A FRAMEWORK FOR SOCIAL CONNECTIVITY ON THE SOUTHERN FLEURIEU PENINSULA

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Background & Introduction

For several years Social Isolation has been repeatedly identified as a priority by the Southern Fleurieu Positive Ageing Taskforce and has shown as the primary priority in local consultations prior to HACC funding rounds. Social Isolation has been of particular interest within the context of mental health and retirement migration.

In April 2004 a forum on mental health of older adults was held. A key outcome from this forum was the need to respond to social isolation, providing meaningful involvement in the community. Members of the forum believed that community involvement and meaningful activity had a significant role in avoiding depression associated with the losses experienced in the ageing process.

In 2005, the Positive Ageing Taskforce undertook a study into the migration and return migration of older people in the Southern Fleurieu. In relation to the population of retirement migrants, this study reported:

> "There is a large and distinct cohort of our older population who migrated to the Southern Fleurieu in their retirement. While it is not advisable to generalize, this study has suggested this cohort to be characterized by reduced local networks (membership of clubs etc) and family support, continued mobility and less confidence in their ability to be cared for within the region."
>
> "The Southern Fleurieu offers a country lifestyle, with an increasing supply of moderately affordable housing relatively close to metropolitan Adelaide. We can expect to see the area continue to attract a migrant retiring population. It might be assumed that these individuals will have access to less support from informal sources (friends, neighbors, family) as a result of their limited length of residency and connection with the local community."
>
> "Social isolation (and the need to facilitate social connection) and a greater dependence on low level support services sooner in the ageing process is likely to result from the increased mobility, decreased social connectivity, reduced informal and family supports and possibly limited financial capacity and available options for this population."

Four factors set the scene for our approach to this study.

1. The Positive Ageing Taskforce has a long history of connection with the Better Practice Project. This project supports the development and implementation of service practices that enhance the citizenship, roles and life strengths of vulnerable people. The Project is HACC funded and provides support, information, training and resource development and is also involved in demonstration projects in partnership with a range of agencies locally and interstate.

2. The mid term review of the 10 year plan for aged services in the Southern Fleurieu Peninsula identified a key focus for the taskforce on primary health, prevention and promotion over the next 5 years.

3. A study undertaken by the City of Victor Harbor in 2005 identified significant continued growth in the older population such that:

   > "…at this point in time it would appear that ABS projections are considerably underestimating the expected population for the City of Victor Harbor over the next two decades, and that Council planning for future social infrastructure should consider locally derived population projections….. Over 32.4% of the population will be aged 65+ by 2007 and this will rise to over 40% by 2022…. Over 55% of the population will be aged 55+ by 2022."

   The report also looked at Alexandrina Coastal and Yankalilla areas, reporting that similar growth rates can be expected for the City of Victor Harbor and Alexandrina Council with the projected growth rates for the District Council of Yankalilla being significantly lower. All three councils will experience a gradual ageing of their population. While the City of Victor Harbor is projected to consistently have a greater percentage of its population over the age of 65+ than Alexandrina or Yankalilla, all areas will consistently have a greater percentage of older residents than the state as a whole.

4. In 2003 Alexandrina Centre for Positive Ageing discovered that the steady and significant increase in the older population was creating a demand for their services & programs (centre based social programs) that could not continue to be met by existing human, financial & spatial resources.

   In early 2004 staff undertook a review of services and decided that a number of potential consumers could be integrated directly back into the community. Participation of these individuals in the supported social environment of ACPA risked increasing dependency and was an unnecessary use of limited resources. On the other hand community based recreation could increase independence, offering a role of participant rather than recipient and a much wider array of opportunities.

   ACPA enlisted peer support from the Better Practice Project, to assist with drafting a conceptual program to meet social and recreational needs using community resources rather than services. By December 2004 ACPA had developed and received funding for the Community Connect Program that today assists individuals to access social and recreational opportunities available in the community.

In this context the Taskforce identified the following factors as being important in their approach to social isolation.

- A need to minimize intervention and avoid over-servicing in order to maximize independence.
- A need to allocate resources wisely and approach service responses in a manner that will be sustainable given future growth.

- A need to address both prevention and treatment

It became apparent that a response to Social Isolation needed to be considered as a whole or continuum, as a framework rather than as a specific service or a group of loosely related services.

