
HACC Social Support for people from Culturally and Linguistically Diverse (CALD) backgrounds

Report

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Acronyms

ABI	Acquired Brain Injury
ACAS	Aged Care Assessment Service
ATSI	Aboriginal and Torres Strait Islander
ADEC	Action on Disabilities Within Ethnic Communities
CACP	Community Aged Care Package
CALD	Culturally and Linguistically Diverse
CEGS	Culturally Equitable Gateways Strategy
CHC	Community Health Centre
DHS	Department of Human Services
DVA	Department of Veterans Affairs
HACC	Home and Community Care
LGA	Local Government Authority
MDS	Minimum Data Set
NARI	National Ageing Research Institute
NESB	Non-English Speaking Background
N&WMR	North and West Metropolitan Region
PAG	Planned Activity Group
PCP	Primary Care Partnership
SCTT	Service Coordination Tool Templates

Executive Summary

The benefits of Social Support Services to the health and wellbeing of older people have been well documented in research studies (Nutbeam 1998; Seeman 2000; Musich, Ignaczak et al. 2001; Giummarra, Black et al. 2004; Haralambous, Black et al. 2004). However, there is little known about the role, including the benefits, of social support for older people from Culturally and Linguistically Diverse (CALD) backgrounds.

The Home and Community Care (HACC) program provides a range of Social Support Services for frail older people, people with a disability and their carers. These Social Support Services include Planned Activity Groups (PAGs) where people are provided with support in a group setting. Social Support Services also include activities funded through Volunteer Coordination such as Carer Support Groups, Friendly Visiting to isolated people in their homes and Telelink services, where people are linked using the telephone. This study focuses on these HACC funded Social Support Services and their link to older people of CALD backgrounds.

Aims and Objectives

The aim of this study was:

1. To evaluate the role of Social Support Services for people from CALD backgrounds to inform future service practice.

The project objectives were to:

1. Develop a profile of current Social Support models and CALD service users in the North and Western Metropolitan (N&WMR) Region.
2. Evaluate the extent to which Social Support Services work towards improving the health and wellbeing of CALD service users.
3. Propose recommendations and model(s) for future Social Support Services in the N&WMR to further improve the health and wellbeing of CALD service users.

Methodology

To address the aims and objectives of the project a variety of research methods were used. This project adopted a qualitative and quantitative methodology to explore in depth the research aim and objectives. The methodology comprised of:

- A survey sent to all N&WMR HACC funded Social Support Service providers requesting information about their services, including aims, role, barriers and innovative practice in Social Support Services;
- Analysis of HACC Minimum Data Set (MDS) data to develop a profile of Social Support users from CALD backgrounds;
- Focus group discussions with Social Support Service users/carers from CALD backgrounds to obtain a consumer perspective of Social Support Services;
- Cost benefit analysis investigating the costs associated with the current services, new service models and financial benefits of the current services; and
- A workshop with service providers to discuss the findings and discuss future directions.

Findings

This study has found that older people from CALD backgrounds are well represented in their usage of Social Support Services. This study has also provided a profile of activities undertaken by Social Support Services and highlighted the benefits that older people from CALD backgrounds gain from participating in Social Support Services. Providing opportunities for socialisation, physical activity and access to support (including carer support) appear to be key functions of most services and key reasons

why service users attend programs. However, particular differences emerged in relation to the needs of individuals with high and/or complex needs and those with low needs.

There were common themes raised by service providers and service users about the benefits of Social Support Services. These included providing opportunities for socialisation, physical activity and recreation, as well as providing a venue for service providers to deliver information and education to clients and carers. The role of PAGs in providing respite to carers was also emphasised. Goals that were reported more specifically for people of CALD background included:

- Increasing knowledge and uptake of HACC services;
- Developing informal support networks for clients and carers from CALD backgrounds; and
- Promoting an understanding of the concept of the carer role within CALD communities.

To assist in meeting these goals, having a program where clients, staff and volunteers spoke the same language appeared to be important to people of CALD backgrounds, in addition to the importance of services being delivered in a culturally sensitive manner. The importance of CALD and mainstream agencies developing partnerships and sharing resources in order to better meet the needs of clients through culturally appropriate service delivery was also emphasised.

A series of barriers to service delivery faced by agencies providing Social Support Services were identified. These related to lack of resources for staffing, equipment, transport and outings and difficulties attracting and retaining volunteers. Despite these barriers, this study has also identified good practices within current services, particularly in relation to the areas of volunteerism, funding initiatives, transport and carer support.

In undertaking the cost benefit analysis, inconsistencies between the various data sources were identified, placing limitations on the conclusions that could be drawn. Trends in performance and fee collection were apparent. A slight trend indicating that agencies are more likely to under achieve targets for High PAG than Core PAG was demonstrated, and it was noted that CALD agencies are less likely to collect fees compared with Local Governments.

Recommendations

Recommendations for the N&WMR of DHS

This study has identified a number of areas to prioritise in future planning and growth funding. It is recommended that the N&WMR of DHS consider the need for:

1. Increased training opportunities for staff and volunteers responding to CALD clients
2. Strategies designed to further support the training, support, recognition and appropriate reimbursement of volunteers
3. Strategies designed to support the delivery of services that understand and are responsive to changing needs of informal carers or HACC eligible clients
4. Improved transport options and/or encouraging enhanced transport sharing arrangements
5. Review of 2005/06 data and exploration of performance reporting inconsistencies and under achieving with agencies and to continue to support agencies to achieve more accurate and consistent performance reporting
6. Further research to develop enhanced classification of clients to improve the targeting of Social Support Services to the HACC target population
7. Development of models of sub-regional waiting list management and assessment of priority of access to manage demand and ensure equity of access across the range of service providers

8. Explore options to better respond to the needs of CALD clients who are moving to the level of High PAG
9. Further consultation with HACC funded agencies regarding the development of strategies to enhance the supports provided to smaller and emerging communities
10. Continued promotion of the Well for Life approach to promoting opportunities for increased physical activity and better nutrition to participants
11. Promote the work currently being undertaken in the redesign of HACC assessment, care coordination and case management activities to ensure that the expected roles and functions of all HACC agencies are clear and achievable.

Recommendations for Social Support Services

It is recommended that Social Support Services consider the need for:

1. Increased consultation with their service users in program planning
2. Flexible and client centred care that is sensitive to the differences amongst carers in how they define their role, their service needs and expectations
3. Information provision to carers about services available and their entitlements as carers
4. Programs that incorporate positive ageing approaches such as promoting the benefits of physical activity in Core PAGs
5. Providing Core and High PAG options where possible so that clients with different needs are not within the same group
6. Strategies to recruit, support, recognise and retain volunteers
7. Implementation of the HACC fees policy, and the development of strategies that encourage clients to contribute fees if possible and demonstrate to clients the benefits derived from their contributions
8. Further developing partnerships with other organisations, particularly in relation to resource sharing arrangements, referral pathways, addressing cross municipal boundary issues and sharing bi-lingual allied health staff.

1. Introduction

The benefits of Social Support Services to the health and wellbeing of older people have been well documented in research studies (Nutbeam 1998; Seeman 2000; Musich, Ignaczak et al. 2001; Giummarra, Black et al. 2004; Haralambous, Black et al. 2004). However, there is little known about the role, including the benefits, of social support for older people from Culturally and Linguistically Diverse (CALD) backgrounds.

The Home and Community Care (HACC) program provides a range of Social Support Services for frail older people, people with a disability and their carers. These Social Support Services include Planned Activity Groups (PAGs) where people are provided with support in a group setting. Social Support Services also include activities funded through Volunteer Coordination such as Carer Support Groups, Friendly Visiting to isolated people in their homes and Telelink services, where people are linked using the telephone. This study focuses on these HACC funded Social Support Services and their link to older people of CALD backgrounds.

Despite numerous initiatives funded and undertaken over almost two decades to engage older people of CALD backgrounds in HACC services, this group is still not as well represented in mainstream HACC programs (Department of Human Services 2004). Planned Activity Groups have been identified as the only HACC service where there have been higher rates of use by older CALD people (Department of Human Services 2004). Ethno-specific¹ and multi-ethnic agencies have been funded to deliver Social Support Services by HACC, in recognition of the social isolation faced by many people in CALD communities, in particular older people (National Ageing Research Institute 2001). In addition to this, many mainstream² agencies such as Community Health Centres and Local Government Authorities provide specifically targeted services for CALD communities.

This project has been funded by the North and West Metropolitan Region (N&WMR) of the DHS. This project evaluates Social Support Services for people from CALD backgrounds to guide future service provision and includes a number of methodological approaches, outlined below.

1.1) Aim

The aim of this project was:

1. To evaluate the role of Social Support Services for people of CALD backgrounds to inform future service practice.

1.2) Objectives

The project objectives were to:

1. Develop a profile of current Social Support models and CALD service users in the N&WMR;
2. Evaluate the extent to which Social Support Services work towards improving the health and wellbeing of CALD service users;
3. Propose recommendations and model(s) for future Social Support Services in the N&WMR to further improve the health and wellbeing of CALD service users.

¹ The term "ethno-specific agency" in this study refers to those organisations whose prime focus is to work with one specific CALD community. "Multi-ethnic agency" refers to those agencies whose focus is to work with a range of CALD communities. In this report, the term "CALD agencies" is used when reference is made to both ethno-specific and multi-ethnic agencies.

² The term "mainstream agencies" in this study refers to those organisations whose focus is to provide services to all members of the community.

1.3) Structure of the Report

The following chapter provides a summary of the research evidence about Social Support Services, including their benefits for clients and carers and examines the context of Social Support Services within the HACC program. It also considers issues relating to the utilisation of Social Support and other HACC services for people from CALD backgrounds.

Chapter 3 outlines the methodology used, which included service provider surveys, service user focus groups, HACC Minimum Data Set (MDS) data analysis, cost benefit analysis and a service provider workshop. Chapter 4 provides a profile of Social Support clients and programs, summarising data from the Minimum Data Set analysis and quantitative data from the service provider surveys. Chapter 5 focuses on the cost benefit analysis and outlines the costs associated with the current services and provides a summary of output by activity. In Chapters 6 and 7, a profile of service practice is provided based on findings from the service provider survey and client and carer focus groups respectively. Chapter 8 provides findings from the service provider workshop, focusing on good practice examples identified by service providers. The final chapter draws together information from each of the phases of the project and provides recommendations for future service delivery.

To protect the confidentiality of participating service users and service providers, names of service users and service providers have not been used in this report. All quotes have been de-identified to maintain anonymity.

2. Literature Review

2.1) Introduction

This chapter is a review of published and unpublished literature and seeks to provide a better understanding of the role and benefits of Social Support Services for older people from CALD backgrounds, with a particular focus on the Victorian context. The aim of this review is to:

1. Identify the role of Social Support Services with older people and, in particular, older people from CALD backgrounds;
2. Identify models of Social Support Services with older people and, in particular, older people from CALD backgrounds; and
3. Identify gaps in the literature in relation to Social Support Services for older people and, in particular, older people from CALD backgrounds.

An overview of Social Support Services in Victoria is presented within the context of the main program that funds and administers such services, the HACC Program. To set the scene, this chapter begins in section two with a discussion of the health and aged care policy environment. This includes discussion of the aim and role of HACC services in general and of Social Support Services in particular. Section two also includes a detailed overview of the policy responses to providing services to older people from CALD backgrounds. Section three includes an overview of Social Support as well as a discussion of the benefits of, and barriers to accessing Social Support Services for older people, including those from CALD backgrounds. The final section of this chapter (section four) focuses on the current situation for older people from CALD backgrounds in relation to service usage and highlights the extent to which older people from CALD backgrounds utilise Social Support Services.

This literature review draws together key recent research, reports and policies regarding older people from CALD backgrounds and Social Support Services. This review has predominantly drawn on literature from the last five years, outlining key findings and providing a snapshot of research evidence and implications for practice. It also provides a context for this research project and guides the methodology.

2.2) Health and Aged Care Policy Context

This section provides an overview of the health care and health promotion policy context in relation to older people, including an outline of the international, national and local environment. This is followed by an outline of the aged care policy context, and a link between health care and aged care policy initiatives.

2.2.1 The Health Care Policy Context

Healthy ageing, historically, has been viewed from a medical perspective with the focal point being the absence of disease (Crowther, Parker et al. 2002). More recently, health promotion has been defined as a process directed towards facilitating individuals to take action and to achieve positive change. (World Health Organization 1986).

The World Health Organisation Ottawa Charter (1986) defines health promotion as:

“The process of enabling people to increase control over, and to improve their health. To reach a state of complete physical, mental and social wellbeing, an individual or group must be able to identify and to realise aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasising social and personal resources, as well as physical capacities.

Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to wellbeing” (World Health Organization 1986, p.1).

This definition recognises a shift from a purely medical perspective to one that defines health as encompassing the dimensions of physical, mental and social wellbeing. Studies about older people and their perceptions of health have found that older people hold a holistic view of health, consistent with the current definition of health promotion as identified by the World Health Organisation (Giummarra, Black et al. 2004).

International and national studies about older people and their perceptions of health have reported that “older people believe that health is intrinsically related to balanced participation in activities in the community, remaining socially integrated and taking personal responsibility for their own health” (Giummarra, Black et al. 2004, p. 7).

In a study undertaken in 2004, older people were asked to define what health meant to them (Haralambous, Black et al. 2004). Participants generally identified health as one, a combination, or all of the dimensions of health as defined by the World Health Organisation and they believed that each of these dimensions was interrelated. For example, many older people believed that people who were socially isolated and who did not have strong social connections were more likely to have poor physical and mental health.

A commitment to health promotion has been reflected not only at the international level, but also at the national and state levels in Australia (Department of Human Services 2003b). In Australia, Governments have responded to trends in changing definitions of health through their policy initiatives. A national review of health promotion efforts (National Health and Medical Research Council 1996) emphasised the need for health promotion efforts to move beyond strategies for reducing specific risk behaviours to the development of strategies for enhancing social support and social integration as a means of promoting health (Lindeman, Nankervis et al. 2001).

To ensure all health and community services are delivered in a coordinated manner, the Victorian Government launched the Primary Care Partnership (PCP) strategy in April 2000, following consultation with the sector (Department of Human Services 2003b). The PCP strategy involves voluntary alliances of primary care providers usually within two or three Local Government Areas. The PCP strategy aims to improve the overall health and wellbeing of Victorians by:

- Improving the experience and outcomes for people who use primary care services; and
- Reducing the preventable use of hospital, medical and residential services through a greater emphasis on health promotion programs and by responding to the early signs of disease and/or people’s need for support (Howe and Warren 2004).

The PCP strategy includes HACC services, community health, General Practice, aged care assessment services, disability support and dental health.

2.2.2 The Aged Care Policy Context

In Australia, the HACC Program is one of the key programs involved in the provision of community care services. The HACC Program is funded jointly by the Commonwealth, State and Territory Governments under the *Home and Community Care Act (Commonwealth) 1985*. In Victoria Local Government also contributes significant funds for the provision of HACC services.

The aims of the HACC Program are to:

1. Provide a comprehensive, coordinated and integrated range of basic maintenance and support service for frail aged people, people with a disability and their carers;
2. Support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing inappropriate admission to long term residential care; and
3. Provide flexible, timely services that respond to the needs of consumers (Department of Human Services 2003c, p. 4).

The type of services funded through the HACC Program include, but are not limited to:

- Nursing care;
- Allied health care;
- Meals and other food services;
- Domestic assistance;
- Personal care;
- Home modification and maintenance;
- Respite care;
- Counselling, support, information and advocacy; and
- Assessment (Australian Government Department of Health and Ageing 2004).

HACC in Victoria

The HACC Program in Victoria operates within the broader health and community service system and is one of the programs involved in the PCP alliance.

Community care services for older people in Victoria are largely administered and provided through the HACC Program. Local Government is a key player in the delivery of these services, with services also delivered by a range of community health, nursing, CALD and community service organisations. In Victoria, HACC services are also known as HACC activities. The Victorian HACC program has identified a similar set of services to those identified by the Commonwealth, with additional Social Support Services including:

- Planned Activity Groups (PAGs); and
- Volunteer Coordination.

Social Support Services for Older People

Social Support Services for older people and older people from CALD backgrounds in Victoria are delivered through the PAG activity and Volunteer Coordination activity. PAGs are centre based and:

“maintain an individual’s ability to live at home and in the community by providing a planned program of activities directed at enhancing skills required for daily living and providing physical, intellectual, emotional and social stimulation” (Department of Human Services 2003c, p. 122).

Volunteer Coordination activities are funded to recruit, train, support and supervise volunteers to provide:

- Friendly Visiting - a volunteer regularly visits the same person to provide companionship;
- Telelink - a group telephone call scheduled at a regular time;
- Carer Support Programs - Volunteer Coordinators can run carer support services themselves, without volunteers;
- Stand-alone transport services that use volunteer drivers;
- Respite - including Host Carer Programs such as those provided by volunteer respite services for families of children with disabilities; and
- Camps for the purpose of respite - volunteers assist in running the camp (Department of Human Services 2003c, p. 136).

These Social Support Services are provided by a range of service providers including CALD agencies, Local Government and community service organisations. Although transport is funded under the volunteer coordination activity and assists in implementing Social Support Programs, it does not provide social support directly and is therefore beyond the scope of the current study.

Policy Responses to Older People of CALD Backgrounds in Victoria

After the introduction of the HACC Program in the mid 1980s, specific developments and initiatives occurred in Victoria regarding the delivery of services to older people from CALD backgrounds. These included the introduction of the HACC Access and Advocacy service in 1988. Forty-seven Access and Advocacy projects were funded in the first two years "to assist service providers to better meet the needs of all people in the HACC target group and to assist consumers to better access HACC services which are relevant to their needs" (Department of Health and Community Services 1993a, p. 5);

The HACC Ethnic Policy Statement was developed by the Victorian State Government HACC Program administrators in the early 1990s. The goal of the HACC Ethnic Policy Statement outlined in the Ethnic Policy Section of the Victorian Home and Community Care Program Manual (Department of Health and Community Services 1993b, p. 2) was to ensure "HACC services are delivered in a manner that meets the special needs of people from a non-English speaking background (NESB)".

In May 1991, a Ministerial Reference Group on HACC Ethnic Services recommended that positive steps be taken to address low utilisation of HACC services by ethnic consumers (Community Services Victoria 1991). The continuation of a number of Advocacy and Access projects was viewed as one of these positive steps. The Access and Advocacy service underwent a name change in 1994, becoming the Program Development and Access (PDA) service. The objective of the PDA service, as outlined in the 1997/98 Funding and Service Agreement, Schedule 3, was "to work with and monitor HACC services to improve the access of people with special needs (in the HACC target group) to the range of HACC services" (Department of Human Services 1997/1998). With the introduction of the PDA service, eighteen projects were funded over a three-year period. Through the PDA service, workers were required to be more closely linked to DHS regional planning processes and assist the DHS to monitor mainstream services, as compared to the Access and Advocacy service. This represented a shift from the advocacy role to one of advisor to the government.

The HACC Cultural Planning Tool was developed by Action on Disabilities Within Ethnic Communities (ADEC) in 1996. The goal of the Cultural Planning Tool is to develop benchmarks and performance measures that can be used for planning and improving mainstream services to people of CALD backgrounds (Department of Human Services and ADEC 1996). The Cultural Planning Tool comprises a set of objectives, strategies and performance measures to assist agencies to achieve effective service provision for people of ethnic backgrounds.

In the early 1990s, HACC Service Development Grants (SDG's) were formalised as a part of the HACC program, with the aim of facilitating ongoing innovation in service delivery and evaluation (Department of Human Services 2003a, p. 1). An analysis of SDGs funded by DHS since the program's inception revealed that a total of 44 (12%) grants were funded to CALD agencies and a total of 52 (15%) grants focused on access for/response to CALD client groups (Department of Human Services 2003a). A number of these SDG's addressed models for delivering services to culturally diverse communities, some of these being based in ethnic community agencies, others saw mainstream agencies adapt their services, and some involved new links between different services (Department of Human Services 2003a).

It was identified that in the (former) Western Metropolitan Region of Melbourne alone, 16 research projects relating to the needs of CALD service users were undertaken in the 1990s (National Ageing Research Institute 2001). These projects included studies regarding specific ethnic communities (i.e. a Serbian study, two Vietnamese studies, a Polish study, two Horn of Africa studies, a Macedonian study, a Turkish Cypriot study and a Croatian study) and issues that affected all ethnic older people (including training requirements, two profiles of ethnic aged projects/services, a service coordination project, two food services projects and a project researching recreation options).

In June 2000, a statewide consultation was held by the then Minister for Housing and Aged Care, the Hon Bronwyn Pike, to identify issues that would guide in the expansion of funding for PAGs (Department of Human Services 2002). During the consultation, the following issues were identified that need to be addressed in order to enhance service provision: service flexibility; service quality; volunteers; the role of these services in care management and carer support; improving client travel arrangements; improving resource allocation; and allied health services. Key target groups identified included: younger people with disabilities; frail older people from Aboriginal and Torres Strait Islander backgrounds, and culturally and linguistically diverse backgrounds; frail older people who are homeless or at risk of becoming homeless. The information provided at the consultation formed future planning frameworks for PAGs.

In March 2003, the Minister for Aged Care endorsed a strategic framework for 2003-06 to guide the allocation of HACC growth funds, as part of the "Better planning and funds allocation for HACC in Victoria - Final Report 2003" (Hon Gavin Jennings Minister for Aged Care 2003b). For regional planning purposes, the framework identified three priority areas as follows:

- **Priority 1** - Increase the supply and improve the responsiveness of 'HACC Basic' services and consolidate the 'HACC Basic' service system around the key Local Government and health sector providers. 'HACC Basic' activities are Home Care, Personal Care, Nursing, Allied Health, Delivered Meals, Property Maintenance, and Assessment and Care Management (p. 9);
- **Priority 2** - Increase the quantity and quality of 'HACC Basic' services for people from CALD backgrounds and develop new collaborative direct service delivery arrangements between mainstream, multicultural and ethno-specific organisations (p. 15); and
- **Priority 3** - Increase the quantity and quality of HACC services for Aboriginal and Torres Strait Islander (ATSI) communities (p. 15).

In late 2003, the Culturally Equitable Gateways Strategy (CEGS) was introduced (Hon Gavin Jennings Minister for Aged Care 2003a). Ethnic agencies and Local Governments were funded for up to three years to work together to improve service provision to ethnic older people. The focus of CEGS is increasing CALD older people's utilisation of home care, personal care, respite care, home delivered meals and property maintenance (i.e. HACC Basic activities).

2.2.3 The Links Between Health and Aged Care Policy

"Integrated health promotion (including early intervention and prevention) were identified in the 2002 Victorian Government's election policy" (Department of Human Services 2003b, p. 29). Recently, the Victorian Government has explicitly stated its vision regarding the role of HACC in promoting the health and wellbeing of older people.

In 2004, the Hon Gavin Jennings, Minister for Aged Care, called for horizontal integration between HACC and related services in Victoria to enable more active interventions in supporting frail aged and disabled people to remain as independent, active, and as connected as possible in their own homes and communities (Howe and Warren 2004). In recent years, there has been a stronger focus on linking HACC services with acute, sub-acute and post-acute services. However, to provide more preventive and active

intervention will require stronger links between primary care, disability services, rehabilitation and health promotion (Howe and Warren 2004).

The Victorian Minister for Aged Care, the Hon Gavin Jennings, in his address to the Victorian Association of Hospitals and Extended Care (VAHEC) on 27th August 2004 (Hon Gavin Jennings Minister for Aged Care 2004) put forward a range of possible directions or questions for the future of community care in Victoria. Some of these directions were:

1. The potential for HACC services to improve the health and wellbeing of service users so that they are able to remain independent and engage with community life; and
2. The potential for home care to change perspective to become a more active model of intervention.

PAGs have been identified in previous research as a potential HACC service that could embrace a more active model of intervention. This research explored health promotion in PAGs and reported that health promoting activities are important for achieving the maintenance and/or improvement of health status for older people attending HACC PAGs (Lindeman, Nankervis et al. 2001). There is limited evidence about the extent to which HACC funded agencies engage in early intervention and prevention activities. The potential for PAGs (Lindeman, Nankervis et al. 2001) and Volunteer Coordination Services (Haralambous, Black et al. 2004) to be involved in health promoting activities has been documented.

This potential has been explored in a recent HACC initiative named Well for Life. Well for Life was introduced in 2003 and targets public sector residential aged care and PAGs. Well for Life is designed to resource PAG providers to promote opportunities for increased physical activity and better nutrition for older people attending their programs. A wide range of agencies, including CALD agencies, has been involved in Well for Life in the N&WMR. The potential for Well for Life to broaden understanding about how evidence-based health promotion approaches might be translated into practice change in aged care settings has been noted in the recent Well for Life Evaluation (Department of Human Services with the Program Evaluation Unit, the University of Melbourne (2005).

2.2.4) Summary

The shift in definitions of health at the international level has been reflected at the national and Victorian state level. A move to a more inclusive understanding of health, encompassing the components of physical, social and mental health, is widely accepted. The HACC program was established to support frail older people and younger people with disabilities, through the provision of a range of services. A number of initiatives have been developed to enhance access to HACC services for people from CALD backgrounds. Recently links have been made between HACC services and health promoting activities, however, there is limited evidence about the extent to which this is occurring both generally and in relation to older people of CALD backgrounds.

2.3) Social Support

2.3.1 Benefits of Social Support

Older People and Social Support

A literature review undertaken in 2004 (Giummarra, Black et al. 2004), reported on the benefits of social support to older people:

“Social mobilisation and the reconnection of older people with their community has been identified as a mechanism for improving overall health and quality of life (Nutbeam 1998). Social mobilisation can take the form of building social networks, supporting participation in social activities, and fostering a commitment to social support and mutual aid among older people (Nutbeam 1998). This is an

important process that can not only improve older people's self-esteem and sense of belonging but also helps to overcome negative perceptions of older people that act as a social barrier to participation in the community" (Nutbeam 1998; Australian Research Group 2003) (p. 3-4).

"Having an extensive social network, or a high level of social integration, has been shown to have a protective effect on health, for example by reducing the incidence of diseases such as coronary heart disease and depression" (Seeman 2000) (p. 7).

In a 2004 study (Haralambous, Black et al. 2004, p. 71) undertaken by NARI:

"Older people described the benefits that they gained from being involved in a variety of different groups, such as physical activity groups or senior citizens groups, and stated that the advantages of participating in these programs were two-fold, benefiting their social health as well as their physical health. Being socially connected was highlighted as protective as it enabled older people to feel valued and motivated to participate in health promoting behaviour".

