Planned Activity as Meaningful Experience

Planned Activity Group and Social Support Good Practice Forum
Friday, 31 May 2002 — Darebin Arts & Entertainment Centre

Abstracts
&
Presentation Summaries

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Keynote Speakers

Kate Driscoll, *Lecturer, Department of Social Science and Planning, RMIT University*

The Meaning of Life: Order, Fragments and Dignity

Introduction

What is the role of Planned Activity Groups (PAG) in the lives of frail older adults and people with disabilities? This paper does not seek to answer this question but to provide some reference points for thinking about the nature, role and provision of Planned Activity and social support. PAG are provided as part of the Home and Community Care (HACC) service mix. According to the Department of Health and Aged Care the HACC program aims to enhance the independence of frail older adults and people with disabilities, and avoid their premature or inappropriate admission to long term residential care.

The Planned Activity service component is designed to maintain an individual's ability to live at home and in the community, by providing activities which enhance the individual's skills required for daily living.[1] The mix of apparently contradictory objectives driving Planned Activity (independence, life skills, support and social interaction) raise a set of policy and practice issues. These include but are not limited to: -

What is the policy environment framing PAG?

What sorts of experiences can be created through PAG?

What responsibility and capacity do service providers have to develop meaningful experiences for individuals?

Who determines what is meaningful?

Thinking about this set of issues has some resonance with the experience of Arna, a 46 year old Asian elephant whose plight has been raised in a Sydney Magistrate's Court[2]. According to Animal Liberation N.S.W, Arna's distressed behaviour is the result of loneliness. However her owner's, Stardust Circus argue that Arna is simply spoilt. A range of experts have presented evidence to the Court, suggesting that Arna is missing the companionship of other elephants. Captive wildlife behaviour expert Dr Sara Winikoff made the following statement;

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1 Background Information on Home and Community Care (HACC) Planned Activity Group Services, provided by the Department of Human Services (unpublished) (no date)

2 Breakfast, Radio National , ABC15th May 2000

"Keeping a social sentient being like an elephant in solitary confinement is unnatural and inhumane as it provides no opportunity for natural interaction which is necessary for mental and physical well being."[3]

Arna's isolation contravenes the N.S.W. Exhibited Animals Protection Act. If elephants manifest a set of identifiable physical responses to loneliness, and this is deemed to constitute cruelty, how might we think about the loneliness of fellow humans?

Evidence is now available to sustain the proposition that social isolation is a risk factor contributing to ill health. However in our readiness to respond to experiences of isolation of people and elephants, we need to consider the context in which they occur. Arna's experience of loneliness has developed since her companion, Bambi, died in 1996 and since that time, Arna has lived alone. For many people isolation is a consequence of the loss of partners, family, friends, work, neighbourhood and community associations. For others, isolation is a consequence of physical and mental health status, immobility, distance, culture, marginalisation, poverty and/or social exclusion. Responding to Arna's circumstances is relatively straightforward; find new elephant friends. However responding to the complexities of human social isolation involves fundamentally deeper considerations about the meaning of social experience it-self.

Policy context

The central contextual issue here is how Australian public policy structures support frail older people and people with disabilities in the 21st century. An uneasy linkage of human rights and economic rationalist logics have transformed 20th century institutional models of service provision for these groups. The provision of public sector support for older adults and people with disabilities characteristic of the post war welfare state is being weakened by the climate of dependency panic which currently sits over Canberra and debates regarding inter-generational equity.

The traditional mix of public policy initiatives which enabled older people, in particular, to live with some measure of security (home ownership, public health care and income support) are less certain to-day. The projected costs associated with an ageing and disabled population represent key drivers for substantial policy change through tighter targeting of income support, health care and pharmaceutical benefits. It appears to be in the national interest to age independently.

Under the banner of welfare reform many areas of public policy have been subjected to the budgetary cleaver. Contrary to this trend HACC is something of a neo-liberal paradox where funding actually grows rather than shrinks. HACC reflects an exemplary model of 'more for less'; more funding and less demand on residential care; more independent living and less dependency on the public sector.

The conceptualisation and development of HACC in the 1980s represented an innovative program of reform. With the benefit of hindsight I think it can be argued that HACC represented an early version of Third Way politics. HACC speaks the language of community, independence, efficiency, system reform, targetted intervention, rights and responsibilities. This is the language of modernising

3 'Arna's Story', Animal Liberation, N.S.W. http://animal-lib.org.au/ama

government and the agenda is less about smaller government and more about governing in different ways for different circumstances.

Unlike the post-war Keynesian enterprise in which the public sector was both provider of last resort and major projects engineer, we have now moved to an environment where governments will pay but not provide or build. Consequently community has assumed a prominence which does not fit well with either the resources or the capacity available.

The Third Way places great emphasis on community because as Scanlon notes, "…community [is] an apparatus of efficient government."[4] HACC utilises a mix of state, market and community investment to distribute resources to older adults and people with disabilities. Within this context community is both an end in itself and a means to an end; it is a mechanism for service delivery and an outcome for service users. Grappling with a neo-liberal public sector dressed in Third Way clothes is difficult conceptually and ideologically. However this policy environment presents both challenges as well as opportunities.

A key strength of the HACC program is that is does offer some policy certainty. The program has bipartisian support Federally and in Victoria, and has experienced sustained funding growth. The range of services funded through the HACC program include community nursing, meals on wheels, home help, personal care, home modification and maintenance, transport, respite care, social support and carer support. Services are delivered by a mix of organisations highlighting the blurred boundaries of state, market and community. These include government agencies, statutory authorities, local government, church organisations, charitable bodies, community organisations and private businesses.

The HACC program tends to loose its certainty in the face of flexible delivery arrangements. While program flexibility is to be applauded in principle, there is a very real danger that such broad categories of service provision, combined with diverse organisational arrangements result in vastly different outcomes for service users. Inevitably the distribution of services within this framework must vary greatly. This is in part because workers and their respective organisations will interpret policy and program guidelines in ways which reflect their values, priorities and understandings, and the constraints which frame their work.

PAGS experiences

To-days session is designed to showcase innovative social support service models which have been developed by practitioners. The capacity to be innovative is, in part, a consequence of this flexibility. Questions regarding the sorts of experiences which are created through Planned Activity cut to chase of HACC outcomes.

We can ask if service users are more independent, if Planned Activity programs have assisted service users to live at home and in the community, if daily living skills have been enhanced and if service users are more social. But in asking these questions of service users, we also have to reflect on and respond to the answers.

These questions fall out of the governmentality of HACC, that is the govern – mentality which favours independence and some vague and undefined notion of

4 Scanlon, C. 'Promises, Promises; the Third Way rewrites neo-iberalism' Arena Magazine, February-March 1999

community. We also need to understand how and why older adults and people with disabilities use these services and something of the impact upon their lives.

Are PAG part of a service delivery package where users are simply in receipt of a set of services or benefits (daily living skills, an enhanced capacity to remain living at home and a constructed social experience)? Or do PAG actually generate what Kevin McDonald calls a 'capacity for action'[5] for older adults and people with disabilities where service users engage in meaningful experiences. Here a tension emerges around the identity of service users as people needing social interaction, daily living skills and independence demonstrated by living at home, and service users as people with hopes and dreams and cultural, spiritual and/or material reasons for living. It is a fundamental tension which confronts many human service workers and it begs the question of what guiding principles frame practice, the best interests of service users or the client wishes.

In thinking about how services are delivered the work of Antonovsky, a medical sociologist provides some useful insights[6]. Antonovsky was puzzled by how it is possible for highly traumatised individuals to manage stress and stay well. His work initially focused upon Holocaust survivors and his explanation was that it was those individuals with a strong sense of coherence who were better able to manage life's challenges. I think that the idea of coherence offers a way to both explain and understand the issues and experiences of PAG users in terms of helping us to understand how people manage and the supports which assist people to manage and stay well. A sense of coherence has three dimensions; comprehensibility; manageability; and meaningfulness.

Comprehensibility refers to a person's world view or ways of seeing the world. How older adults and people with disabilities see the world is in part a reflection of the social construction of ageing and disability; if people are named and treated as dependent, different or other then this will feature in their identity construction. If people are given the freedom to develop their own sense of identity and identities, of who they are, of what they can be then the world is less limiting and restrictive.

Manageability encompasses the mix of material, social, cultural and spiritual resources to which an individual has access. Here the availability of responsive health care, caring support services and friendship networks assist people to develop a sense of control and empowerment rather adopt a victim mentality.

The final dimension of Antonovsky's model is meaningfulness. This means having areas of daily life (people, places, events and experiences) that people care about, that are worthy of emotional, physical and intellectual investment. It may by the passion of a punter, painter or pianist and is highly individualised. Meaningfulness is that which moves us; a relationship; fragments from a rich and full life; religious devotion. What is meaningful emerges from people's lived experience and can be shared through narrative, discourse and being.

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5 McDonald, K. 'Social Welfare: Reconstituting the Political?' Proceedings of National Social Conference, Sydney, 1989, SPRC Reports and Proceedings, No. 81

6 Antonovsky, A. (1987) Unravelling the mystery of health; how people manage stress and stay well, San Francisco, Jossey-Bass

Antonovsky, A. (1979) Health, stress and coping, San Francisco, Jossey-Bass

I want to suggest that the sense of coherence model provides a framework for guiding the operation of PAG. Interestingly ethno specific and Koori agencies provide the most hours of Planned Activity (95% and 90% respectively)[7]. Without knowing the nature of these programs I would suggest that these agencies can readily connect with and recognise issues around comprehensibility and world views.

The HACC program generally and PAG in particular attempt to contribute to manageability through the provision of a set of material (meals, maintenance, personal care) and social support resources. How these services are provided is critical for older adults and people with disabilities in relation to questions of control and empowerment.

Meaningfulness is difficult to incorporate in programs designed to maintain daily living skills. Yet without meaningfulness Planned Activity is simply reducible to instrumental rationality and survival training. As a site of social support PAG have a responsibility and capacity to develop meaningful experiences for service users. The answer to the question of what is a meaningful experience can only be decided by the service user. However there are signposts which can assist. The first has to be in relation to the extent to which PAG generate a site of engagement, or 'metaphysical space' (Deem, 1986)[8] That is a space which provides a safe physical and emotional environment, opportunities for intellectual, cultural, physical and social engagement and the development of capacity for action which is driven by the interests and experiences of older adults and people with disabilities.

Conclusion

The campaign for Arna was not successful. The magistrate found that Arna was indeed lonely but dismissed the case on the grounds that that Stardust Circus did not deliberately intend to cause cruelty. However Animal Liberation N.S.W. intends to appeal to the Supreme Court.

Some 75% PAG users only used the PAG component of the HACC service system[9] . This might suggest that older adults and people with disabilities are actually looking for social support and meaningful experiences. Planned Activity Groups can contribute to the health and well being of older adults and people with disabilities. But this will only occur if service users are empowered to do the choosing; choosing to explore what is meaningful in their lives and choosing to give meaning to life. We need to use care and dignity in order to hear the messages which people give us. Our society has mechanisms for responding to the loneliness of elephants. Can the same be said for older adults and people with disabilities?

PAG co-ordinators and managers also have a capacity for action in terms of shaping the nature of the PAG policy beast. It is possible to influence the nature and role of PAG as spaces of meaningful engagement. The challenge is to demonstrate how this is the case for older adults and people with disabilities and to feed these experiences into the policy loop. The policy environment can be driven by bottom up evidence just as readily as it can be driven by the instrumental agendas from above.

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7 Department of Human Services, Home Care in Victoria, September Quarter, 2001

8 Deem, R. (1986) All Work and No Play: A Study of Women and Leisure, Open University Press, Milton Keynes

9 Department of Human Services, op cit

A final word on older elephants. A non-profit foundation called Retirement Sanctuary is setting-up Australia's first elephant refuge for retired zoo and circus elephants. Arbu, GG and Tanya will be the first residents.

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Sue Hendy, *Director of Organisational Development, Council on the Ageing Victoria*

Beyond the Looking Glass

This paper attempts to examine the world of an ageing person and the way the "aged care system" then attempts to deal with their needs, especially their social and recreational needs. Thanks must go to David Hooker and Patricia Reeve for their contribution to these ideas.

In thinking about ageing, my thoughts go to a concept of "I am who I am until other people decide I am something else". So what do I mean? Our society has developed a notion of ageing, usually based on myth and stereotype, that at some point along the life continuum sees older people as incompetent, physically frail and unable to carry out decision making for themselves, to name a few. This in turn leads to those of us working with older people to, at some level, take on these ideas and respond accordingly.

Let me explain in more detail. Here I am, with a job, family responsibilities, community involvement, leisure interests of varying kinds, and a range of social networks and friendships. If I have a stroke, and am deemed to require some level of services from the "aged care system", I am examined from this service system perspective, which maybe deemed as a looking glass, where distortions occur and are seen as the reality, and the worker/service provider then redefines me and responds.

The service system has been developed over time and can respond within its defined "bag of tricks" which is pre-defined by policy and funding guidelines. So the response I receive is what can be given, which may not match what is needed or wanted. I will explore this concept further to illuminate what impact this has on people's lives and how as part of the service system we may need to think beyond the looking glass.

A critique of the disability and aged sectors gives us insight into how the rights of people in either category is different, and how we might learn from each other, for the benefit of the consumer, and to assist us in better providing for the social and recreational needs of these people. Language is a central aspect of this critique and how it directly influences our mind and its constructs, attitudes and actions.

I will then attempt to explore the role of recreation in supporting individuals in lifestyle and meaningful pursuit, as well as in supporting, building and/or rebuilding an individuals social networks and friendships.