Limitations of the study

- By nature of social isolation, we must assume that we are not aware of many isolated people.
- Also due to the nature of social isolation, this project decided that service providers and community representatives would provide greater access and insight into isolation than might be achieved through attempts to consult directly with isolated people.
- Estimates of the prevalence and incidence of social isolation are limited to the observations and assessments of individuals based on a broad definition of social isolation and available research.

Definitions

Population health is an approach to health that aims to improve the health of an entire population. One major step in achieving this aim is to reduce health inequities among population groups. Population health seeks to step beyond the individual-level focus of mainstream medicine and public health by addressing a broad range of factors that impact health on a population-level, such as environment, social structure, resource distribution, etc. An important theme in population health is importance of social determinants of health and the relatively minor impact that medicine and healthcare have on improving health overall. (http://www.answers.com)

From a population health perspective, health has been defined not simply as a state free from disease but as "the capacity of people to adapt to, respond to, or control life's challenges and changes" (Frankish et al., 1996).

Context

Defining the problem

What is social isolation

The literature review conducted as part of this study (Appendix 1) provided a number of definitions for social isolation. These can perhaps be summarised by considering the objective and subjective measures of both social and emotional isolation. In doing so we define social isolation as

- A low level of involvement in community life, particularly where the older person perceives this level of involvement as inadequate.
- A lack of relationships with other people, particularly where this is reflected in the older persons feeling of loneliness or dissatisfaction with lack of meaningful interpersonal contact.

In developing this framework consultation was undertaken with service providers and community representatives. Those surveyed often commented that while they perceived another individual to be isolated, that this perception was not shared by the individual themselves. Often the individual themselves did not feel that their level of social contact was inadequate or that they lacked meaningful relationships.

This reflects, what appears to be a regular incongruence between the objective and subjective measures of social isolation and raises several other questions.

1. If the individual is not dissatisfied with their social participation does this mean that they are not isolated?
2. Do the health issues identified in the literature review as resulting from social isolation exist in those who are objectively and subjectively isolated or just those who are objectively isolated?
3. Is it inappropriate to respond to social isolation where it is not perceived by the individual to be a problem? The Practice Review conducted as part of this study (Appendix 2) identified that some service providers use practical support for people as a means of opening up opportunities for social contact (in circumstances where an individual may not be accepting of a need for greater social contact).
4. Is this incongruence a result of the service provider's narrow view of what it means to participate in the community or have meaningful relationships? If Mrs. Jones lives alone, rarely sees other people and has no family, but knits rugs for homeless children – is she isolated. Perhaps Mrs. Jones feels that by knitting rugs she is contributing and participating in a very meaningful way and perhaps she feels like she has a relationship with the organisation she sends her rugs to and the people she helps?

Why address Social Isolation?

Social isolation has been linked with suicide, participation in fewer health promoting activities, engaging in more health compromising activities, reduced likelihood of timely access to health care, increased likelihood of admission to residential care, dementia,

general poor health, increased incidence of heart disease, psychological distress and increased affect of socio-economic disadvantage (Appendix 1 - Literature Review).

What is social participation?

More widely understood concepts of social participation include involvement in activities such as volunteering, sport, clubs etc. as well as the interaction with friends and family. However can we broaden our understanding of social participation using the concepts of involvement with community and presence of relationships, from the definition of social isolation?

In this sense Social Participation does not necessarily mean meeting with a group of people. An individual might be involved in a number of groups, although, not gaining any meaningful relationships from this involvement, still feels lonely and therefore is still isolated.

It is also worth considering whether social participation must involve direct contact with other individuals? Can reading a newspaper provide a sense of participation through knowing what is occurring in ones community? Is keeping your garden pretty having a relationship with the community through your role in contributing to it's pleasant appearance? Can social participation be simply having a role in something beyond yourself such as knitting rugs for Russian orphans, creating an artwork or having a pen pal? Could looking after a pet constitute having a relationship?

Perhaps the most important question is could these things achieve a similar health and wellbeing outcome to more traditional concepts of social participation? In fact studies have shown that having a pet can help people live healthier, happier lives. Owning a pet has been credited with helping to lower a person's heart rate and blood pressure and for reducing stress, decreasing anxiety and depression, increasing self esteem and reducing loneliness. Many pet owners believe that a pet can also be a great cure for loneliness. And where humans sometimes fail, dogs and cats have been reported to be successful in cutting through the barriers that isolate people with physical and/or emotional disabilities.