This study recommended that volunteer based services could play an active role in further supporting people to increase their activity and social connectedness and promote and maintain independence. A profile undertaken in 2001 of HACC services and agencies in the (former) Western Metropolitan Region reported that agencies representing CALD communities have taken up Volunteer Coordination funding to develop Friendly Visiting services and PAGs in recognition of the social isolation faced by many people in CALD communities, in particular older people (National Ageing Research Institute 2001). Of the 37 agencies funded to deliver PAGs, at the time of this study, 13 (35%) were ethno-specific agencies. However, there is limited evidence about the role and benefits of CALD volunteer and Social Support Services. There is also limited documentation about why ethnic agencies have taken up this role. It could be suggested that the importance of language and culture are core to social connections.

Not only are there physical and mental health benefits to participating in health promoting activities and being socially connected, but there have also been reports of economic benefits. Increased use of health promoting services has the potential to improve health status and, hence, lead to decreased medical costs and hospital utilisation (Musich, Ignaczak et al. 2001).

Social Support, Physical Activity and Older People

It is important for older people to maintain their physical health, in particular, muscle strength, flexibility, range of motion and sense of balance, as the decline in these abilities frequently contributes to falls and functional decline (Burbank, Reibe et al. 2002). A qualitative study undertaken in the late 1990's (Brown, Fuller et al. 1999) found that social support was one of the motivating factors for older people to engage in physical activity.

Previous research found that while older people from CALD backgrounds may have recognised the importance of physical activity, they were generally more active socially than physically (Haralambous, Osborne et al. 2003). Most participants in this research did not make links between their physical and social activities but placed very strong value on their social interactions and activities. Given the value placed on social support by older people from CALD backgrounds, this study recommended that existing Social Support infrastructure be utilised to promote and support physical activity programs:

"Developing strategies for health professionals to provide information through the existing social club infrastructure could be an area for further consideration, with discussions on current and potential health risks such as obesity and diabetes.

Health professionals could also have a key role in highlighting appropriate physical activity options for people with health problems such as arthritis" (Haralambous, Osborne et al. 2003, p. 59).

This is in line with the message put forward by the Minister for Aged Care, the Hon Gavin Jennings, and the goal identified in the Western Metropolitan Region CALD Aged Care Strategic Plan (2003-2008), proposing a more active model of intervention in Social Support Services and focusing on wellbeing, illness prevention and illness management.

2.3.2 Barriers to Accessing Social Support

Obstacles for Older People

Many older people are prevented from participating in social activities due to broader environmental barriers. Poor access to public transport has been found to be a barrier to older people participating in physical and social activity (Haralambous, Osborne et al. 2003). "While access to public transport can promote healthy, active lifestyles in older people there are a number of obstacles associated with their use" (Giummarra, Black et al. 2004, p. 21). These obstacles include the costs associated with public transport, the limited number of services on weekends and in the evening, and physical limitations (Heaney, Moreham et al. 2001; Giummarra, Black et al. 2004) including difficulty stepping onto buses and trams (Haralambous, Osborne et al. 2003).

"The constructed and natural environment cannot be considered in isolation as they are closely related to social, economic and political environments" (Giummarra, Black et al. 2004, p. 23). A significant factor in the constructed environment that has been found to influence participation in physical activity by older people in Australia is the condition of footpaths, and whether they are perceived to be safe (Booth, Owen et al. 2000; Haralambous, Osborne et al. 2003). Other barriers to participating in health promoting activities include low socio-economic status, fear of crime and reduced sense of community (Haralambous, Osborne et al. 2003; Kaplan and Kaplan 2003; Haralambous, Black et al. 2004).

Lack of amenities, proximity of industry to housing, poorer housing and litter may lead to a lack of trust and lower levels of social participation at a community level and locational disadvantage (Macintyre and Ellaway 2000; Baum and Palmer 2002). Environments that support people to go out and interact with others include neutral places such as corner shops and cafes, parks with community facilities, and pleasant environmental features, such as green spaces (Baum and Palmer 2002) and beaches (Bauman, Smith et al. 1998).

Obstacles for Older People from CALD Backgrounds

"In addition to the above-mentioned barriers, cultural groups often face other additional obstacles and challenges to participation in health promoting activities, and accessing services" (Giummarra, Black et al. 2004, p. 5). These barriers include language, racism and discrimination on the basis of cultural stereotypes, and limited services that are culturally sensitive (Victorian Health Promotion Foundation 1999; Black, Osborne et al. 2004). The Victorian Health Promotion Foundation reported that "it is important not to undermine a cultural group's religious, racial or cultural integrity as this has a negative impact on identity and sense of belonging and may lead to people feeling a sense of humiliation and shame about their heritage" (Giummarra, Black et al. 2004, p. 5).

Older Croatian people participating in a 2003 NARI study (focusing on barriers and motivators to participation in physical activity), reported that language and lack of cultural sensitivity were major barriers to their participating in health promoting activities, such as swimming in the local pool (Haralambous, Osborne et al. 2003). Similarly, in a 2004 study developing a 10 year plan for Croatian and Bosnian-

Herzegovinian communities in Victoria, it was reported that ageing Croatians and their carers are under utilising various aged care services (including HACC) due to:

- Lack of awareness of services;
- Negative community attitudes and perceptions about services; and
- The service sectors limited capacity and capability to address the communities' specific cultural, religious, social and linguistic needs (Dimitriadis and Freidin 2004).

2.3.3 Summary

The benefits of social support and social connectedness for older people have been well documented. Social support improves an older persons overall wellbeing and independence. Linking physical and social activities and addressing environmental barriers will further motivate older people to participate in health promoting activities.

Family connections and participation in social activities are strong amongst older CALD people. However, there is limited evidence about the benefits of Social Support Services for older people from CALD backgrounds. In addition to the broader environmental barriers experienced by all older people, older people of CALD backgrounds also face cultural barriers.

2.4) Service Usage Patterns

The most recent analysis and profile of HACC service users (*Who Gets HACC 2003-2004*), notes that the HACC MDS has two indicators of ethnicity: country of birth and language spoken at home. In 2003-2004, 21% of clients came from over 85 non-English speaking countries. More than 80 languages were recorded, with twelve percent of clients speaking a language other than English at home.

Older people of CALD backgrounds have, however, generally been reported as under represented in most HACC services in Victoria compared to their population (Department of Human Services 2004). PAGs have been identified as the only HACC service where there have been higher rates of use by older CALD people (Department of Human Services 2004).

In late 2003, the Victorian Government responded to the issue of underutilisation of HACC services by older people from CALD backgrounds through the introduction of the CEGS. The strategy is comprised of the following elements:

- Capacity-building in local government assessment and care management to provide a culturally-friendly gateway to HACC services and ensure appropriate linkage with ethno-specific agencies
- Capacity-building in large and established ethno-specific services to provide practical, hands-on support to local councils to offer culturally appropriate services and enhance service linkage
- Funding for flexible service responses by small and emerging ethnic services
- Leadership and sectoral development within and across ethno-specific, multicultural and local government sectors to improve service provision
- A bilingual/multicultural staff recruitment project in HACC.

An evaluation framework has been designed to assess whether CEGS has been successful in achieving a greater representation of people aged 65+ from CALD backgrounds among those using HACC services. It is anticipated that results from this evaluation will be available in 2007. Initial data generated from the HACC MDS compares the percentage growth in client numbers by country of birth and language spoken at home against an agreed baseline (refer to Tables 1 and 2). This data shows a statewide trend in higher uptake of

HACC services by older people from CALD backgrounds: this trend is particularly pronounced in the N&WMR.

Table 1: Regional and Statewide comparison of the % growth in client numbers from Jul-Dec 2003 to Jul-Dec 2004 by country of birth

Country of Birth	Jul-Dec 2003 to Jul-Dec 2004		
	Northern & Western Metro Region	Southern & Eastern Metro Regions	Statewide
English Speaking Country including Australia	3.10%	0.46%	1.84%
Non English Speaking Country	12.04%	3.99%	8.75%

Table 2: Regional and Statewide comparison of the % growth in client numbers from Jul-Dec 2003 to Jul-Dec 2004 by language spoken at home

Language spoken at home	Jul-Dec 2003 to Jul-Dec 2004		
	Northern & Western Metro Region	Southern & Eastern Metro Regions	Statewide
English Speaking	4.05%	1.49%	2.82%
Language Other than English	12.39%	5.78%	10.37%

2.4.3 Summary

Older people from CALD backgrounds remain generally under represented in their usage of HACC services: conclusions about the impact of CEGS on this issue will emerge in 2007. Interestingly, PAGs are the only HACC service where there have been higher rates of use by older CALD people. Further research is required to explore the reasons behind this.

2.5) Conclusion

Although a great deal has been written about the benefits of social support and older people, very little is known about the benefits of Social Support Services in Australia for older people from CALD backgrounds.

The role of Social Support Services (i.e. PAGs and Volunteer Coordination) is clearly documented in HACC policy. Current HACC policy and government directions are shifting focus to a more active model of intervention. Recently, links have been made between HACC services and health promoting activities, however, there is limited evidence about the extent to which this is occurring with older people generally and with older people from CALD backgrounds.

2.5.1 Summary of Areas Requiring Further Research

The following areas for further research have been identified in this literature review:

- The extent to which HACC Social Support Services can undertake health promoting activities;
- The reasons why older people of CALD backgrounds seem to be using PAGs more than other HACC services; and
- Whether PAGs and Volunteer Coordination services could be a more active model of intervention, as recommended in previous research studies.

2.5.2 Models of Social Support

Whilst models of social support have not been identified in the literature, this literature review has highlighted the benefits of participation in social support that could guide service providers in the development of models of service delivery. Further exploration of the reasons why older people of CALD backgrounds value these services could also guide future service development. The capacity of Social Support Services to develop more active models of intervention, with opportunities for increased physical activity and other health promoting activities targeted at older people from CALD backgrounds could also be explored.

3. Methodology

This project adopted a qualitative and quantitative methodology to explore in depth the research aim and objectives. The methodology comprised of:

- A survey sent to all N&WMR HACC funded Social Support Service providers requesting information about their services, including aims, role, barriers and innovative practice in Social Support Services;
- Analysis of HACC MDS data to develop a profile of Social Support users from CALD backgrounds;
- Focus group discussions with Social Support Service users and carers from CALD backgrounds to obtain a consumer perspective of Social Support Services;
- Cost benefit analysis investigating the costs associated with the current services, new service models and financial benefits of the current services;
- A Workshop with service providers to discuss the findings and future directions; and
- A Project Management Group to provide advice and support.

3.1) Service Provider Survey

A survey was emailed/posted to all agencies receiving HACC funding to provide Social Support. The N&WMR DHS office provided a list of agencies.

The survey covered the following topics:

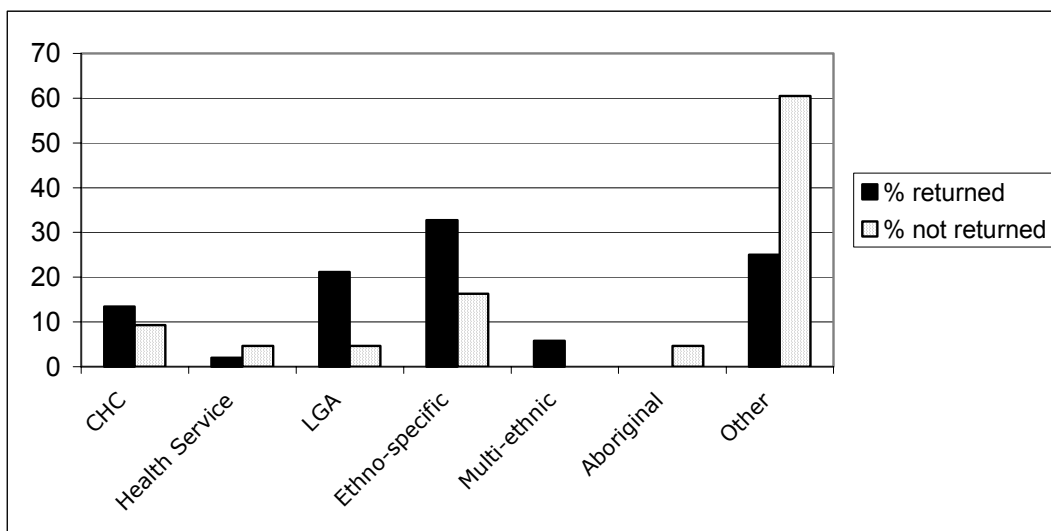
- Profile of Social Support Services provided (types of programs, target groups, number of clients, staff and volunteers, % under 65 years and % CALD clients, activities undertaken within programs);
- Service aim/role;
- Target audience;
- Intake;
- Assessment and care planning;
- Referral pathways; and
- Networks with other agencies.

Under each section of the survey (excluding the service profile component) were questions relating to current practice, barriers to current practice and ideas for future Social Support Service models.

Of the 52 surveys submitted, 20 were received from agencies targeting CALD clients including 17 ethno-specific and three multi-ethnic agencies. Mainstream agencies included 11 Local Government Authorities, seven Community Health Centres, one Health Service and 13 'other' agencies (e.g. community service organisations).

After the surveys were distributed, a targeted follow up occurred to increase response rates. Follow up of non-returned surveys concentrated on larger Social Support Service providers and CALD agencies where larger numbers of CALD clients were likely to attend. This led to a response bias towards Local Government Authorities and CALD agencies as shown in Figure 1. Figure 1 shows that one third of the surveys returned were from CALD agencies. "Other" agencies accounted for the largest proportion of agencies not responding (60% of non-responding agencies), possibly reflecting that these agencies were not targeted in the follow up.

Figure 1: Agency type by percentage of returned and not returned surveys



Note: All black bars total 100%; all shaded bars total 100%.

Table 3 shows the types of Social Support Programs delivered by the 52 agencies completing the survey.

Table 3: Response Rate of Programs by Agency Type Responding to Survey

	Mainstream Agencies, n=32 (%)	CALD Agencies, n=20 (%)
Core PAG	23 (71.9)	18 (90.0)
High PAG	18 (53.1)	9 (45.0)
Friendly Visiting	2 (6.3)	15 (75.0)
Telelink	0 (0)	3 (15.0)
Carer support programs	3 (9.4)	4 (20.0)
Other	6 (18.8)	5 (25.0)

Note: Agencies may provide more than one type of Program.

3.2) HACC Minimum Data Set Data

MDS Data regarding service provision and demographic data for clients in the N&WMR from the first quarter of 2005 (January-March inclusive) was obtained. MDS data was used to develop a demographic profile of clients accessing Social Support Services in the region. Access for CALD clients was also analysed by comparing the proportion of CALD clients accessing Social Support Services compared to the proportion of the older population from a CALD background.

3.3) Focus Groups

Four focus groups were conducted with service users and carers to obtain a consumer perspective of experiences with Social Support Services. Focus groups were conducted across the region and were held with service users and carers accessing Social Support Services provided by ethno-specific agencies and mainstream agencies. Criteria for selecting services to participate in the focus groups included:

- At least one ethno-specific service;
- At least one mainstream service;
- A maximum of two language groups within one focus group (for ease of translation);

- Ensuring there was a mix of more established groups and more recently arrived (to Australia) groups;
- Ensuring access to a separate room on site for the focus group to be conducted; and
- Ensuring there was a spread across the N&WMMR.

People from CALD backgrounds over the age of 18 using HACC funded Social Support Services were recruited through the coordinators of the Social Support Services they were involved with. Multi-ethnic and ethno-specific service representatives on the Project Management Group assisted with recruitment for focus groups through their service networks. The Social Support Services coordinators distributed an expression of interest flyer, translated into the appropriate language, to service users and carers of their program who were able to provide informed consent (i.e. did not have cognitive impairment). Ability to provide informed consent was determined by the service coordinators. If interested in participating, service users and carers chose to contact either NARI research staff or the Social Support Services coordinator. After expressing an interest in participating, researchers or Social Support Service coordinators confirmed the location and time of the focus group with the participant.

The flyer indicated that not participating in the focus group would not impact on future provision of Social Support Services. The aim was to recruit 6-8 participants in each focus group. However, up to 10 participants were accepted (taking into consideration that some participants who expressed an interest may not attend on the day).

Staff from the agencies where participants were recruited were not present at the focus groups, to allow participants to freely express their views. Interpreters were organised and there was only one instance where an interpreter did not arrive and an ethnic support worker was required to provide this role. It was appropriate in this instance as the group was newly arrived and their preference was to have a support worker of their own background present.

Focus groups explored:

- Why people from CALD backgrounds use Social Support Services;
- The strengths of the service and suggested areas for improvement;
- The benefits of being supported by a program targeting people from one's own cultural background;
- The benefits for carers;
- How important volunteers are to the service; and
- Whether participants felt there are other aspects currently not undertaken that should be undertaken by the service.

Focus group participants completed a brief survey at the end of the focus groups that included some basic demographic data, which assisted in providing a profile of the participants involved. This survey included:

- Age, gender and country of birth;
- Whether participants were accessing other HACC services;
- How long they have been using HACC Social Support Services; and
- Whether they were aware of other HACC services.

Two NARI researchers conducted the focus groups with one guiding the discussion and the other taking notes. The focus groups were tape-recorded, after approval was obtained from participants. This allowed for the transcribing of notes from the session.

3.4) Cost Benefit Analysis

The cost benefit analysis involved the following components:

- The cost associated with the current services;
- The cost associated with new service models; and
- A summary of output by activity.

This step was guided by data collected in the service provider survey, focus groups and MDS analysis. In these earlier steps, staff and service users identified the roles undertaken by the Social Support Services and made suggestions for future service provision.

In consultation with N&WMR DHS, a target group of 20 agencies were selected from the region for inclusion in the cost database. The criteria for selecting agencies included:

- Achieving a manageable number for cost analysis and review with approximately 20 thought to be reasonable;
- Including those agencies offering PAG and Volunteer Coordination services that had participated in and returned the service provider survey;
- Including those agencies that had provided or indicated an intention to provide DHS with the 04/05 Annual Acquittal form; and
- Achieving a representative sample from both mainstream and ethno-specific agencies with large and smaller agencies represented.

Of the 20 agencies selected:

- Ten were ethno-specific agencies;
- Seven were Local Government Authorities; and
- Three were Community Health Centres.

3.5) Service Provider Workshop

After completion of the focus groups, service provider surveys, MDS analysis and cost benefit analysis, service providers who completed the service provider survey were invited to attend a workshop. The workshop aimed to provide service providers with the key findings from the project to date, identify good practice examples and provide participants an opportunity to raise issues not already identified. The focus of the workshop was to identify innovative approaches to assist Social Support Services to overcome barriers to providing Social Support Services to people from CALD backgrounds. The workshop was conducted at a central location in the region.

As for the focus groups, two research staff were at the workshop. One facilitated the service provider workshop and one was responsible for note taking during the session. Notes were recorded electronically as participants provided their feedback from the sessions. Members of the Project Management Group also assisted in guiding the group discussions and the Cost and Funding Model Consultant was in attendance to provide information if required.

The workshop agenda and discussion questions are included as Appendix 1.

3.6) Project Management

A Project Management Group, comprising the project team, representatives from the N&WMR DHS, central DHS, multi-ethnic agencies and ethno-specific agencies in the N&WMR, oversaw the project.

Approval of the methodology was obtained through the Melbourne Health Human Research and Ethics Committee.

4. Findings: Profile of Social Support Clients and Programs

This chapter provides a profile of Social Support client characteristics and of the Social Support Programs operating in the N&WMR. The profile of client characteristics is drawn from data from the National HACC MDS for the January-March quarter 2005. The chapter begins with a broad summary regarding the CALD status of Social Support clients in all of Victoria, followed by a more detailed analysis of characteristics of Social Support clients in the N&WMR, including age, gender, living arrangements and CALD background. The profile of Social Support Services in the region is drawn from survey data completed by 55% of all HACC funded Social Support Services in the N&WMR.

4.1) Statewide MDS Data

Victorian MDS data indicates:

- 5% of all HACC clients access Social Support Services (7934 clients);
- 12% of the clients who access all HACC funded services are from CALD backgrounds, as defined by speaking a language other than English at home (missing data = 5%); and
- 22% of Victorian HACC Social Support clients are from CALD backgrounds (missing data = 11%).

The median age of clients accessing Social Support Services in Victoria was 78 years [Interquartile range 66-84yrs]. The median hours of Social Support accessed by each Social Support client over the three month MDS data collection period was 10 hours [Interquartile range=4-24hrs].

Tables 4 and 5 show the ten most common languages and countries of birth of Victorian Social Support clients.

Table 4: Ten Most Common Languages Spoken by Victorian Social Support Clients.

Language	Number of clients (%)
English	5726 (71.7)
Italian	293 (3.7)
Cantonese	177 (2.2)
Serbian	141 (1.8)
Polish	136 (1.7)
Netherlandic	120 (1.5)
Croatian	86 (1.1)
Greek	83 (1.0)
Russian	75 (0.9)
Vietnamese	66 (0.8)
All other languages	552 (6.9)
Not adequately described/missing	531 (6.6)
Total	7986 (100.0)

Table 5: Ten Most Common Countries of Birth of Victorian Social Support Clients.

Country of Birth	Number of clients (%)
Australia	4830 (60.5)
England	384 (4.8)
Italy	370 (4.6)
China	189 (2.4)
Netherlands	167 (2.1)
Poland	167 (2.1)
Greece	104 (1.3)
Croatia	103 (1.3)
Germany	97 (1.2)
Bosnia and Herzegovina	87 (1.1)
All other countries	1152 (14.4)
Not adequately described/missing	336 (4.2)
Total	7986 (100.0)

Table 6 indicates that agencies classified as 'other' (e.g. community service organisations) provide Social Support Services to the largest number of clients and provide the most hours of support. CALD agencies are the second largest provider of Social Support Services in Victoria.

Table 6: Victorian Social Support Clients by Agency Category.

Agency Category	Number of Social Support clients (%)	Hours of Social Support provided (%)
Other	5049 (64.4)	99809 (72.6)
CALD	1333 (17.0)	24269 (17.7)
Community Health	617 (7.9)	4146 (3.0)
Hospitals	435 (5.6)	3254 (2.4)
Local Government Authority (LGA)	277 (3.5)	3649 (2.7)
Bush Nursing	29 (0.4)	508 (0.4)
ATSI	48 (0.6)	326 (0.2)
Linkages	46 (0.6)	1501 (1.1)
Total	7834 (100.0)	137462 (100.0)

**These are unique categories allocated by DHS on the MDS database. There may be a small number of clients receiving Social Support from two different agencies and therefore they will be double counted in the total.*

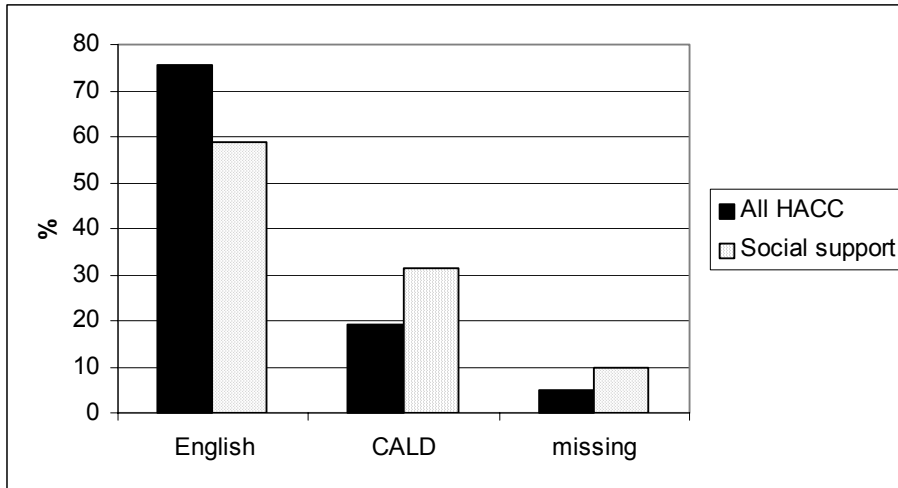
4.2) Profile of N&WMR Social Support Clients (MDS data)

The N&WMR provides services to a significant proportion of the Victorian HACC population. Of the eight regions in the state, the N&WMR provides services to 24% of all Victorian HACC clients and 24% of all HACC Social Support clients. Data from the MDS for the January-March period 2005 indicates that 1915 clients accessed Social Support Services in the N&WMR.

4.2.1 Cultural Background

The N&WMR is characterised by a large CALD population. In the 65 years and over population, 39% of people speak a language other than English (Australian Bureau of Statistics 2003). This is reflected in a larger proportion of CALD clients accessing HACC services in the region (20% - missing data=5%) compared to the state overall (12%). Although there is under representation of CALD clients accessing many HACC services, they are better represented in HACC funded Social Support Services with 32% of Social Support users in the region having a CALD background (See Figure 2 below).

Figure 2: CALD Status of all HACC and Social Support Clients in the N&WMR



For the purpose of this analysis 'CALD' was defined using the MDS variable; 'main language spoken at home'. It is acknowledged that although this is only one aspect of CALD status, it was expected that main language spoken at home was likely to impact on knowledge of and access to HACC services. One of the limitations of this approach was that Aboriginal and Torres Strait Islander (ATSI) clients were usually included in the English speaking group, and not distinguished as a separate cultural group. In Figure 2, and the demographic data below, the English speaking HACC population in the N&WMR includes 298 (0.8%) ATSI clients. For Social Support Services, twenty clients (1.1%) were Aboriginal or Torres Strait Islanders.

Tables 7-10 provide the 10 most commonly spoken languages and countries of birth for clients across the N&WMR as well as for clients accessing Social Support Services in the N&WMR.