Finally I will explore what can be done as a worker in the field, to make sense of these ideas in a way which enable participants in PAGs to participate to their fullest

in all that they can. We will examine some key questions to assist us to find the way forward, these include: How do we understand this world? What conceptual rigour do we undertake to explore the world and needs of older people? How much do we create their future and vision another way?

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Good Practice & Innovative Service Models Concurrent Sessions

Session 1 — Partnerships

Adriana Smith, *Manager, Gateway Social Support Options*

What's the Catch?

Working together collaboratively has helped us to let people know,
THERE IS NO CATCH.

Gateway Social Support Options (GSSO), situated in the Western suburbs of Melbourne, is a community based, non-profit organisation that caters to the social support needs of the HACC community and relies heavily on the services provided by volunteers.

GSSO's catchment currently includes the Cities of Hobsons Bay, Maribyrnong and Brimbank.

Collaboration

The year 2000 and beyond, saw Gateway Social Support Options develop and continue a partnership with The Department of Natural Resources and Environment – FishCare Program, to deliver an effective activity that would have expected outcomes in the areas of enhanced access, increased participation and reduced isolation for our client group.

This partnership resulted with Gateway Social Support Options introducing a new planned activity, **The Big Catch Program – Fishing Adventures.**

Partnerships allow organisations to focus on their areas of expertise, without compromising quality of service to the HACC consumer. Each stakeholder brings its strengths and therefore a better service.

With the support of Gateway volunteers, the HACC consumer has been able to partake in a well-supported program that has provided an opportunity to build confidences, reduce social isolation and promote physical activity.

Gateway has strengthened formal links with various service providers within its catchment area, particularly with Western Region Community Health Centre and Outreach Services, to ensure the referral of suitable individuals to this program; with each agency having it's own responsibilities to ensure that the program continues.

Whilst breaking down the barriers, the objective was to provide the participant with outcomes that would include reduced dependency, increased confidence and certainly a healthier and more active lifestyle. It also provided opportunities for the participants to develop relationships of trust and to encourage others to follow the same pathway by drawing the community together.

Working with HACC clients from complex needs / insecure housing has proven itself to be challenging. Individuals residing in this environment are often part of a transient community with very specific needs, with housing being one of their highest priorities on a daily basis. With this being the case, there is little time to be concerned about having fun. However with GSSO's PAGs there is a high focus on joining in and socializing. Little does the consumer know the therapy he/she is receiving. PAGs can be beneficial and responsive to the hidden and not so obvious needs of this group of HACC clients.

Building up relationships of trust has definitely been identified as imperative. This transient community can be suspicious of one's motives and need to be convinced that there is **no catch** and that we're trying to help. Creating partnerships at a local level has assisted Gateway to reassure the HACC client and provide the necessary social support to enhance the quality of life.

The fishing adventures provides an activity that is stimulating and is of some value to the participant, offering them social support that enables the individual to remain involved and be integrated into the community, regardless of their physical, mental or financial challenges and barriers

Often social support / recreational opportunities are restricted to individuals who have some capacity and confidence to participate. Gateway's projects such as Fishing, Progressive Past Times and Healthy Alternatives have successfully endeavoured to activate those individuals who were often self removed from any opportunity which was offered to them.

Teamwork strengthens the working relationships between all parties but is only effective if all parties are kept informed and are able to communicate with one another and have a forum to:

- Communicate
- Plan/Program development
- Resolve issues, if any
- Seek support
- Provide feedback
- Evaluate

Using innovation and creating partnerships has resulted in:

- Bringing the Community Together
- Increased participation and activity
- New initiatives
- Reduced social barriers
- Creation of recreational pathways
- Ambassadors to recreational activity

The success of the Big Catch Program is attributed to the collaborative approach used in achieving the outcomes, which have resulted in less isolation and more active Australians. Networking to provide a service has been the only manageable way to be effective in what we do.

Having a collaborative approach, creating links and relationships has been vital in the development of Gateway's planned activity groups. Liaison between other community and sporting organisations, such as community centres, neighbourhood houses, colleges and sporting clubs, has enabled volunteers to direct clients towards a more active and diverse lifestyle.

Volunteers are important stakeholders in the delivery of PAGs as they are relied upon to provide assistance and support to enhance access and ensure the clients participation.

We consider that this type of planned activity group enhances access and participation, assisting HACC consumers with complex needs to remain involved and be integrated into the community. Focusing on the expertise that individual parties provide has enabled us to deliver a quality-planned activity.

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Moreland Community Health Service

Referral and Assessment Coordination for Planned Activity Groups – A Sub-Regional Approach

This paper was originally presented at the 2002 HACC Conference held in Adelaide titled – Holistic and Creative Choices. There was considerable interest expressed in the model at that time and we are pleased to present the paper again in a Victorian context.

The paper discusses the development and introduction of a sub regional Planned Activity Group referral and assessment model involving seven PAG providers in the local government areas of Hume and Moreland.

The providers of the programs are members or involved in the Hume Moreland Primary Care Partnership and receive funding for the PAGs though HACC. There is a total of approximately 60 sessions and of over 950 units of service funded each week.

The services involved have worked closely together over a number of years participating in; a regional ADASS review; the development of and PAG Policy and Procedures Manual; and in a pilot project of a single entry point for referrals and assessments.

This pilot referral and assessment project was recognised as a valuable model for both clients and the service providers. For clients there was the ability of linking the individual into the program that best suited their needs and reducing assessments

for PAG programs. The benefits for Service Providers included an opportunity for greater collaboration and support and a greater understanding of services offered in the sub region. The model was recognised as one of good practice and received funding in the 99/2000 funding round to continue and further develop the model implemented in the pilot.

The model has now been in operation for twelve months and the following values and limitations have been noted.

The identified **values of the model** have included:

- Increased coordination between all of the PAG programs in the sub-region. This has generated many other spin offs including sharing resources and ideas, collaborative approaches to planning and networking for PAG coordinators and staff.
- The establishment of one central waiting list for each of the programs. This has assisted in identifying unmet needs and potential areas for funding applications. There has also been a great deal of positive feedback from referring agencies who are very supportive of the one point of referral for all PAG programs. Agencies have explained that in the past they have been unsure of where to locate PAGs and who to make referrals to, which has in some instances led to referrals not been made at all.

Despite the many benefits of this model, there are **challenges** that continue to arise. These have included: time constraints, adjusting to new approaches to service delivery and the development of one assessment tool.

Since commencement of the Assessment role, referrals for PAGs in the sub-region have been consistently over 40 per month. When the position commenced it was estimated that only 30 referrals would be received per month. From this it could be assumed that having one point of entry has in fact increased the number of referrals, therefore, supports this model of service delivery. At this point, it must be noted is that the current amount of time allocated to this position does not reflect the demand.

The position has been operating for almost a year, which has allowed us to identify some **potential service developments.** From the commencement it has become evident that the needs of the target groups would better met through increased coordination that transcends organisations and focus on the common elements of service delivery. Some areas that may benefit from cross-organisation coordination are volunteers, casual staff pools, service planning and transport. Through this position it has also become apparent that there is a need to review the programs currently offered by each service provider. This need has grown from the identification of unmet needs in the sub-region.

In conclusion, despite the various challenges that have arisen, it can be said that these have been far outweighed by the values of this new approach to service delivery. It is recognised that there are some areas that require further development to ensure the ongoing success of the position. This model is a living example of service providers working collaboratively, which will be increasingly important for many of us with the realisation of Primary Care Partnerships.

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Rani Riegel, *Program Convenor, Eltham Community Health Service*

Beyond The Walls: A Combined Approach to Overnight Respite Care

BANYULE CITY COUNCIL—

Banyule City Council, in partnership with Eltham Community Health Centre PAG in the Shire of Nillumbik, operates an overnight stay program, which is funded by the Commonwealth National Respite for Carers Program. In conjunction with this program, we run a full day Saturday program, funded by the Victorian Aged Care Program Carer Initiatives. Clients may attend a Friday program at either Banyule's regular PAG or the MultiCultural Dementia Specific Program, or Eltham Community Centre's program, which is also funded by National Respite for Carers. They may then stay overnight at Banyule City Council's Binnak Park Overnight Respite facility, and remain at the centre for the Saturday program. These programs offer clients and their caregivers a respite opportunity which is flexible and which can be tailored to meet their individual needs.

In setting up a partnership with Eltham Community Health Centre, we found that there were four key elements on which an agreed perspective was required.

1. Due to the nature and level of staff and the physical limitations of our service, we are unable to offer respite to clients who require complex medical or physical assistance such as that offered by residential respite facilities. We therefore offer the service to clients who may require assistance with personal hygiene where one staff member only is required, and no lifting devices are needed. Assistance with medication is limited to prompting, as we do not employ nursing staff. All other activities of daily living are accommodated within the program, provided they do not require complex nursing care.
2. We have an agreed set of assessment forms, which provide information on the client and their carer(s). The CIARR form includes data on the clients personal care abilities and needs, living arrangements, relevant health information, contact details and General Practitioner, reasons for referral and other services currently received. Additionally, we complete the ADASS Client Care Information Record. This provides complementary information on the clients' health and medication requirements, continence, dietary preferences and needs, Life history, Interests and Activities. Finally, we ask that caregivers undertake to provide the names and contact details of two people who will attend the overnight stay to take the client. This would generally be due to illness or as a result of the client's wishes.
3. The facility for the overnight stay is located in Banyule City Council's Adult Day Care Centre, Binnak Park, which is located in Bundoora. Council operates the Planned Activity Groups from this centre and it is here that the clients are

able to participate in the Saturday program if they and their caregiver so desire. There is a small bedroom, equipped with bed and bedside cabinet, for the client to sleep in. The worker is able to sleep in a purpose bought recliner chair. The centre has toilet and shower facilities for personal hygiene and a fully equipped kitchen for preparation of meals. There is a television, video and stereo, as well as all the usual components of an activities program. The facility has a lovely outdoor area, with garden and chook pen. Clients enjoy spending time in this area on fine days and on summer evenings. There is a high perimeter fence, which the staff member ensures is locked after they enter the premises.

4. We employ one staff member in the Overnight Program. The present worker has been employed in this role for several years and enjoys the opportunity to get to know a number of clients almost as well as she would know a family member, and to work to assist them and their family carers to maximise their respite stay. The worker has a HACC Certificate III in Personal Care. She is an experienced member our team and contributes to the overall program directions and knows the team at Eltham CHC well also.

A typical Client

To illustrate the benefits of our combined service, here is a snapshot of a typical client.

Mrs A is 85 years old and lives with her daughter and son in law in their home. Mrs A has Alzheimer’s Disease, Osteoarthritis and Diabetes. She is generally well, although frail. Her diabetes is controlled with oral medication, which she is able to take herself when reminded. Occasionally, Mrs A forgets to go to the toilet so the staff member reminds her to do so at regular intervals. Mrs A prefers to eat softer foods and of course is on a diabetic diet. Due to her memory problems, it is necessary to remind her to chew and swallow her food. Mrs A’s daughter is frustrated by her mother’s repetitive behaviours and the way she constantly follows her about the house. As they live in Eltham, Mrs A attends the Friday PAG at Eltham Community Health Centre. They have been referred by an Assessment Officer for the Friday overnight program.

On receiving this referral at Banyule City Council PAG, we first contact the Eltham CHC to discuss the client and ensure that we will be able to meet their needs. Eltham CHC shares their assessment notes and any relevant information with Banyule PAG. Where necessary, an appointment may be made for a Co-Coordinator to visit the family to complete the required emergency contact details and gather any information which may be useful to the overnight stay worker. This includes details of the client’s bedtime and early morning routines and preferences.

Mrs A now attends the Eltham PAG weekly and once per month (average), our worker picks her up from this group and they go back to the Binnak Park centre for the overnight stay. Both worker and Mrs A know each other well by now and have a comfortable routine for the evening. Mrs A stays in the Saturday program, which operates until 5 pm. Mrs A’s family pick her up from the centre on Saturday afternoon.

This approach to delivering a service, which meets the needs of clients and their families, has proved extremely successful. Generally, carers are able to book their family member in for the service and plan ahead for some time to achieve their own goals, whether that is a night out or simply a night at home, without worry. It has proved to be a solution for carers who feel unable to, or unhappy about, accessing residential respite, but who would quickly reach crisis point without some time for themselves and their families. It provides a softer approach to residential respite – by allowing clients to experience time away from their caregivers they are less resistant to longer periods of respite when this becomes necessary. Our partnership with Eltham CHC has provided our clients and caregivers with a positive solution to their need for extended overnight respite care.

Contact details

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ELTHAM COMMUNITY HEALTH CENTRE—

Introduction

Once a week every Tuesday a Group of young (by young I mean under 60 years) meet at the ECHC. The common thread is that at some stage in their life they have acquired a brain injury. The range in resulting disabilities is vast – from being wheelchair dependent to having an invisible disability.

The Doughnuts got their name from a poem and I thought I might read it to you so that you might understand why they chose that name.

> *As you amble on through life my friend – whatever be your goal*
> *Keep you eye e upon the middle and not upon the hole.*

The important thing being that you focus on what you have, not what you are lacking.

Rationale

Traditionally, people who have sustained an ABI are not acknowledged as having different needs to the frail elderly with disabilities.

The current ABI PAG at the ECHC operates under the same guidelines as the other HACC funded PAGs for the frail elderly. The participants are offered a four-hour social support program between 10–2 pm on the same day of the week. The centre provides transport to and from the group.

A service gap exists in relation to the availability of after hours recreational and social opportunities for people with a disability. Traditionally PAGs have offered programs during limited daytime hours. This has resulted in participants 'fitting into' our model rather than our service being flexible in approach. It must be remember that people with disabilities are not only disabled during working hours.