A definition of social participation is crucial to considering the reason for and ways of responding to social isolation. In responding to social isolation the intent is to improve wellbeing. While studies have shown social isolation to affect health and wellbeing they have not been so clear as to why. However it is generally assumed that social isolation improves health and wellbeing by:

- providing purpose and value which then impacts on stress and healthy behaviours
- encouraging activity
- providing connections with the community that improve timely and appropriate access to services

If then, these less traditional concepts of social participation provide some, if not all, of these benefits, should they not be added to our understanding of what constitutes social participation? In fact this broader definition may be very helpful in adding to the breadth of opportunities to respond to social isolation.

Perhaps we should consider social participation as a continuum in which the characteristics that define participation and the point defining isolation are different for every individual and are defined by their nature, circumstances and perceptions.

Public Policy Responses

State and federal policy documents certainly concur with the importance of social participation in health and independence of older people. However while these documents support a significant focus on the issue of social isolation, it does not seem to be equally strongly supported by resourcing and innovation in the delivery of care.

Integrated Planning

Policy documents support responses such as increased volunteering, longer workforce participation, improving transport, increasing recreational opportunities. These responses require integrated planning approaches which, experience has shown, are notoriously difficult to achieve. While the outcomes of such policies may not be apparent it is also plausible that the outcomes are not there.

The opportunity however to affect these types of responses at the local level may be more likely given the collaborative relationship already present in the Southern Fleurieu Peninsula and the 'runs already on the board' in integrated planning activities. Local Government awareness of ageing and social participation in the Southern Fleurieu is admirable and there is ample opportunity to further build on the collaborative relationship between local government and the service sector to improve the consideration of ageing and participation in everything from master planning to open space strategies, infrastructure planning and economic development activities.

Social Isolation (Prevention) as a Priority?

How can you deprive Mrs. Jones of the extra two hours care per week that will help her stay out of a Nursing Home in favour of helping a bunch of people have fun at the horse races? When put that way it's not an easy question to respond to. While the arguments for prevention are sound, the answer "we *may* be preventing the admission of that 'bunch of people' to Nursing Home in 5 years time" does not seem to be enough. Government policy supports social participation as part of a wider commitment across both health and aged care to population health, primary health and a greater focus on prevention and promotion. However, like the health sector, there is a struggle (both politically and morally) with the allocation of limited resources at this end of the spectrum rather than the more publicly emotive aspects of higher level care.

Traditionally the aged care service system has placed the greatest importance on meeting the physical and health needs of individuals. In the interviews undertaken with service providers, some service providers identified that unmet basic needs made it very difficult for older people to "even think about it (social participation)". Interestingly this concept echo's "Maslow's Hierarchy of Needs", a theory in psychology that Abraham Maslow proposed in his 1943 paper A Theory of Human Motivation. The theory contends that as humans meet 'basic needs', they seek to satisfy successively 'higher needs'. Maslow grouped these needs in order beginning with Physiological, then Safety followed by Love/Belonging, Esteem and lastly Actualization

However client centred services (A Unique Life to Live) often report that clients rate social and emotional outcomes as of significantly higher importance. The local transport service will assist with transport to a physiotherapy appointment but not to a luncheon date. These priorities are generally determined by policy affected by funding criteria or limitations, not client needs or preferences.

In light of these arguments we need to consider where Social Isolation fits in local priorities. We need to understand the relative allocation of resources to various levels of care within the region and understand that while meeting individuals basic needs may be a prerequisite to social participation, each individuals 'hierarchy of needs' may also be different.

Incidence and Prevalence

As discussed later in this document, Social Isolation is difficult to identify. By their nature socially isolated individuals have little contact with the local community and therefore are not easily identified as such. However it was seen as important to our capacity to implement the proposed framework for social isolation, to have a broad understanding of the possible number of socially isolated people to whom the framework will need to respond.

A range of studies were reviewed as a part of this project. These studies (Literature Review Appendix 1) gave a fair indication that at least 10% of people aged 65 and over are socially isolated and a further 12% are at risk. This provides one basis for estimating the current prevalence of social isolation in the Southern Fleurieu Peninsula (see Table 1). Using this method it is estimated that there are currently nearly 700 isolated individuals across the Southern Fleurieu with more than 800 individuals at risk of becoming isolated. As shown in table 1, these figures could be expected to increase by around 50% in the next 15 years.