Table 7: Main Language Spoken at Home by all N&WMR HACC Clients

	All N&WMR HACC clients (%)
English	29129 (75.6)
Italian	2925 (7.6)
Greek	991 (2.6)
Vietnamese	353 (0.9)
Arabic	269 (0.7)
Polish	257 (0.7)
Cantonese	250 (0.7)
Macedonian	247 (0.6)
Maltese	206 (0.5)
Mandarin	187 (0.5)
All other languages	1774 (4.6)
Not adequately described/missing	1938 (5.0)
Total	38526 (100.0)

Table 8: Main Language Spoken at Home by N&WMR Social Support clients

	N&WMR Social Support clients (%)
English	1127 (58.9)
Italian	123 (6.4)
Serbian	57 (3.0)
Cantonese	50 (2.6)
Polish	43 (2.2)
Vietnamese	41 (2.1)
Croatian	32 (1.7)
Greek	31 (1.6)
Netherlandic	28 (1.5)
Macedonian	27 (1.4)
All other languages	171 (8.9)
Not adequately described/missing	185 (9.7)
Total	1915 (100.0)

Table 9: Country of Birth of Clients of all HACC N&WMR HACC clients

	All N&WMR HACC clients (%)
Australia	23285 (60.4)
Italy	3775 (9.8)
England	1671 (4.3)
Greece	1151 (3.0)
Poland	495 (1.3)
Malta	441 (1.1)
China	414 (1.1)
Vietnam	404 (1.0)
Egypt	404 (1.0)
Germany	396 (1.0)
All other countries	4460 (11.6)
Not adequately described/missing	1630 (4.2)
Total	38526 (100.0)

Table 10: Country of birth of N&WMR Social Support clients

	N&WMR Social Support clients (%)
Australia	999 (52.2)
Italy	143 (7.5)
England	74 (3.9)
China	60 (3.1)
Poland	50 (2.6)
Vietnam	43 (2.2)
Greece	41 (2.1)
Netherlands	38 (2.0)
Malta	36 (1.9)
Bosnia and Herzegovina	36 (1.9)
All other countries	329 (17.2)
Not adequately described/missing	66 (3.4)
Total	1915 (100.0)

Table 11 reports the number of clients accessing Social Support Services by agency type and CALD status. Whilst 'other' agencies were providing services to the largest number of clients, these clients were predominately English speaking with CALD clients having lower levels of representation. Access for CALD clients occurred mainly through CALD agencies. Community Health had a small number of clients but provided services to a larger proportion of CALD clients than other mainstream agencies. Overall, 27% of clients received Social Support Services in the N&WMR through CALD agencies and 81% of CALD Social Support clients accessed Social Support through CALD agencies.

Table 11: CALD Status of Social Support Clients in the N&WMR by Agency Type*

	English (%)	CALD (%)	Not stated (%)	Total
Other	860 (83.8)	53 (5.2)	113 (11.0)	1026 (100.0)
CALD	8 (1.6)	478 (98.0)	2 (0.4)	488 (100.0)
Community Health	77 (50.3)	41 (26.8)	35 (22.9)	153 (100.0)
LGA	67 (82.7)	13 (16.0)	1 (1.2)	81 (100.0)
Hospitals	62 (88.6)	3 (4.3)	5 (7.1)	70 (100.0)
ATSI	11 (100)	-	-	11 (100.0)
RDNS	10 (90.9)	1 (9.1)	-	10 (100.0)

*If fewer than 10 clients from one service type, service type removed from table.

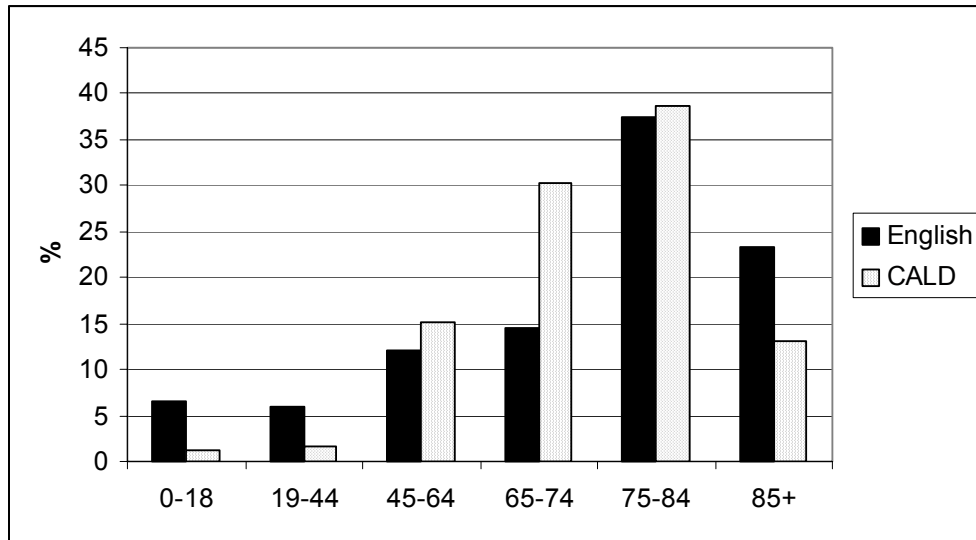
4.2.2 Age and Gender of Social Support Clients in the N&WMR

A higher proportion of Social Support clients were female compared to HACC client users overall (74% of Social Support compared to 67% of HACC users). Of those accessing Social Support Services, 72.8% of English speaking clients were female compared to 75.3% of CALD clients. Table 12 and Figure 3 indicate the difference in ages of CALD clients compared to English speaking Social Support clients. English speaking clients tend to cover a broader spread of ages with CALD clients less likely to be in the under 44 year old and over 85 year old categories. CALD clients in the 65 – 74 age group represent twice the proportion of English speaking clients in this age group.

Table 12: Age of Social Support and all HACC Clients in the N&WMR.

	Social Support Clients (%)		All HACC clients (%)
	English	CALD	
0-18	74 (6.6)	8 (1.3)	1275 (3.3)
19-44	68 (6.0)	10 (1.7)	2367 (6.1)
45-64	136 (12.1)	91 (15.1)	5221 (13.6)
65-74	163 (14.5)	182 (30.2)	7785 (20.2)
75-84	423 (37.5)	233 (38.6)	14363 (37.3)
85+	263 (23.3)	79 (13.1)	7515 (19.5)
Total	1127 (100.0)	603 (100.0)	38526 (100.0)

Figure 3: Age of Social Support Clients in the N&WMR by CALD Status.



4.2.3 Living Arrangements, Carer Status and Pension Status of Social Support Clients in the N&WMR

Table 13 shows that a higher proportion of Social Support users live alone compared with those accessing HACC services overall. There is also a larger proportion of English speaking Social Support clients living alone than CALD Social Support clients.

Table 13: Living Arrangements of Social Support and all HACC Clients in the N&WMR.

	Social Support Clients (%)		All HACC clients (%)
	English	CALD	
Lives alone	615 (55.5)	234 (39.9)	14535 (37.7)
Lives with family	357 (32.2)	297 (50.7)	17550 (45.6)
Lives with others	82 (7.4)	16 (2.7)	1915 (5.0)
Inadequately described/missing data	55 (5.0)	39 (6.7)	4526 (11.8)
Total	1109 (100.0)	586 (100.0)	38526 (100.0)

Table 14 reports carer residency status. Of note is the large proportion of missing data for this measure. Of the available data, it appears that CALD clients are more likely to have a carer, either co-resident or non-resident.

Table 14: Carer Residency Status of Social Support and all HACC Clients in the N&WMR.

	Social Support Clients (%)		All HACC clients (%)
	English	CALD	
Co-resident carer	221 (19.6)	175 (29.0)	10789 (28.0)
Non-resident carer	98 (8.7)	89 (14.8)	5597 (14.5)
No Carer	166 (14.7)	21 (3.5)	10696 (27.8)
Inadequately described/missing	642 (57.0)	318 (52.7)	11444 (29.7)
Total	1127 (100.0)	603 (100.0)	38526 (100.0)

Table 15 shows the relationship of carers to the care recipient where data is available. Available data supports the demographic profile emerging. The larger number of mother carers for English speaking clients is consistent with the age profile of around 7% of English speaking clients being under the age of 18.

Table 15: Relationship of Carer of Social Support and all HACC Clients in the N&WMR*

	Social Support Clients (%)		All HACC clients (%)
	English	CALD	
Wife/female partner	41(12.5)	45 (12.4)	2781 (17.0)
Husband/male partner	37 (11.3)	52 (14.3)	3195 (19.5)
Mother	70 (21.4)	13 (3.6)	1407 (8.6)
Father	5 (1.5)	1 (0.3)	132 (0.8)
Daughter/daughter-in-law	94 (28.8)	98 (26.9)	4072 (24.9)
Son/son-in-law	56 (17.1)	55 (15.1)	1907 (11.6)
Other - female	19 (5.8)	5 (1.4)	939 (5.7)
Other - male	5 (1.5)	5 (1.4)	301 (1.8)
Inadequately described/missing	0 (0.0)	90 (24.7)	1652 (10.1)
Total	327 (100.0)	364 (100.0)	16386 (100.0)

**Percentages calculated from total number of clients excluding those reported to have no carer (see Table 14 above).*

Table 16 indicates that fewer Social Support clients than HACC clients overall are owners/purchasers of their residence. CALD Social Support clients are more likely to have a public or private rental residence than English speaking Social Support clients. Interestingly, English speaking Social Support clients were considerably more likely to live in a supported residential service than CALD Social Support or HACC clients generally.

Table 16: Accommodation Setting of Social Support and all HACC Clients in the N&WMR

	Social Support Clients (%)		All HACC clients (%)
	English	CALD	
Own/purchasing residence	658 (59.2)	328 (55.8)	26496 (68.8)
Private rental residence	73 (6.6)	84 (14.3)	2752 (7.1)
Public rental residence	89 (8.0)	103 (17.5)	2538 (6.6)
Supported Residential Service	132 (11.9)	3 (0.5)	647 (1.7)
Independent Unit within retirement village	28 (2.5)	6 (1.0)	481 (1.2)
Other	34 (3.1)	9 (1.5)	1188 (3.1)
Inadequately described/missing	93 (8.4)	46 (7.8)	4424 (11.5)
Total	1107 (100.0)	579 (100.0)	38526 (100.0)

Pension status of Social Support clients was similar to HACC clients overall. CALD Social Support clients were more likely to be receiving an aged pension than English speaking Social Support clients, whilst English speaking clients were more likely to be receiving a Veterans' Affairs Pension. A larger proportion of English speaking than CALD Social Support clients were not receiving a government pension or benefit (refer to Table 17).

Table 17: Pension Status of Social Support and all HACC Clients in the N&WMR.

	Social Support Clients (%)		All HACC clients (%)
	English	CALD	
Aged Pension	625 (56.3)	421 (73.5)	21734 (56.4)
Veterans' Affairs Pension	83 (7.5)	3 (0.5)	2131 (5.5)
Disability Support Pension	151 (13.6)	69 (12.0)	4068 (10.6)
Carer Payment (Pension)	18 (1.6)	10 (1.7)	491 (1.3)
Unemployment related benefits	0 (0)	1 (0.2)	171 (0.4)
Other government pension or benefit	33 (3.0)	20 (3.5)	1733 (4.5)
No government pension or benefit	60 (5.4)	9 (1.6)	2147 (5.6)
Inadequately described/missing	141 (12.7)	40 (7.0)	6051 (15.7)
Total	1111 (100.0)	573 (100.0)	38526 (100)

4.2.4 Respite Service Use

An analysis was undertaken to determine the number of Social Support clients who were also accessing HACC in-home respite services to examine the relationship between Social Support Services and in-home respite services. Across all HACC services in the N&WMR, 396 (1%) clients were reported to be accessing in-home respite services, with 12.8% of these clients from CALD backgrounds. Of clients accessing Social Support Services, only five clients (0.3%) also accessed in-home respite services, three of whom were English speaking and two did not have CALD status reported.

4.3) Profile of N&WMR Social Support Programs (Survey data)

One component of the survey distributed to Social Support agencies requested information about the Social Support Programs those agencies operated, including target groups and number of clients, staff (number and EFT) and volunteers (number and EFT).

4.3.1 Core PAG

In total, 23 mainstream and 18 CALD agencies reported providing Core PAG sessions. Across these agencies there were 118 PAGs run through mainstream agencies of which 26 groups (22%) targeted people from CALD backgrounds. CALD agencies reported running 69 PAGs. Table 18 outlines the particular target groups according to agency type. There are 23 different CALD target groups represented in PAGs responding to the survey.

Table 18: Core PAG Groups by Target Population and Agency Type

	Numbers of groups and target population	
	CALD target group	Other target group
Mainstream Agency	5 Italian (1 dementia) 4 multicultural frail aged 4 CALD (not specified) 3 community based 2 multicultural 2 Chinese (1 carer) 2 Aboriginal and Torres Strait Islander 1 Kurdish frail aged 1 Russian frail aged 1 Hmong aged 1 Greek (females only) 1 Vietnamese 1 Macedonian	52 frail aged 14 carers 8 disability (aged 16-65) 6 low income/homeless 3 Acquired Brain Injury (ABI) 3 age group specific 2 male frail aged 2 mental health, males 18-64 1 frail women 1 dementia
Total mainstream agency Core PAGs	28	92
CALD Agency	10 carers groups 7 Chinese 6 Italian 6 Macedonian 5 Maltese 5 Turkish 5 Greek (1 for younger people) 4 Vietnamese women 4 African 3 Spanish 3 Polish 2 German 1 multicultural 1 Croatian 1 Romanian Serbian (number not specified*) 1 Filipino 1 Finish 1 Arabic 1 disability 1 Indian and Sri Lankan	NA
Total CALD agency Core PAGs	69	
Total Core PAGs	97	92

**The number of Serbian groups was not specified on the survey. For the total it has been included as one PAG. There may be more PAGs run by this agency and therefore, more than 69 PAGs amongst CALD agencies responding to the survey.*

Table 19 shows that there are approximately 3782 clients accessing the 187 Core PAGs reported in the survey. *This is in contrast to the MDS data that indicates there are only 1915 clients accessing all Social Support Services in the N&WMR.*

Approximately 68% of clients are from CALD backgrounds and 16% are under the age of 65 years.

Table 19: Profile of Clients attending Core PAGs*

	Mainstream (%)	CALD (%)	TOTAL (%)
Number of CALD clients (%)	928 (43.4)	1643 (100.0)	2571 (68.0)
Total number of clients	2139	1643	3782

**There may be an over-representation of CALD agencies/CALD clients due to follow up of agencies servicing CALD clients. Also, approximately half the data provided by agencies was recorded as an estimate rather than a service record.*

Figures for staff and volunteers were not fully completed by agencies, with some agencies reporting number of staff but not EFT or vice versa or not recording either. Of the data available, mainstream agencies reported 120 staff (47 EFT) and 63 volunteers and CALD agencies reported 66 staff (14 EFT) and 126 volunteers. There appears therefore to be a trend for CALD agencies to have a higher pool of volunteer staff and for mainstream agencies to rely to a greater extent on paid staff.

Activities reported to be undertaken in Core PAGs are shown in detail in Appendix 2A. Activities that most agencies reported undertaking in most sessions included socialising and meal provision. Games and crafts were also commonly undertaken. There were some differences in the frequency of activities reported by mainstream compared to CALD agencies. Mainstream agencies reported undertaking more physical activities such as games, dancing and gardening than CALD agencies. Assistance with personal care tasks such as meals and toileting was higher in mainstream agencies than CALD agencies. Education was reported as being undertaken by around 50% of Core PAGs provided through CALD agencies on many or most sessions compared to 20% of mainstream agencies.

4.3.2 High PAG

Twenty-seven agencies reported providing High PAG, of which nine were CALD agencies. In total, these agencies reported providing 109 High PAG sessions of which 37 (34%) targeted a multicultural or specific CALD group (See Table 20). High PAGs were more commonly run through mainstream agencies (84% of High PAGs). High PAGs targeted nine specific CALD groups, considerably fewer than Core PAGs (targeting 23 specific CALD groups).

Table 20: High PAG Groups by Target Population and Agency Type

Agency	Numbers of groups and target population	
	CALD target group	Other target group
Mainstream Agency	5 dementia multicultural 4 multicultural 3 Italian dementia specific 3 ethno-specific (not specified) 2 Italian 1 CALD psychosocial 1 Vietnamese 1 Greek	26 dementia specific 19 psychosocial 10 younger people with disabilities 8 aged 4 mixed 2 ABI 2 men's (1 ABI) 1 women's
Total Mainstream agency High PAGs	20	72
CALD Agency	3 Italian 3 Vietnamese 2 Macedonian 2 Greek (dementia) 2 Polish (1 mixed Core and High PAG) 1 Greek (younger people with disabilities) 1 Horn of Africa 1 Finish 1 Filipino (Core and High PAG mixed) 1 Spanish (Core and High PAG mixed)	NA
Total CALD agency High PAGs	17	
Total High PAGs	37	72

Table 21 shows that 87% of clients accessing High PAGs from the responding agencies are accessing them through a mainstream agency. There is good representation of CALD clients accessing High PAGs (38% compared to 39% of the general 65+ population). However while 38% of High PAG clients were from CALD backgrounds, this rate is much lower than their rate of representation in Core PAGs (68%). This may indicate lower needs amongst the CALD population or it could reflect the lower level of High PAG provision through CALD agencies compared to Core PAGs.

Table 21: Profile of Clients attending High PAGs*

	Mainstream (%)	CALD (%)	TOTAL (%)
Number of CALD clients (%)	390 (28.8)	201 (100.0)	591 (38.0)
Total number of clients	1356	201	1557

**There may be an over-representation of CALD agencies/CALD clients due to focused follow up on agencies servicing CALD clients. Also, approximately half the data provided by agencies was recorded as an estimate rather than a service record.*

Again, data for staff and volunteers was inconsistently reported. Data available indicated that there were 98 staff (41 EFT) and 43 volunteers in mainstream High PAGs, and 27 staff (10 EFT) and 8 volunteers in CALD agency High PAGs.

Socialising, meal provision, games involving physical activities and assistance with meals and toileting were activities frequently undertaken in High PAGs (refer to Appendix 2B for more detail).

High PAGs differed in various ways from Core PAGs. For example:

- Education was more common in Core PAGs than High PAGs;
- Music therapy/singing was more common in High PAGs than Core PAGs; and
- Assistance with personal care tasks such as meals and toileting was higher in High PAGs than Core PAGs and higher in mainstream High PAGs than CALD agency High PAGs.

High PAGs provided by mainstream and CALD agencies also differed in the frequency of some activities:

- Assistance with personal care tasks, outings and theme days were more common in mainstream than CALD High PAGs (12% of mainstream compared to 33% of CALD agencies never took clients on outings); and
- Reading and writing letters was more commonly undertaken in CALD than mainstream High PAGs.

4.3.3 Friendly Visiting

Seventeen agencies reported providing Friendly Visiting services, with the majority of these (15 agencies, 88%) being CALD agencies. Table 22 indicates that of the responding agencies, Friendly Visiting is a service predominately provided by CALD agencies for CALD clients.

Table 22: Profile of Clients of Friendly Visiting Programs*

	Mainstream (%)	CALD (%)	TOTAL (%)
Number of CALD clients (%)	5 (50.0)	685 (100.0)	690 (99.3)
Total number of clients	10	685	695

**There may be an over-representation of CALD agencies/CALD clients due to focused follow up on agencies servicing CALD clients. Also, approximately half the data provided by agencies was recorded as an estimate rather than a service record*

Five hundred and sixty-two volunteers were reported to be providing Friendly Visiting services with 88% of these volunteering through CALD agencies.

Socialising was the most commonly reported activity undertaken within Friendly Visiting services. Games, education, discussing how to access services and reading/writing letters were more commonly reported activities in CALD than mainstream Friendly Visiting services (See Appendix 2C for more detail).

4.3.4 Telelink

Three CALD agencies reported conducting Telelink programs for CALD clients servicing 70 clients. Ten clients (14%) were under the age of 65 years. These services were run with minimal staff and volunteer time (less than 1 EFT for each agency).

Two agencies described their Telelink as providing socialisation in 'many sessions', with one of these agencies also reporting that 'discussing how to access services' was undertaken during 'many sessions'. One program described their Telelink service as providing occasional outings, theme days, education, discussing how to access services, socialising, reading/writing letters, shopping/paying bills and a neighbourhood lunch group.

4.3.5 Carer Support

Four CALD and three mainstream agencies reported providing carer support programs for 139 carers (one agency did not report the number of carers accessing this program). Most clients were from CALD backgrounds (101 carers, 72.7%) and 16 were under the age of 65 years (11.5%). Of the four agencies that reported staff and volunteer numbers, there were a total of 18 staff (4 EFT) and 21 volunteers (5.3 EFT).

Socialising and discussing how to access services were the most commonly reported activities undertaken in carer support programs (Refer to Appendix 2D for more detail). Other activities undertaken on most or many sessions by a quarter of agencies included music therapy/singing, crafts, outings, meal provision and education.

4.3.6 Other

Other Social Support Programs were described by six mainstream and five CALD agencies. These programs combined provided services to 2511 clients. The programs are described below:

- Three CALD agencies run Social Support/senior citizens groups servicing 1484 CALD clients (10% under 65 years, 1 staff – 1 EFT and 124 volunteers – 12 EFT);
- Community transport (2 agencies):
 - 8 vehicles servicing 810 clients (40% under 65 years, 60% CALD, 17 staff - 14 EFT, and 50 volunteers - 15 EFT); and
 - 92 clients (5% under 65 years, 10% CALD, 1 staff member – 0.5 EFT);
- Lunch with the bunch (69 clients, 11 CALD, 1 staff member – 0.8 EFT, 30 volunteers – 10 EFT);
- Annual camp for 45 CALD clients (7 under 65 years, 1 staff member and 2 volunteers);
- Carers of people with dementia initiative (30 clients, 3 under the age of 65, 25 CALD clients, 4 staff – 1.4 EFT);
- Petlinks program (11 clients, 10 CALD, 1 staff member - 0.05 EFT, 4 volunteers – 0.4 EFT);
- Volunteer host respite for families of children with a disability for 62 families (5 part time staff and 62 volunteers).

4.4) Summary of Social Support Profile

In summary, the N&WMR provides HACC services to a considerable proportion of the Victorian HACC client population. The region is also characterised by a large CALD population. Analysis of MDS data showed that overall the CALD population was underrepresented in HACC services, however, they tended to have greater representation in Social Support Programs. Whilst 'other' agencies were the largest providers of Social Support Services, the majority of CALD Social Support clients were accessing Social Support through CALD agencies. The demographic profile of Social Support clients in the region (n=1915) showed that English speaking clients were more likely to be in the younger age groups (under 44 years) and very old age group (85+ years). CALD clients were more likely to have a carer and less likely to be living alone. Socio-economic indicators (pension status and living arrangement) show that CALD clients may be slightly more likely than English speaking clients to access a government pension and slightly less likely to be owners/purchasers of their residence.

Analysis of survey data from 55% of Social Support providers in the N&WMR, however, shows discrepancies between this data and the MDS data. Agencies responding to the service provider survey reported providing services to approximately 5300 clients in PAGs alone – more than double the number of clients reported in the MDS. It became evident when comparing numbers of clients reported on the survey with number of clients recorded on the MDS that the MDS was missing data for a substantial proportion of clients or that the survey data had some level of overstatement.

Findings from the survey data reported 187 Core PAGs in operation of which 69 were run through CALD agencies and 95 were targeted to CALD clients. A large number of Core PAGs were targeted to specific cultural groups covering 23 different languages. In total, 68% of Core PAG clients were from CALD backgrounds. CALD agencies tended to rely more heavily on volunteers to provide Core PAGs than mainstream agencies.

CALD agencies provided 16% of the High PAGs compared to 37% of Core PAGs. Overall, 38% of High PAG clients were from CALD backgrounds, compared to 68% for Core PAGs. The proportion of CALD clients was much lower in High PAGs than Core PAGs. This may indicate lower needs amongst the CALD population or it could reflect the lower level of High PAG provision through CALD agencies compared to Core PAGs. Although these proportions suggest over-representation of CALD clients accessing PAGs, this could reflect a bias in the survey sample where CALD agencies were targeted in follow-up of non-returned surveys.

Friendly Visiting and Telelink are services predominately provided by CALD agencies to CALD clients and again reflect services relying to a greater extent on volunteers. Carer support services were provided by four CALD agencies and three mainstream agencies with 73% of clients being from a CALD background. There were also a number of other programs listed under the category 'other'. A community transport service in the Northern part of the region reported providing transport to approximately 900 clients. Some CALD agencies also reported running Social Support/senior citizen type groups to approximately 1500 older CALD clients.

Activities undertaken in Social Support Programs were also examined. There were some differences in the types of activities undertaken by CALD and mainstream agencies and by Core and High PAGs:

- Education was reported as being undertaken by around 50% of Core PAGs provided through CALD agencies on many or most sessions compared to 20% of mainstream agencies and around 10% of High PAGs in mainstream and CALD agencies;
- Games with physical activity were more common in mainstream Core PAGs than CALD Core PAGs but more common in High PAGs in CALD agencies than mainstream;
- Outings were more common in mainstream High and Core PAGs than CALD agency PAGs;
- Music therapy/singing was more common in High PAGs than Core PAGs; and
- Assistance with personal care tasks such as meals and toileting was higher in High PAGs than Core PAGs and higher in mainstream than CALD agencies.

5. Findings: Cost Benefit Analysis

This chapter reports on the findings of the cost benefit analysis, undertaken as part of this study.

5.1) Study Target Group

A group of twenty agencies were selected for inclusion in the cost database. The criteria for selection of agencies consisted of the following:

- Achieving a manageable number for cost analysis and review;
- Including those agencies offering PAG services that had participated in and returned the NARI survey;
- Including those agencies that had provided DHS with the 04/05 Annual Acquittal form (due in September 2005); and
- Achieving a representative sample from both mainstream and ethno-specific agencies with large and smaller agencies represented.

The 20 agencies selected consisted of:

- Local Government Authorities (7);
- Ethno-specific agencies (10); and
- Community Health Centres (3).

5.2) Data Elements

The following documents were reviewed:

- Annual service agreements for each agency including both funded activity targets and budgets;
- MDS 2004/05 output reports for each agency;
- Quarterly 2004/05 report summaries of outputs for each agency; and
- Copies of signed and finalised annual acquittal returns for 2004/05.