Saturday Evening program

In an attempt to address this service gap, The ECHC is piloting a PAG, which attempts to offer socialisation experiences for participants, which take them beyond

the 4 walls of the centre. The Saturday evening program operates once per month and aims to better meet the social and recreational needs of younger people.
The program offers participants the opportunity to do more mainstreams weekend recreational activities, activities which more able bodied people take for granted and do every weekend. These activities might be going to the movies, going to listen to a band or organising a catch-up with other ABI groups. As much as possible the group members are given the opportunity of making suggestions and are actively involved in planning the activities.

This program grew out of expressed client needs for a more normalised opportunity to socialise and the enthusiasm of the staff to offer clients something that they themselves see as being important, that is the chance to get out in the community and experience the richness and diversity that makes up the whole world in which we live.

The rationale behind offering an out of hours program was the recognition of the need for flexible recreational options. Earlier on in its inception the clients in the Saturday program identified outings and activities which required longer sessions. The staff was able to accommodate these requests by combining two sessions and have a bi-monthly all-day session. One such outing involved a visit to an historical homestead in Yarra Glen, with lunch at a nearby cafe followed by a short drive to a local winery where the group enjoyed Devonshire tea before returning home.

At a recent state forum contact was made with an ABI group in Gippsland.
The ECHC hosted a visit by this group on a Saturday where the two groups met for a BBQ. The Doughnuts are soon looking forward to trekking to Drouin to return the visit. The opportunity for meeting with other ABI groups provides a valuable chance for participants to make new friends, to share experiences and stories and to feel connected to other people in the community.

Objectives

The main objective of the Saturday Evening program is to increase the confidence and self esteem of younger people who have an ABI. Depression and social isolation are common experiences for young adults with an ABI and meaningful socialisation experiences can be an important determinant of an individual's sense of well-being.

Other objectives of the program are the provision of valuable weekend respite for carers and the opportunity to increase community awareness of the issues surrounding ABI.

Evaluation

It is recognised that socialisation programs are very difficult to evaluate.
The objectives of the program are often not specific to the needs of the program participants and as such not easily defined or measured.

Although the program has not yet been formally evaluated, there is regular feedback from the participants. Participating numbers is also a good indication of whether the program is meeting participants' needs.

A recent student to our service advised that an appropriate evaluation tool could be a focus group involving all members of the group. This research tool could help us

identify what the participants consider to be important objectives of the program and then facilitate discussion as to whether these objectives are being met.

Some of the areas that we would explore would be the following:

- How would participants define:
    - quality of life
    - their particular socialisation needs
    - self esteem
    - confidence
- What do they want or expect from attending the program
- What do they like/dislike about the program
- What other services could be provided to more effectively meet their needs.

It is proposed this program will be evaluated in June 2002.

Contact details

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Good Practice & Innovative Service Models Concurrent Sessions

Session 2 — Innovation

Yvonne Honey, *Coordinator, REACH Social Support and Respite Services, Sandybeach Neighbourhood House*, with Brenda Vogt, Lorraine Baker & Virginia Mort

REACH Social Support Services

REACH is a vital, innovative Social Support program that operates from a local community centre. We provide a range of interest-based activity groups for frail older people, people with dementia and their carers. Our emphasis has always been to provide meaningful, empowering and stimulating activities in a friendly, caring and pleasant environment. Our groups are in high demand with clients, carers and referring agencies. They are interesting, sociable and enjoyable. We would like to share the success of our program by presenting the philosophy upon which our programs are based and the principles and practices which make our groups unique.

Our philosophy is that everyone deserves to have access to interesting activities and a sense of purpose in their lives as well as opportunities to interact with other people. Elderly people who are isolated need extra support to achieve this. So we provide a choice of interesting, quality activities and the opportunity to meet with others. And then we make sure that the support and transport is there to enable people to become involved.

We aim is to address the social, emotional and intellectual needs of older people. Our programs are designed to fulfil this aim. All are based around specific interests or activities and have a social component. Our approach is to consider these needs first and find an activity or group that suits the interests and personality of the individual. We try to address any limitations in terms of health, memory loss or disability after we have ascertained what group or activity someone would most benefit from. We provide ongoing emotional and physical support to make sure that people can get the most from the activity or group of their choice.

The specific programs are:

Armchair Travel

These weekly travel talks provide a pleasant social occasion combined with intellectual stimulation and take people on a virtual journey out of Melbourne into a world they once visited (or would have liked to visit!). They can be very positive for people with memory loss – visual reminders of places once visited can bring back happy memories for them.

Life Stories

This is an intimate, social reminiscing and writing group that provides a wonderful forum for sharing, creativity and validation.

Music Alive

We have three music groups that all include group singing, celebrations of special events, theme sessions, performances by individual clients, games, quizzes and guest performers. Monthly concerts provide quality entertainment. The sessions are interactive and empower people through participation and a sense of belonging to something special and vibrant

Artbeat

Artbeat weekly sessions provide a variety of creative experiences through the use of assorted materials and a range of techniques and themes. In a friendly and supportive environment that caters for beginners and those with experience, participants are encouraged to work at their own pace. We provide opportunities for creative expression that foster a sense of competence, purpose and personal growth.

Excursion Program

We offer monthly coach outings tailored to suite people with limited mobility. We visit many different locations and venues in and around Melbourne. People are picked up from home and offered support during the day. A sociable morning tea or lunch is always included in the day's activities. We encourage carers to come with their partners on these outings, as they are able to share some quality time together in a relaxed and supportive environment.

Peer Training and Support

We offer regular outreach training sessions and workshops in the areas of Music Activities and Artmaking.

REACHarge Respite

REACHARGE Respite for Carers provides out- of- home respite with a social focus for older people or people with dementia in the municipalities of Bayside, Kingston and Glen Eira. Carers are able to have a short break and either choose to stay at home or go out while the person receiving care is accompanied to one of the activities listed above or to an activity of their choice. One to one and small group respite is tailored around the interests of the people being cared for. Examples of this are fishing and golf. Carers can be secure in the knowledge that their family member is enjoying a stimulating social activity in a supportive environment.

Monthly carer's lunches provide the opportunity to socialize and many carers have formed friendships and have received support from each other. They are also able to pass on information relating to different aspects of caring, particularly respite facilities. The people who are being cared for are able to attend activity groups for the duration of the lunches.

Some key elements of our program are:

- A unique staffing model which includes specialized staff organizing and running groups and the total involvement of paid and volunteer drivers in all aspects of the program
- Our dedicated and committed team of skilled, talented and generous volunteers

- The flexible and customized transport service
- Successful integration of people with dementia in mainstream groups.
- Involvement with local community
- Involvement in community arts projects
- Ability to cater for clients with complex needs
- Offering people choices and respecting their ability to choose
- High satisfaction rate amongst clients and carers
- Working in partnership with other agencies and services to provide the best possible outcomes for clients

REACH is a rich and diverse program through which older people become empowered and develop social networks and lasting friendships. They achieve a real feeling of belonging and once more have a sense of purpose in their lives.

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Neil Wakeman, *Chief Executive Officer, Manningham Community Health Service*

Good News Stories from the Men's Shed

In February 2000, after two years of dreaming, planning and funding applications, the Manningham Men's Shed finally opened for business.

Conducted by the Manningham Community Health Service with funding provided by the HACC Program, The Shed was the first of its type to be established in metropolitan Melbourne. It grew out of an emerging recognition of the needs of older men with a physical frailty or disability, and younger men with a disability, for whom few, if any, targeted programs have been provided in the past.

The Shed recognises the special significance of the home workshop or backyard shed in the lives of many men, many of whom may now live in accommodation which does not have a place for them to undertake handyman or hobbyist activities.
The Shed provides men with a place to meet, socialise and work independently or together on projects of their own choosing, such as woodwork, toy making, or simply fiddling with and fixing 'things', in a traditional male environment.

The Shed is a purpose built facility, a 'no frills' steel structure, on a bare concrete slab. It is equipped with an appropriate range of wood working machinery and hand tools, several workbenches, an old radio and a beer fridge (sadly, with no beer) in one corner. As a concession to the frail health of some of the older clients, the roof is insulated and reverse cycle air conditioners have been installed, to maintain a reasonably comfortable work environment. A sink (rescued from a hard garbage pile), hot and cold running water, and a 'hand-me-down' table and some old kitchen chairs ($30 from a garage sale) complete the 'furnishings'.

The program runs on five days each week, with 8–12 regular participants in each group, a coordinator and a dedicated group of volunteers. Our men have a variety of

disabilities, including acquired brain injuries and physical disabilities as the result of strokes, motor vehicle accidents, industrial accidents or illness. One participant is legally blind, some are youngish, others are elderly (our most senior is 92 years old) and a couple are exhibiting early signs of dementia – in short, ordinary blokes with major challenges in their lives.

To date the program has proved extraordinarily popular — retention rate over the first two years has been very high, and the participants and their carers all speak most positively about the benefits they have received from the program. The Shed has created a great deal of interest and we understand that several other men's sheds, modelled on our facility, are currently on the drawing board in other locations in Victoria. We are doing whatever we can to assist the sponsors of these developments.

Our presentation will accentuate the positive aspects of The Shed – we hope it will inspire others to consider doing what we have done to improve the social, mental and physical health of a particularly vulnerable group in our society.

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Dianne Wiseman, *Central Bayside Community Health Services*

Southern Psychogeriatric Activity Service (SPAS)

Participation in social and leisure activities is the right of every member of our society. Social and leisure activities have a myriad of benefits, including connecting and reconnecting us to our communities.

Many older adults with psychiatric disabilities and/or dementia have difficulty participating in social and leisure activities due to a variety of factors, including: the effects of their disabilities, stigma in our society associated with psychiatric illness and society's stereotyped views of older adults and the activities they enjoy.

We need to address these issues to ensure that older adults with psychiatric disabilities and dementia can participate in social and leisure activities. Traditionally, specialist psychogeriatric day programs have been set up to do this. Surely, true community integration can only happen when older adult with psychiatric disabilities are participating in the mainstream leisure and social activities and groups which the general population of older adults enjoys.

The Southern Psychogeriatric Activity Service (SPAS) is a creative, responsive service which links older adults with psychiatric disabilities and dementia into mainstream social and leisure activities in each person's local community.

This presentation will discuss the work of SPAS and will present the practical application of a model to achieve true community integration. We will tell you about some of our recent innovative work including a group for younger people with dementia and our work with SRS/rooming house residents.

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Good Practice & Innovative Service Models Concurrent Sessions

Session 3 — Special Needs Groups— Homeless/Supported Residential Services Residents

Marie Hapke, *Team Leader Special Needs Arts & Recreation, City of Port Phillip*

SRS Social Support & Recreation Development Project
(Port Phillip, Stonnington, Glen Eira, Bayside, Kingston)

This project addresses the constraints on access to social support and recreation opportunities for residents of SRSs, with and emphasis on those living in pension-only SRSs. The approach is service system development.

Background to the Project

SRS residents in pension-only SRSs

Within the Cities of Port Phillip and Stonnington there are a large number of pension-only SRSs. Generally the residents of these SRSs experience a number of health, disability and social problems, with a high incidence of chronic mental health issues, trauma and/or substance related ABI, intellectual disability and social/behavioural issues, as well as ageing issues. The age range of residents is typically lower that in more traditional supported residential services, with a small number of people in their 20s, a substantial proportion aged 30–60, as well as a significant number of people over 60 years.

The age and disability profile of these residents creates a complex care environment in the SRSs, which being pension-only, have very limited resources to provide any additional activities- there is a significant need for recreation and social support activities for these residents, many of whom feel there are few peers in their ‘home’ setting.

Issues in planning activities for SRS residents

A number of issues have emerged over time, including difficulties promoting activities through SRS proprietors, clashes with other activities provided through other services, and sense that access to activities for residents was very uneven, in that some residents were involved with a number of activities, while many others appeared to have very little access to activities. There was no systematic coordination around information about what activities were being provided, and this was an impediment to coordinating the planning of any new activities to ensure that they were complementary to the existing activities. These issues relate to the fragmented nature of the service system around SRS residents, and a resulting lack of coordination and information sharing.

Development of the Port Phillip SRS Recreation & Social Support Network

There was clearly a need to bring a range of service providers together to address these issues of fragmentation in the provision of activities for SRS residents.

The Student Project

The student project documented a number of issues and perspectives from each of the surveyed groups. Proprietors were asked for their views, and their knowledge of available activities, and their experiences with Activity providers, and the Activity providers were asked about their current level of provision for SRS residents, and also about any difficulties in catering for SRS residents.

Key conclusions from the student project were:

- The lack of coordinated and easily accessible information about available activities was an impediment for Proprietors in terms of their capacity to refer residents to activities, and a problem for Activity providers in terms of their capacity to plan activities which would complement the existing activities.
- There are a number of factors within SRS which determine the pattern of referral by proprietors. There are factors within the SRSs and within Activity services which jeopardize the ongoing involvement of SRS residents in activities.
- There are significant 'interface' issues in terms of communication between Activity providers and proprietors.
- Residents in general, have a very limited knowledge of what activities are available, and have very limited capacity to advocate on their own behalf regarding the kind of activities they may enjoy. A more intensive project which identified key residents would be more successful in this regard.

The Student Project led to a proposal which was funded through a HACC Service System Resourcing grant in 2001. Our project is in the establishment phase.

The SRS Social Support & Recreation Development Project is auspiced by the City of Port Phillip within the Special Needs Arts & Recreation Service, and is supported by a Project Steering Group comprising representatives from key services across the five municipalities in which the project works.