Table 1: Prevalence of Social Isolation in the Southern Fleurieu

	2005	2010	2015	2020
Alexandrina				
Population 65+	2366	2730	3219	3760
Socially Isolated	236.6	273	321.9	376
At Risk	283.92	327.6	386.28	451.2
Victor Harbor				
Population 65+	3830	4338	5017	5706
Socially Isolated	383	433.8	501.7	570.6
At Risk	459.6	520.56	602.04	684.72
Yankalilla				
Population 65+	781	908	1097	1259
Socially Isolated	78.1	90.8	109.7	125.9
At Risk	93.72	108.96	131.64	151.08
Total				
Population 65+	6977	7976	9333	10725
Socially Isolated	697.7	797.6	933.3	1072.5
At Risk	837.24	957.12	1119.96	1287

This estimate of 697 isolated individuals across the Southern Fleurieu is quite close to the 605 isolated individuals identified in consultation with community representatives and service providers (Community Representative & Service Provider Consultation – Appendix 3).

The proposed framework for Social Isolation identifies various levels of response to isolation depending on the support needs of the isolated person. To facilitate the implementation of this framework, in terms of understanding the potential demand on

different levels of response, it was important to have some estimate of the demand on each level of response.

A closer analysis of the types of participants in programs offered by the Alexandrina Centre for Positive Ageing was used to estimate the demand that a population will have on each level of response (Appendix 4: Social Participation Estimated Target Population). In 2005, 303 older people received assistance with participation in social activities through the Alexandrina Centre for Positive Ageing. 87 of these people had moderate to high social support needs. These varied from a need for encouragement to participate and/or low level physical assistance to significant personal care needs, anxiety and/or behaviours. Similar levels of service:

- in Victor Harbor would support 463 individuals of whom 141 would have moderate to high social support needs.
- in Yankalilla would support 104 individuals of whom 29 would have moderate to high social support needs.

In 2020 this would increase to 475 individuals in Alexandrina (137 with moderate to high needs), 686 in Victor Harbor (209 with moderate to high needs) and 158 in Yankalilla (46 with moderate to high needs).

What are the causes and contributors?

The Literature Review conducted as part of this study identified a range of factors contributing to social isolation. These are: health status, Sex (males being more isolated), geographic location, living alone, closeness of personal relationships, ethnic status, marital status, mental health, employment status, socio-economic resources including income, communication losses, network characteristics including neighborhood friendliness and social initiation, loss (in its many forms), being a Carer, transport difficulties and retirement migration.

Interviews with service providers and community representatives (Appendix 3) raised a number of factors contributing to social isolation. Other than the expected contributors of health, support needs and transport the following were also raised by a number of respondents:

- Respondents felt that a number of individuals that were considered socially isolated did not believe they were isolated, did not want to increase their participation or were resistant to assistance.
- A lack of connection with the community found in newcomers to the area.
- Incontinence and sensory loss as significant issues.
- Individuals who were isolated as a result of embarrassment about the physical appearance of their disability (i.e. paralysis and eating).
- Cases where social isolation resulted from an inability to meet ones basic needs for personal care. The focus on these needs then detracted from meeting any next level needs such as that for social participation.
- Individuals who were unable to participate socially due to daily living activities being entirely time and energy consuming.
- A perception that many people don't think about their retirement, they don't plan it and don't understand the implications of their retirement decisions. Some reported that "Men can lose their identity and sense of usefulness when they no longer work".
- Unclear and unsupported pathways into groups or activities can make it quite difficult for people to become involved, particularly when the individual has low confidence. While individuals may be interested in a particular activity, the group may not have defined roles for new members or may not have procedures for greeting and inducting new or potential members. Potential members then feel that they are not welcome or needed.

Other factors raised included lack of appropriate activities, Carers duties, confidence, death of a partner, information about available opportunities, financial issues, geographical isolation, and psychological issues.

Respondents generally felt that individuals who were "truly" isolated required quite intensive support to re-connect with the community. This involved responding to:

- a lack of awareness or acknowledgment in people that they have actually become isolated and how it is affecting them
- individuals acceptance of help

- the stigma associated with being lonely
- grief
- poor social skills
- behavioural problems
- hearing impairment
- finding relevant, appropriate, challenging or intellectually stimulating activities or interests
- depression
- a need for someone to lean on and to motivate.