5.3) Throughput or Activity Data Sources

Following review of data obtained, a number of decisions were made about the data elements to be included in the cost study. These are summarised below as follows:

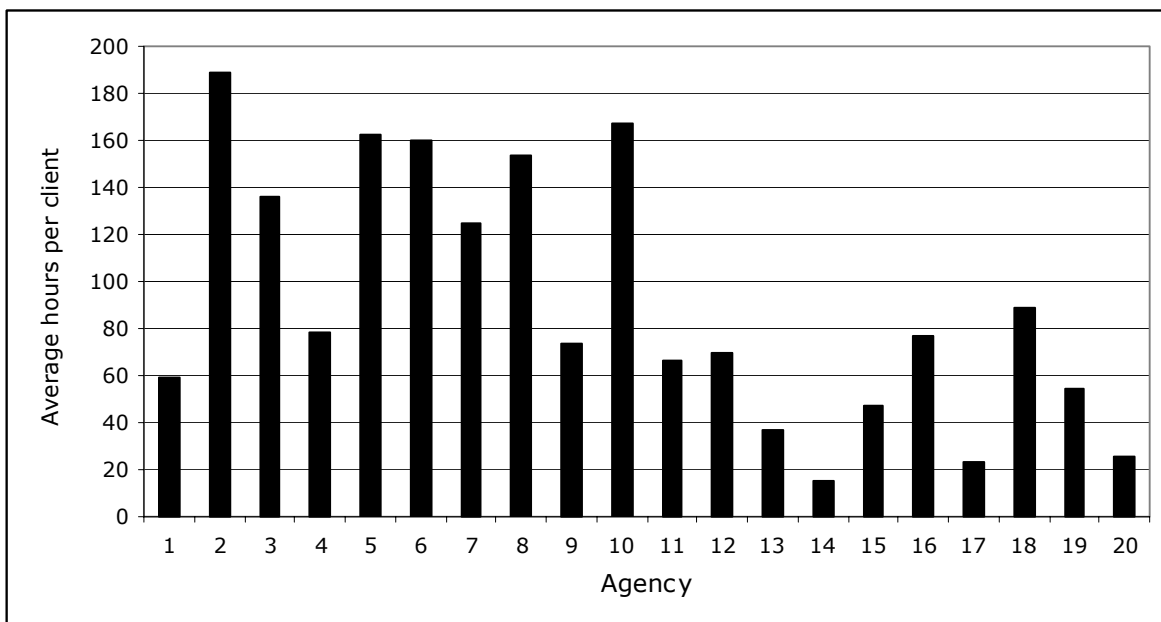
- Data used would be from the completed 2004/05 financial year in order to have a full years completed output (activity hours reported) and cost (funding) data;
- Review of annual activity reporting data for 2004/05 from MDS database, Quarterly return data and the agency annual acquittals showed discrepancies in reported outputs for some agencies between each of the three data sources for 2004/05. For example agency #3 for Core PAG reported 15140 actual hours for 2004/05 in the MDS, 13813 hours in the quarterly returns and 10996 hours on the signed annual acquittal forms;
- Other apparent discrepancies appear in agency reporting of actual client numbers. Some agencies seemingly report the number of clients who have received PAG services and they are only counted once (for example 40 individuals) while others seem to be reporting these 40 individuals by the number of times they attended a PAG group during the year (thus for example 120 clients in total);
- In order to demonstrate this counting issue the average hours of PAG received per client was calculated based on reported numbers of PAG clients and actual hours of PAG delivered in the annual 2004/05 agency acquittal forms. It can be noted from Figure 4 below for Core PAG that there are considerable variations in the calculated actual average hours per client across each agency. A similar degree of variability in hours per client exists for High PAG;
- It is understood that MDS accuracy has improved in 2005/06 however in view of the above mentioned discrepancies between data sets for 2004/05, it was decided that

only the annual acquittal forms that have been signed off on by each agency would be used as the definitive and final activity output data sources; and

- Both cost and output data would be reported in the same format as the output data reported on the acquittal forms, so although agencies may operate several Core PAG groups for example, these are summarised at one line level in the acquittal forms as Core PAG and similarly with High PAG.

The following graph illustrates the inconsistency of counting and reporting of clients by agencies referred to above. The researchers divided the total PAG hours by clients reported by agencies and in one broad group of agencies this produced a high average hours per client compared to a low hours per client in the other group. The different average hours per client are a consequence of the way agencies count and report client numbers.

Figure 4: Graph of Actual Annual Hours Reported per Client for Core PAG in 2004/05



5.4) Budget and Cost Data Sources

Agencies do not report annual expenditure based on costing of funded activity lines (as cost of Core PAG and High PAG), but rather in a global or financial accounts style of annual report for the whole agency.

It is understood that this format reports high level line items such as Salaries and Wages, Superannuation, Rentals, Other expenses etc. for the agency. So there is no activity based costing undertaken to show how input (budget funded) resources have been actually utilised in relation to outputs achieved for each of the funded activities. While such a study is not difficult to implement it is beyond both the time frame and aims of this current study.

It was agreed that the determined "cost" of the various activities in this report would be the final DHS and Department of Veterans Affairs (DVA) [see section 5.6 below] input budget for 2004/05 for each activity plus any fees received. It would be assumed that the entire budget allocated for each activity (Core PAG, High PAG and Volunteer Coordination) plus any fees raised had been fully expended and was thus equivalent to the actual cost of the outputs.

Agreed annual activity outputs targets and budget dollars data (DHS and DVA) for each funded activity was obtained from the service agreements and fees collected by agencies were obtained from the annual agency acquittal reports.

5.5) Fees Collected by Agencies

Agencies are required (within HACC guidelines) to collect fees from clients participating in the various HACC services, however it is clear from the various acquittals reviewed that not all agencies do so. Of the 20 agencies providing acquittal forms eight did not report any fees collected. These agencies included the following:

- Ethno-specific agencies (5);
- Community Health Centres (2); and
- Local Government Authorities (1).

Given that over half of the agencies collected fees and also report on the acquittal form that these fees were all fully expended on the activity, it seemed reasonable that fees be added to the DHS budget to form part of the overall budget and thus, part of the cost of services outputs in the study.

On average fees collected contributed 6% of the (known) overall input budget for Core PAG for the 20 agencies, however, this figure ranged from 2% to 35% of total input funding utilised in the individual agencies. The proportion of fees to total funding was 10% or more in five agencies.

For High PAG, fees collected constituted overall 4% of total input funds with less of a range in variation in the contribution of fees over the individual agencies than in Core PAG, this being from 0.3% of total funds to 12%. The fees collected by individual agencies are detailed in the table below.

Table 23: Fees collected by individual agencies

No.	Core PAG DHS Budgets				High PAG DHS Budgets			
	Budget 2004/05	Fees Collected	Total Input \$'s	Fees % of Budget	Budget 2004/05	Fees Collected	Total Input \$'s	Fees % of Budget
1	261490	10870	272360	4%	219880	8895	228775	4%
2	67390	8693	76083	11%	33667	3725	37392	10%
3	194495	20900	215395	10%	221523	30000	251523	12%
4	19205	0	19205	0%				
5	127530	30223	157753	19%	448847	38000	486847	8%
6	212483	30176	242659	12%	77695	4140	81835	5%
7	266084	5190	271274	2%	409765	1088	410853	0.3%
8	321682	21237	342919	6%	159419	0	159419	0%
9	30693	1364	32057	4%	12303	0	12303	0%
10	172329	13410	185739	7%	123494	5425	128919	4%
11					65676	1103	66779	2%
12	16467	0	16467	0%				
13	94717	0	94717	0%				
14	28453	15441	43894	35%	83939	0	83939	0%
15	120523	2504	123027	2%				
16	151086	0	151086	0%	208148	0	208148	0%
17	13668	0	13668	0%				
18	186331	0	186331	0%				
19	12350	0	12350	0%				
20	107671	0	107671	0%	258656	15873	274529	6%
	2404647	160008	2564655	6%	2323012	108249	2431261	4%

5.6) Department of Veterans' Affairs

A number of agencies have funding for providing Social Support activities to DVA clients and it is understood that these hours are included in the output hours reported in the acquittal forms. Hence it was decided to also roll these budgets in to the overall budget figure when calculating costs per hour for each activity.

5.7) Summary of Comparative Data Findings

In total 20 agency acquittal forms were received and processed and the study findings are outlined below.

The most striking finding in Core PAG (refer below to the following table and graphs of each activity) is that collectively the 20 agencies reported 35972 (or 15%) more hours than the DHS 2004/05 target set for the agencies overall.

By contrast, in High PAG the agencies overall reported a 2831 under achievement of 2004/05 targets with only five out of the 12 agencies funded for this activity reporting above the DHS target. (Note one other agency #18 is not funded for High PAG but reported 4604 hours in 2004/05.) In some cases agencies that provided both Core and High PAG underachieved in one but exceeded their targets in the other, "balancing out" their overall performance.

The project scope did not include detailed audit or verification with the agencies of actual hours reported on annual acquittal forms nor has any direct follow up been undertaken by the researchers with those agencies reporting significantly large (relative to other agencies) under or over achievement of hours compared to DHS targets.

Table 24: Agency Core PAG and High PAG Outputs and Costs 2004/05

No.	Core PAG DHS Targets, Outputs and Hourly Costs				High PAG DHS Targets, Outputs and Hourly Costs			
	DHS Target 04/05	Actual Hours 04/05	C/F DHS Target	\$ Cost per hour	DHS Target 04/05	Actual Hours 04/05	C/F DHS Target	\$ Cost per hour
1	25788	26099	311	10.44	15387	15048	-339	15.2
2	6646	6410	-236	11.87	2356	2700	344	13.85
3	19181	10996	-8185	19.59	15502	12925	-2577	19.46
4	1894	1883	-11	10.2			0	0
5	12577	19770	7193	7.98	31200	23150	-8050	21.03
6	20955	23835	2880	10.18	5437	3390	-2047	24.14
7	26241	26409	168	10.27	28675	32682	4007	12.57
8	31724	25533	-6191	13.43	11156	9636	-1520	16.54
9	3027	2425	-602	13.22	861	825	-36	14.91
10	16995	15920	-1075	11.67	8642	10470	1828	12.31
11	4596	3175	-1421	21.03			0	0
12	1624	3887	2263	4.24			0	0
13	9341	39989	30648	2.37			0	0
14	2806	5367	2561	8.18	5874	6325	451	13.27
15	11866	3288	-8578	37.42			0	
16	14900	37406	22506	4.04	14566	16865	2299	12.34
17	1348	2244	896	6.09			0	0
18	18376	10535	-7841	17.69	0	4604	4604	N/Appl
19	1218	1905	687	6.48			0	0
20	10393	10392	-1	10.36	17716	15921	-1795	17.24
Totals	241496	277468	35972	9.16	157372	154541	-2831	15.54

Source: DHS 2004/05 Service Agreements, Agency 2004/05 Acquittal Forms

Notes:

1. Calculated dollar cost per hour is original DHS input budgets (and any DVA budget funds) plus actual fees agencies collected divided by actual activity hours reported by agencies.
2. No cost per hour is calculated for High PAG in agency #18, as this agency had no DHS budget for this activity in 2004/05.
3. DHS provide input funding for Core PAG and High PAG at \$10.14 and \$14.29 per hour of PAG output respectively.

5.8) Core PAG Findings

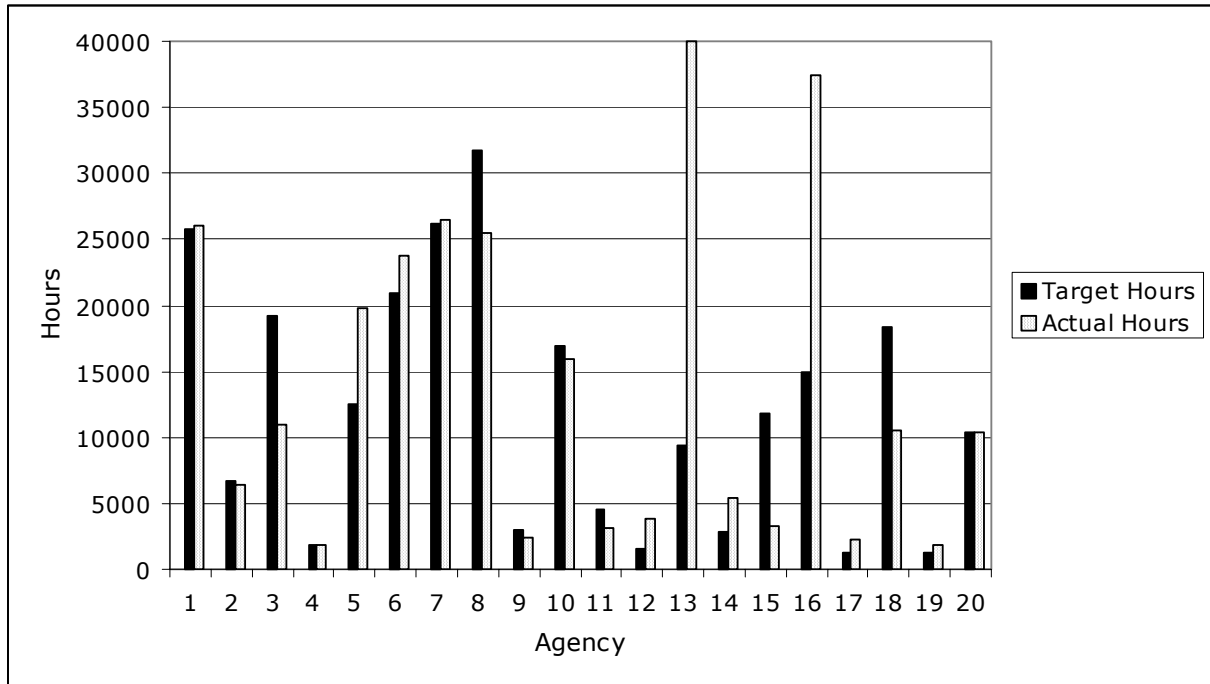
5.8.1) Core PAG Actual Hours of Throughput

Although 10 out of 20 agencies in the above table were exceeding DHS service agreement Core PAG targets most are doing so only by modest amounts of between 2000-3000 hours over. Three of the agencies that were over target in Core PAG were almost exactly offset by being under on High PAG targets.

While overall targets were exceeded by 35872 in 2004/05 most of this had come from two ethno-specific agencies (numbers 13 and 16) where the extra output hours were considerably greater than DHS targets (30648 and 22506 hours respectively). This is to some extent offset by agencies #3, #8, #15 and #18 that are in total 30895 actual hours under target. Agencies #3 and #8 are also down on the High PAG targets.

The individual agency performances of actual Core PAG hours compared to DHS targets for 2004/05 are clearly illustrated in Figure 5 below.

Figure 5: Graph of Agency Excess or Deficit of Actual Hours Compared to DHS Targets for Core PAG in 2004/05 (See Notes 1 & 3 Table 24)



Note:

1. First column is DHS hours target for 2004/05.
2. Second column is actual hours reported on 2004/05 annual acquittal forms by agencies.

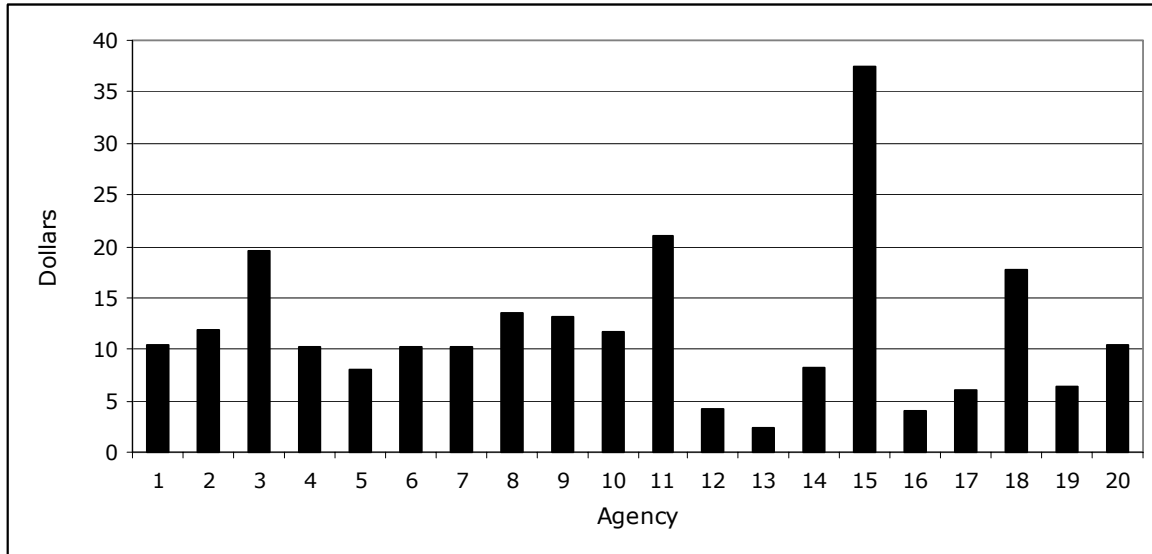
5.8.2) Core PAG Actual Cost per Hour

It was noted above that agencies are not currently geared (and in most cases probably lack the resources) to supply activity costs data, so that "cost" in this report means the original DHS and DVA 04/05 input budget funds plus any fee collection reported.

Some agencies in Figure 5 above appear very low cost per hour when compared to input funding and other agencies (e.g. Agency #13 for Core PAG at \$2.37/hour actual compared to \$10.14 per hour DHS funding and \$9.60 actual average overall). However, they are not necessarily more efficient than others. Rather because they have greatly exceeded the targeted hours in the acquittal reports, the hourly cost is lower than the \$10.14 per hour of input finding.

Conversely those agencies with high costs per hour in Figure 6 below (for example #15 at \$37.42 per hour actual) are those that have significantly under achieved the original DHS targets and still using (presumably) all of the original budgeted resources plus any fees collected.

Figure 6: Graph of Agency Actual Cost per Hour for Core PAG in 2004/05



5.9) High PAG Findings

5.9.1) High PAG Actual Hours of Throughput

In High PAG a majority of agencies have under achieved DHS targets with three instances of an agency under achieving in both Core PAG and High PAG.

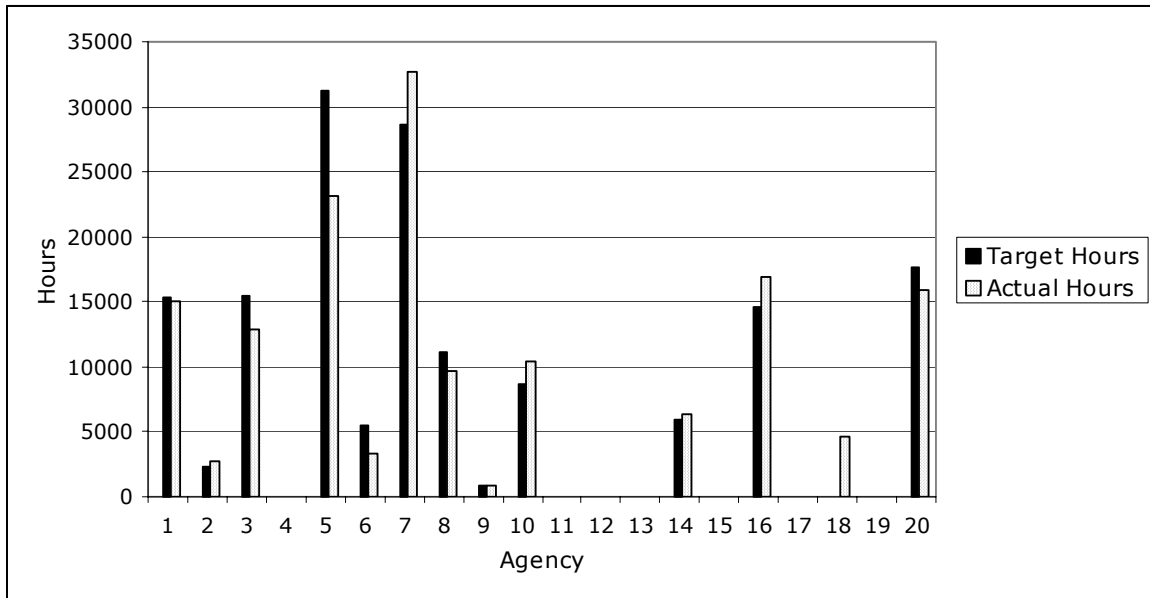
Agency #5 in particular reported a deficit of 8050 High PAG hours below target although this is in large part offset by the same agency being 7193 over target on Core PAG.

Of those agencies that have exceeded targets in High PAG, some almost break even or slightly down on Core PAG targets so these are being offset by the agency over achieving on High PAG.

One agency (#18) was down on Core PAG but reported 4604 High PAG hours without having any DHS budget for this activity in 2004/05.

These results might indicate an increasing level of more dependent and/or complex clients in these specific agencies and thus increased demand for High PAG services rather than Core PAG as clients' age and move from Core PAG to High PAG.

Figure 7: Graph of Agency Excess or Deficit of Actual Hours Compared to DHS Targets for High PAG in 2004/05



Notes:

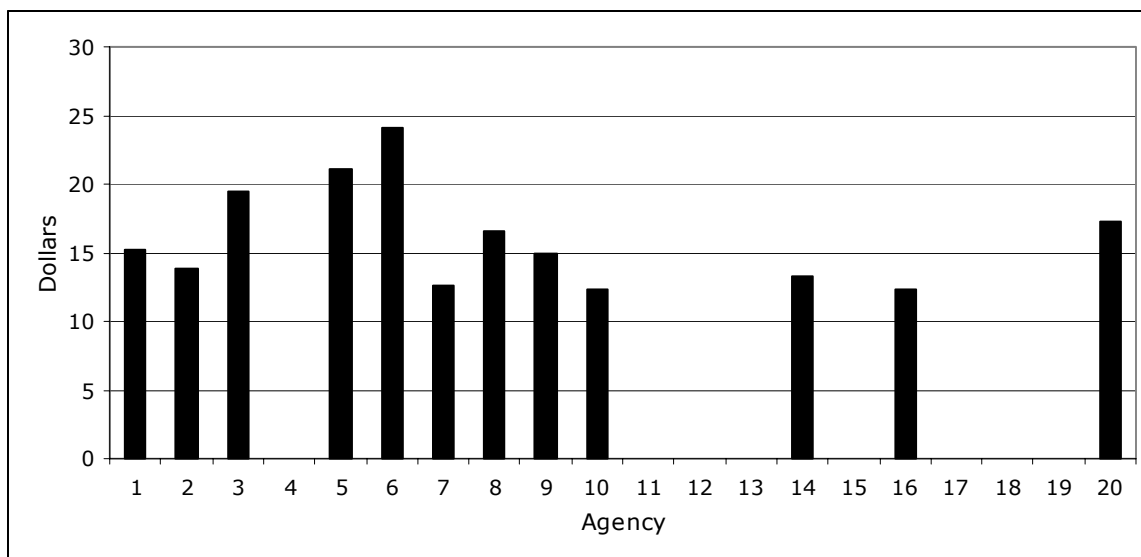
1. First column is DHS target hours for 2004/05.
2. Second column is actual hours reported on 2004/05 annual acquittal forms by agencies.

5.9.2) High PAG Actual Cost per Hour

The comments above in relation to Core PAG, about input costs and cost per hour, apply to High PAG also. It should be noted that agencies under achieving against their targets for High PAG such as agency #5 below, will in turn report a much higher cost per hour than the \$14.29 per hour funded by DHS. This is simply because the original dollar input budget has not been adjusted and the agency has underachieved on actual hours compared to target. In other words the agency is delivering less with the same budget.

Conversely agencies that have over delivered against their targets are doing more and with the original input budget used for calculations the hourly rate must be less than the funded rate.

Figure 8: Graph of Agency Actual Cost per Hour for High PAG in 2004/05



5.10) Sustaining PAG Activity Hours

It is clear from the tables and graphs above that some agencies that are underperforming against targets in one PAG activity area are offsetting this to some extent by being over target in the other PAG activity area.

Further the funding for the two activity streams probably overlaps and an under run in one activity stream possibly financially supports overruns in the other in some instances. Thus agency five for example is 7193 hours above Core PAG targets at an actual hourly cost of \$7.98, which is lower when compared to DHS hourly funded rate of \$10.14 because of the extra outputs. However agency #5 is 8050 hours down on High PAG targets with an actual hourly cost of \$21.03 (higher when compared to DHS hourly funded rate of \$14.29).

Given the higher hourly funding for High PAG, this agency should have easily been able to finance the Core PAG over run from the High PAG under run of target hours; however this "buffer" is not available for agencies such as #13 that only offers Core PAG and has greatly exceeded target.

For a small number of agencies however the cost analysis has indicated significant net overall actual hours achieved in excess of DHS targets.

Agencies 13 and 16 in particular are 358% and 151% over targets respectively. Agency 13 does not offer High PAG so it has no potential funding "buffer" from being under in hours from this activity stream. Agency 16 does offer High PAG but is 2299 over in this activity so it is unlikely to have realised any funding buffer from this activity stream.

This has raised the question of how those agencies that have greatly overachieved DHS annual targets in 2004/05 year supported these extra outputs.

Limited consultation with agencies via discussion with workshop participants and Project Management Group representatives has indicated that those agencies reporting over target PAG hours are possibly financially supporting this additional throughput by using:

- Money from other funding sources including other HACC funds and external non HACC sources of funding;

- Fundraising activities;
- Fees raised from participants;
- Increased numbers of volunteers; and
- Some dilution of the quality of the service (e.g. by having more clients per group than originally budgeted for and combined PAG groups).

At the project workshop held on 24th November 2005 a number of points were raised by participants relative to funding of Social Support activities and using external sources of revenues to do this (see Chapter 8 for more detail). These included:

- Agency use of volunteers is increasing in order to meet the demand for Social Support Services within existing DHS budgets;
- In some ethnic groups fees are not seen as being appropriate by clients and agencies have real concerns that even small fees discourage clients from attending at all or coming as often as would be beneficial to them;
- Most agencies do see fees as appropriate for increasing revenues and it was suggested that where fees are not currently raised clients need to be better educated about the benefits they receive from attending Social Support activities such as PAG in return for payment of a very small fee;
- Not all agencies have the skills and staff to seek out external sources of revenues as almost all such funds involve development of submission applications. It was noted that the bigger, more well established agencies have greater capacity in this area than the smaller agencies; and
- Agencies indicated that opportunity for revenue raising is limited. At one extreme an agency has raised funds to pay for a club house and vehicle over the past 15 years, which in turn gave it an ongoing cash flow from hire/rentals of these assets. Other agencies limit their efforts to small raffles and fetes.

5.11) Summary

This analysis has highlighted the following:

- Conflicting performance reporting by agencies which placed limits on the extent of the analysis or conclusions that could be drawn;
- Some agencies over achieving their targets;
- A slight trend indicating that agencies are more likely to under achieve targets for High PAG than Core PAG;
- Eight of the 20 agencies do not collect fees and in comparison to Local Government services, CALD agencies are less likely to collect fees; and
- Of those agencies collecting fees, there is a large variance in the extent to which these contribute to the provision of services.

6. Findings: Service Practice Profile (Service User Focus Group Feedback)

This chapter reports on the outcomes of the four focus groups conducted with service users and carers accessing Social Support Services.

6.1) Participant Profile

Whilst most participants attended PAGs, some also used Friendly Visiting and Telelink services.