The Steering Group currently has representatives from Inner South Community Health Service – SRS HACC Advocacy Worker, ARBIAS Community Recreation Access Project SRS Advisor – Southern Region DHS, City of Stonnington – Social Support Program, City of Port Phillip – Eroke , Joint Councils Access For All Abilities, Community Connections – City of Kingston, and SPAS (SRS position vacant)

Key Elements of the Service System Approach

The **SRS Social Support & Recreation Development Project** is premised on the idea that there are several key stakeholders in the service system, all of which either currently or potentially impact on the problems, and the solution making process. The approach is to engage with the key stakeholders and to work with them to identify how they can contribute to the solution making process, and to secure their commitment to working on issues in their 'patch'.

A key role for the project worker is to work proactively with the stakeholders to develop a common understanding about the key issues, and a systems view of the problems and issues – rather than attributing the problems to a particular service, or the deficits of the residents or proprietors.

The solutions will be found in making some change in the way each of the stakeholders currently address the problem – decisions about the nature of the desired changes need to be informed by a view of the system as a whole, so that interface issues between the various stakeholders are identified, and responded to.

The presentation will present the strategies which are being developed to engage with the stakeholders, and will describe the outcomes which we are seeking. Specific project objectives are described below:

- Developing comprehensive and coordinated information strategies to inform outreach workers, activity providers, SRS proprietors and SRS residents about the range of activity options available, how they can be accessed, etc.
- Promote Responsive Service Development, by working with activity providers to achieve a coordinated approach to the planning and delivery of existing social support and recreation services to optimise their responsiveness to the needs of these SRS residents.
- Developing a systematic approach to ensure that all residents in the target group are referred for social support/recreation activities, and that the outcomes of these referrals are monitored over time.

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Netty Horton, *Chief Executive Officer*
Ruth Gordon, *Project Officer, Council to Homeless Persons*

Local Service Planning: A Model of Encouragement – The HACC Cluster Model

General observations about the barriers and issues for mainstream services when coming into contact with homeless people. Learnings based on the HACC Cluster model and early pilots of the training project about perceptions of homelessness.

Opportunities and ways of breaking down barriers.

Discussion of the HACC cluster and service development projects both in Melbourne and Brimbank. What encouraged people to work together? What were the barriers? How well is the issue of homelessness understood. How do homeless services relate to other services within other systems?

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Greg Pratt & **Brendan Burtan,** *Peninsula Support Services*

Mornington Peninsula Supported Residential Service Activity Program

The presentation will first introduce Peninsula Support Services and its role in providing services to people with Mental Illness who live on the Mornington Peninsula. In July 2000 PSS was allocated Home and Community Care (HACC) funding to provide group activities and outings to residents of pension only Supported Residential Services (SRSs) located on the Mornington Peninsula.

The presentation will introduce this youthful and evolving program and discuss in detail the current Program Objectives and Program Structure. The discussion will then move on to examination of the complex roles played by Program Staff, the challenges staff have encountered, and the real and anticipated outcomes of the program.

The presentation will utilise an evaluation report completed by independent consultants six months ago to provide an objective perspective to the discussion. Significant events and anecdotal stories will be used to flavour the discussion of the Program's short history, alongside accumulated Photographic materials that better illustrate the characters and context involved.

Our young program is dedicated to remaining flexible and ever evolving as it adapts to the varying needs of its participants. Comments, feedback, and suggestions from the audience would be highly appreciated.

Introduction

Peninsula Support Services Inc. (PSS) commenced operation in 1988 and is currently the largest Psychiatric Disability Support Service in operation on the Mornington Peninsula. In July 2000 PSS was allocated Home and Community Care (HACC) funding to provide group activities and outings to residents of pension only Supported Residential Services (SRSs) located on the Mornington Peninsula.

Program Structure

PSS delivers weekly group activities to four pension-only SRSs located between Seaford and Mornington. Teams of two staff visit each SRS once or twice per week for a period of two to three hours. The program has a 12-seat van at its disposal, as well as other equipment, to facilitate group outings. There is an emphasis by staff upon involving SRS residents in determining particulars regarding the type of activities and outings that are facilitated.

Residents of an SRS pay from 85% to 90% of their pension for accommodation and meals. The remaining income is used for medication and other personal items. There is usually no remaining income to cover for recreational activities. This situation compounds the isolation and marginalisation of this group. The profile of residents of these SRSs includes a range of ages and disabilities, with around 70% presenting with a diagnosed psychiatric disability. Prior to the implementation of this program, this group was not represented in the client profile of PSS service users.

Poly drug use and challenging behaviours are also apparent. Many of the clients have previously resided in institutional care and have moved to this form of accommodation as a result of government policy changes of de-institutionalisation. Developing trust with this group has required consistency and a non-judgemental approach to service delivery.

Partnership

Partnerships with relevant service providers have been fundamental to providing a holistic service to clients. A special interest group had been formed that includes representatives from:

- Peninsula Community Health Service (MI Health Team)
- Department of Human Services (SRS Program Adviser)
- Peninsula Health (Adult Community Mental Health Service)
- Peninsula Support Service

This group discusses strategies to better meet the needs of the client group. Case management, health issues and the any concerns presented by clients in relation to their rights are discussed.

The groups has also supported research projects and looked at developing and supporting new initiatives to improve access to services within the sub-region. Recent examples include:

- Visiting GP services to all SRSs
- Research into the experiences of young people in SRSs.

Program Objectives

- To deliver options to people living in pension-only SRSs that are inclusive and accessible.
- To recognise the diversity of issues and barriers experienced by SRS residents.
- To facilitate environments within which participants feel safe, comfortable, respected and involved.
- To ensure a high level of input from program participants regarding the detail and direction of the program.
- To maintain respectful and co-operative working relationships with SRS managers and staff.
- To incorporate practical and regular procedures for review and evaluation of program structure and delivery.
- To facilitate linkages into the PSS/Impact Adult Day Programs for SRS Residents with Psychiatric Disabilities.

Defining the Role of Program Staff

- To deliver weekly group activities and outings to Peninsula SRS residents
- To ensure that the requirements of the program philosophy (above) are met
- To promote other PSS services to appropriate PSS target group

- To liaise with SRS managers, the program manager, and other advisory bodies, with regard to issues or concerns arising from program delivery
- To refer SRS residents to appropriate services as the need arises

Challenges

- SRS proprietors/managers have different agenda's/values
- Diverse range of client needs, ages and disabilities
- Limited funding & lack of participant's financial resources
- Dealing with challenging behaviours/safety issues for staff & participants
- Engaging of more reclusive & withdrawn residents
- Recording relevant information on participants
- Time restrictions
- Dealing with a transient population

Outcomes

- Increase in the number of SRS participants accessing PSS day program.
- Increase confidence of SRS participants.
- Development of organisational learning in diverse areas of disabilities.
- Positive & open relationship between SRS managers/proprietors & PSS staff
- Increase opportunities for SRS residents to access social and recreational activities outside the SRS.

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Good Practice & Innovative Service Models Concurrent Sessions

Session 4 — Social Connections Through Language & Culture

Connie San Jose, *Social Support Coordinator, Filipino Community Council of Victoria*

Language the Key to Social Connectedness in Providing Responsive Social Support Programs

Introduction

Like most Ethno Specific Social Support Coordinators, I work Part-Time, 28 hours per week and a sole worker. The Council is under an elected management committee and supported by volunteers.

I would like to recognise the good work you do and encourage you to continue. Your vast knowledge and experience should be shared and heard. Being the workers on the ground, we are in the best position to identify the needs and through appropriate consultation, we are in the best position to articulate them.

I hope you will enjoy the forum, and I look forward to hearing today's outcome.

In 1995, the Inner Western Region Migrant Resource Centre initiated a research to look at the Home and Community Care Needs of the Filipino frail elderly, the isolated, people with disabilities and their carers. Since the 1980s the MRC has been a major catalyst in responding to the ageing of ethnic communities in the Western suburbs and the development of appropriate linguistic and cultural services.

I was privileged to conduct the study and commissioned as well to implement the recommendations of the research. In 1996, funding was granted by the Department of Human Services through its Home and Community Care Program to the Filipino Community Council of Victoria for the establishment of Social Support Programs.

Problems / Keys Issues Identified

1. Isolation – dispersed Filipino community in the metropolitan and non-metropolitan areas
2. Lack of proper information
3. Transport problem
4. Interpersonal relationship conflict in three-generation household (grandparents, parents, and grandchildren)
5. Migration in later life
6. Gender imbalance – female – 63.38% (12,830), males 36.17% (7,271)

The Filipino Community Council of Victoria delivers a diverse and expanding range of socially acceptable social support programs across the Western and Northern Regions. We have introduced innovative and creative approaches that are culturally

relevant, highly engaging and responsive to the changing needs of the Filipino HACC target group. Consultation with service users, volunteers, and management committee plus ongoing reviews/evaluation contributed to positive program outcomes.

1. Friendly Visiting Program

Apart from the weekly volunteer visits, we have introduced the following:

- Morning or afternoon tea or coffee with a neighbour
- Neighbourhood Meals – for consumers who are public housing tenants and people living in pension level supported residential accommodation
- Group Shopping – 3 to 4 people in one neighbourhood monthly with a volunteer
- Go to the Cinema
- Have cappuccino or latte after shopping — gives them a feeling of normality and enjoy things that active people do
- Group of carers taken out for a movie by volunteers. Lack of financial resources limits this to once or twice a year. 30.9% of our service users are public housing tenants (living alone) and 69.1% are living with spouses or their families.

2. Transport Support Program

Volunteers provide transport to:

- Doctor's and hospital appointments
- Recreation option like the Senior Citizens Club – access to Council Senior Citizens Centres or community facilities only on weekends. Public transport on Sundays is non existent i.e. bus
- Shopping
- Church
- Day Centre/PAG

The one to one support is important to frail elderly or people with disabilities e.g. legally blind, stroke victims and people with dementia.

3. Tele-link Program

Our oldest recipient of this program is 97 years old. She was an author of many Filipino books, a journalist and still writes for Philippine newspapers here and back home. Two volunteers transcribe her articles regularly.

4. Planned Activity Group

Attending the Day Centre reduces isolation by providing opportunities for meeting with people who share the same language, common history and culture.

Filipinos are artistic and musically inclined and it projects the culture we inherited from our forefathers. This heritage makes us strong to face problems in our lives.

Filipinos are group oriented, so they respond very well in PAG programs. They are raised in an environment where they have to depend on their relationship with others in order to survive. If their relationship is satisfactory, they are happy and secure.

Love, happiness, sadness, frustration is always expressed through music. This is a major component of the Day Centre activities. We dwell on their abilities and talents expressed through love of poetry, writing, playing musical instruments and singing.

PAG Activities

- Music Therapy
- Gentle Exercise
- Tai-Chi
- Massage
- Group Support and Interest group discussion
- Outside Entertainer – bi-monthly
- Health Education Program – healthy eating (nutrition), safety in and outside home, managing incontinence, information on dementia, home aids, falls prevention, etc.
- Sharing Ethnic Meals
- Outing – twice a year – eating out, visit to parks and other places of interest
- Indoor activities
- Theme Celebrations like Easter, May Festival, Christmas, Mother's Day and Father's Day
- Annual Respite Weekend for Carers and Carees. This has been funded twice by Carer Links West, an event looked forward too by participants.
  The weekend respite has been successful, a quality time out or break for both carers and carees. Participants displayed uplifting of spirits, joy, delight and was rewarding in the extreme to me as the coordinator.

5. Resource to the Filipino Elderly Advisory Council and Seven Filipino Senior Citizens Clubs under its umbrella.

The Advisory Council coordinates and monitors activities of the member organisations. They also:

- Liaise with different government and non-government bodies
- Represent the Filipino Elderly Community in forums and provides input to discussion papers issues relevant to them
- Sits in Steering Committee like Council on the Ageing and International year of Older people

They are the active elderly. When they came to Australia, they found that they are living longer and find another 15 years of healthy and productive life in front of them. However, the problem is the art of knowing "how to use those years", how to

channel and find resources for their newfound freedom. They are the future service users of HACC.

The Volunteers

The Filipino Community Council is fortunate to have highly dedicated and skilled volunteers to help deliver our Social Support programs. I would like to acknowledge their invaluable support for adapting well to this year's demand and challenges and for working together as a team to provide culturally relevant and socially acceptable services.

The Role of Ethno Specific PAG in broader service system

Language is very important in PAG. The program is best value for money as it ensures most valuable outcomes for a small CALD community in terms of cultural relevance, effectiveness, quality, access, inclusiveness and responsiveness. Cultural relevance of a program is important because it provides a sense of belonging, affinity and connectedness with others. It gives meaning to social existence in providing appropriate and sensitive response to situations, attitudes, beliefs, etc. Model to date is effective, meets clear outcomes but could still be improved with increased financial resources.

Many people from culturally and linguistically diverse backgrounds are denied the chance to participate in the services they get because they are unable to communicate and be understood. The most critical aspect to language is social connectedness. This is particularly important in social support programs such as planned activity groups.

Partnership and Links with other HACC Providers

Close links and liaison with mainstream service providers is maintained through cross referrals, case management and shared use of resources through training and health education activities ex: Local Government, Community Health Centres, CACP, Linkages, RDNS and Rehabilitation Centres.

Preventative approach through advocacy, information and referral and access to appropriate services is also maintained.

PCP Participation

I am actively involved in the Western Metropolitan Region PCP Cross alliance service coordination project. Participation is vital to ensure that issues for CALD communities are understood and taken up by PCP partnerships. I am feeling the effects of the complex consultation and workshops process and the additional demands on our resources, the impact on a sole worker in maintaining the services, as well as contributing to the reform changes.

The Future – Projection of Older Filipino Immigrants 1996—2026

The older population born in the Philippines is projected to expand substantially between 2011 and 2026 from 11,200 to 42,700. This represents 280% growth rate over the period. By 2026 there will be 6,400 (0.6%) persons age 80 and over who were born in the Philippines living in Australia.