Acceptance

Individuals may not consider or accept that they are isolated or may not be comfortable accepting, asking for or admitting they need help (Literature Review, Service Provider and Community Representative Consultation). There are five factors that could be seen to contribute to this situation. They are:

- Awareness: This includes an awareness of their own feelings and what is causing them. It is also an awareness of the impact of their isolation on their health and on their ability to remain living in their own home.
- Repression: Accepting and admitting that you are lonely may bring with it awareness that "family don't want to spend time with you" or "people don't want to be friends with you".
- Underlying factors: These might include a lack of confidence or self worth, they may relate to embarrassment about physical appearance or disability which is seen to be socially unacceptable.
- Social Acceptance or Stigma: Few people would find it easy to admit they are lonely. Loneliness is to be pitied or may be judged by attached assumptions about why people don't have friends.
- Character: It may be that an individual has never been a "social being". Some people need little sense of participation to be happy or may achieve a sense of participation, satisfaction and self worth from activities we don't usually recognise as social participation such as watching the news, Oprah or reading a book or newspaper.

Promoting Social Connection, A framework approach

The proposed framework is based upon:

1. A common way of working with individuals to enable them to enhance their social connections in ways that appreciate their needs, goals, skills and abilities, opportunities, inhibitors, social history and character.
2. A planned and coordinated structure of community resources, services and supports to ensure that all aspects of social isolation are covered by a community, encouraging:
    - A whole of Community approach to prevention,
    - A service system that values and supports social involvement
    - Prevention for at risk individuals, and
    - Individualised support with minimum possible intervention
3. Implementation according to common principles.

A Common Way of Working with Individuals

The following approach is suggested as identified in literature, best practice and consultation. In this approach all support will be based on the individual, their character, goals, strengths, skills and needs. The aim of support will be to assist the individual to achieve their goals, enhancing their citizenship, roles and life strengths.

A key resource for this approach is the April 2000 report of the Better Practice Project – "A Unique Life To Live" (Aged Care and Housing Group).

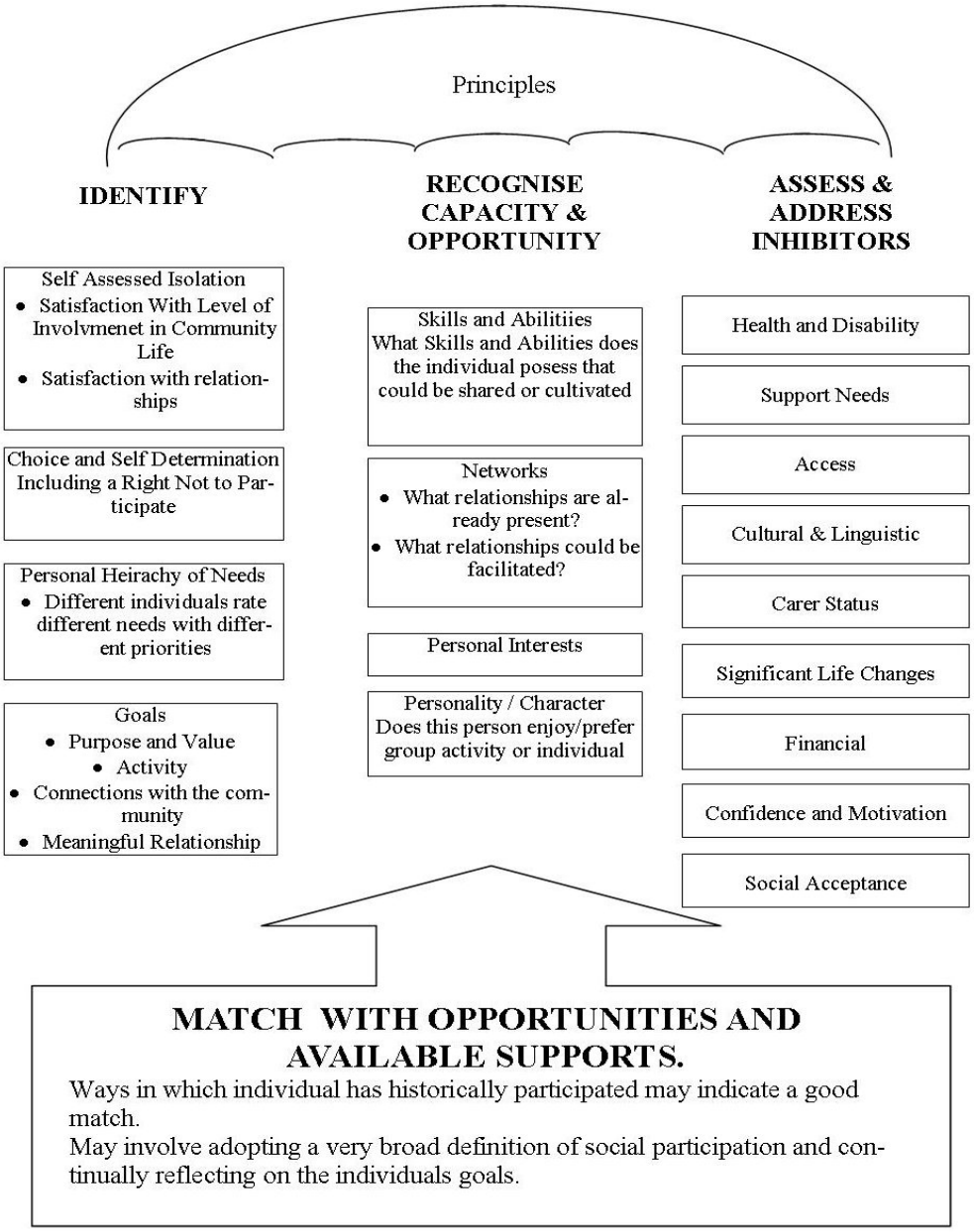
This approach addresses:

- Identification of need. It recognises that for each individual, social participation:
  - Is prioritised differently
  - achieves a different purpose or goal

  As such it accepts that isolation can only truly be identified by the individual themselves and and that individuals have a right not to participate.
- Recognition of capacity and opportunity. It recognises the skills, abilities, networks and relationships of individuals as the greatest resource in meeting their needs for social participation
- Assessment of inhibitors. This involves identifying and addressing the range of factors that may prevent an individual from participating successfully.
- Matching needs and opportunities. This entails matching the skills, abilities, character, interests, networks and relationships of the individual to identify opportunities for social connection within a broad definition of social participation.
- Principles. The approach is based around principles of minimal intervention, sustainability and community.

Chart 1: Social Connectivity Framework

Individualised Approach



Identification of need

The identification of at risk or isolated individuals must consider

Self Assessed Isolation or Risk

Earlier discussion around what social participation is, arrives at the conclusion that we should consider social participation as a continuum in which the characteristics that define participation and the point defining isolation are different for every individual and are defined by their nature, circumstances and perceptions.

This conclusion then assumes that only the individual is capable of determining their own level of satisfaction with their community life and with their relationships.

Choice and Self Determination

A trap that is easy for well-meaning people to fall into is to assume that all older people have a desire to participate in community life and activities. This is not always the case and people who do not participate do not necessarily feel socially isolated.

Personal Hierarchy of Needs

With limited resources the need for social connectivity can be lost among needs for assistance with basic daily living. Evaluation of public policy, current practice and literature raised the argument that while meeting individuals basic needs may be a prerequisite to social participation, each individuals 'hierarchy of needs' may be different. An individuals prioritisation of social participation with respect to other needs may not match with our own, but must be recognised within an individualised approach.

Goals

For the purposes of this project, social connectivity was described in terms of a range of goals or outcomes. These goals may include:

- Achieving purpose and value, a sense of satisfaction.
- Encouraging activity ('use it or lose it')
- Providing connections with the community that improve timely and appropriate access to services .
- Developing meaningful (two way) relationships.

These goals may be interrelated or exclusive and different responses might be needed to assist individuals to achieve different goals.

- A response to social isolation must acknowledge that participation in activities does not, alone, prevent an individual from being 'lonely' and from the adverse consequences of isolation. Rather, participation in activities is just one of many means to the development of satisfying relationships, a sense of connection and purpose in life.
- Similarly the presence of a relationship does not imply that the relationship is meaningful or satisfying and that it will prevent an individual from being lonely.
- Individuals may gain a greater sense of satisfaction and self worth from offering a relationship (either with an individual or with the community) some benefit or value

by providing a service rather than receiving one. We should consider volunteering very broadly. A range of activities of a volunteering nature should be available to all people. Depending on ability, this might involve knitting rugs for Russian orphans, making toys or propagating plants for sale to raise money. Programs that offer a continuum between the role of volunteer and recipient have been particularly successful (Appendix 2 – Practice Review). While some participants in these programs receive quite a bit of support they also feel like they are providing a service to the community.