Thirty-six people participated in the four focus groups. A multicultural group, two established ethno-specific groups and a newly arrived ethno-specific group were conducted. The multicultural and the two established ethno-specific groups each had ten participants and the newly arrived group had six participants. Eighteen of the participants were female (50.0%) and 17 were male (48.6%). One participant did not state their gender in the survey. The average age of participants was 73 years and seven months. Two participants did not report their date of birth in the survey. All participants were born outside of Australia.

Most participants arrived in Australia in the 1980s, however, date of arrival ranged from "1940s" to "2000 onwards". The decade of arrival is documented in Table 25.

Table 25: Participants' Decade of Arrival

Decade of Arrival	Number of Participants (%) n=36
1940's	1 (2.8%)
1950's	4 (11.1%)
1960's	3 (8.3%)
1970's	4 (11.1%)
1980's	11 (30.6%)
1990's	9 (25.0%)
2000 onwards	1 (2.8%)
Missing	3 (8.3%)

Participants had been involved in Social Support Services for differing lengths of time. Three (8.3%) participants had been involved in the Social Support Services for over ten years, 7 (19.4%) participants for 5-10 years, 22 (61.1%) participants for 1-5 years and four (11.1%) participants for less than 12 months.

The use and knowledge of HACC services varied between groups. Table 26 outlines the numbers of focus group participants currently using each HACC service and Table 27 outlines participants awareness of HACC services. The most commonly utilised services by the focus group participants were home care, property maintenance and personal care. The least utilised services were Linkages/Community Aged Care Packages (CACPs), residential respite and delivered meals. The participants using HACC services were predominantly from the multicultural group and one of the established ethno-specific groups. These two groups also indicated a higher level of awareness of HACC services than the newly arrived and second ethno-specific group. In total, the participants were most aware of home care, delivered meals and personal care. They were least aware of Linkages/CACPs and Personal Alerts. Although over half of the

participants in the focus groups were aware of delivered meals it was one of the least utilised services. Analysing this data it should be noted that there was a considerable age difference between the groups. The average age of one ethno-specific group was 80, the average age of the multicultural group was 76 and the average age of the other ethno-specific group was 73. The newly arrived group was, on average, ten years younger (average age of 63). The diversity in ages between the groups, in addition to length of stay in Australia, and cultural and language differences may explain the differences between awareness and use of services.

Table 26: Participants Use of HACC Services

HACC Service	Focus group				Total n=36
	Multicultural n=10	Newly arrived n=6	Ethno- specific (1) n=10	Ethno- specific (2) n=10	
Home care	5	0	4*	4	13 (36.1%)
Property maintenance	3	1*	3	0	7 (19.4%)
Personal care	4	0	0	2	6 (16.7%)
Allied health	5	0	0	0	5 (13.9%)
In home respite	3	0	0	2	5 (13.9%)
Personal Alert	3	0	0	1	4 (11.1%)
District nursing service	3	0	0	1	4 (11.1%)
Delivered meals	2	0	0	1	3 (8.3%)
Residential respite	3	0	0	0	3 (8.3%)
Linkages/CACPs	1	0	0	1	2 (5.6%)

**Discrepancy between participants using the service but also stating they are not aware of the service (See Table 27).*

Table 27: Participants Awareness of HACC Services

HACC Service	Focus group				Total n=36
	Multicultural n=10	Newly arrived n=6	Ethno- specific (1) n=10	Ethno- specific (2) n=10	
Home care	7	0	3	10	20 (55.6%)
Property maintenance	5	0	4	6	15 (41.7%)
Personal care	5	0	0	8	24 (66.7%)
Allied health	8	0	0	4	12 (33.3%)
In home respite	5	0	0	8	13 (36.1%)
Personal Alert	3	0	0	4	7 (19.4%)
District nursing service	5	0	0	9	14 (38.9%)
Delivered meals	6	0	4	10	20 (55.6%)
Residential respite	4	0	0	7	11 (30.6%)
Linkages/CACPs	2	0	0	2	4 (11.1%)

The remainder of this chapter outlines participants' responses to the questions raised, according to themes that have emerged.

6.2) Reasons and Benefits of Accessing Social Support Services

Participants were asked to comment on their reasons for attending the PAG and for accessing Friendly Visiting and Telmlink services. They were also asked to comment on the benefits of these services.

Reasons for using Social Support Services were usually the same as the benefits for using them. The reasons and benefits included access to socialisation and activities, information and education, and respite for the carer. These are outlined in sections 6.2.1-6.2.3 below.

Participants were also asked to comment on how they found out about the service. A number of participants across all groups stated that they found out about the Social Support Service through family/friends. This did not vary according to cultural group. Table 28 outlines the responses to this question by Social Support group.

Table 28: How Did You Find Out About the Group?

	Family/ friend (10)	Council (3)	Ethnic agency (2)	Self (2)	Attend information session (1)	Word of mouth (1)
Multicultural Group	✓ ✓	✓ ✓ ✓		✓ ✓	✓	
Newly Arrived Group	✓ ✓					
Established Ethno-Specific Group (1)	✓ ✓ ✓ ✓					
Established Ethno-Specific Group (2)	✓ ✓		✓ ✓			✓

6.2.1 Socialisation and Activities

Participants across all focus groups identified access to a range of social and physical activities as the reasons and benefits of attending PAGs. Participants across all groups stated that they attended the PAGs as they enjoyed socialising and many stated that by attending the groups, they were combating feelings of isolation and loneliness.

"Because I have nobody else to talk to and socialise with and I come here to have fun and join others."

"Whole week I'm alone. This is the only day when I meet others."

Participants also stated that when they attend the PAGs it makes them "happy" and makes them "feel good".

"The only thing I could say is in this group there is no envy, there is no arrogance here. Nobody is proud, everybody is willing to help one another. There is a feeling of togetherness and a feeling of belonging in the group, As for myself I want to come here as much as possible because there is happiness. If you are going to live in this world you want to be happy and contented. And if you are home alone

in the house you feel bored, it is very boring, you feel depressed, you are lonely and sad."

"Coming here makes you excited, even though the date you are going to come here, lets say tomorrow, today you are already excited about what is going to happen tomorrow."

"I come here because they love me very much and they help me terribly so I love coming here."

Members of an ethno-specific group also made the following comment in relation to the Telelink service and how it provides socialisation:

"We have this Telelink, it is through the Telstra. At least 10 people are being called every Friday at 1.00–1.30 in the afternoon... We are being called through the phone then our telephone open and everyone who is included in the Telelink, their telephones are all opened in one. We are chatting as if we are here but through telephone. We enjoy it through the phone too."

Recreation activities such as games and outings were major reasons why participants attended the PAGs and were also cited as benefits for attending. Members of the newly arrived community requested structured and planned activities to be introduced in their program:

"Come for activities, dancing, exercising, exchanging experiences, something good."

"I am alone practically because I am blind that is why I enjoy coming to the group. All day sitting at home sometimes listening to radio, that is all. I am very happy with this club sometime go out to restaurants, sometimes go out in the country, I am very pleased with it."

Physical activities including dancing and exercise programs, and visiting physiotherapists were reasons cited by participants across all groups for attending the group and were also cited by participants from three of the four groups as benefits they get from attending the PAG:

"We walk, the older people walk, it is very good for the body, if we have worries... Walking for 45 minutes, when we come back we are very relaxed. We are very happy, old people and the disabled people, all the time want the care for the community and the [name provided] Council look after these people."

"We did have a physiotherapist come for the light exercise, not to talk about health, but they also did come about diabetes, a diabetes session, and eyes, and a dentist came."

"We would like swimming and spa, the [name of the pool] pool is not too far from here, one day and then come here for lunch."

"Coming to this group is my happiness. Because everybody is happy, we are doing what we can do, exercising, dancing, chatting with each other, getting information from the government. In this group I have learned lots of things especially from [PAG Coordinator]. She tells me everything, explains everything, what the government is doing for us ..."

"They also show us appropriate sport activity for our age and this is good for our health."

6.2.2 Information and education

Participants across all groups stated that one of the reasons and benefits of attending the PAG was being provided with information from guest speakers, such as health professionals, about a range of health and safety issues and broader aged care services:

"I'm alone when my children leave, work or school. When I come to this group I have so many benefits – cultural – there are different departments who come there, who tell us information about fire, fire protection, fire prevention, how to prepare healthy food and also health sessions."

"They have come, a lot of doctors and talked to us about everything. They tell us every second week that someone is coming to talk to us about our, eyes, ears etc."

"They [Council staff] talk about how to reach them about your meals, about your home care, about your respite."

6.2.3 Respite for Carers

When asked why they attend the PAG, members of one of the ethno-specific established groups who were carers stated that the group provided them with respite from their caring role:

"Yes, I'm also a carer for my wife because during winter-time she could hardly walk and I have to support her. Besides that we have many good things here, especially for our health, we have exercises, dances and play games in this room."

"She comes here because she is happy and gives her respite from caring for her husband. That is why she looks forward to coming over here. She cares for her husband, her husband is disabled. Her son and daughter look after her husband while she is here. She looks forward to coming here."

6.3) Benefits of Attending an Ethno-Specific Group

Participants were asked to describe the benefits of being supported by a program that is aimed at people from their own cultural background. The following themes emerged in response to this question.

6.3.1 Share Stories and Cultural Experiences

Participants from the three ethno-specific groups discussed the benefits of meeting with people of their own cultural backgrounds. They emphasised the importance of having the opportunity of sharing stories and cultural experiences:

"Difficult, we need our culture someone to provide services who understand us."

"Being together, we get to talk, to joke around, laugh and hear stories."

"If possible I do not like it [the group] mixed. Our habit is the same, we can do what we want."

6.3.2 Common Language

Sharing the same language was raised as an important factor that encouraged participants to attend a group. This was raised in all of the focus groups.

Most of the participants in the multicultural group who raised language as a factor said it was not a barrier to their participation as they spoke many languages and did not have concerns with communication. However, for members of the three ethno-specific

groups, attending a group with others who shared the same language was a very important factor:

"The only language I can speak is [language named]."

"We come for companionship, talk to each other in our own language and our people, and we enjoy ourselves."

"When you come here you get the happiness from the group, because everybody there are no language barriers, most of the people here are [names culture], we speak all our own language, we can express our own self."

For a member of one of the ethno-specific groups (established) who was accessing Home Help, language was not as an important factor for this service as it was in the PAG where communication was a core component.

6.3.3 Multicultural Group

Members of the multicultural group emphasised the value of attending a group with people from other cultures. They stated that they accepted each other's traditions and learnt from each other and many also stated that they would like more nationalities in their group. Members of one of the established ethno-specific groups also stated that they would like other cultures involved in their group:

"I'm happy to meet with people of different cultures because of the positive attitudes they have."

"I always like to meet new people because I want them to understand my needs and me theirs."

"It would be nice if we could be mixed, not only all [names culture], probably it would be better because you would be learning more of the culture."

"I would like to say that because if you are grouping with your own you will not be helping the body of knowledge of other cultures, so I think it would be much better if you will be with other groups, other cultures."

A participant from one of the ethno-specific groups appreciated that the group was already mixed due to mixed marriages in that community.

6.4) Benefits for Carers

Participants were asked to describe the benefits of the PAG/Friendly Visiting/Telelink Service for their carers.

6.4.1 Carers Happy for Care Recipient to Attend a PAG

Participants across all groups said that their carers were happy for them to attend and a participant from the newly arrived ethno-specific group stated that he would like to see a specific group for women of that community be established:

"My daughter lives near by and she is very happy for me to come."

"Yes my son is happy that I attend, they look after me, help with my medications, shopping."

6.4.2 Socialisation and Stimulation

Participants from the two established ethno-specific groups described the importance of socialisation for either themselves as carers or as care recipients:

"My husband looks after me and takes care of me, he does everything around the house, cooks, cleans, does the washing. I have had 3 heart attacks and operations, they had to teach me to talk and walk again, even lifting a cup is difficult. Without my husband I would not be able to have a normal life. I've lost a grandchild and daughter, and have another sick grandchild, and am very depressed about that... My husband also attends the group, but today he is at home cleaning... He's always here."

"My wife [sitting next to participant], who I care for, has 2 oxygen machines at home, she can't go without them... I enjoy coming here talking to my friends, playing games, bingo and cards, passing the time with them and then we go home and I cut the wood for the stove so my wife can be warm."

"So it is very important for her to come here [participant speaks on behalf of another] because it gives her the opportunity to have respite from caring for her husband and also makes her forget some of her problems because she gets obviously agitated."

A participant described how her husband, who had frontal lobe dementia, was stimulated by attending the PAG:

"I will say, when my husband was alive I was a carer, when I bring my husband here his outlook on his health problems pick up and different, because he mixes with many people. When he has frontal lobe dementia, sometimes his behaviour is affected, but when we have games, he knows also, before me, he know where to start and he be so happy to get a prize. You could just see he was being stimulated by coming to a group like this."

6.5) Importance of Volunteers to the Service

Participants were asked to comment on how important volunteers were to the service they were involved in. Responses are summarised in Table 29.

Table 29: How Important Are Volunteers to the Service You Provide?

Comment	Group	Number of participants
The service does not have volunteers and/or the participant is not aware of volunteers	Multicultural Group, Newly Arrived Group and Established Ethno-specific Group (1)	6
Need a volunteer/still waiting for one	Multicultural Group	3
Very important to the service and very willing to help	Established Ethno-specific Group (2)	9

It appeared that participants from the established ethno-specific group were more aware of the role of volunteers and their comments about volunteers in the Social Support Service were very positive. Specific comments from this particular group included:

"They are really so willing and dedicated. You could not see any sour face in the room and even when you want to ask them for water or what not, still they do."

Sometimes hard to find people who could do volunteer work but in this group you see them all happy."

"They pick us up from the house to this place and then brought home. In their own cars."

"What can I say about the volunteers, well, they are very helpful, they are very kind and doing their duties kindly. If you are very weak they will accompany you. It's very good, I cannot say nothing about the volunteers, they are all very good."

6.6) Suggestions for Improvements to Services

Participants were asked to comment on how they believed Social Support Services could be improved. Comments included a need for increased activities, additional government assistance and particular issues were raised from newly arrived participants.

6.6.1 Increased Activities

One of the most frequent and most common issues raised from participants across all groups was that they needed increased activities provided. This, in particular, included social activities, but also included physical activities and educational programs.

Participants across all groups repeatedly raised additional social activities, in particular outings, as activities they would like to occur more. Participants requested both local and interstate outings and often stated that, as migrants, they often missed out on the opportunities to see other parts of Australia when they were younger. Similarly, newly arrived migrants raised the same issue:

"Increase our outgoing trips outside; like going to Sydney, bus trips, excursions."

"Like some tours with help of the group with transport facilities. My children work and can't see anything of Australia. I am able to pay for it just with help of the transport."

"More activities when we come here. We come from 10.00am-3.00pm, five to six hours, what are we going to do, just talking. It's boring."

"The reason is if there are no activities, if I come here everyday when we come we only have 10-15% of activity, you need more activities, if no activity what will you do."

"The members are really longing for more outings and more sight seeing."

Participants from one of the established ethno-specific groups stated that they had a visiting podiatrist that attended their PAG. However, participants from other groups reported that they would like more exercise programs and physiotherapists to visit their groups:

"Special physiotherapy to assist with massage; I have sore neck and shoulders."

"The program started actively first, now it is going down, not going up. Before there were some exercises, some health people came for education and groups coming to talk, and some exercise, but after we moved from there [previous venue] to here there was no exercises."

"I want more instructors for exercises, not only one instructor or two or three, if possible, we need different kinds of exercises, not Tai Chi alone. If possible we need some equipment for the gym, like bicycle inside, because older people's legs are very weak, that is why we need more exercise."

Participants mentioned the benefits of having guest speakers visit their group to discuss various health issues, including mental health and wellbeing. They were concerned that this did not happen often enough:

"Yes of course, if a speaker comes once a month, or every two months, which is good, but it's been 2 years."

"We should have doctors specifically to talk to us about our problems, nerve problems. Some of us have problems with our nerves and are anxious."

6.6.2 Increased Government Assistance

Participants across all groups identified areas where they would like additional support from government. This included provision of transport, increased service hours, equipment, financial support and considerations by Local Government to address cross boundary issues.

Participants reported that services could be improved through the provision of transport and improved parking so participants could get to programs. Participants from one of the established ethno-specific groups and some participants from the newly arrived ethno-specific group mostly raised this issue:

"Transport is one part as well, the support worker used to pick up some people and this was an encouragement as well."

"There are many sick people who want to come but cannot because of the transport."

"We are happy here with everything except the parking. It sometimes takes an hour or more to find a car park, once you've parked then you only have 10 minutes left with the people around... What can I do in 10 minutes? It's not worth coming. We would appreciate transport to be provided, maybe a little mini bus that could gather them from their houses and bring them here."

"How can I get on the bus with this frame? I live close but it is still difficult to get here, so we need transport."

For members of one of the established ethno-specific groups, in particular, additional hours of provision of PAGs was one of the main suggestions for service improvement. Members of this group also suggested meals be provided whilst the group is meeting:

"One or two hours extra."

"But would appreciate it if we had more hours than we have now, at least 3 hours, and if the council could support us by, for example, providing breakfast, even if we have to pay a little for it, because there are some diabetics in the group and they must eat."

"Lunch is not provided, only if we bring our own."

However, members of the multicultural group and the other established ethno-specific group also raised this comment:

"We would like it to be every week."

"Another thing is the Social Support group is giving us a very good service, the only thing if we could suggest, in my opinion, to increase the frequency of the meetings."

"...If possible instead of Friday we would like 2 days or 3 days of services."

Members of the newly arrived ethno-specific group raised the need for additional and improved equipment. For members of the newly arrived group, this referred to having access to a facility of their own:

"We need Victorian Government support... We need one base/space like other communities, that has playgrounds and every thing inside. This is what we need."

Members of the established ethno-specific group required equipment for volunteers to assist in their tasks:

"In my observation also I can see how volunteers really work as a team. Maybe if there will be some kind of funding for example, equipment because every time we eat there are some volunteers still. They are occupied there so do not have the opportunity to join. So if there was some kind of dishwasher machine to be used by the volunteers to lighten their work."

Members of one of the established ethno-specific groups suggested ways in which additional financial support would assist their group:

"Grateful to government for helping us, it's good, I have some more suggestions if the government does give us some more funds. Like this hall, I want the hall to be a little bit bigger, it is small for us. It is a very small space."

"Services would be improved if the government gives more financial support... We can go more outside and enjoy and we can have different speakers to give us some ideas to help our ageing people."

Members of the newly arrived ethno-specific group stated that more members of their community would be supported if local/neighbouring councils worked across geographic communities:

"Some people want to come but they are outside the [catchment] area."

"Is it possible for example, for [names two neighbouring councils] to join together for this program?"

6.6.3 Addressing Needs of New Communities

Participants from the newly arrived ethno-specific group raised issues that they believed were specific to new communities. Participants from this PAG believed that as members of a new community they lacked the knowledge and information required about services and entitlements:

"We don't have knowledge or can identify our rights, we don't know if we have right or not, we need more information."

They also believed that more established groups had more activities and opportunities, for example, mixed gender groups, buses for trips, better facilities and their own space for meetings:

"Other groups have more activities, grouping of female and male going together on outings and exercising."

"I think what we need to request from [names two neighbouring councils] is we need a base/space like other communities, for our community. What we need is only this."

These participants believed that having a larger venue and a space of their own would enable more members to attend and increase their membership.

A participant from the group commented that the concerns of new communities were not listened to as the broader community was racist towards new communities, however others in the group strongly disagreed.

These representatives and newly arrived participants from the multicultural group were particularly concerned about missing out on opportunities to learn English:

"Everything is good but I want to speak English, want English lessons."

"When we came here as elderly people and were badly in need of English support but were not provided with English lessons. Attending for only one week then my wife died and I went overseas." [Participant missed out on 500 hours of English lessons]

"I want to make one comment, my opinion, there is one point that I am not happy, that is the activity we receive here. For example, the English language classes, the activity here begins, then ends. Two or three months ago there was a teacher, she was teaching English, then after 4 week ago she stopped but we don't know why."

6.6.4 Knowledge of Services (In-Home Respite)

Some carer participants reported that they attended PAGs as a form of respite for themselves. The facilitators explored whether these participants were aware of in-home respite and were interested to identify who cared for the care recipient whilst the carer attended the group. This emerged as an issue in one group (established ethno-specific). It appeared that most of the participants who responded had not heard of in-home respite and one of these stated that if required, they would contact the local council. One participant stated that their daughter cared for the care recipient while they were at the group:

"Very important she has respite for her husband [participant speaks on behalf of another] while she comes over here, but it is provided by a child, by her daughter."

6.6.5 No Improvements Required

Despite comments above, participants were generally satisfied with the services they received and thankful to the government and their support agencies. Some participants believed that no improvements were needed to the services:

"Everything is fine because we were lonely – now it's ok."

"We are very happy with what we are receiving, thank you."

"Drive all your troubles away."

6.7) Conclusion

The following key themes have emerged from the focus groups:

6.7.1 Reasons and benefits of Social Support Services

- Socialisation and activities;
- Information and education; and
- Respite for carers.

6.7.2 Benefits of ethno-specific and multicultural groups

- Sharing stories and cultural experiences;
- Common language; and
- Meeting people and learning about their culture in a multicultural group.

6.7.3 Benefits for carers

- Carers pleased about participants' attendance at group; and
- Provides socialisation and stimulation.

6.7.4 Importance of volunteers

- Only one group made comments about volunteers but where these comments were made, they were of a very positive nature.

6.7.5 Suggestions for improvement

- Increased activities (including social, physical and educational activities);
- Increased government assistance –
 - Transport/parking;
 - Increased service hours and meals provision;
 - Additional equipment;
 - Financial support;
 - Addressing geographic boundaries;
- Addressing needs of new communities –
 - Needing knowledge/information;
 - More activities;
 - Venues and meeting space; and
- Increased promotion of in-home respite services.

7. Findings: Service Practice Profile (Service Provider Survey Feedback)

This chapter reports on the service provider survey findings regarding service practice issues.

7.1) Service Aim/Role

Social Support Services were asked to describe the aim/role of their service. The majority of services described providing opportunities for socialisation, social support and reducing isolation as their main role. A large number of services also described providing support, respite and information for carers as well as maintaining the independence and skills of daily living for care recipients as the aim/role of their service. Providing access to health promotion, recreation opportunities and working to improve quality of life were also commonly reported aims of Social Support Services. A smaller number of services described part of their aim as assisting clients to remain at home and in the community. The provision of transport to enable people to safely access the community was the primary aim of one program. Recruiting and supporting volunteers was also described as part of the aim of two agencies. One CHC described a program that was focused on physical health promotion:

"To support older adults to maintain/improve their health and wellbeing, improve their balance, reduce pain, increase flexibility, increase muscle and bone strength and maintain as much independence as possible."

Some services described broader aims of their Social Support Program encompassing health promotion principles relating to reconnecting people with their community:

"To help people with chronic mental health issues to stay connected with community, provide a safe environment where they can explore emotions, feelings, thoughts – be creative and learn more about themselves."

"To increase community awareness of the needs and rights of people with a disability."

"Decrease social isolation by increasing confidence and assisting clients to develop friends they can in turn interact with outside the program. Access to allied health service and referrals for services, providing interesting interactive programs that are designed and owned by the clients that participate in them. Facilitate group discussions, provision of guest speakers to increase knowledge and demystify service provision and pre conceived ideas relating to medical conditions. Monitoring of personal care requirements."

Often the aim of the program included specifying the target group (see also section 7.2) of the service. Programs generally described targeting the HACC population including frail older people, people with disabilities and their carers. Some programs targeted particular age groups such as frail aged, children with disabilities, young adults, people with a disability aged between 16 and 65, or families with a child with a disability. Other groups targeted specific groups such as people who are socially isolated, low income earners, homeless women, men with a mental illness, people with an acquired disability, people with dementia, or people with chronic mental illness.

CALD agencies described similar aims to mainstream services such as socialisation, maintaining independence, health promotion, enhancing quality of life and supporting carers. However, CALD agencies also described some additional roles including:

- Increasing knowledge of and access and integration into broader services;

- Facilitating empowerment of clients and their carers;
- Developing informal support network for clients and carers from ethnic backgrounds;
- Promoting the concept of carer within CALD communities;
- Socialising with others of similar cultural background;
- Providing culturally responsive services; and
- Visiting older people in hospitals, nursing homes and hostels.

In addition to providing a description of their aim, agencies were asked to indicate whether a range of possible aims were: a primary or secondary role; not a role; or not possible within current funding. The aims included:

- Socialisation;
- Health promotion;
- Education;
- Physical activity;
- Respite for carers;
- Referring clients to other services;
- Assessment and care planning; and
- Assisting clients to regain/maintain activities of daily living.

Consistent with the aims/roles described above, most agencies identified socialisation as a primary role/aim of their service, with two agencies (one mainstream and one CALD) describing it as a secondary role/aim. Appendix 3 shows the responses to each of these aims for mainstream and CALD agencies. CALD agencies were more likely to describe health promotion as a primary role than mainstream agencies. Mainstream agencies were more likely to report physical activity to be a primary aim than CALD agencies. Education and referring clients to other services were generally reported by agencies to be a secondary role. CALD agencies were considerably more likely than mainstream agencies to report that aims such as the provision of respite, assessment and care planning, and assisting clients to regain/maintain activities of daily living were not possible within current funding.

Survey respondents were asked to comment on the roles/aims of their program. One agency reported that the needs of clients were increasing and that Social Support Services were becoming an attractive substitute for more costly in-home respite options. Another reported that if respite for the carer occurred it was a by-product of the engagement with the group and not a primary aim. One agency described the importance of differentiating between Core and High PAG. Core PAG was focussed on social support, whilst the complex needs of clients attending High PAG meant that these services had a much stronger emphasis on respite, assessment and care planning. Community transport was reported to be fundamental for allowing access to Social Support Services and the community. One agency raised concerns that transport was not identified as a discrete Social Support Service within the survey. PAG was described as an important entry point to other services, particularly for Aboriginal and Torres Strait Islanders and people from CALD backgrounds. For people of CALD backgrounds, Social Support was also described as vital to the community. Many agencies also reported barriers achieving the roles of their service. These are described later in the Chapter (See Section 7.7).

7.1.1 Other Activities

Many agencies reported additional activities that they would like to include in their service/program. Activities reported by CALD and mainstream agencies were consistent.

Outings/Camps

Additional funding to extend outings and overnight trips was reported by 14 agencies. Some agencies currently did not offer outings but would like to be able to offer them. Some already offered them but would prefer to have additional options such as taking

clients shopping for clothes, overnight outings, longer trips to regional Victoria, evening excursions such as twilight balls and cinema trips and occasional holidays.