In Victoria by 2006 it is estimated that 60+ will represent 6% of the total population of 20,121 (1996 census). This excludes new arrivals after 1996 census. Older persons

who were born in the Philippines are concentrated in New South Wales – 57.6% and 21.8% in Victoria.

In 1996 we were the 13th highest with Philippine born population but in 2026 we will go up to the 6th. The reality facing the Filipino Community Council or the community is the demand for HACC and other formal Community Care services. Rapid changes in the age structure of the Filipino community will have serious implications for service provision and for the ability of the community to provide appropriate care.

I hope that the unit costs for providing social support programs will be increased and the $ funding formula will be based on needs. Building on the strength of specialist agencies will support them in taking the initiative to address their own problem. It will also enhance their services through responsive and acceptable programs. It gives them a voice in design, service planning, delivering and evaluation of the program affecting them.

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Megs Osborne, *PAG/ADASS Coordinator*
Cheryl Follet, *Carers Respite & Information Service, The Cottage (Wodonga City Council)*

Volunteer Visitor & Respite Service: Pilot Project

In 2000 a HACC service development research project, Made to Measure looked at utilising community based resources and activities more effectively for Planned Activity Groups and Social Support Activities. An essential recommendation from the project was the need for a way to link people into appropriate community based activities. A partnership was formed between City of Wodonga ADASS and Carers Respite Information Service. The rationale for the partnership was based on the expertise of the City of Wodonga ADASS program for volunteer coordination and the jointly recognised need of carers and clients for respite and social support opportunities.

A pilot project, which is a social support and respite model, was developed. It utilises volunteers to link people into community activities and to maintain, develop and support social networks and connections. This social support and respite model has been able to respond to diverse and complex needs in ways that are age and culturally appropriate.

Volunteers are recruited and trained utilising a training package ADASS staff developed. The training package has been a key element of the project with volunteers receiving information to enable them to work effectively in their role as a volunteer. Each volunteer receives a resource package and on-going education is provided through in-service training.

One of the strengths of the social support and respite model is the appropriate matching of client needs to volunteer interest and skills, e.g. an identified mutual interest in jazz music. Another essential element of success is the ongoing monitoring and support of volunteers, clients and carers. For these matches to be effective the outcomes for the volunteer and client must be mutually beneficial. We have many

case examples to draw from, the following are just a few to demonstrate the diversity, and flexibility of the services we are able to provide to meet the needs of our clients.

Case examples:

- A volunteer took a client for her admission to nursing home. This relieved the emotional stresses on the family and the result was a more positive experience for everyone.
- A client with no family locally was to go on respite to hostel but had not seen the facility. A volunteer was able to take her for a visit and the client was much happier having met the staff and seen where she was going to stay.
- A client in her early 60s from a culturally and linguistically diverse background was referred by a mental health service. She was grieving, suffering from depression and panic attacks after the loss of her husband. With no family or close friends, she was very isolated. A volunteer was able to support her. The long-term outcome was so positive that she now lives a very active life linked into culturally appropriate groups and has become a volunteer herself.
- A client who had suffered a breakdown and would not leave her home has been supported by her volunteer over a long period and is now participates in many community activities. Initially the volunteer supported her in attending ten pin bowling and a gym program but she is now confident to attend these on her own and does not rely on her volunteer. She now has the confidence to do such things as go shopping, to the hairdressers and to invite her volunteer to join her for lunch at a restaurant.
- A client wanted to purchase a summer wardrobe but did not have family who could take her to do this. A volunteer was arranged to take her shopping and for lunch. This was such an enjoyable day for her, having company and coming home with lovely new clothes.
- A Carer wanted to have her hair permed but felt unable to leave her partner on his own for so many hours. A volunteer was organised to spend the afternoon socially with the partner, which he enjoyed and the care was able to enjoy the experience of some pampering without worrying.

To respond to the need to increase the number of volunteers required within the program a partnership has been formed with Wodonga TAFE, Health, Social & Community Studies section. The partnership has enabled students to gain placement credit for the hours they participate in the program. The partnership has provided a mutual benefit to both the social support and respite model and to the students. They have gained valuable experience and contact with their potential client group.

The result of this social support and respite model has been a significant increase in the number of social support and/or respite hours provided to a broader client base. This increase in responsiveness is proving to be very cost effective and beneficial to all partners.

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Luzma Sanchez, *ADASS Service Unit Manager Brimbank City Council*

A positive perspective: A mainstream agency providing multicultural services

"No one is culturally or linguistically neutral.
Everyone belongs to a culture, however it may be so familiar,
We are not always conscious of it"
(Mathorpe, 1991)

More than 41% of the residents in Brimbank Council come from a diverse background. Brimbank Sub Regional services provide a range of services through the Planned Activity Groups (PAGs) which enable residents to continue living at home and participate in community life.

Brimbank Sub Regional PAGs services cater for 300 individuals on a weekly basis. It delivers twenty programs: ten for individuals who suffer memory loss and dementia and the other ten for frail aged.

This paper will cover the delivery of multicultural services by a mainstream agency, in particular our program's goals, activities, challenges and key elements.

Every day at our centres is a Multicultural Day. A number of individuals from diverse cultures come together to share … to share their stories, experiences, traditions, languages and most importantly to HAVE FUN together!

These programs are delivered with the support of four paid staff members (one Coordinator and three Program Assistants) at each centre. PAGs also have a number of volunteers who assist in the day-to-day tasks. More than 50% of our staff are bilingual and we are fortunate enough to have multilingual staff.

Program Goals

Our main goals are:

- To provide a safe environment and friendly approach
- To provide activities that are culturally appropriate
- To provide a culturally relevant meal service
- To provide a responsive program by using a common language and by being sensitive towards clients' needs and feelings.
- To encourage clients to be part of the activity's planning.

Activities

Sub Regional PAGs provide a variety of activities across the different groups. Our aim is to support the mental, physical, recreational and spiritual aspects of our clients. Some of these activities are:

- Recreational activities: Music plays a key role in our centres. Clients fully participate in activities such as dancing and singing. Music Therapy is one of the main activities provided to individuals with memory loss and dementia. A Music Therapist attends the centres in a monthly basis.
- Innovative activities: grape crushing and chucks therapy.

Health Promotion

Health promotion in PAGs is becoming vital as the clients who are attending the programs present higher physical and mental needs.

Brimbank Sub Regional PAGs services has invited, in the past, health professional speakers to talk to our clients. However, we want to give this area a greater emphasis. Our aim, this year, is to provide awareness and information sessions to all our staff as well as our clients including those from culturally and linguistically diverse (CALD) communities.

Challenges

For some ethnic aged groups the concept 'day care centre' is hard to grasp. It either does not exist in their culture or applies to other specific services such as children's facilities. Anecdotal and scientific data has shown that some ethnic aged groups have chosen to refer to the day centre as 'the club' (Sanchez, 2000).

To provide activities for such a diverse group is a challenging task. In order to facilitate the program delivery, some groups are divided in subgroups and to cater for their cultural preferences. Our activity approach is currently under review, and we are looking for ways to maximize our client's satisfaction as well as the utilisation of our human resources.

Key Elements

The following are some of the vital elements for the provision of a successful multicultural program.

- Each individual is treated with respect. Various aspects of the client's background are considered, such as language, cultural factors, social and family networks, recentness of arrival, amongst others.
- Staff members' attitudes play a key role in the planning, development and implementation of a successful program.
- Awareness about the issues affecting the ethnic aged has been fundamental in assisting us, the service providers, in gaining a better understanding of those issues and maintaining cultural identity in community settings.

Some of the strategies that have assisted us to do so are:

  - an open mind,
  - learning about other cultures
  - researching on the client's preferences, likes and dislikes
  - and networking.

The challenge of an ageing population is at Australia's front step. We, as service providers, need to prepare well in the planning and implementation of appropriate programs that will cater for all including individuals from the CALD communities.

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Good Practice & Innovative Service Models Concurrent Sessions

Session 5 – Isolation

Patricia Roberts, *Coordinator, Indigo Shire*

Planned Activity as a Meaningful Experience in the Indigo Shire Towns of Kiewa, Kergunyah, Tangambalanga and Sandy Creek

Background

In July 1998 Indigo Shire commenced the Community Meal project in the small town of Tangambalanga servicing the isolated areas of Kergunya, Kiewa and Sandy Creek. This region is a small pocket of the shire situated in the North Eastern part of Victoria bordering the neighbouring Shires of Towong, Alpine and Wodonga.

The response to this project indicated that there were older people and families who fell within the HAAC target group who were isolated and receiving no services. After conducting a survey and consultations with small Community Groups funding was received to set up a Planned Activity Group to service this area in 2001.

Role of PAG in the Broader Service System

- The aim of the service is to bring people from outlying farms and townships who were socially isolated together where they would be able to join in different recreational activities
- Generate and recapture the feeling of community which had been lost because of age or disability
- Go on outings selected by Client Group
- Share interests
- Pass on generational skills to younger people in the community by participating with the local school on combined projects
- Form alliances with other PCP partnerships and engage in "Healthy Communities Projects"
- Provide flexible options for participants of target group

The presentation will include:

- Statistics showing population and % of service anticipated in the area
- Demographic information
- Barriers confronting program

- Issues to be resolved
- What program has achieved up to date
- Future objectives

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Bonnie Whyte, *Activity Group Coordinator, Boort District Hospital*

Men on the Move

The Planned Activity Group at The Boort District Hospital was initially established to bridge the isolation gap of rural men, with these people living 110 km from the closest provincial city.

A program for men, "Cooking Well, Eating Well", involved seven men who formed a core group, that encouraged us to explore further contacts with isolated men in our community. Activity Group Staff in conjunction with the Community Health Coordinator established the need for a male orientated program. Local knowledge assisted greatly in the development of the volunteer program and the initial contacts which allowed the process to evolve.

The pilot program of "Men on the Move" was established in 2000 with community networks promoted and developed to assist participants to live independently and encourage socialisation. It raised an awareness of Community services available to those living at home, and created social contacts, that enhanced their quality of life.

This program has had tremendous success, with ongoing assistance from volunteers who gave the program motivation and inspiration. After working through the evaluation process a positive outcome was achieved and a successful submission for 2002 funding.

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Julia Ward, *Coordinator Life Writing Correspondence*
Liliana Parrella, *Coordinator HCEP Hawthorn Community Education Project*

Telelink Writing Classes

The Life Writing Correspondence Course is a project that originates from Hawthorn Community Education Centre. It is a state-wide program. The Life Writing provides a service for people who are housebound but not thought-bound and includes those people who are isolated, for whatever reason. The course offers a broad range of imaginative topics designed to stimulate both memory and imagination. Writers are individually linked to an encourager, conventionally called tutor, who, each month,

reads the writer's work and offers carefully worded comments that may include hints on how to make the writing more effective.

Each year a piece of writing from every participant is published in *Recollections*. A copy of *Recollections* is sent to the Archival Section of the State Library, as well as local libraries, private homes etc.

The LWCC is the underpinning for our Telelink Writing Classes. Our volunteer encouragers provide a broad spectrum of expertise – fresh and off beat ideas for topics, (for example, *Passion, Laughter,*) expertise in editing, proof reading of scripts and innovative ways of taking the projects into the broader community. For example, writing short performance scripts edited down from work inspired by Telelink.

The outward turning of the mind positively affects the body. Best of all we participants forget our illness, disabilities, nobody feels patronised, a rare experience for some of us, we are equally valued as people. We are ordinarily denied any educational access because all of us are isolated, unable to get to conventional classes. Telelink Writing Classes are not a luxury but a necessity

Telelink is the term used to describe the linking together of individuals via their home phones to form a group where eight writers, plus the facilitator and tutor, can speak with each other for 45 minutes from the comfort of their own home. Each term is composed of five classes, fortnightly, at a prearranged time and date and lasting 45 minutes.

Our Telelink Writing Classes are highly structured. The topic for discussion is sent to the writer prior to each link.

Telelink Writing Classes were developed in response to a need to have immediate feedback for writers isolated through age, illness, geographic isolation etc. We wanted to create a supportive, friendly and informative environment and Telelink has filled this gap. From the letters and phone calls we receive, it's obvious that feelings of isolation and lack of self worth are rapidly replaced by a sense of accomplishment and an understanding that everyone has a story worth telling. Another of the many outcomes is the mutual support that is so generously offered during the links. Writers develop friendships — exchanging stories, letters, phone calls that continue when the link has finished. It's important to mention that although many of our writers suffer from chronic illness they rarely refer to it during our time together on Telelink.

For this forum on 'planned activity,' the topic for discussion will be *Through the Window.* Each writer will have already written their first assignment and sent it in to the facilitator – myself, to be photocopied and posted on to the tutor for reading and discussion on the link. It's the first class, four more will follow. Liliana Parrella and I will read an abbreviated script of a typical Telelink so that you may easily understand how it works.

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Lauren O'Neill, *Coordinator Cobaw Community Health Service*

Taking the Mountain to Mohamed – PAGs in SRSs

Presenting a model of planned activity delivery that targets and has positive outcomes for a diverse and a sometimes-difficult group of people, while combining community participants with residents of an SRA using the SRA as the venue. Program has been successfully run for 18 months.

Initial Aims and Objectives of program

- Encourage participation of residents of an SRA in a country town who were reluctant and often distressed about attending activities outside their own home-usually due to past experience and/or disability.
- Introduce potential residents from the community to the SRA to facilitate easier transition if it occurred in the future.
- Increase the number of people from the community visiting the SRA to extend social connections.
- Provide an activity program that had positive outcomes for and was meaningful to an extremely diverse group.

