associated with physical health difficulties among veterans; diagnosed before the age of 55, MDD and PTSD may be significant risk factors for dementia and other forms of cognitive impairment.[75] People with co-occurring PTSD/MDD also represent a high-risk group for cardiovascular disease and other health problems, and therefore deserve careful attention from health and aged care systems.[76]

81. There is an extensive literature regarding nursing care for the specific needs and preferences of veterans outside military contexts. Much of this evidence comes from the United States.[77] There have been calls for more research to be undertaken to

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[72] Australian Institute of Health and Welfare (AIHW). 2018. Older Australia at a Glance [Internet]. Australian Government. Available online: https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/diverse-groups-of-older-australians/veterans

[73] Yeung P, Allen J, Godfrey HK, Alpass F, Stephens C. 2019. Risk and protective factors for wellbeing in older veterans in New Zealand. *Aging and Mental Health.* 23(8): 992-999.

[74] Perng HJ, Chiu YL, Chung CH, Kao S, Chien WC. 2019. Fall and risk factors for veterans and non-veterans inpatients over the age of 65 years: 14 years of long-term data analysis. *BMJ Open.* 9(8):e030650.

[75] Bhattarai J, Oehlert ME, Multon KD, Sumerall SW. 2019. Dementia and Cognitive Impairment Among U.S. Veterans With a History of MDD or PTSD: A Retrospective Cohort Study Based on Sex and Race. *Journal of Aging and Health*. 31(8):1398-1422.

[76] Nichter B, Norman S, Haller M, Peirtrzark RH. 2019. Physical health burden of PTSD, depression, and their comorbidity in the U.S. veteran population: Morbidity, functioning, and disability. *Journal of Psychosomatic Research*. 124: 109744

[77] Cooper L, Andrew S, Fossey M. 2016. Educating nurses to care for military veterans in civilian hospitals: An integrated literature review. *Nurse Educ Today*. Dec(47):68-73.

develop, test, and evaluate educational innovations for preparing students and nurses delivering care to military veterans in civilian healthcare settings which could be extended to include the aged care sector.