Transport

A community transport service reported requiring additional capacity to transport clients to PAGs, medical appointments and during evenings and weekends. Eight other agencies also reported a need for increased transport options, including one that suggested that the provision of a dedicated bus would enable greater flexibility and choice.

Exercise and Allied Health

Further capacity to run exercise sessions was reported by a number of agencies. Specific exercise reported included swimming, gardening, strength training, gym and group walks. Access to additional allied health, such as physiotherapists for exercise programs and podiatry, was also reported by a number of agencies. Additional access to GPs was reported by one agency. Two agencies reported that they would like to be able to purchase some exercise equipment including an exercise bike and treadmill. One agency actively undertook fundraising activities such as trivia nights and fetes to raise funds to purchase equipment.

Education

Some agencies reported that additional education such as English language classes, falls prevention, food safety programs and information sessions by professionals would be beneficial.

Arts and Entertainment

Five agencies reported additional arts and entertainment programs that they would like to extend or introduce including entertainers, culture specific art programs, craft for men and professionally run music therapy.

Assessment and Care Planning

Two agencies reported wanting to extend assessment and care planning capacity (refer also to section 7.4).

Additional Visiting

A number of agencies, particularly CALD agencies, requested extending the capacity for visiting clients in the community including visiting clients in rural areas (CALD agency), in hospital, nursing homes and hostels, and in the client's own home.

Other

One agency reported wanting to provide clients with hairdressing/grooming and another two wanted to provide cooking. One agency would like to be able to provide a volunteer/carer recognition event. Other agencies wanted to extend programs, such as, offering programs on weekends and dividing groups according to specific conditions/needs, such as dementia or stroke. Two agencies reported they would like to receive funding to support a carer support group and PAG like seniors groups that were currently run without funding.

7.1.2 Undertaking Tasks That Are the Responsibility of Other Services

Seven mainstream agencies and seven CALD agencies reported taking on other activities that they felt were the responsibility of other HACC funded services. Mainstream services reported undertaking additional roles including case management, advocacy, respite, personal care (showering), cleaning flats and assisting clients to relocate accommodation, counselling, transport, nursing, delivering meals, shopping and taking people to appointments. CALD agencies reported undertaking assessment and care planning tasks beyond their funding agreements.

Nine mainstream and 11 CALD agencies reported undertaking activities that they felt were the responsibility of other non-HACC funded services. Mainstream agencies reported taking on case management for high level clients not on a package and for monitoring clients on packages due to a lack of face to face contact by CACP case managers. Other tasks that were reported to be undertaken by mainstream Social Support Services included undertaking nursing duties such as PEG feeds (percutaneous endoscopic gastrostomy catheter), oxygen and medication; physiotherapy; information provision; referrals for Aged Care Assessment Service (ACAS) assessments and subsidised taxi carer allowances. Mainstream services also described undertaking activities that were the responsibility of protective services, disability services, mental health services and financial, advocacy and legal services. Activities which CALD agencies undertook but felt were the responsibility of non-HACC funded services included case management, transportation and translating materials.

7.1.3 Modifying the Role of Social Support Services

Agencies were asked whether they would like to broaden or narrow the aim/role of their service in any way. No agency wanted to narrow the role of their service, although one agency did not feel that case management should be continued by their service as it was not the responsibility of volunteers.

There was a diverse range of suggestions that agencies identified in relation to broadening their role. In addition to the other activities agencies would like to include (See Section 7.1.1), a number of suggestions were reported by both mainstream and CALD agencies including:

- Provision of in-home respite for carers/including overnight respite;
- Extend geographical boundaries of existing services; and
- Recognise and expand the role of assessment, case management and monitoring roles undertaken by Social Support Services, including additional training of staff to undertake these tasks.

Mainstream agencies also suggested:

- Increased computer classes;
- Involvement with acute sector in discharge planning;
- Inclusion of allied health professionals to assist in planning, training and evaluations;
- Provision of services for clients under 60 years;
- Staff training in comprehensive case management, activities, personal care, assisting older people;
- Additional support for males;
- Recurrently funded recreation program for homeless women;
- More CALD specific programs;
- School holiday program for teenagers with a disability; and
- Employment of someone from a CALD background to more actively involve CALD families in this mainstream service.

Some respondents specified ways of changing the model of Social Support Service. One agency wanted to adopt a more recreational model promoting wellbeing. Other suggestions from mainstream agencies included:

"I think there could be an extra tier between PAG and in-home respite services aimed at recipients whose attendance at PAG is really more about carer respite and less about their interaction and wanting to be part of a social/recreation program. This would have higher staff/client ratios and would be more of a focus on respite for carers. This service could possibly be run from hostel/nursing home in the area which could provide access to nursing staff, lifting equipment etc."

"To provide coordination of community based PAG groups, run within specific ethnic communities by interested individuals in that community."

"More time for planning and development of local links – we have many groups in Council and in the community and it is about having the time to network and ensure referral agencies etc are aware of what is available to support individuals and groups."

Suggestions only from CALD agencies included:

- Increasing capacity of current services (to address waiting lists, ageing of CALD populations and increased frailty of clients);
- English classes;
- Increased volunteer participation;
- Increased bilingual specialist professional workers and health education programs including topics such as diabetes and healthy eating;
- Culturally sensitive bilingual training program for carers;
- Provide more emotional support;
- *"Provide a complete array of community services such as Counselling, Social Support, Interpreting and General information, thus, offering a 'One stop' shop"*; and
- Be able to respond to the needs of new and emerging communities.

One multi-ethnic service described their successful carer support model that focuses on community development and self advocacy. The service assists carers to develop skills to assist them to access different services. The agency recommended that it would be useful to expand this program across regions and to small emerging communities, for example:

- Chinese and Arabic carer support groups in the Eastern Metropolitan Region;
- Afghan, Italian, Kurdish and Vietnamese in the N&WMR; and
- Arabic, Turkish and Somalian in the Southern Metropolitan Region.

7.2) Target Groups

Social support agencies generally targeted their services to all clients in the HACC target population (frail aged, younger people with disabilities and carers) or to specific groups in the HACC target population, such as the frail aged or people under the age of 18 years with a disability (See Table 30). All CALD agencies and a quarter of mainstream agencies described targeting people from CALD backgrounds to access Social Support Services. Approximately one third of agencies described targeting services to socially isolated people. A third of mainstream agencies specified only servicing clients in a specific geographic catchment, whilst CALD agencies did not stipulate this. A small number of agencies targeted people who were homeless or had a low income, had dementia, were a specific gender, had mental health issues, were refugees or were of ATSI background.

Table 30: Target Group by Agency Type

	Mainstream (n=29)	CALD agencies (n=26)
CALD background	7 (24.1)	26 (100.0)
Frail aged	15 (51.7)	13 (50.0)
Socially isolated	9 (31.0)	6 (23.1)
HACC	6 (20.7)	8 (30.8)
Carers	10 (34.5)	3 (11.5)
Geographic	10 (34.5)	1 (3.8)
18-64 age group HACC	6 (20.7)	1 (3.8)
Homeless/low income	5 (17.2)	2 (7.7)
Younger people with a disability	4 (13.8)	2 (7.7)
Dementia	6 (20.7)	
Specific gender	3 (10.3)	1 (3.8)
Mental health	3 (10.3)	
Refugee		1 (3.8)
ATSI	1 (3.4)	

Respondents also reported on whether they would like to extend their target group. Most participants reported wanting to extend their target audience to offer more CALD specific groups. This response could have been influenced by the fact that the survey's prime focus was on people of CALD backgrounds. Some respondents wanted to extend their target group into other geographical areas. A few agencies wanted to extend services to clients with more complex needs but could not do this due to lack of specific equipment such as hoists in vehicles. Other suggestions included:

- Additional services for carers including carer support programs;
- Dementia services for CALD clients;
- Support for younger people with early onset dementia; and
- Services for people with ABI.

7.3) Intake and Demand for Services

Respondents generally reported high demand for Social Support Services. In total 34 agencies (65%) reported having a waiting list for clients to access services. A higher proportion of CALD agencies had a waiting list than mainstream agencies (82% compared to 57%). In total, 839 clients were reported to be waiting to access Social Support Services by responding agencies. The 16 mainstream agencies that had waiting lists had a total of 467 clients waiting to access services ranging from a two week to five year waiting period, with most having a waiting period of more than two months. Three hundred and seventy two clients were waiting to access Social Support Services through 18 CALD agencies with similar waiting periods as those reported by mainstream agencies.

Priority for services was determined using various approaches. One agency reported that an assessment coordinator managed referrals and a waiting list at a sub-regional level where there was a four week wait for an assessment and then approximately two weeks for commencement of services. One agency reported prioritising "according to staffing, client mix, age groups, sex, time on waiting lists, family need and location of group". A number of mainstream and CALD agencies reported using a priority of access (POA) tool, including the POA tool developed by NARI. One participant made the comment that although the clients may be prioritised there also needs to be volunteers matched with clients and this may mean that a lower priority client accesses a service

before a higher priority client. Most agencies however, reported prioritising clients according to need and considered various factors such as:

- Level of social isolation/level of support/living alone;
- Carer stress/carers in crisis;
- Dementia;
- CALD background;
- ATSI background;
- High needs;
- Potential for premature placement in residential care if service not provided;
- Physical needs;
- Risk factors (e.g. abuse, safety); and
- If on route of community transport route.

Some services prioritised clients based on suitability of the service or existing services accessed by the client such as:

- Group dynamics;
- Lower priority if client already on package; and
- Existing service levels/access to other PAG (already accessing will reduce priority).

In addition to resource limitations (See Section 7.7.1), agencies reported a range of reasons for increased service demand including;

- CALD population becoming more aware of CALD services and more confident to access a service where they can communicate in their own language;
- Success/satisfaction with the program/word of mouth has increased knowledge of service and demand; and
- The ageing of the population, clients moving from Core to High level of service, increased needs of population. One agency reported currently reviewing clients who did not meet PAG eligibility criteria and were being discharged to meet increasing demands of ageing population in the municipality.

Some strategies suggested for increasing access to services included:

- Re-assessment of all existing clients to determine eligibility;
- Increased communication with assessment officers regarding client referrals;
- Outreach worker to link clients to service;
- Continued support of CEGS;
- Increased partnerships between agencies (CALD with mainstream); and
- Promotion of services in local newspapers, speaking at senior citizens groups, ethnic media, translated brochures, on-hold messages on agency customer service phones, churches, local shops and information to local GPs and ACAS teams.

7.4) Assessment and Care Planning

7.4.1 Who Undertakes Assessments?

PAG coordinators/team leaders were most commonly reported to assess clients for Social Support Services. Social workers, PAG assistants, and activities/recreation staff were also responsible for assessments in some agencies. Eight agencies had assessment officers undertaking assessments, and three agencies involved all agency staff in assessments. A number of agencies relied on external agencies to undertake assessments including case managers, ACAS, health professionals, CHCs and hospitals. Two CALD agencies relied on trained volunteers to undertake assessments.

7.4.2 Care Planning and Goal Setting

Approximately half the CALD agencies and two thirds of mainstream agencies developed care plans for clients. Those who did not develop care plans reported that they either did not have the resources or skills to develop them or that another service undertook this role.

Common goals on client care plans were consistent with overall goals of the service such as socialisation, assisting with skills of daily living and maintaining independence, physical health and general wellbeing. Other goals included providing a break for carers and increasing enjoyment in life. CALD agencies also cited additional goals, such as, empowering people to make informed decisions, challenging the client's mindset about accessing relevant services and getting into the 'mainstream of Australian society'.

Services that developed goals usually involved clients in the goal setting process. Carers, and to a lesser extent other services, were also involved in developing client goals by most agencies. One mainstream agency reported that for clients with complex needs a case meeting between key stakeholders may be held.

A number of CALD agencies cited the importance of involving other agencies in the care plan to assist integrating clients in mainstream services and to utilise skills of external allied health staff.

7.4.3 Ideas for Future Social Support Service models

Respondents were asked to comment on whether they think formal involvement of allied health staff within their service would assist in care planning and achieving the aims of their Social Support Service. Both mainstream and CALD agencies mentioned that this would provide for a more holistic approach to client care, enhance multidisciplinary care, improve outcomes and avoid duplication. For staff from CALD agencies, cultural issues were also mentioned, including the need for bilingual workers, as well as workers needing to be aware of and sensitive to cultural practices.

Ten agencies also indicated that there were already links with allied health staff either directly employed through the service or accessed for education sessions or through referral pathways. Some agencies had close links with local CHCs.

A number of agencies did not feel that it was appropriate to link up with allied health staff due to the nature of their service and wanting to avoid a medical model of care:

"We also find that running Centre separate from a health setting reduces stigma associated with attendance – not seen as part of the health system – more like a neighbourhood house feel. Need to be careful not to 'over-medicalise' the service."

"We are a specialised service providing psychosocial rehabilitation. People come for a specific reason e.g. breaking isolation, socialisation and not other health issues."

7.5) Referral Pathways

This section and Table 31 provide an overview of service types that Social Support Service refer their clients to. From this analysis, it appears that referral patterns are similar for both mainstream and CALD agencies, particularly for HACC basic services. There were some exceptions, i.e. CALD agencies are less likely to refer onto allied health services, 'other' Social Support Services (either through mainstream or CALD agencies) and exercise programs. Mainstream agencies were less likely to refer clients to Linkages/CACPs, nursing and Personal Alert. Four mainstream providers reported

referring clients for ACAS assessment. Other services referred to by agencies included: case management, meals, Carelinks/Carer Respite Centres, healthy living activities, legal aid, financial counsellors and palliative care. Overall, CALD and mainstream agencies commonly referred clients to other services, indicating that Social Support Services are providing a point of entry to other HACC and aged care services.

Table 31: Service Types that Social Support Agencies refer Clients to

	Mainstream (23)	CALD (20)
Personal Care	18 (78.3)	17 (85.0)
Home Care	19 (82.6)	19 (95.0)
Delivered meals	16 (69.6)	15 (75.0)
Property Maintenance	17 (73.9)	17 (85.0)
Other Social Support Services through mainstream service	20 (87.0)	11 (55.0)
Other Social Support Services through ethno-specific/multi-ethnic service	19 (82.6)	8 (40.0)
Allied Health/Community Rehabilitation/Community Health	21 (91.3)	12 (60.0)
Exercise programs	12 (52.2)	7 (35.0)
Linkages/CACPs	17 (73.9)	18 (90.0)
Nursing	9 (39.1)	11 (55.0)
Personal Alert	9 (39.1)	11 (55.0)
In-home respite care	14 (60.9)	14 (70.0)
Residential respite care	9 (39.1)	10 (50.0)

A range of potential strategies were identified by mainstream agencies for improving appropriateness of services for CALD clients including:

- Increased number of bi-lingual staff and volunteers;
- More information available in other languages;
- Increased training of front line staff in providing culturally sensitive care;
- Better access to interpreters;
- Improved partnerships between mainstream and CALD agencies;
- Having large enough numbers of clients to run CALD specific programs;
- CEGS;
- Cultural Action Plan;
- Lobby TAFE and Universities to encourage people from CALD background to enrol in further education; and
- Adequate time for research, planning, networking and backfill.

In addition to the strategies listed above, CALD agencies also reported that mainstream agencies should link more closely with CALD agencies to use their knowledge of their community and for training programs. One agency suggested that mainstream agencies needed to broker services from CALD agencies to service CALD clients.

Strategies for improving referrals between agencies included:

- Simplifying/modifying the Service Coordination Tools (SCTT) and increasing the suitability of tool for children;
- Encouraging agencies to use the SCTT – one agency reported never receiving a referral on a SCTT;
- Increasing capacity of agencies to use E-referrals;
- Increasing promotion of services available/regularly updated directory of services;
- Central intake point for referrals;

- Up to date database of agencies with vacancies;
- Improving partnerships, communication and consultation between agencies; and
- Acknowledgement of referrals and timely action.

Additional issues raised by CALD agencies included having appropriate assessment staff and having joint assessments between mainstream and CALD agency assessors. One agency also reported that there needed to be more networking between agencies to improve recognition that all agencies have something to offer clients and that agencies do not 'own' clients.

7.6) Networks With Other Agencies

Agencies were asked to describe whether they had formal or informal networks with other agencies and to describe what these networks involved. Figures 9 and 10 indicate that both mainstream and CALD agencies were more likely to have an informal than formal partnerships with other ethno-specific and multi-ethnic services. Mainstream agencies were more likely to have formal than informal partnerships with mainstream providers (Local Government, ACAS, acute and sub-acute services) compared to CALD agencies.

Figure 9: Formal Partnerships with Other Agencies

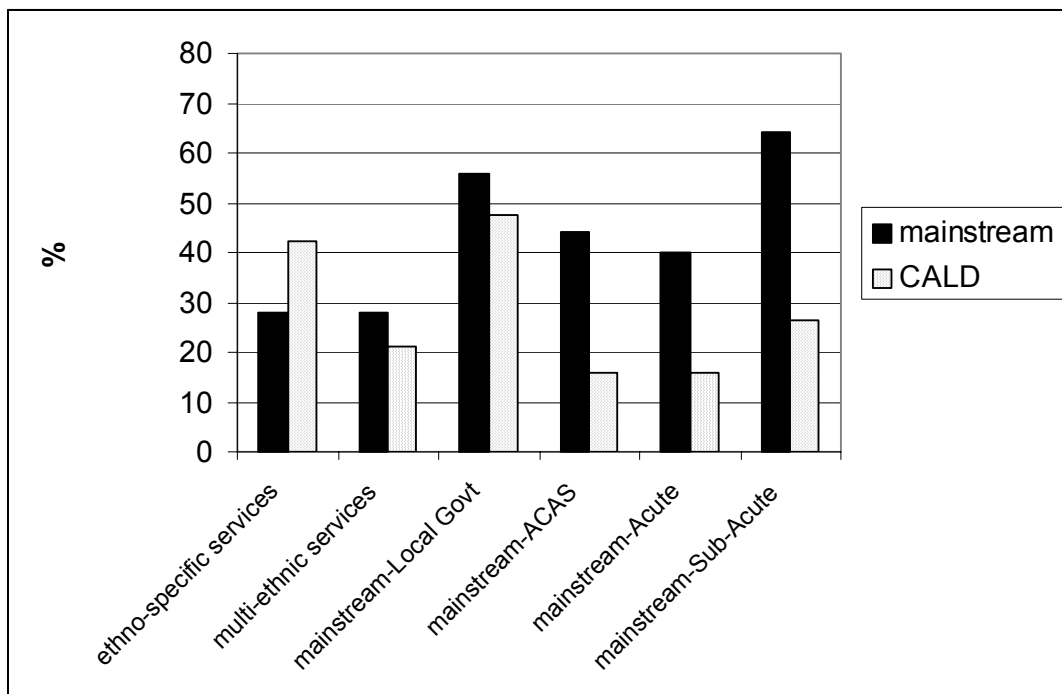
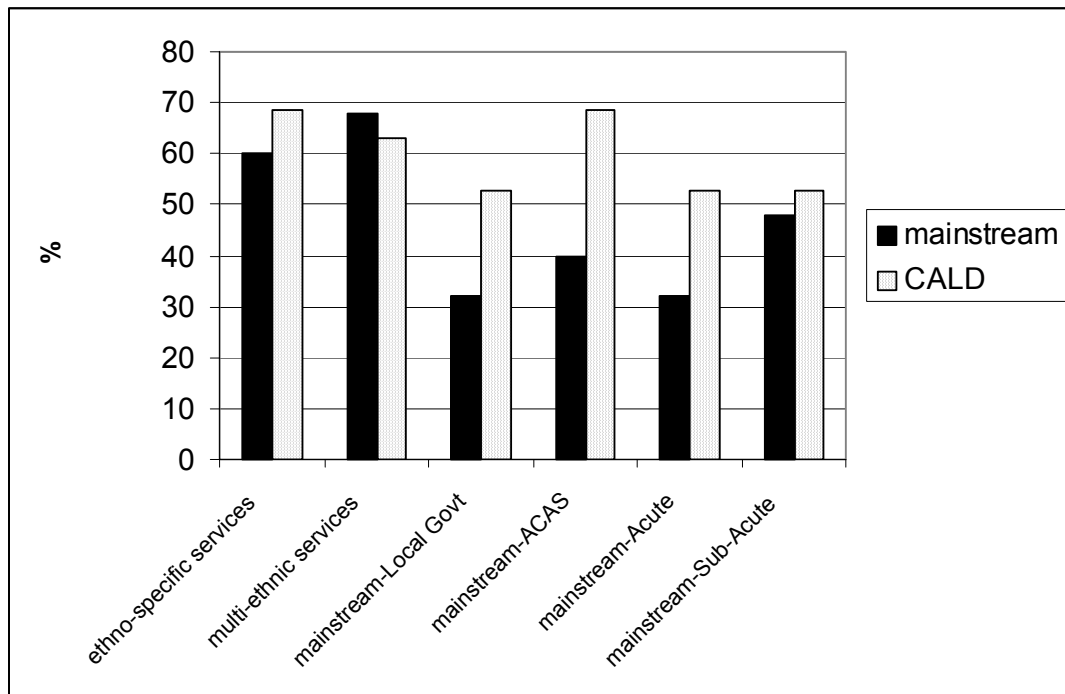


Figure 10: Informal Partnerships With Other Agencies



Most agencies described involvement in formal and/or informal networks. Informal networks usually involved information sharing and referrals. Formal networks more frequently involved information sharing at regular regional/sub-regional meetings including:

- Aged Services Networks;
- Disability Networks;
- Ethnic Services Networks;
- Mental Health meetings;
- Respite program network;
- PCP alliances;
- CEGS Network;
- PAG coordinators Network Group;
- HACC forums (bi-monthly); and
- ACAS service provider Network.

Formal networks were reported to consider local issues and work on joint projects. There were also a few examples of sharing resources, budget support, and brokerage agreements. There were few differences between mainstream and CALD agencies except that CALD agencies were involved in Ethnic Services Networks and more often reported involvement in CEGS. One ethnic agency indicated that the implementation of CEGS had brought them closer to and assisted in the development of formal partnerships with Local Government.

7.7) Barriers faced by Social Support agencies

In all aspects of the service model, service providers reported barriers to service delivery. The key barriers related to lack of resources for adequate staffing, equipment and outings, difficulty attracting volunteers and limited transport availability.

7.7.1 Limited resources

Most of the barriers to providing social support services related to inadequate resources and funding. The lack of funding was attributed by a number of agencies to the lack of growth funds over the previous two years and the unit cost of service not increasing with the increased cost of providing the service;

“Our waiting list is closed at present; there has been no HACC (growth) funding for over 2 years and our waiting list has increased nearly 40%.”

Some agencies also reported that the growing needs of their clients were not matched with a change in their funding. Unit costs were also described as not meeting agency overheads or management costs.

Lack of funding limited agencies' capacity to run more costly programs including outings. It also limited capacity for purchasing equipment such as exercise bikes/treadmills to promote physical activity within the program and mobility aids. Some venues were not appropriate for some of the activities that agencies would like to have undertaken (for example, not adequate/appropriate space for undertaking exercise programs).

Lack of resources and lack of time was reported to contribute to limited capacity to undertake continuous improvement activities, such as research to identify service gaps, networking, facilitating and following up external referrals. Additional strategies for reaching isolated people such as peer support and outreach were also impeded by lack of resources.

The perceptions of limited resources noted above need to be considered in the context of many agencies reporting delivery of services beyond those funded by DHS.

7.7.2 Lack of access to suitable staff and volunteers

Lack of funding leads to a range of barriers in relation to lack of suitable staff. For example, there was not enough coordinator hours available to recruit, train and assess more volunteers. Inadequate staff skills were described as a barrier for undertaking health promotion and therapeutic physical activity programs and for developing care plans. Staff resistance to change was also identified as a barrier by one respondent.

Agencies reported difficulties recruiting volunteers and that lack of reasonable travel allowances to compensate for the increasing cost of fuel was a major barrier. Limited resources to adequately train, supervise and recognise the valuable contribution of volunteers was raised. Poor skills and low literacy amongst volunteers was also described as a barrier to using volunteers. Being able to attract volunteers suitable for particular clients and who were available on a regular basis at a time that suited the client was also an obstacle reported by one agency. This sometimes meant that a client with lower level needs was able to receive volunteer Social Support before a higher level needs client.

7.7.3 Lack of transport options

Transport issues were raised as a major obstacle for their clients to access social support services. Specific issues related to:

- Increasing cost of fuel;
- Time required to transport isolated families in outer suburban areas;

- Vehicle hoists not compatible with all wheelchairs;
- Caps on number of reduced price taxi fares; *“Transport is a major problem. [This agency] finds it very hard to hire mini buses from councils and hence sometimes needs to use taxis which is costly for the agency and the client who uses up their taxi concession cards”*;
- Cost and poor access to public transport; *“The lack of frequent, reliable, accessible public transport and cost of public transport prevents people from attending groups.”*

For CALD agencies, often covering a larger geographic area meant that transport time and costs were greater than for agencies providing services in a more localised area.

7.7.4 Client characteristics

Some agencies described characteristics of clients as being a barrier to running activities. A particular issue was having clients with different physical and cognitive abilities within the one group, or having to combine High and Core level clients into the one PAG. The high and complex needs of clients were also described as a barrier to running some activities.

Difficulties motivating clients was also reported, particularly for clients with mental health issues where issues of low self esteem, medication side effects and anxiety could be present. Clients with dementia often commenced services when dementia was advanced and clients tended to prefer to stay at home. One agency described difficulties trying to engage older people in actively participating in the establishment of programs and projects.

Clients limited capacity to financially contribute to the program was described as a barrier to running additional activities.

Some clients were reluctant to have a care plan developed, with some clients wanting to attend programs for recreational benefits without answering a series of questions. Sometimes clients were suspicious of why so much personal information needed to be collected, whilst dementia, and mental health issues were also cited as barriers to developing a care plan or client goals. One agency providing services to homeless people found that clients were reluctant to participate in assessment and care planning and that the process required many months to build up a relationship and trust.

7.7.5 Level of commitment required to establish networks between agencies

The time, effort and commitment required for developing and maintaining good networks with external agencies was a major barrier. A number of agencies reported that they did not see the benefit or need for developing partnerships and would prefer money to go towards more direct service provision. One agency reported there was limited acknowledgement of the long lead times and costs of establishing a functional non-competitive relationship with another service provider and there was inadequate cross policy agreement on eligibility/targeting between Community Health and HACC funded allied health services. Diversity between agencies was also a barrier to establishing networks such as the different target groups of different agencies (i.e. younger people with a disability compared to frail older people), different agency sizes, different priorities and different infrastructure costs per service. A few small agencies (mainstream and CALD) identified barriers to working with dominant and large organisations including Local Government and Community Health. A larger mainstream organisation reported difficulties forming networks due to the large number of agencies and therefore having to focus on key/larger agencies.