Areas to be covered

- History of this particular SRA and its place in the community.
- Graphic representations of demographics of current resident population – 40 to 80 years, Psychiatric disability, Intellectual disability, Acquired Brain Injury, Physical disability, Dementia, Alcoholic Brain Syndrome, NESB.
- Behaviours of participants – would normally prevent them from attending outside activities due to their insecurities and community attitudes.
- The Actual Activities – formally run appropriate games and activities, socialisation.
- Staff qualities and training.
- Where the aims and objectives achieved?
- What is the cost to the service and the participants?
- Positive outcomes for participants
    - Increase in level of trust of people outside the SRA – community members and services
    - Introduces community into SRA
    - Breaks down social barriers and historical perceptions.
    - Some residents of SRA now confident enough to attend activities and functions in the general community.

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Good Practice & Innovative Service Models Concurrent Sessions

Session 6 — Complexity

Judy Anderson, *Coordinator, Peter James Centre, Killara Campus*

Day-Care for Younger Adults with a Dementia

In 1997 carers of younger people with a dementia (i.e. aged 45 to 65) lobbied the Peter James Centre, and HACC, to provide a day respite program aimed at this particular grouping. Until then the only day-care available for this group was with conventional aged care facilities. Clients would often refuse to attend these facilities because of the wide disparity in the ages and physical abilities of other attendees. These programs were usually limited to passive in-house programs and provided little or no stimulation for the younger age group.

In January 1998 the 'Friday Group' was formed under the auspice of the Peter James Centre, and funded by HACC. The Group was initially set up by Garry Jackel, Manager of the Psychiatric Day Hospital, and I was asked, as Coordinator at 'Killara' Adult Day Care Centre, to join him to implement the program.

The initial weekly program envisaged an outing/visit once a fortnight, with an in-house activity for the intervening week. The 'outings' proved to be quite manageable but the 'in-house' program was a complete failure, the Clients becoming easily restless and bored, leading to some distress for all concerned. By listening to feedback from Carers, and through trial and error, this has led to a much-revised format involving a weekly outing in a twelve-seat bus to a wide range of quite conventional tourist venues and activities in and around Melbourne. This has proved highly successful, with many of our Clients now exclusively attending with this Group.

The presentation will focus on this successful format, and its proven need for specific HACC programs of this type.

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Gayle McPherson & **Barbara Wright,** *Interchange Western Region Association Inc*

Respite Through Recreation

Interchange Western Region provides a range of respite, recreation, social and other support services to children (0–18 years) and young adults (18–35 years) with a disability, and their families living in the Western Metropolitan Region of Melbourne. This includes the municipalities of Brimbank, Hobsons Bay, Maribyrnong, Melbourne, Moonee Valley, Wyndham and the Shire of Melton.

Interchange is a non-government, non-profit, community based and managed organisation which was established in 1982 to provide respite to carers through the volunteer host service.

The Host Program is a family based respite care scheme which supports children with a disability and their families through the careful matching of a host/host family living in their area who generally cares for that child on a regular basis, usually one weekend per month. These days some people, hosts and families, prefer single day visits and/or an occasional overnight stay. This program provides regular support and respite to carers while providing the young person with the disability with friends of their own outside of their family, a broad range of social experiences and 'respite' from the parents and siblings.

Up until 1994 the Host program was the only form of respite that Interchange Western provided. Owing to the changing social and respite needs of families in regards to their adolescent children, long waiting lists and the shortage of available hosts, Interchange sought funding through the Commonwealth Respite for Carers Program (HACC) to pilot a new program 'Respite thru Recreation'. This program was designed to meet the families need for a regular break and provide adolescents, with a disability, aged 12–18 years, with an opportunity to make and maintain friendships with their peers through a range of social and recreational activities.

The original intention was to run a centre based program for 20–25 teenagers with a disability, using two paid staff, supported by a team of suitably screened, trained, enthusiastic and reliable, young volunteers (18–35 years of age). Disabilities included intellectual, sensory, developmental delay, autism spectrum, Down Syndrome, physical and multiple disabilities, including epilepsy. The program was to operate fortnightly, on the weekend, with the activities of six hours duration – for families imitating the Host Model of two days per month in line with our original aims. This aim is still the model that we base the majority of our activities on.

The first thing we learnt was that a centre based activity for active, hormonally charged adolescents already 'penned up' for five days a week, was an error of judgement. We became community based after four activities.

The second thing we learnt was that a large group accessing community events 'stood out like a sore thumb', was difficult for staff and volunteers to supervise and support and certainly didn't maximise opportunities for developing close relationships between participants. So the large group was broken down into smaller more manageable groups with similar interests and of a similar age.

Our intention has always been to pursue activities which were typical of the age group with or without a disability, and that the only activities which would not occur would only be those a particular individual might chose not to participate in. Activities needed to be affordable as carers would be required to meet their child's activity costs, which include meals, drinks, transport (community buses hire or public transport), entry fees, rides, etc.

Locations needed to be within a reasonable distance, with the intention to educate the child and their family as to what was available close to home, the possibilities for participation, accessibility and easily imitated by the family on their own. The child would be come familiar with their community and the community with them.

Participants needs, interests and input would always be part of planning and last but by no means least we needed to establish a code of behaviour aligned to acceptable community 'norms'. Participants would need to display or work towards behaviour which was acceptable to the community, their carers and our program staff and would not harm or make other group members uncomfortable, embarrassed, fearful or ashamed. Group participants assisted in the development and ongoing 'enforcement' of these group guidelines.

Another big lesson was the availability of committed, reliable and regular volunteers. As with the Host Program this has been an ongoing challenge. We have had, and still have some extremely committed volunteers but not in sufficient numbers to support the regular inclusion of participants requiring 1:1 levels of support. For these participants, individual funding is sought to employ a 1:1 support worker who is 'matched' to that particular child.

In 1997 the size of our waiting lists for planned activities, the demand for a similar program for participants turning 19, and the desperate need for participants to maintain friendships and relationships, led to Interchange broadening the age group of participants and pursuing the development and funding for more groups.

Since 1998 Interchange Western has been providing two planned activity groups for young adults 18–25 years of age, with low care needs and supported by one paid worker. These groups also operate on a fortnightly basis throughout term and may occur on the weekend or in the evening during the week. These activities are of 3½ to 6 hours duration. Group size, level of disability, interests and staffing levels determines the makeup of each group.

Since 1999 with HACC Planned Activity Group funding, Interchange Western has developed more programs based on the individual needs of participants. There is a school holiday program for participants 8–14 years of age (20 days per annum), two more youth groups, 12–18 years and three groups for young adults 18–35 years of age operating on a fortnightly basis.

Most activities are community based but there is one group entirely centre based. This group meets monthly for an activity of six hours duration with a high staff/participant ratio. The group caters for individuals with very high or complex care needs, or those unsuited to community based activities.

In general we do not have a waiting list as participants who do not have a 'regular spot' in a group are invited to fill gaps in suitable groups when vacancies occur due to illness, other commitments or disinterest in the activity taking place. This is

referred to as the 'Interchange Bench'. Places are filled taking into account support levels and participant care needs, disability, age group mix, the availability of staff or volunteers who know the child, and the time the child was last offered a space on an activity.

All activities are aimed at providing flexible support in a variety of settings, tailor made as much as possible to individual needs, within reason respecting the dignity of risk, maximise opportunities for socialisation and the maintenance of relationships.

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Brenda Baker, *Planned Activities Group Assistant, Latrobe City*

Partnerships with the Office of Housing

Description of the advantages of sharing resources between government bodies, together with a discussion on the problems arising, and how they have been dealt with. The presentation will cover—

- The partnership between the Office of Housing and Latrobe City ADASS Program
- How did it begin
- How does it work
- What the build has in space available that benefits the program and clients attending
- Benefits to Aged residents living in the units
- Benefits to Clients attending
- Advantages of getting volunteers from the units
- Utilizing a resource that wasn't being used
- Disability access
- Sharing the costs of amenities – power, water, etc
- Sharing the replacement costs of equipment
- Funding being able to produce more hours and less costs on renting
- Access for drivers transporting clients in vehicles
- Staff and clients in a friendly user friendly building

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Dianne McClelland, *Program Worker, Housing Support for the Aged*
Richard McKinna, *Men's Program Worker, Team Leader Support Team*
Merri Housing

Social Connection Activities Project

MERRI HOUSING SERVICE

Merri Housing Service is a community-based agency, which provides a range of services to homeless and marginalised men, women and children. Merri Housing Service is funded by the Commonwealth and State Governments. It receives funding for a range of Supported Accommodation Assistance Programs (SAAP) and Home and Community Care Programs. Specifically the Organisation is responsible for the delivery of crisis response and case management based services to:

- Aged people living in low cost accommodation in the North East region who have a range of complex needs and are isolated from mainstream and specialist services. This program seeks to use Community Development principles to link the target group to various services in their community and increase their social support networks.
- Families in the city of Darebin, Banyule, Moreland and Yarra with the aim of securing appropriate housing options for where the families are homeless or a risk of being homeless. Referrals and support in accessing services to assist with any issues that contributed to their homelessness.
- Men and women residing in transitional and appropriate longer term housing in the community through the Women's Support Program and Men's Support Program. These programs aim to stabilise clients within their accommodation by assisting them to address any issues that threaten such stability and ultimately to help them to achieve their maximum level of independence.
- People living in low cost accommodation in the North East region that have a range of complex needs and are isolated from mainstream and specialist services through the Community Connections Program and Crisis Response Program. An emphasis of these programs is to forge linkages with services in the region to improve the service system for the target group.

THE SOCIAL CONNECTION ACTIVITIES PROJECT

Introduction

The Social Connection Activities Project aims to provide low-level intervention to the target population recognising their need to access social activities and facilitating the development of a social support network to promote good health.

Merri Housing Service through its Housing Support for the Aged Program identified a need for social connection activities as a protective intervention strategy for tenants in low cost Office of Housing accommodation who are experiencing social isolation

Profile target group

- 50 years or over, residing in Darebin, Moreland and Banyule.
- Require monitoring and support to maintain stable tenancy arrangements and access services

- Socially marginalised and/or isolated and have unmet support needs.
- No family support networks
- Have poor living skills and difficulty in maintaining basic levels of self or home care.
- Poverty

Referral Source

Access to the project is via referrals from the Housing Support for the Aged Program and the Community Connections Program.

Activity Types

In our opinion the activity type isn't the most important aspect. What is really important is creating a space where people can feel comfortable and have the opportunity to take part in communication with each other. The worker acts as a facilitator for this process, working with the group to determine what activities are suitable and encouraging a friendly and safe environment.

Another important aspect of the group is the feeling of acceptance that comes from being with peers that share a similar life experience, for example a drug or alcohol addiction, imprisonment, loss of assets, no family supports etc. The focus is on building relationships and ending isolation.

The client group is given the opportunity to help determine where they would like their group to go to and the type of activities they would like to be involved with.

The sorts of activities that have taken place have been BBQ's, trips to the Zoo, Art Galleries, Community Gardens and Lunches at restaurants.

Program Philosophy

The program aims to work with socially isolated people and give them a time and place to be with other people in a safe and enjoyable environment. To large extent this program aims to combat loneliness and give people a sense of involvement in activity. For some it will lead them to have the confidence to re-establish themselves in a broader community.

Social and Health Benefits

"Social support and good social relations make an important contribution to health. Social support helps give people the emotional and practical resources they need. Belonging to a social network of communication and mutual obligation makes people feel cared for loved esteemed and valued. This has a powerful protective effect on health". (The Solid Facts. Social Determinants of Health. 1998).

At Merri Housing Service we have also observed the benefits of the Social Connections Activity Group and have found them to be extensive and varied. One of the most obvious is the new friendships that have formed and that continue outside of the Social Connections Activity Project. For people that have been socially isolated for any length of time regular communication with new friends has profound effects; from the way they groom themselves to their attendance to their health.

It has also been seen to be beneficial to casework aiding in establishing a relationship, health promotion, information delivery, linkage to services, connection to mainstream services and groups.

Merri Housing Service acknowledges that poverty and poor social circumstance affect health throughout life. The Social Connections Activity Program seeks to address this in service delivery.

Contact details

Dianne McLelland or Richard Mckinna, Housing Support for the Aged, 9 Langwells Parade, Northcote, VIC. 3070. –Ph: (03) 9482 3488 – Fax: (03) 9482 3119
– E-mail: diannem@infoxchange.et.au and rmckinna@infoxchange.net.au

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Good Practice & Innovative Service Models Concurrent Sessions

Session 7 — Diversity

Carolyn Mclean, *Community Services Manager*
Joan Andrews, *Team Leader Aged & Disability Services, City of Kingston*

Kingston Social Support Program: Meeting the Diverse Needs of the Community

Introduction

The City of Kingston's Community Services team have progressively developed a range of social support programs to target the diverse needs of its community. The City is characterised by one of the LGAs with the highest veteran population, an ageing population and a diverse range of residents from culturally and linguistically diverse groups. In the development of the range of social support programs over the last three years, Community Services has aimed to provide programs that cater for the different needs of a diverse population.

Background

In 1999, Kingston's Community Services undertook a review of the social support services that were being delivered to the community with a focus on analysing the access of different community groups within Kingston. This review found that:

1. Minimal numbers of residents from culturally and linguistically diverse groups were accessing social support programs.
2. Isolated and frail HACC clients had limited access to either individual or group support. This pertained particularly to many of the MOW clients.
3. Affordable transport for HACC clients to attend medical appointments did not exist, and
4. Some of the more mobile HACC clients did not belong to groups that provided 'days out" and these clients were seeking companionship and a structured social event.

Development of Programs

1. Development of Social Support Programs for Culturally and Linguistically Diverse Groups.

As a result of the access and equity review of social support programs, the City of Kingston applied to the Department of Human Services for a service development grant to develop inclusive social support and MOW programs for these groups within the community. The City of Kingston provided additional resources to also develop and implement a HACC Communication strategy. The HACC

communication strategy provided the ability to gather information from the CALD Senior Citizen Groups concerning their social support and nutritional needs.

Three demonstration projects were trialled that provided social support with the addition of a culturally acceptable meal. These three projects were:

- The delivery of an authentic Greek meal to HACC eligible clients.
- The co ordination and transport of smaller CALD Senior Citizen groups to meet at a 'Healthy Choice" restaurant of their choice followed up with a leisure activity.
- The financial support of CALD Senior Citizen groups to assist the production of a culturally authentic meal for their HACC eligible members. This also involved the support of Kingston's Environmental Health department to assist the development of safe food practices.

All three projects have now become recurrently funded by the Department of Human Services and the City of Kingston. The least successful of these methods was the delivery of the authentic Greek meal. The evaluation results detail that this project was not so successful, not because of the quality of the food, but because of the delivery and preparation of a meal by a stranger, which is then eaten in isolation is not culturally acceptable.

Isolated and frail HACC clients

The survey conducted as part of the review found that isolated and frail HACC clients were interested in participating in social lunches and also, for those who could not get out of the house, having a one on one visitor. Surveys of MOW volunteers found that a number of volunteers were interested in supporting HACC clients on a social basis, rather than just delivering MOW.

To combine the needs of both HACC client and volunteers, two programs were developed. The first involved co coordinating and transporting MOW clients to a regular monthly social outing. This involved a meal and social activities at RSL clubs. RSL clubs have been enthusiastic partners in this project, providing volunteers to socialise with the MOW clients. Transport has been provided through a mixture of the community bus service and volunteers providing transport. The City of Kingston provides a financial subsidy for the lunch and the RSL provides three excellent courses at a discount rate.

A visitors program has also commenced for HACC clients that are too frail to be able to go out of the house often. This program is staffed by volunteers who visit the clients on a weekly basis and provide social support. This program was developed in response to volunteer feedback concerning some of the people that were on their MOW rounds who were very isolated. As these volunteers had already developed an acquaintance with the person, a structured volunteer program allowed a higher level of contact and friendship to develop.

Volunteer Community transport

Many HACC clients provided feedback that if regular medical appointments were required, transport became unaffordable, if reliant on the aged pension. As a result of this feedback, Kingston Community Services developed a volunteer community transport service. Volunteers are provided 50 cents subsidy per kilometre directly

from the client. This service is important, because apart from people being able to access medical services through affordable transport it represents a sustainable community model. This service builds community capacity, as it is about people within the community volunteering their time which in turn raises their awareness of aged care issues. We now have 120 transport trips per month, servicing 35 to 40 number of clients per month.

In addition, the volunteers are able to wait with the client while they have their appointments, which provides companionship and confidence for the more frail and vulnerable. Volunteers also assist with transport where one spouse may be living at home and their partner in a nursing home.

Getting out and about

Another need arising from the review was that many of the more mobile HACC clients did not belong to a specific club or organisation that provided social support activities. Some of these clients were not necessarily attracted to the structured programs offered through Senior Citizen Groups but would like to be able to meet people and visit interesting places.

To meet these needs, Kingston Community Services provides regular day outings to HACC clients within the community. These day outings are subsidised by Kingston Councils with a small fee, usually $8 paid by the client. These outings include a lunch, morning and afternoon tea. As can be expected, demand exceeds supply of available bus places for these outings.

This service is very important in terms of preventing social isolation and providing the opportunity for people to develop friendships with other people, who might live in different neighbourhoods.

Contact details

Name: Carolyn Mclean or Joan Andrews, City of Kingston, –Ph: (03) 9581 4850 (Carolyn) and 9581 4828 (Joan) – E-mail: carolyn.mcclean@kingston.vic.gov.au and joan.andrews@kingston.vic.gov.au

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Jan Treurniet, *Executive Officer, Do Care Geelong*

Do Care Social Support Groups Program

A typical Best Practice Volunteer Program (according to Geoff Freeman, Director of Criterion Consulting, Melb – IYOV Conference Melbourne 2001) has:

- Focussed management with relevant skills and values
- Flexible and responsible management system
- Motivated and well-trained volunteers
- High level of client satisfaction
- A culture orientated towards continual improvement
- A safe healthy environment /good workplace relations

DoCare Geelong was established in 1979 … It's a *grass-roots* organisation linking frail aged socially isolated people with the community through carefully matched volunteers.

All the Programs are free of charge and based on the philosophy of friendship – not service provision.

PLANNED ACTIVITY GROUPS.

DoCare's groups are about connecting people. They're about INTERdependence:

- Communication
- Consultation
- Inclusion
- Encouragement
- Patience
- Tolerance
- Understanding
- And a healthy dose of humour!

Partnerships of

- Clients
- Volunteers
- The DoCare organisation
- The Community

They're about fun, flexibility AND FRIENDSHIP.

They are about providing a meaningful experience each time the group get together.

We have approximately 15 groups going out per month – All are unique!

Each group has

- A volunteer facilitator
- Volunteer driver
- Approximately 6 to 8 people form a Group
- They 'own' the group
- They decide **where** and **what**
- Volunteers enable the clients to do the activities that they choose.

What do they do? Movies, fish and chips at the beach, walks, exercises, museums but mostly they eat drink and be Merry!

Client Assessment

The manager allows plenty of time during the home visit assessment to **listen** and **learn**…

- Why the client needs assistance to socialise
- To encourage and motivate
- To establish what their interest are
- To hear about their life experiences, personality, culture and social history
- To know who they are.

Volunteer Support

All DoCare volunteers go through an orientation process.

1. Interview
2. Compulsory comprehensive information sessions
3. Police check
4. Verbal reference check

They receive:

- Position Description
- Detailed Handbook – specific to each Program
- Certificate of Attendance – detailing Session topics
- HACC Guidelines
- Insurance details
- Bus-driving session with Instructor
- The on-going support of the Social Groups Manager.

Before matching a volunteer driver or facilitator to a group, the manager meets with each volunteer. The personality and communication skills of the volunteer play an important part in how they interact and contribute in group situations. They need to be able to work as part of a team – be available to listen to concerns, deal with any problems on an outing – be a friend AND most importantly – HAVE FUN!

The team dynamics can make or break a Group.

Organisational Support

DoCare's strength lies in what I call 'the parallel tracks'. Both equally important, mutually beneficial, separate – but in partnership.

OPERATIONAL – The 'How' we do it	***WARM FUZZIES – The Outcome for the client***
Vision, Philosophy, Culture	Satisfaction, Fulfilment
Skilled professional Staff	Quality of Life
Policies and Procedures	Fun, Friendship
Evaluation / Monitoring	Good health & well-being
Trained, supported volunteers	Motivation

Solid funding base

Records and Documentation

Review Processes

Social Networks

Sharing, Trust, Choices, Control

Sounds to me like Geoff Freeman's 'Typical Best Practice Volunteer Program'!

DoCare Geelong Social Support Programs **are** about people.

The concept is simple – it works!

DoCare Volunteers Do Make a Difference!

Contact details

Jan Treurniet, Do Care Geelong Co-op Ltd. –Ph: (03) 5229 9669 – Fax: (03) 5229 3221 – E-mail: docare@pipeline.com.au

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Scott Sheppard, *Manager, MOIRA Interchange*

Siblings Playing and Learning and Talking Together – SPLATT

According to the HACC Service Guidelines, Social Support – the "Scope of the service includes: carer support groups"

We believe that by supporting the families of children with a disability as "carer support groups", siblings as part of the family are indeed "carers" in this sense and need to be supported as well in appropriate ways.

There is more to a family than the child with special needs and his or her parents, we need to include the whole family: child, parent/s, brothers and sisters, grandparents and other family members.

Moira provides a range of support services for families of children who have disabilities with a family centred approach, including:

- Respite services, recreation – shops, camps, youth groups etc/host
- Respite coordination
- Parent/carer support – mothers/fathers/support groups/workshops/ education
- Case management and brokerage, accommodation and outreach services.

About 5 years ago over 80% of families surveyed identified that they wanted some sort of support or service for their children who had a sibling with a disability.

The parent support program together with the ICS program worked together to develop a program of support for siblings.

They resourced the pilot program with dollars and shared knowledge and experience.

They recognised that they did not have all of the necessary skills and expertise, so they approached others to further develop the concept.

In developing the program, those concerned soon realised that the issues and emotions that they would be dealing with were considerable and that there needed

to be a clear structure that guided the participants through the experience, supported them and introducing strategies to deal with some of the issues raised.

The program needed to be fun, appropriate and interesting for the children concerned and very importantly affordable for the agency to provide.

SPLATT was the result of this collaboration

At this stage the program was being funded from both parent support and ICS on an ad hoc basis with no recurrent funding being secured. Applied for recurrent funding in the HACC funding rounds. It took a couple of unsuccessful rounds before we were successful. Initial funding got the program up and running, provided stability and consistency.

Soon realised that there may be times when very serious issues may be raised by the children and that you couldn't just leave them "hanging" and unsupported with huge unresolved issues after the camp.

So some additional funding was sought to allow for some follow up 1:1 counselling to be made available if required.

Continuous improvement model.

Received an increase in funding to enable an additional camp per year.

Chat room, 6 to 8 year olds day, mentoring.

We would like to develop partnerships with other agencies to ensure consistent services across the region.

The current HACC funding does not cover the real cost of providing this program, we are committed to supporting families in this way, we are seeking funding increases and other resources to further develop this much needed service.

Contact details:
Copies of the program manual are available for purchase by contacting:
Elizabeth Bruce (Psychologist) – Ph: (03) 9563 8677 – E-mail: ebruce@vicnet.net.au

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Julia Nirchberg, *ADASS Team Leader, City of Greater Dandenong*

Festive Friends

As a part of our service we run 13 planned activity groups. These vary in number of clients, representation of professional disciplines and target populations.
For example, each week we run two programs targeted at Vietnamese community.

Each program offers up to 26 places and focuses mainly on socialization and health education.

Other examples are our Anglo Indian and European programs. These offer up to 14 places in each. The main focus of these groups is client reminiscing and diversional therapy.

Further, our Dementia specific group caters specifically for a small group limited to 10 clients with very advanced dementia.

Broadly speaking, the services we offer to these clients are mainly therapeutic and are designed to maintain them at home as independent as possible.

I hope you are getting a picture of the diverse nature of our service and of our extensive repertoire. Despite the broad range of services we offered, we believed there was an opportunity to innovate in response to client needs.

Thus, today, we are very proud to present our relatively new and certainly innovative program called “Festive Friends”.

First, I would like to tell you a little bit about what the program is about and how it became a part of our service. Many services in our municipality were closed for two weeks over the Christmas break. This included our service.

However, every year we noticed our clients became hugely disappointed when we advised them of the Christmas break. In addition, we noticed increased interest and enquiries from carers at that time of year. So we took a step back, and began to think about what was really going on.

We learned that no day activities were available in our municipality during this time of year. There was a commonly held belief that our clients preferred to be with their families and that few would attend services if offered during the Christmas break. As you are all aware, this runs counter to the evidence.

In fact, people are becoming more and more isolated even from their families. For many people, Christmas is “just another day and nothing much to do”!

Our Municipality has a large and growing Asian population. This means that for about 20% of all elderly people in the City of Greater Dandenong Christmas does not have any cultural significance. This leaves them with no alternative activities over the Christmas period.

All this was our reasoning behind the grant application to the Department.

Our application was successful – we were offered the opportunity to make a difference.

As we received the money one month before the commencement of the program, our “Festive Friends” began to take a definite shape very swiftly. In one month we had to generate publicity, accept and process referrals, book staff and volunteers, plan transportation, meals and activities.

All this took careful planning, staff training, brainstorming and generally very hard work. Inevitably, some tensions also arose. But in the end, all our hard work paid off.

Our experience can be very useful for those of you who are thinking about a similar project. Thus I must mention higher then usual staffing costs for public holidays, difficulties in arranging transportation and meals for clients, as most services are closed at this time of year. We were lucky to have our council bus service offer their buses for us and our staff to drive the buses. Otherwise this exercise could be very difficult. For meals we had to plan ahead and do some of our shopping to stock up for Public Holidays.

Staffing the program became a big problem. As you can imagine, Christmas Day and Boxing Day were the hardest. However a double time and a half pay attracted just enough people.

The Festive Friends program in December 2000 and December 2001 ran for 11 days, including Christmas Day and Boxing Day.

When designing the program we attempted to create something very different from our usual day activities. Each program had to be unique and be full of festive spirit. Two out of the 11 days were designed to cater specifically for Asian Communities.

Twenty-one core and five high clients attended daily. Three program assistants and hands-on program coordinator took part in this cheerful exercise. Four volunteers offered their time daily.

Our Program plans included:

- Special Devonshire tea on arrival
- Festive celebrations
- Exercise programs
- Reminiscence sessions
- Pampering sessions and much more

HIGHLIGHTS: (presented by Savun Rim)

- Tai Chi
- Music therapy
- Special meals and party nibbles (menus presented) presented and decorated in traditional ways-candles and all
- Lucky door price daily
- Christmas arts (samples presented)
- Christmas cooking activities (client and volunteers in groups making traditional Christmas sweets) (sample of a recipe presented)
- Flexible transportation options: taxis and wheelchair taxi, buses and a council car
- Volunteers
- Christmas sing along before the end of the program
- Singing competitions in different languages
- Party poppers exercise program

Contact details

Julia Nirchberg, City of Greater Dandenong, –Ph: (03) 9558 4490 – Mobile: 0419 872958 – E-mail: Jnirch@cgd.vic.gov/au

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Good Practice & Innovative Service Models Concurrent Sessions

Session 8 — Defining Good Practice & Innovation

Mary Cigognini, *Manager Extended Care*
Daniella Vicarrello & Paul Buckingham, *Program Workers,*
Darebin Community Health Services

Hearing the Voice of Older People

The Planned Activity Groups at Darebin Community Health did not have a history of promoting discussion of issues between group members, nor of meaningful participation by group members in the decisions of their program.