CALD agencies reported barriers such as other services not acknowledging their skills or not understanding the services that CALD agencies provide. Another issue for CALD

agencies was related to covering a large geographical area and the need to attend numerous network meetings in different regions.

7.7.6 Barriers for referring clients to other services

Barriers were identified for referring clients to other services. Issues identified included:

- Lack of knowledge of what other services have to offer;
- Difficulty keeping up to date with the rapidly changing range of services;
- Lack of a referral manual;
- Agencies not using E-referrals;
- Inappropriate referrals and expectations built up by referring agencies;
- Reluctance to refer on due to waiting lists at other services;
- Care planning, monitoring and referring to other services was under-valued and under-resourced in Social Support Services;
- Referral not a primary role of service; and
- No appropriate service to refer on to (for example no flexible programs for people with mental health or behavioural issues or for clients with very high needs requiring nursing support).

7.7.7 Barriers specifically for CALD clients

One of the key difficulties in establishing and running programs for CALD groups was the large geographic areas that needed to be covered. Most CALD agencies covered large areas to provide access to people in their community across Melbourne. To be able to run an ethno-specific group for small and emerging CALD groups required intake from a large geographic area, raising the cost of transport. Agencies covering larger geographic areas also had a larger number of service provider networks to be involved in.

Language barriers also created difficulties for providing culturally appropriate services for clients from CALD backgrounds. These barriers included the cost of interpreters and difficulties recruiting appropriately skilled bi-lingual workers, particularly for less established groups; *"Can't have the range of languages across a small number of staff."* Mainstream agencies also reported issues such as literacy only in community language, many dialects from one country and paperwork only available in English as barriers to providing services to older people from CALD backgrounds.

A range of barriers were identified in relation to culture and cultural expectations. Some agencies reported that there was a lack of culturally appropriate mainstream services, particularly for CALD clients with dementia. Agencies reported that clients from CALD backgrounds were concerned about invasion of privacy and personal information being passed on to other agencies and were not confident about accessing other services. Differences in the range of programs offered in Australia compared to country of origin were also described as creating confusion for clients. Illiteracy and input from family members were also described as barriers to running programs for CALD clients. Lack of culturally appropriate facilities, such as segregated swimming for Muslim men was also identified.

A range of issues were reported for particular CALD groups, such as emerging communities:

"Lack of Social Support funding has contributed to increasing the level of isolation of small emerging communities, where they desperately need to be informed, linked with other related services in an appropriate cultural environment. A good example is the Afghan Community in the Northern region."

One agency emphasised the particular needs of newly arrived women from the Horn of Africa. This agency stated that women from the Horn of Africa often do not have access to extended family as they did in Africa and are not confident to move into hostel or

nursing home care because of language, culture and religion. For this community, there is therefore a greater reliance on community based services.

7.8) Summary of Service Provider Suggestions for Broader Changes to Social Support Services

This section identifies the key issues/suggestions for broader changes to Social Support Services raised by service providers who completed the survey.

7.8.1 Resources and Support

- Additional capacity to expand activities to include outings, allied health interventions, education (such as English classes, computer classes, falls prevention and food safety), professional music therapy, arts, crafts and cooking programs;
- Additional capacity to provide after hours services;
- Further distinction between Core and High PAG- increased capacity to run Core PAGs separately to High PAGs. Further changes to High PAG to undertake more carer respite and assessment;
- Additional support for some groups including new and emerging CALD populations, people from CALD backgrounds with dementia, younger people with early onset dementia and clients with ABI;
- Better provision of suitable equipment such as hoists for vehicles, exercise equipment and space in venues to undertake various activities;
- Additional services for carers including respite and carer support programs; and
- Sufficient resources to support PAG coordinators in administrative and planning activities without impacting on hours of direct service.

7.8.2 Service Access

- Improved access to transport. Current barriers include poor access to public transport, caps on taxi subsidies, increased fuel costs, fewer volunteers, lack of hoists;
- More staff and volunteers with appropriate skills and access to education and support;
- Better access to bi-lingual staff and bilingual allied health support/more culturally sensitive services;
- Better access to interpreters;
- Addressing needs of younger people with a disability and ensuring that appropriate age specific Social Support Services are available.

7.8.3 Promotion and information

- More advertisement of services and translated information;
- Access to an up to date directory of services, including information about where vacancies in services exist.

7.8.4 Networks and partnerships

- Better networks between agencies (CALD and mainstream) and Social Support and allied health staff (although some concerns about basing services on a medical model);
- Investigation of the role of assessment and care planning within Social Support Programs. Some agencies want this role reduced, others report that it is not adequately funded and needs to be increased.
- Analysis of the role of ethnic senior citizens clubs and the relationship they have to formally funded Social Support Programs to investigate ways to improve co-ordination across these services; and
- A transition program for clients and/or their carers when the client enters residential care.

7.8.5 Intake and Referral

- Improved referral pathways through better use of the SCTT, the revision of the SCTT to be more suitable for children and use of E-referral.
- Consideration of a central intake for referrals. Also adhering to common practices/protocols developed through PCPs.

8. Findings: Good Practice Initiatives (Service Provider Workshop)

This chapter reports on the outcomes of the half-day service provider consultation workshop conducted towards the completion of the project.

8.1) Introduction

Service providers who returned surveys were invited to attend the service provider workshop. A total of 52 agencies were sent invitations, including:

- Ethno-specific agencies (17);
- Multi-ethnic agencies (3);
- Local Government Authorities (11);
- CHCs (7);
- Health service (1); and
- Other (13).

Participants who attended represented mainstream, ethno-specific and multi-ethnic agencies involved with Social Support Services. In total, 19 agencies were represented, comprised of:

- Ethno-specific agencies (7);
- Multi-ethnic agencies (3);
- Local Government Authorities (5);
- CHCs (3); and
- Other (1).

The aim of the workshop was to:

- Present project findings;
- Discuss current good practice examples; and
- Contribute to future directions and recommendations.

DHS was not represented at the workshop as this may have inhibited discussion, however, the Regional DHS Aged Services Manager briefly attended to provide an introduction and an overview of the project. Following this introduction, the workshop began with an outline of the project, including aims, objectives, methodology and key findings to date. The purpose of the workshop was to allow for consultation, and to identify current innovative approaches to service provision to assist Social Support Services to overcome barriers to providing Social Support Services to people from CALD backgrounds.

This introduction and overview was followed by two group discussions. The first session focused on identification of good practice examples within current service delivery in the areas of volunteers, carer support, agency fund raising and transport initiatives. The second session of the workshop focused on identifying factors that would enhance implementation of good practice initiatives in these four areas. These areas were chosen as a focus of the workshop as they emerged as key issues in the earlier phases of the study. Hence, it was felt that it was critical to identify any positive initiatives that may guide and support service providers in their day-to-day practice. At the completion of each session, feedback was provided to the large group and further information shared and obtained about additional initiatives.

8.2) Good Practice Strategies

Existing good practice initiatives and additional strategies for improving practice for the four discussion topics of volunteers, carer support, agency fund raising and transport initiatives were identified.

8.2.1 Volunteers

Participants identified a range of good practice initiatives and strategies in relation to recruiting and supporting volunteers.

Recognition of the Role of Volunteers

Many participants raised the importance of recognising and rewarding volunteers for the critical role they undertake within the service. Some good practice initiatives included:

- Providing adequate in-house training. It was suggested that volunteers could access the HACC training calendar to assist with this;
- Maintaining morale through recognising the benefits of volunteering;
- Mentioning volunteers in annual reports;
- Nominating volunteers for awards;
- Providing emotional support and adequate debriefing to volunteers; and
- Rewarding volunteers via volunteer recognition events, inviting volunteers to other events and taking them on outings (one agency reported that these activities had been supported by grants from sources such as Local Government Authorities and Vic Health).

Specific Cultural Issues

The following specific cultural practices were identified:

- Ensuring cultural compatibility between volunteer and client; and
- One CALD agency reported going to the broader CALD community for assistance with recruitment.

Recruitment Strategies

The following strategies were reported to enhance volunteer recruitment:

- Media promotion;
- Promote volunteering in tertiary institutions;
- One agency encourages volunteers to bring a friend along on volunteer days to demonstrate tasks undertaken by the service;
- A central agency within the region that the prime role of recruiting volunteers – services could use this agency when they need to recruit;
- Promoting the value of being a volunteer;
- Drawing on the non-HACC residential care sector and the disability sector for recruitment; and
- Encouraging former carers to become volunteers.

Maintaining Volunteers

The following initiatives focus on maintaining volunteers:

- Identifying and being aware of hours that volunteers work, as often workers tend to underestimate volunteer contributions;
- Reducing the frequency of shopping undertaken by volunteers;
- Matching skills of volunteers to clients;
- Increasing efficiency of volunteer time by linking one volunteer with a few clients (particularly with transporting clients as documented on 8.2.4);
- Partnerships between agencies regarding the placing of volunteers, to meet each other's goals; and

- Adequate reimbursement for expenses, for example, meal allowances and telephone expenses.

Good Management of Volunteers

The importance of managing volunteers using a coordinated approach was also reported including:

- Good management, for example, not running an ad hoc service as good coordination can increase service efficiency;
- Giving volunteers a clear message about the role of volunteers and, if relevant, ensuring volunteers do not have an expectation that they may be employed within the agency;
- Agencies maintaining a list of funding sources for supporting/recognising volunteers; and
- Drawing on existing resources, such as agencies that coordinate volunteers (including exploring the capacity of these agencies to focus on volunteers from CALD backgrounds).

8.2.2 Carer Support

A range of strategies were identified that could guide services when implementing initiatives to support carers.

Flexible Services

The need for a diverse range of service options that meet individual needs was identified:

- In responding to the needs of carers and care recipients, an agency reported running two support groups simultaneously – carer group/care recipient group;
- Services considering brokerage models, for example, purchasing in most appropriate care such as language specific staff; and
- Ensuring service providers are providing client centred care and are sensitive to the differences amongst carers in how they define their role, their service needs and expectations. For example, allowing carer and care recipient to attend the same program if that is their preference.

Respite

A range of strategies were suggested for ensuring carers were receiving adequate respite from their caring role and that respite options were flexible to meet individual carer's needs:

- Respite should allow the carer to actually have a break and participate in Social Support opportunities;
- Importance of opportunities for respite where carer and care recipient can spend quality time together if that is their preference;
- Opportunities be provided for 1-2 nights of residential respite rather than two weeks at a time; and
- Social Support Services to have in-home respite services for carers as well.

Supporting Carers

A range of activities were undertaken that provided support for carers:

- Carer retreats on weekend, subsidised outings, socialisation and education;
- Flexible programs, for example, carers and care recipients coming to programs together as it is more culturally appropriate for couples to attend programs together;
- Recognising the changing needs of carers as they move in and out of the caring role
- Providing a Social Support Program for carers whilst the care recipient is in the High PAG program;
- Making connections with the community during the commencement of a group; and

- Recognising that the carer often also needs care themselves whilst they are providing care and acknowledging that Social Support Services are a form of respite for carers.

Providing Information to Carers

It was reported that carers needed more information about the services and resources they could access. Strategies included:

- Ongoing awareness raising of respite services and other carers services, particularly for CALD communities; and
- Consistent policy across the region as different agencies have different policies in relation to carer support.

8.2.3 Agency Fund Raising

Participants identified a range of strategies that could support agency funding raising. However, it was also acknowledged that funds obtained through these means should not be used to provide HACC Social Support Services but to rather enhance existing HACC funded activities.

Fund Raising Ideas

Fund raising initiatives included:

- Traditional activities such as event days, raffles, dinner dances;
- Seeking in-kind support from large companies;
- Encouraging donations from funding bodies and trust funds;
- Undertaking a radiothon using ethnic radio, as culturally appropriate (it was also stated that for some CALD groups, fund raising is culturally inappropriate);
- Visiting www.ourcommunity.com for information about funding opportunities;
- Liaising with members of specific CALD communities (e.g. community leaders) to support disadvantaged members of that community;
- Having a worker dedicated to fundraising. One agency has recognised the role as a separate one and has a staff member dedicated to writing submissions and seeking funding;
- Using volunteers to assist with fundraising; and
- Encouraging fees for clients. Participants reported that fees are an expectation in mainstream services but appear to be a deterrent for CALD groups.

Partnerships

One ethno-specific agency provided the following example of a funding partnership:

- A ethno-specific agency prepared a submission to Carer Links West for the provision of respite for clients with high level needs who were attending the Core PAG Program, yet had very particular needs that the Core PAG Program was not able to respond to. Carer Links West provided the funding to the ethno-specific agency for respite to be provided to the high needs clients, outside of the normal Core PAG program, but within the ethno-specific agency setting.

8.2.4 Transport Initiatives

Initiatives were identified for resource sharing and increasing access to transport to PAGs.

Volunteers

Initiatives that focus on transport and volunteers included:

- Streamlining the number of clients picked up by a volunteer to be taken to a PAG program, i.e. a volunteer picking up more than one client, particularly when clients live in close proximity;

- Volunteers used for transporting clients to PAGs, and being reimbursed for the petrol cost; and
- Volunteer database for transport and having recruitment of volunteers targeted to provide transport for clients to participate in spiritual and cultural activities.

Partnerships/Resource Sharing Arrangements

Participants reported that agencies across the region were sharing transport resources and that this was a positive approach to service provision. Good practice initiatives described included:

- One LGA embarking on a resource sharing initiative with Red Cross, drawing on Red Cross volunteers to support the PAG program;
- Partnerships between LGAs and CALD agencies to share resources such as community buses for transporting clients to PAG programs;
- Using Infoxchange Australia Transport Seeker, which is freely available on the Internet. This resource identifies vehicles that can be shared and provides information for how to access them. It is particularly useful for agencies wanting to book transport on an occasional basis for outings;
- Running a bus as opposed to cars, as this was reported to be more cost effective. It was suggested that sharing buses between a few agencies could be explored; and
- Larger organisations, such as Local Government Authorities to have a department dedicated to transport initiatives across all Local Government services (as one LGA does).

8.3) Summary

This chapter has focused on presenting the findings of the service provider workshop. Workshop participants identified a range of current good practice initiatives around the areas of volunteers, carer support, agency fund raising and transport, and factors that would enhance the implementation of these good practice initiatives. Partnerships, service linkages and resource sharing arrangements seemed to be common themes raised across all four areas when participants were identifying good practice initiatives.

9. Summary and Recommendations

This study has provided evidence that involvement in Social Support Services is valued by people from CALD backgrounds, who receive a range of benefits from their participation. The importance of Social Support Services for people of CALD backgrounds should not be underestimated in future service planning.

This study has used a qualitative and quantitative approach to address the aim of the research, which was to evaluate the role of HACC funded Social Support Services for people of CALD backgrounds to inform future service practice. The objectives of the study were to:

1. Develop a profile of current Social Support models and CALD service users in the N&WMR.
2. Evaluate the extent to which Social Support Services work towards improving the health and wellbeing of CALD service users.
3. Propose recommendations and model(s) for future Social Support Services in the N&WMR to further improve the health and wellbeing of CALD service users.

One of the potential limitations of using qualitative methodology is that the findings cannot be generalised to all service users or services. However, the methodology used in this study has provided a rich account of the direct experiences of both service users and service providers. It has documented the personal experiences of service providers and service users in regard to Social Support and has generated suggestions from both groups about service improvements. For the qualitative components of the service provider survey, a 55% response rate provided information about a broad range of issues faced by a large number of Social Support Services. This response rate did, however, prevent the development of a complete profile of the range of Social Support Services available in the region. It also became evident when comparing numbers of clients reported on the service provider survey with numbers of clients recorded on the MDS that discrepancies were present. It would seem that the MDS was missing data for a substantial proportion of clients or that the survey data had some level of overstatement.

The cost benefit analysis was limited in terms of the number of agencies analysed, and analysis difficulties were compounded by different levels of performance reported by agencies.

This chapter draws together information from the findings of the various phases of the study as outlined in the previous chapters. It is summarised according to the three objectives of the study.

9.1) Objective 1: Profile

This section summarises key findings from the information obtained through the MDS analysis, cost benefit analysis and quantitative data from the service provider survey when developing a profile of current service users and services.

9.1.1 Profile of Current Users

The DHS N&WMR provides HACC services to a considerable proportion of the Victorian HACC client population. The region is also characterised by a large CALD population. Analysis of MDS data showed that overall the CALD population was underrepresented in HACC services, however, they tended to have greater representation in Social Support Programs. Whilst 'other' agencies were the largest providers of Social Support Services, the majority of CALD Social Support clients were accessing Social Support through CALD agencies. The demographic profile of Social Support clients in the region (n=1915) showed that English speaking clients were more likely to be in the younger age groups

(under 44 years) and very old age group (85+ years). Consistent with this finding, CALD clients were also more likely to have a carer and less likely to be living alone. Socio-economic indicators (pension status and living arrangement) show that CALD clients may be slightly more likely than English speaking clients to access a government pension and slightly less likely to be owners/purchasers of their residence.

9.1.2 Profile of Current Services

According to findings from the survey, CALD clients are more represented in Core PAGs, Friendly Visiting and Telelink services, and less represented in High PAGs. Possible explanations for this could include service configuration: CALD agencies provide services to the majority of CALD clients and are more likely to offer PAG Core services. Alternatively, the concentration of CALD service users in PAG Core may reflect CALD service user needs at this time. These findings do, however, suggest that there will be relatively higher demands for culturally appropriate High PAGs than other Social Support services in the future.

Socialising, physical activity, games and meal provision were the main activities being provided in Social Support Programs. There were some differences between CALD and mainstream agencies in the extent to which they provided certain activities. Education was reported as being undertaken by around 50% of Core PAGs provided through CALD agencies on many or most sessions compared to 20% of mainstream agencies and around 10% of High PAGs in mainstream and CALD agencies. Outings were more common in mainstream High and Core PAGs than in CALD agency PAGs.

In relation to the cost benefit analysis, it was evident that most agencies were exceeding their required DHS targets, in some cases by large numbers.

CALD agencies are currently providing Social Support Services that have a high reliance on volunteers, e.g. Core PAG, Friendly Visiting and Telelink. Only a small number of CALD agencies provide High PAGs, which require staff with specific skills such as personal care skills. In the future, the N&WMR will need to consider population growth and ensure that there is adequate provision of culturally appropriate High PAG.

9.2) Objective 2: Improving Health and Well Being

There were common themes raised by service providers and service users about the benefits of Social Support Services. These included:

- Socialisation and/or reducing isolation were described as the main role for Social Support Services;
- A large number of service providers described providing support, respite and information for carers as well as maintaining independence and skills of living for care recipients. Some service users also mentioned the benefits for carers when they attended Social Support Services;
- Participants across all focus groups stated that one of the reasons and benefits of attending the Planned Activity Group was being provided with information about a range of health and safety issues as well as broader aged care services; and
- Improving quality of life through physical activities, and providing opportunities for recreation were also commonly reported as reasons for, and benefits of, participating in programs by service users. Service providers also reported this as one of the aims of Social Support Services.

Goals that were reported more specifically for people of CALD background were:

- Increasing knowledge of and encouraging utilisation of broader services;
- Developing informal support network for clients and carers from ethnic backgrounds; and
- Promoting the concept of carer within CALD communities.

To assist in meeting these goals, having a program where clients, staff and/or volunteers who spoke the same language appeared to be of key importance to people of CALD backgrounds. The importance of CALD and mainstream agencies in developing partnerships and sharing resources was also demonstrated as promoting culturally appropriate service delivery and working together to meet the needs of clients.

9.2.1 Service Barriers

This study has identified a range of resource limitations faced by Social Support Services. Service providers have identified increasing demand for services, increasing needs of clients, lack of growth funding over the previous three years and unit prices not rising with the costs of service delivery as impacting on service delivery. This is within a context of some agencies over-delivering against service targets and some agencies not collecting fees to support their services.

Lack of resources has contributed to barriers that service providers have faced in providing Social Support Services aiming to improve the health and wellbeing of CALD service users, including:

- Limited staff and volunteers with appropriate skills and access to education;
- Limited access to bi-lingual staff and bilingual allied health support;
- Limited flexibility (e.g. after hours services, capacity to separate clients with low and high needs);
- Limited capacity to meet needs of specific groups (e.g. carers, newly arrived communities, younger people with disabilities);
- Limited access to interpreters and written information in community languages;
- Limited capacity to provide activities such as outings; and
- Limited equipment (e.g. hoists for vehicles, exercise equipment and space in venues to undertake various activities);

Barriers such as lack of transport were exacerbated for CALD agencies due to the sometimes large geographic areas they service.

In undertaking the cost benefit analysis for this study, inconsistencies between the various databases were outlined. As agencies become more familiar with MDS reporting, MDS data quality improved in 2005/06, however, the timeliness of acquittal forms, accuracy and consistency between the various data reporting systems has not been demonstrated. This results in limited benefit being derived from the cost analysis.

9.3) Objective 3: Recommendations

Objective 3 was to propose recommendations and model(s) for future services. As this study evolved, it was felt that new model(s) of service provision were not required, but, rather, existing practices could be sustained through innovative approaches and enhanced support.

Recommendations have been developed as a result of the findings of this study and are detailed below according to whether it is targeted to government or Social Support Services.

9.3.1 Recommendations for the N&WMR of DHS

This study has identified a number of areas to prioritise in future planning and growth funding. It is recommended that the N&WMR of DHS consider the need for:

1. Increased training opportunities for staff and volunteers responding to CALD clients
2. Strategies designed to further support the training, support, recognition and appropriate reimbursement of volunteers
3. Strategies designed to support the delivery of services that understand and are responsive to changing needs of informal carers or HACC eligible clients

4. Improved transport options and/or encouraging enhanced transport sharing arrangements
5. Review of 2005/06 data and exploration of performance reporting inconsistencies and under achieving with agencies and to continue to support agencies to achieve more accurate and consistent performance reporting
6. Further research to develop enhanced classification of clients to improve the targeting of Social Support Services to the HACC target population
7. Development of models of sub-regional waiting list management and assessment of priority of access to manage demand and ensure equity of access across the range of service providers
8. Explore options to better respond to the needs of CALD clients who are moving to the level of High PAG
9. Further consultation with HACC funded agencies regarding the development of strategies to enhance the supports provided to smaller and emerging communities
10. Continued promotion of the Well for Life approach to promoting opportunities for increased physical activity and better nutrition to participants
11. Promote the work currently being undertaken in the redesign of HACC assessment, care coordination and case management activities to ensure that the expected roles and functions of all HACC agencies are clear and achievable.

9.3.2 Recommendations for Social Support Services

It is recommended that Social Support Services consider the need for:

1. Increased consultation with their service users in program planning
2. Flexible and client centred care that is sensitive to the differences amongst carers in how they define their role, their service needs and expectations
3. Information provision to carers about services available and their entitlements as carers
4. Programs that incorporate positive ageing approaches such as promoting the benefits of physical activity in Core PAGs
5. Providing Core and High PAG options where possible so that clients with different needs are not within the same group
6. Strategies to recruit, support, recognise and retain volunteers
7. Implementation of the HACC fees policy, and the development of strategies that encourage clients to contribute fees if possible and demonstrate to clients the benefits derived from their contributions
8. Further developing partnerships with other organisations, particularly in relation to resource sharing arrangements, referral pathways, addressing cross municipal boundary issues and sharing bi-lingual allied health staff.

9.4) Summary and Conclusion

This research project has provided valuable insights about the role of HACC funded Social Support Services. The qualitative and quantitative methods were appropriate to obtain service users and service providers direct experiences of services, as well as undertaking quantitative analysis of data through surveys, MDS and cost benefit analysis.

The factors identified by service providers and service users have provided the basis for the development of strategies and recommendations to guide future service planning. Information about current activities, service usage patterns, barriers within services, benefits and strengths of current services and good practice examples, have all contributed to providing an overall comprehensive profile of the role of Social Support Services to inform future service practice.

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11. Appendices

Appendix 1: Service Provider Workshop Agenda and Discussion Questions

Workshop Agenda

9.45am-10.00am	Registration
10.00am-10.30am	Welcome/workshop overview (Project overview/findings)
10.30am-11.00am	Group Discussions (Current good practice examples)
11.00am-11.15am	Morning Tea
11.15am-11.45pm	Feedback re Group Discussions (Feedback/summarise/introduce next session)
11.45pm-12.30pm	Group Discussions (Strategies re future service)
12.30pm-12.45pm	Feedback re Group Discussions
12.45pm-1.00pm	Summarise (Next Steps) & Close
1.00pm-2.00pm	Lunch

Discussion questions

1. Can you identify current good practice examples either within your service/agency, Local Government area, PCP?
Consider the good practice examples against the following areas:
 - Volunteers
 - Carer Support
 - Agency fund raising
 - Transport initiatives*How do these initiative address the needs of clients with:*
 - Low needs
 - High needs
2. Can you suggest strategies for future service provision in either of the following areas (break into four groups):
 - Volunteers – recruitment and maintenance
 - Carer Support – initiatives to support carers
 - Agency fund raising – including implementing fees
 - Transport initiatives – consider resource sharing?
3. Identify enablers that will assist these strategies to be implemented?
4. Are there additional strategies you would suggest regarding the future of Social Support Services?