There is even a more serious problem in the way, in which Planned Activity Groups in general operate, which contributes to the further disempowerment of the group members.

The reasons are complex and they include the cycle between preconceived ideas about older people by program workers and the "safe" unchallenging environments and expectations generated which in themselves seem to promote a lack of enthusiasm and initiative by group members in planned activity groups.

During 1999 a pilot process was initiated within the Tuesday ladies planned activity group to promote small group discussion about growing older. It was seen to be an opportunity for older people to listen, share their experiences and analysis. Older people have fewer opportunities to be part of this reflection and discussion. It was also an opportunity for staff to reflect on their own assumptions about older people they are working with, directly about issues that had been regarded as taboo.

There were difficulties in carrying out this process. There were even more difficulties in sustaining the opportunity to develop it further, not only within the other groups, but also further exploration and discussion of other social issues.

As a result of this process the planned activity ideas group has been established. The objectives of this group are to further promote meaningful participation of group members. This working group promotes a participatory process of dialogue and shared decision –making between group members, staff and management of the planned activity groups program on issues relevant to older people and further development of the Darebin Community Health planned activity groups program.

We invite you to use this experience as a springboard and resource for the work you are doing with older people. We especially believe that this sort of dialogue can be stimulated in many settings where older people are already coming together. It is also important to acknowledge the importance of openness and flexibility of the staff of Planned Activity Groups to promote this initiative.

It is this readiness for new initiatives that can further enrich the opportunities for the participants of the Older People that attend Planned Activity Groups.

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Ph: (03) 9478 5711 – Fax: (03) 9478 9647 – E-mail: Mcigognini@darebinch.com.au

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Lori Anderson, *Manager*
Marisa Caputo, *Complex Needs Support Worker, Coolibah Centre*

Responding to the Complexity of Needs

The Coolibah Centre was implemented to address the needs of older people on low incomes who live in rented and often sub standard accommodation. Many of the members are from non-English speaking backgrounds and all have a disability or other condition that limits opportunities to participate in regular community activities.

The Coolibah program is based on a holistic approach with the health, welfare, social and leisure needs of the target group taken into account. A wide range of flexible options is available for clients including recreational activities, trips, outings, social support, health care and meals.

Information, advocacy and referral are provided and links have been established with a wide range of other agencies including housing, income support, community and mental health services, disability services, doctors and local hospitals.

Clients are assessed, a care plan is developed with the client, goals, strategies and timelines are identified. Clients identify their needs such as developing a budget, using the public transport system, current information from Centrelink to name a few. Staff are then able to ensure the above services visit the centre and inform clients about their services.

An ATSS (Adult Training Support Service) program also operates within the Coolibah Centre. For some of our clients an intellectual disability has restricted their participation within the community. The aim of our program is to tailor the program to the individuals needs or wishes, that it is age appropriate and that the clients feel included and once again part of the wider community. One of the added advantages for the ATSS program is its environment and versatility. The ATSS is a specific program incorporated into the Coolibah Centre. Here clients are given an opportunity to participate in a program or activity or if they wish to catch up with friends over lunch or a cup of coffee. Although the program offers “Choice” an individualised monthly planner is essential.

One of the major advantages in having an “in house” ATSS with mainstream Day Centre is the interaction between clients from both programs all of whom have complex needs.

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Reg Blow, *Manager, Aboriginal Community Elders Services*

Welcome/Respect/Self Identity

Introduction

The Aim of the this session is to provide an overview of the Aboriginal Community Elders Services; Day Care program which operates out of the Iris Lovett-Gardner Caring Place in East Brunswick.

Target group

Our Day Care client group is Aboriginal people or non-Aboriginal people who may have an Aboriginal spouse or be connected in some way to the Aboriginal community. However there are Non-Aboriginal people living at the centre who have no connections at all with the Aboriginal community, these people are also welcomed to attend our program.

Philosophy

The Day Care Program operates on a certain philosophy, in addition to the general aim of Day Care Centres, that is to provide services that will assist the client to maintain their independent living life style for as long as possible. There is also a cultural theme to address some major issues in the lives of our client group, their Aboriginality, their cultural identity and their place within the Aboriginal community.

Program

This is why our program sessions are developed with Aboriginal people real needs in mind and why the central theme and main building plank of our program is our "Spiritual Journey of Self Discovery".

Process (How does it work and what are the outcomes?)

In order to present program sessions that are wanted and needed by our clients and to develop and maintain best practices, it is essential that these sessions have meaning and benefits to the program participants. Regular consultation with the group is paramount to enable the group to have equity and ownership of the program.

In addition, these sessions are designed to engage our participants in activities that they want and need, so that there are some benefits, with positive outcomes so that they want to continue to attend the program.
Sessions

In order to achieve the above, it is essential to know where your clients are coming from and to develop processes to assist the clients to know where they should be going. In some ways it is a mapping/goal setting planning process to set directions for the client and the clientele in general.

Group dynamics are another essential component of the process to bond the group and/or sections of the group so that they have the opportunity to have shared experiences and opportunities to connect with one another either one to one or to the group.

Outcomes

The main outcomes of the program sessions are to have the participants increase their confidence and self esteem through their belief in their own skills and abilities plus to see them selves as Aboriginal people with a cultural heritage that they can be really proud of and claim as their birthright.

Outreach

It is important that this program is shared with other Aboriginal communities throughout Victoria. As a first step the Day Care program is now involved with an outreach program in the Western Suburbs. It is proposed to extent the program in the future to the Healesville and Dandenong Aboriginal communities respectively.

Hopefully, other Aboriginal communities through Victoria will develop and conduct their Day Care Programs with a cultural component for their own individual and community culture awareness program. An interesting extension of an Aged Care Program is to have the Elders write/tell their stories so that future generations will have some real account of Aboriginal history as told by an Aboriginal person/s.

Contact details

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Carol Wilson, *Manager Southern Peninsula Community Care*
Ila Howard, *Coordinator, Banksia Centre, Brotherhood of St Laurence*

Trust/Cooperation/Great Outcomes

The coordinators/managers of eight PAG services on the Mornington Peninsula have been meeting for several years on a bi-monthly basis. Some of the programs are small, others are large and complex. The partners are

- Banksia Centre – Brotherhood of St Laurence
- Andrew Kerr Day Centre – Mornington
- Memory Lane – Somerville – MPSC
- Southern Peninsula Community Care – Rosebud
- Rosewood House – Peninsula Health Network
- Mt Eliza Community Contact
- Mornington Greek Group – Migrant Resource Centre
- Baxter Day Care – Baxter Village.

The meetings are an opportunity to share successes, provide support to coordinators and discuss difficulties.

The coordinators have all derived great benefit from this coalition and the programs provide a more flexible, innovative and responsive service.

TRUST is the foundation of our network, we have learned that we can share our concerns and our discussions do not go any further. As coordinators we have all had

difficulties concerning either staff, volunteers, committees of management, clients or carers. Having a network of colleagues who may have encountered similar concerns has been beneficial and reassuring.

LOBBYING is another role that has come from this group. As individual services we felt the PAGS had a minor presence at District Care Planning Meetings. We now send a representative to represent all PAGS and our concerns and issues are acknowledged as being relevant and worthy of discussion.

INCREASED FUNDING has been a tangible benefit to this group.

We demonstrated that we were working co-operatively and could be partners in a Flexible Service Response Grant. We do not see ourselves as competitors in the funding rounds but partners in providing the best outcomes for our clients.

Contact details

Carol Wilson, Southern Peninsula Community Care Inc., –Ph: (03) 5986 5255 –E-mail: spcc@cdi.com.au or Ila Howard, Banksia Centre, Brotherhood of St Laurence,
–Ph: (03) 9783 5907 and 9782 9322 – E-mail: ihoward@bsl.org.au

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Plenary Panel

Perspectives on Planned Activity Group Services

David Hooker, *Resource Worker, Alzheimer's Association Victoria*

Why is it that Katie wears wings?

In this whirlwind exploration of:

1. The themes from the broader service system
2. Partnerships between service providers,
3. The diversity of needs of those people who are interested in accessing PAGs, and,
4. Responding to the complexity of needs of individuals

I am offering you three, three minute sketches on the following.

Firstly, I would like to share with you the history, purpose, operation and client group of AAV. Share (quickly) with you the changes that have taken place within our organization over the past three years. And, explore the reasons why these changes have occurred and reflect on the things that clients have told us.

Secondly; I would like to share some thoughts on PAGs; what our clients like about them; what our clients don't like about them; explore the possible reasons for the differences in responses; and share with you the reason why it is that Katie wears wings.

Thirdly; I am going to present a brief case study, which highlights the complex needs of individuals, the benefits of cross agency cooperation, and reflects on the challenges facing PAGs in the future.

Contact details
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– E-mail: dhooker@alzvic.asn.au

Gill Pierce, *Policy Worker, Carers Victoria*

Meaningful Respite: the Carer’s Perspective

Unpaid carers have diverse needs and diverse values about the type of the respite experience they want for their friend or family member. They also have many common requirements.

The paper will outline the expressed preferences of carers in relation to PAGS, drawn from a significant consultation with carers about their respite preferences in

the Western Metropolitan Region and some of the learning gained through the experiences of Carers Victoria and the Victorian Carer Services Network.

For the person they care for many carers want:

- The PAG or social support program to be a positive and engaging experience. This means
  - Activities that are relevant to the interests, preferences and history of the person they care for. There are many examples of these … both centre and community based.
  - Responsiveness to the usual routines and needs of the person needing care.
  - Trust and communication with staff who form positive, respectful relationships with each client, and work to understand those with communication difficulties.
  - Continuity of care staff as far as possible.

In some circumstances carers want:

  - Cultural and language sensitivity; many gains have been made in this area.
  - Confidence in the capacity of staff to support people with dementia or other challenging conditions.
  - Suitable and physically safe facilities.
  - Small group, homelike care arrangements for those with confusion or short term memory loss.

In relation to their own needs many carers want:

- Recognition and understanding. This may mean
  - Acknowledgment of the expertise they may have.
  - Demonstrated understanding of loss and grief issues and difficulties with transitions.
  - Welcoming open door policies.
  - Unhurried transitions as necessary.
  - Open two-way communication.
  - Emotional support when there is conflict between their needs and the preferences of the person they care for.
  - Opportunities for mutual support.
- Flexible service models which are responsive to carer needs including:
  - Flexible hours of operation- twilight groups, weekend programs, longer day hours, occasional care at short notice.
  - Support for working carers.
  - Planned Activity Groups with overnight care capacity.

The achievement of ‘Carer friendly practices’ in planned activity groups, volunteer social support programs and host family programs will be discussed and illustrated from the perspective of inclusive policies, practices and procedures at key service points.

Future challenges for PAGS will be outlined. These may include:

- Workforce recruitment, retention and training issues and the future staff mix.
- The implications of demographic and social changes: the need for new models.
- Quality improvement systems.
- Sharing good practice.

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Nada Stojkovic, *Coordinator, Ethnic Aged and Disability Services, Inner Western Region Migrant Resource Centre*

HACC Ethno Specific Network Operating in the Western Metropolitan Region, Melbourne

For a number of years coordinators of social support, planned activity groups and volunteer coordination services have been meeting in the Western Metropolitan Region in Melbourne for the purposes of peer support, information sharing and working together on joint projects. Administrative support is provided by the Inner Western Region Migrant Resource Centre through the HACC Program and Program Development and Access funding.

The network has grown in both numbers and in the development of its individual members' understanding of policy issues and capacity to participate in the sector alongside much bigger and better resourced mainstream agencies. It not only provides a voice for its 32 members and the communities they serve but provides a resource to Government, NGOs and consultants wishing to engage with CALD communities.

Since the introduction of Primary Care Partnerships in Victoria the Inner Western Region Migrant Resource Centre has represented the network on the 3 PCPs that cover the Western Metropolitan Region. Information flows in both directions informing the reform process and enabling the small, diverse agencies in the network to participate as a group. This model exists only in this Region in Victoria and has been attracting notice (and envy) from other Regions.

Development of the members' skills, capacity, understanding and interest to participate is evidenced by the growing attendance at meetings, forums and consultations and the consequently raised profile of the CALD sector and its concerns. Currently work is being undertaken on developing a shared policy position so that members can represent the sector rather than their individual agencies.

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Dianne Wiseman, *Central Bayside Community Health Services,*
Southern Psychogeriatric Activity Service

Panel Presentation

SPAS workers are in a unique situation. They get to see first hand the nitty gritty of almost all of the Day Centres and Social Support Programs in the Southern Region. We are forever amazed at the diversity of both our clients and the activities available for them to attend. But we always need more – diversity that is, not clients.

SPAS' vision for the future is more groups, more options for more people. No two day centres need to be the same. There is no one best formula, no one best group. Best practice is dynamic service provision meeting the changing needs of your clients.

Groups don't have to be centre based but they can be. They don't have to be age or disability based, but they can be. Look at the personalities in your groups – their likes and dislikes. Think about how things can be done differently.

Respite doesn't mean only giving the carer a break. The only respite that actually works in the long term is that which provides a positive, enjoyable experience for the client. If they are happy, then the carer really gets a break.

Staff at day centres need knowledge and experience and support. Their invaluable work is hard work. Ongoing education, support from within and out of the centre is crucial to keeping good and happy staff. Day centres need to start to be able to look at the clients needs first and create ways of meeting them. Just deciding which group they will fit into is not enough. We need to be daring and create new opportunities, using partnerships to do this. Let's try some new things.

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