Appendix 2: Activities Undertaken in Social Support Services

Appendix 2A: Core PAG Activities Undertaken

	Most sessions (Mainstream % / CALD %)	Many sessions (Mainstream % / CALD %)	Every few weeks (Mainstream % / CALD %)	A few times a year (Mainstream % / CALD %)	Never/missing (Mainstream % / CALD %)
Games involving physical activity (eg lawn bowls, bocce)/exercises/walking	45.2 (60.0 / 31.8)	21.4 (25.0 / 18.2)	11.9 (15.0 / 9.1)	14.3 (0 / 27.3)	7.1 (0 / 13.6)
Gardening and/or assisting with gardening	2.4 (5.0 / 0)	4.8 (10.0 / 0)	7.1 (10.0/4.5)	28.6 (35.0 / 22.7)	57.1 (40.0 / 72.7)
Dancing	9.5 (15.0 / 4.5)	7.1 (5.0 / 4.8)	2.4 (10.0 / 0)	40.5 (40.0 / 40.9)	40.5 (35.0 / 45.5)
Music Therapy/Singing	9.5 (15.0 / 4.5)	16.7 (20.0 / 13.6)	11.9 (15.0 / 9.1)	23.8 (10.0 / 36.4)	38.1 (40.0 / 36.4)
Games (eg board games, bingo)	33.3 (25.0 / 40.9)	19.0 (30.0 / 9.1)	11.9 (15.0 / 9.1)	14.3 (5.0 / 22.7)	21.4 (25.0 / 18.2)
Cooking	7.1 (0 / 13.6)	4.8 (0 / 9.1)	9.5 (15.0 / 4.5)	28.6 (30.0 / 27.3)	50.0 (55.0 / 45.5)
Crafts	23.8 (25.0 / 22.7)	21.4 (30.0 / 13.6)	14.3 (15.0 / 13.6)	19.0 (15.0 / 22.7)	21.4 (15.0 / 27.3)
Outings	9.5 (15.0 / 4.5)	16.7 (20.0 / 13.6)	26.2 (35.0 / 18.2)	33.3 (15.0 / 50.0)	21.4 (15.0 / 27.3)
Meal provision	59.5 (60.0 / 59.1)	11.9 (10.0 / 13.6)	2.4 (5.0 / 0)	2.4 (5.0 / 0)	23.8 (20.0 / 27.3)
Theme days/Special events (such as BBQ, picnic)	0 (0 / 0)	23.8 (30.0 / 18.2)	16.7 (20.0 / 13.6)	50.0 (35.0 / 63.9)	9.5 (15.0 / 4.5)
Holidays	0 (0 / 0)	0 (0 / 0)	0 (0 / 0)	35.7 (30.0 / 40.9)	64.3 (70.0 / 59.1)
Education about health issues and life skills (eg guest speakers)	7.1 (5.0 / 9.1)	31.0 (15.0 / 45.5)	16.7 (20.0 / 13.6)	35.7 (40.0 / 31.8)	9.5 (20.0 / 0)
Discussing how to access services	9.5 (10.0 / 9.1)	21.4 (20.0 / 22.7)	9.5 (0 / 18.2)	38.1 (45.0 / 31.8)	21.4 (25.0 / 18.2)
Personal Care: Grooming	4.8 (10.0 / 0)	4.8 (5.0 / 4.5)	4.8 (0 / 9.1)	16.7 (20.0 / 13.6)	69.0 (65.0 / 72.7)
Personal Care: Assistance with meals	14.3 (25.0 / 4.5)	2.4 (0 / 4.5)	7.1 (10.0 / 4.5)	14.3 (20.0 / 9.1)	61.9 (45.0 / 77.3)
Personal Care: Assistance with showering	2.4 (5.0 / 0)	2.4 (5.0 / 0)	0 (0 / 0)	9.5 (10.0 / 9.1)	85.7 (80.0 / 90.9)
Personal Care: Assistance with toileting	9.5 (20.0 / 0)	14.3 (25.0 / 4.5)	2.4 (5.0 / 0)	7.1 (5.0 / 9.1)	66.7 (45.0 / 86.4)
Socialising	66.7 (70.0 / 63.6)	19.0 (25.0 / 13.6)	0 (0 / 0)	4.8 (0 / 9.1)	9.5 (5.0 / 13.6)
Reading/writing letters	7.1 (10.0 / 4.5)	26.2 (20.0 / 31.8)	7.1 (10.0 / 4.5)	11.9 (5.0 / 18.2)	47.6 (55.0 / 40.9)
Shopping/paying bills	2.4 (5.0 / 0)	9.5 (10.0 / 9.1)	7.1 (5.0 / 9.1)	14.3 (20.0 / 9.1)	66.7 (60.0 / 72.7)

Nine agencies also listed other activities undertaken in their Core PAG group including: assessment/case management, camps, English, hairdressing, massage, students serving meals, lunch groups, visiting museum/galleries/movies and weekends.

Appendix 2B: High PAG Activities Undertaken

	Most sessions (Mainstream % / CALD %)	Many sessions (Mainstream % / CALD %)	Every few weeks (Mainstream % / CALD %)	A few times a year (Mainstream % / CALD %)	Never/missing (Mainstream % / CALD %)
Games involving physical activity (eg lawn bowls, bocce)/exercises/walking	61.5 (64.7 / 55.6)	23.1 (17.6 / 33.3)	7.7 (11.8 / 0)	0 (0 / 0)	7.7 (5.9 / 11.1)
Gardening and/or assisting with gardening	3.8 (5.9 / 0)	0 (0 / 0)	15.4 (17.6 / 11.1)	38.5 (35.3 / 44.4)	42.3 (41.2 / 44.4)
Dancing	11.5 (11.8 / 11.1)	11.5 (11.8 / 11.1)	15.4 (17.6 / 11.1)	42.3 (41.2 / 44.4)	19.2 (17.6 / 22.2)
Music Therapy/Singing	11.5 (11.8 / 11.1)	34.6 (35.3 / 33.3)	15.4 (11.8 / 22.2)	19.2 (23.5 / 11.1)	19.2 (17.6 / 22.2)
Games (eg board games, bingo)	38.5 (29.4 / 55.6)	11.5 (17.6 / 0)	23.1 (29.4 / 11.1)	11.5 (11.8 / 11.1)	15.4 (11.8 / 22.2)
Cooking	7.7 (5.9 / 11.1)	3.8 (5.9 / 0)	15.4 (17.6 / 11.1)	26.9 (23.5 / 33.3)	46.2 (47.1 / 44.4)
Crafts	23.1 (23.5 / 22.2)	34.6 (41.2 / 22.2)	7.7 (5.9 / 11.1)	19.2 (17.6 / 22.2)	15.4 (11.8 / 22.2)
Outings	3.8 (5.9 / 0)	19.2 (23.5 / 11.1)	34.6 (47.1 / 11.1)	23.1 (11.8 / 44.4)	19.2 (11.8 / 33.3)
Meal provision	80.8 (82.4 / 77.8)	0 (0 / 0)	0 (0 / 0)	11.5 (11.8 / 11.1)	7.7 (5.9 / 11.1)
Theme days/Special events (such as BBQ, picnic)	7.7 (11.8 / 0)	23.1 (29.4 / 11.1)	23.1 (29.4 / 11.1)	38.5 (23.5 / 66.7)	7.7 (5.9 / 11.1)
Holidays	0 (0 / 0)	0 (0 / 0)	0 (0 / 0)	23.1 (17.6 / 33.3)	76.9 (82.4 / 66.7)
Education about health issues and life skills (eg guest speakers)	0 (0 / 0)	7.7 (5.9 / 11.1)	15.4 (17.6 / 11.1)	46.2 (35.3 / 66.7)	30.8 (41.2 / 11.1)
Discussing how to access services	3.8 (5.9 / 0)	15.4 (11.8 / 22.2)	15.4 (11.8 / 22.2)	34.6 (35.3 / 33.3)	30.8 (35.3 / 22.2)
Personal Care: Grooming	26.9 (35.3 / 11.1)	11.5 (11.8 / 11.1)	7.7 (11.8 / 0)	7.7 (5.9 / 11.1)	46.2 (35.3 / 66.7)
Personal Care: Assistance with meals	61.5 (70.6 / 44.4)	11.5 (11.8 / 11.1)	7.7 (5.9 / 11.1)	0 (0 / 0)	19.2 (11.8 / 33.3)
Personal Care: Assistance with showering	11.5 (17.6 / 0)	7.7 (5.9 / 11.1)	0 (0 / 0)	7.7 (11.8 / 0)	73.1 (64.7 / 88.9)
Personal Care: Assistance with toileting	61.5 (70.6 / 44.4)	11.5 (11.8 / 11.1)	3.8 (5.9 / 0)	3.8 (0 / 11.1)	29.4 (11.8 / 33.3)
Socialising	84.6 (88.2 / 77.8)	0 (0 / 0)	7.7 (0 / 22.2)	3.8 (5.9 / 0)	3.8 (5.9 / 0)
Reading/writing letters	7.7 (5.9 / 11.1)	38.5 (35.3 / 44.4)	11.5 (17.6 / 0)	3.8 (5.9 / 0)	38.5 (35.3 / 44.4)
Shopping/paying bills	0 (0 / 0)	3.8 (5.9 / 0)	7.7 (5.9 / 11.1)	11.5 (11.8 / 11.1)	76.9 (76.5 / 77.8)

Other High PAG activities listed by 2 agencies included creative therapy (many sessions) and neighbour lunch group (few times a year).

Appendix 2C: Friendly Visiting Activities Undertaken

	Most sessions (Mainstream % / CALD %)	Many sessions (Mainstream % / CALD %)	Every few weeks (Mainstream % / CALD %)	A few times a year (Mainstream % / CALD %)	Never/missing (Mainstream % / CALD %)
Games involving physical activity (eg lawn bowls, bocce)/exercises/walking	22.2 (0 / 25.0)	5.6 (0 / 12.5)	16.7 (50.0 / 12.5)	11.1 (0 / 12.5)	44.4 (50.0 / 43.8)
Gardening and/or assisting with gardening	-	-	22.2 (50.0 / 18.8)	22.2 (0 / 25.0)	55.6 (50.0 / 56.3)
Dancing	-	-	-	5.6 (0 / 12.5)	94.4 (100 / 93.8)
Music Therapy/Singing	-	-	5.6 (0 / 6.3)	27.8 (0 / 31.3)	66.7 (100 / 62.5)
Games (eg board games, bingo)	11.1 (0 / 12.5)	11.1 (0 / 12.5)	16.7 (50.0 / 12.5)	22.2 (0 / 25.0)	38.9 (50.0 / 37.5)
Cooking	11.1 (50.0 / 6.3)	5.6 (0 / 6.3)	-	5.6 (0 / 6.3)	77.8 (50.0 / 81.3)
Crafts	-	5.6 (0 / 6.3)	16.7 (0 / 18.8)	5.6 (0 / 6.3)	72.2 (100 / 68.8)
Outings	11.1 (0 / 12.5)	22.2 (50.0 / 18.8)	16.7 (0 / 18.8)	22.2 (0 / 25.0)	27.8 (50.0 / 25.0)
Meal provision	-	5.6 (0 / 6.3)	-	11.1 (0 / 12.5)	83.3 (100 / 81.3)
Theme days/Special events (such as BBQ, picnic)	-	5.6 (0 / 6.3)	5.6 (0 / 6.3)	44.4 (50.0 / 38.9)	44.4 (50.0 / 43.8)
Holidays	-	-	-	16.7 (0 / 18.8)	83.3 (100 / 81.3)
Education about health issues and life skills (eg guest speakers)	5.6 (0 / 6.3)	16.7 (0 / 18.8)	-	22.2 (0 / 25.0)	55.6 (100 / 50.0)
Discussing how to access services	11.1 (0 / 12.5)	16.7 (0 / 18.8)	16.7 (0 / 18.8)	22.2 (0 / 25.0)	33.3 (100 / 25.0)
Personal Care: Grooming	-	-	11.1 (0 / 12.5)	-	88.9 (100 / 87.5)
Personal Care: Assistance with meals	-	-	11.1 (0 / 12.5)	-	88.9 (100 / 87.5)
Personal Care: Assistance with showering	-	-	-	5.6 (0 / 6.3)	94.4 (100 / 93.8)
Personal Care: Assistance with toileting	-	-	-	11.1 (0 / 12.5)	88.9 (100 / 87.5)
Socialising	55.6 (0 / 62.5)	16.7 (50.0 / 12.5)	5.6 (0 / 6.3)	5.6 (0 / 6.3)	16.7 (50.0 / 12.5)
Reading/writing letters	22.2 (0 / 25.0)	-	22.2 (0 / 25.0)	22.2 (50.0 / 18.8)	33.3 (50.0 / 31.3)
Shopping/paying bills	16.7 (0 / 18.8)	22.2 (50.0 / 18.8)	11.1 (50.0 / 6.3)	22.2 (0 / 25.0)	27.8 (0 / 31.3)

Other activities cited included neighbourhood lunch group, assessment and case management, referral to other services, religious events and transporting to appointments.

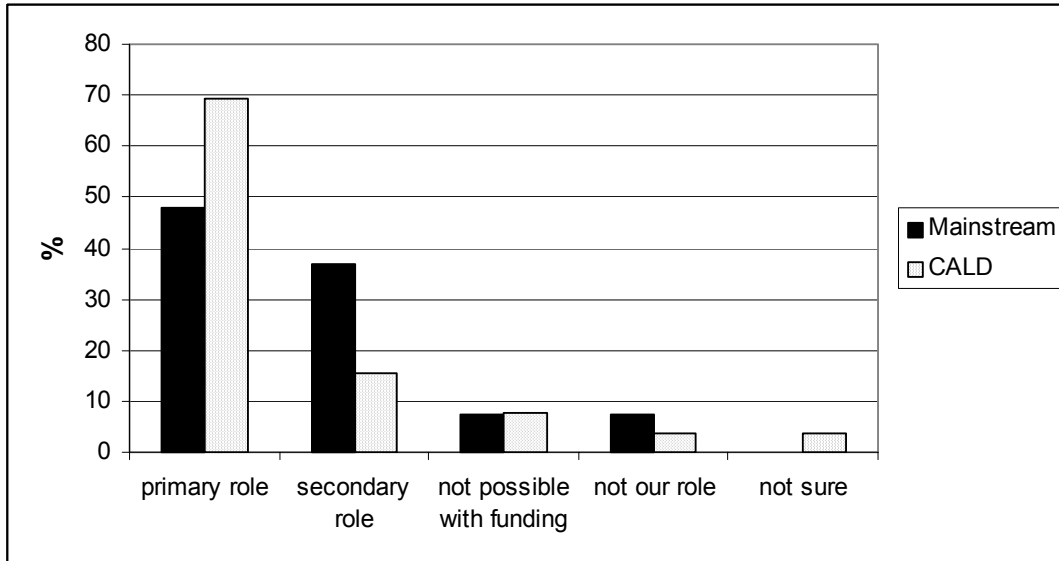
Appendix 2D: Carer Support Program Activities Undertaken

	Most sessions (Mainstream % / CALD %)	Many sessions (Mainstream % / CALD %)	Every few weeks (Mainstream % / CALD %)	A few times a year (Mainstream % / CALD %)	Never/missing (Mainstream % / CALD %)
Games involving physical activity (eg lawn bowls, bocce)/exercises/walking	-	12.5 (0 / 20.0)	25.0 (33.3 / 20.0)	12.5 (33.3 / 0)	50.0 (33.3 / 60.0)
Gardening and/or assisting with gardening	-	-	-	-	87.5 (100 / 80.0)
Dancing	-	-	-	25.0 (33.3 / 20.0)	75.0 (66.7 / 80.0)
Music Therapy/Singing	-	25.0 (66.7 / 0)	12.5 (0 / 20.0)	12.5 (0 / 20.0)	50.0 (33.3 / 60.0)
Games (eg board games, bingo)	-	12.5 (33.3 / 0)	12.5 (0 / 20.0)	12.5 (0 / 20.0)	62.5 (66.7 / 60.0)
Cooking	12.5 (0 / 20.0)	-	-	12.5 (0 / 20.0)	75.0 (33.3 / 60.0)
Crafts	-	25.0 (33.3 / 20.0)	25.0 (33.3 / 20.0)	-	50.0 (33.3 / 60.0)
Outings	12.5 (33.3 / 0)	12.5 (0 / 20.0)	-	37.5 (66.7 / 20.0)	37.5 (0 / 60.0)
Meal provision	12.5 (33.3 / 0)	12.5 (0 / 20.0)	-	12.5 (33.3 / 0)	62.5 (33.3 / 80.0)
Theme days/Special events (such as BBQ, picnic)	12.5 (33.3 / 0)	-	12.5 (0 / 20.0)	25.0 (33.3 / 20.0)	50.0 (33.3 / 60.0)
Holidays	-	-	-	25.0 (33.3 / 20.0)	75.0 (66.7 / 80.0)
Education about health issues and life skills (eg guest speakers)	-	25.0 (0 / 40.0)	25.0 (66.7 / 0)	12.5 (33.3 / 0)	37.5 (0 / 60.0)
Discussing how to access services	37.5 (33.3 / 40.0)	25.0 (33.3 / 20.0)	-	25.0 (33.3 / 20.0)	37.5 (0 / 60.0)
Personal Care: Grooming	-	-	-	12.5 (0 / 20.0)	87.5 (100 / 80.0)
Personal Care: Assistance with toileting	-	12.5 (33.3 / 0)	-	-	87.5 (66.7 / 100)
Socialising	62.5 (66.7 / 60.0)	-	25.0 (33.3 / 20.0)	12.5 (0 / 20.0)	-
Reading/writing letters	12.5 (0 / 20.0)	-	12.5 (0 / 20.0)	37.5 (66.7 / 20.0)	37.5 (33.3 / 40.0)
Shopping/paying bills	-	-	-	25.0 (33.3 / 20.0)	75.0 (66.7 / 80.0)

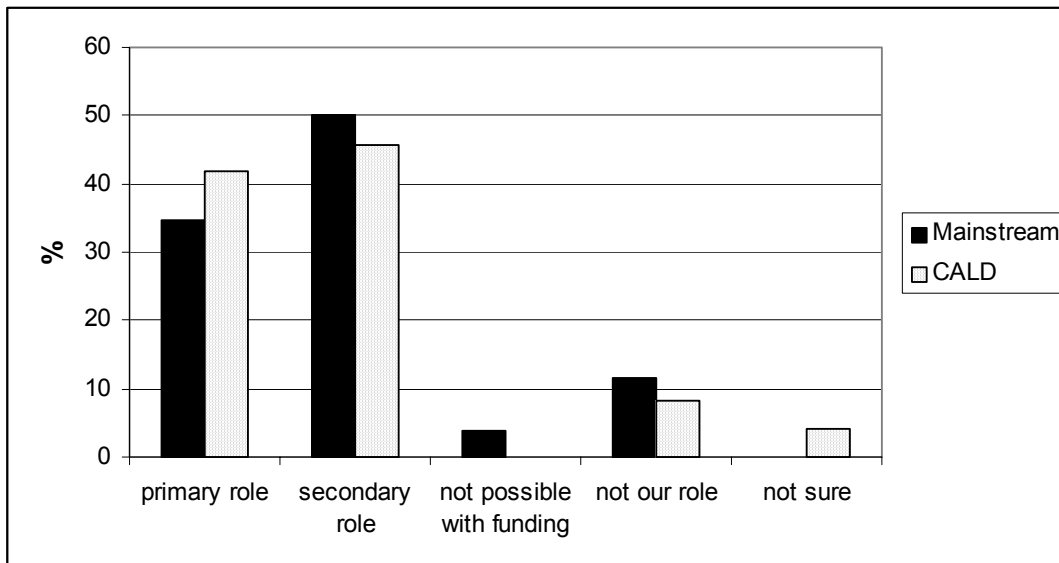
One CALD agency also cited undertaking assessment and case management at most sessions

Appendix 3: Service aims for Mainstream and CALD agencies

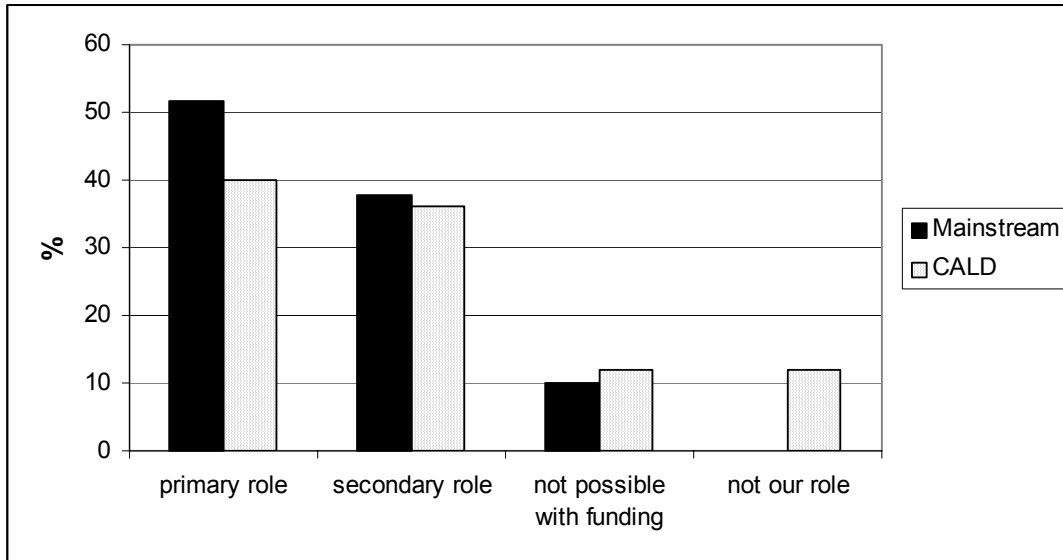
Health Promotion



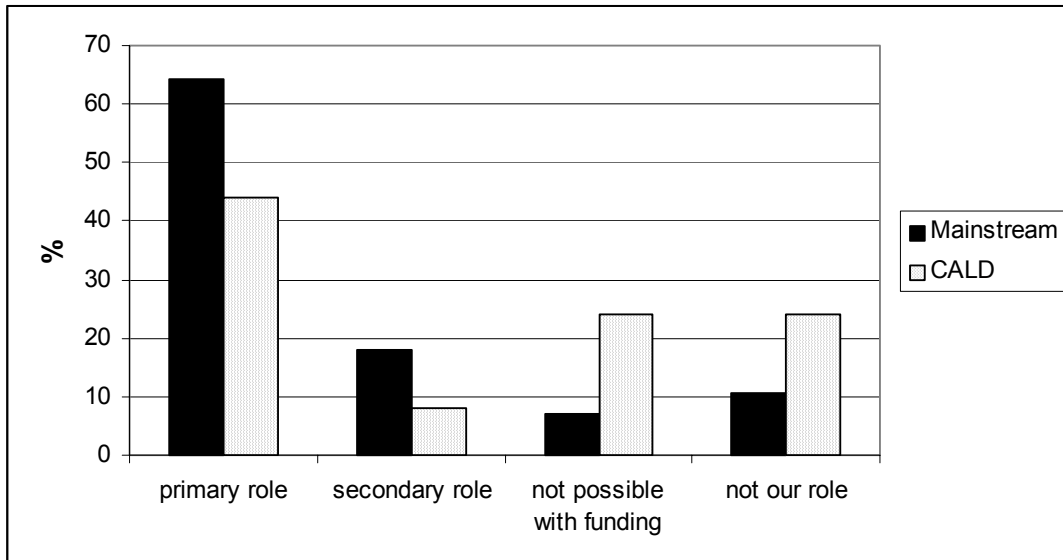
Education



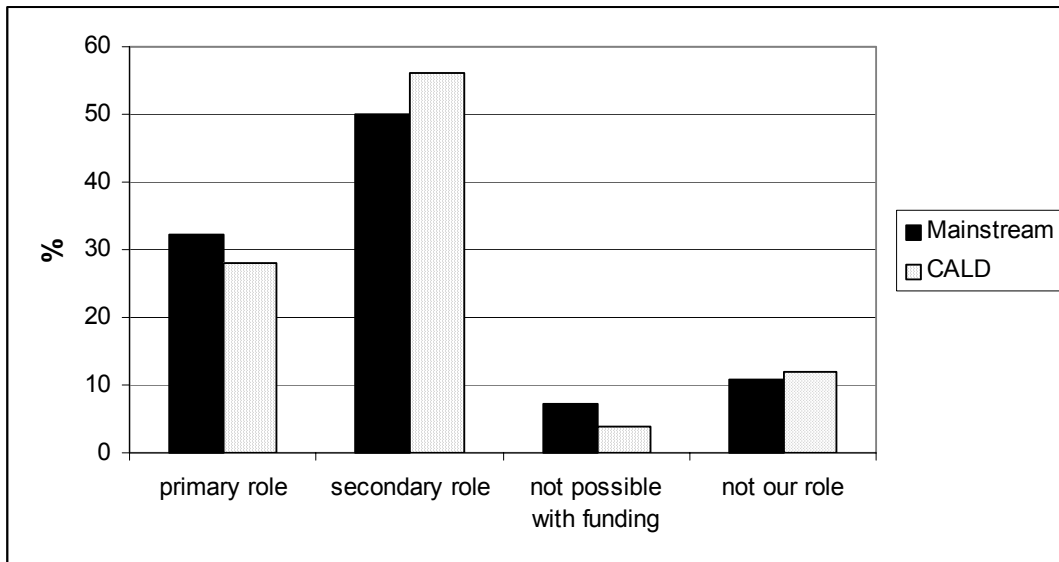
Physical Activity



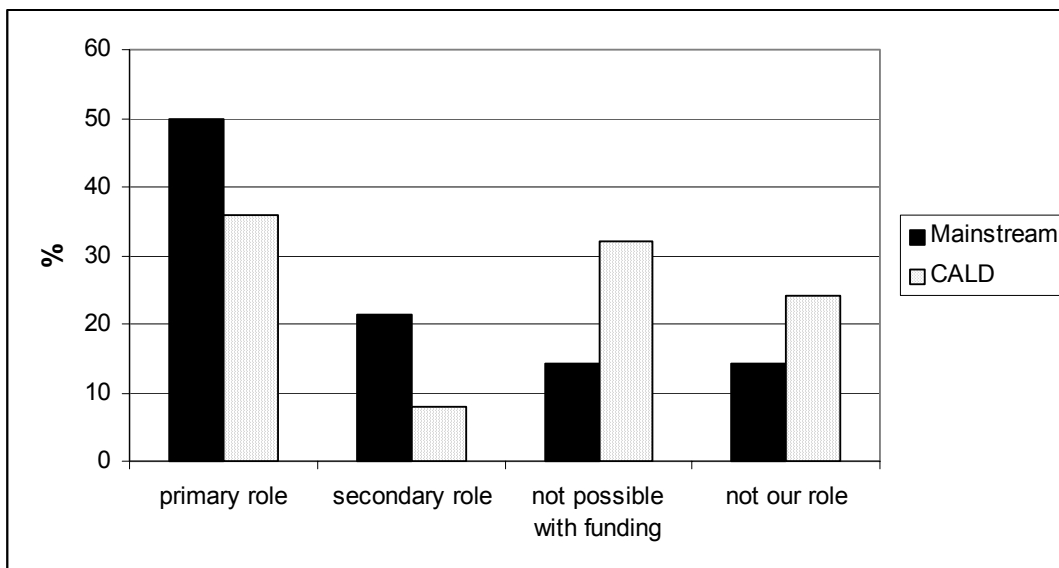
Respite for Carers



Referring Clients to Other Services



Assessment and Care Planning



Assisting Clients to Regain/Maintain Activities of Daily Living