Recognise Capacity, Opportunity, Character, Culture and History

It is particularly important for individuals to identify and recognise their strengths, skills and abilities and to identify how to share or cultivate these. This will enable individuals to achieve personal growth a sense purpose, value and achievement.

Building on existing networks and relationships will generally provide much better outcomes. Assisting the individual to identify those networks and relationships they have in their life (no matter how limited or neglected) is an important step in assisting the individual to enhance their social connections.

Building on the genuine interests of the individual will facilitate motivation and offer a bonding point of commonality with others.

An understanding of the individuals history, culture, personality, preferences and character will assist in recognising what the individual has to offer.

Assess and Address Inhibitors

Many factors have been identified as impacting on an individuals ability to be involved in community life or develop and maintain relationships. These include, but are not limited to:

- Poor health, poor mobility, sensory loss, cognitive deficits and other disabilities.
- Basic support needs such as assistance with personal care that affect an individuals ability to prepare for or participate socially.
- Access issues including transport, geographical isolation, accessibility of the built environment and access to information about available social opportunities.
- Concerns with regard to social acceptance as a result of disability, including reduced mental capacity, disfigurement or other aesthetic issues and dependence.
- Special cultural or language needs
- Financial limitations or considerations
- Significant life changes, grief and loss
- Being a Carer
- Poor self confidence, motivation or social skills.

These factors will be unique to each individual. The service provider will need to allow time and to form a relationship of trust with the individual in order to develop a full understanding of the factors affecting the individuals capacity to make social connections and how they may be addressed.

Matching

Successful social connections will be facilitated as a result of a good match between the individuals goals; their capacity and opportunity, character and culture and their special needs (identified as inhibitors).

Ways in which the individual has historically participated socially will generally indicate a good fit between their interests, character, skills and opportunities the community has to offer.

This matching process may involve adopting a very broad definition of social participation and continually reflecting on the individuals goals.

Principles

At a broad level the concept of minimal intervention forms an overarching principle behind this framework. At an individual level it is crucial to maximising social outcomes. Independence provides a greater sense of achievement. While independence means something different for each individual, depending on their needs and abilities, it is important that individuals are encouraged to be as independent as they can. The minimum possible level of intervention should be considered to achieve the individuals goals.

A Planned and Coordinated Structure of Services and Supports

In considering services and supports this framework aims to ensure that the community responds to all aspects of social isolation. In essence the framework encourages:

1. A Population Health Approach – Prevention & Community Capacity . This involves a whole of Community approach to prevention. A community that:
   - Physically and socially encourages and facilitates engagement through direct and indirect relationships, and participation in social activities.
   - Facilitates access to social opportunities including appropriate venues, transport and friendly communities.
   - Offers a diverse range of opportunities to participate, catering for different interests, needs and abilities, groups and individuals, direct and indirect relationships.
   - Is aware of the benefits of social participation

2. Population Health – Intervention. This involves a service system that values and supports social involvement. A service system that;
   - Recognises, nurtures and utilizes the skills and abilities, knowledge, experience and personalities of service recipients.
   - Provides adequate basic services that enable individuals to participate socially, communicate and contribute to relationships.
   - Allows individuals to prioritise their needs, enabling them to use the limited resources available to them in the most appropriate way.

Identification of at risk and socially isolated individuals.

3. Prevention for at risk individuals. A service system that
   - Quickly identifies at risk persons or groups
   - Is aware of and responds to causes and barriers to promote social connectivity at the population health and individual level
   - Provides a range of supports to respond to at risk or isolated individuals, favouring minimal intervention, self help and independence.

4. Individualised support with social participation
   ⇒ A range of supports to enable individuals to be assisted to participate socially in the community and to create and maintain relationships
      - Directly (between the individual and another individual)
      - indirectly (through a role which implies a role in or relationship with the community)
      - through community participation (as a means to developing relationships with individuals and with the community)

   with the appropriate (minimal) level of support.

The Structure of Services and Supports to promote Social Connectivity has been described along 2 overlapping continuums. These are:

- Responding *collectively* (Population Health approach) *or individually* to the factors that contribute to isolation. Collective responses will have a whole of community outcome. Individual responses involve working with affected persons or groups providing particular responses to these individuals.
- *Preventing or intervening* in social isolation. Preventative responses involve ensuring that social participation is maintained. Interventional responses involve responding to the needs of individuals who are to some degree socially isolated.

Chart 2: Social Connectivity Framework

A Planned and Coordinated System of Services and Supports

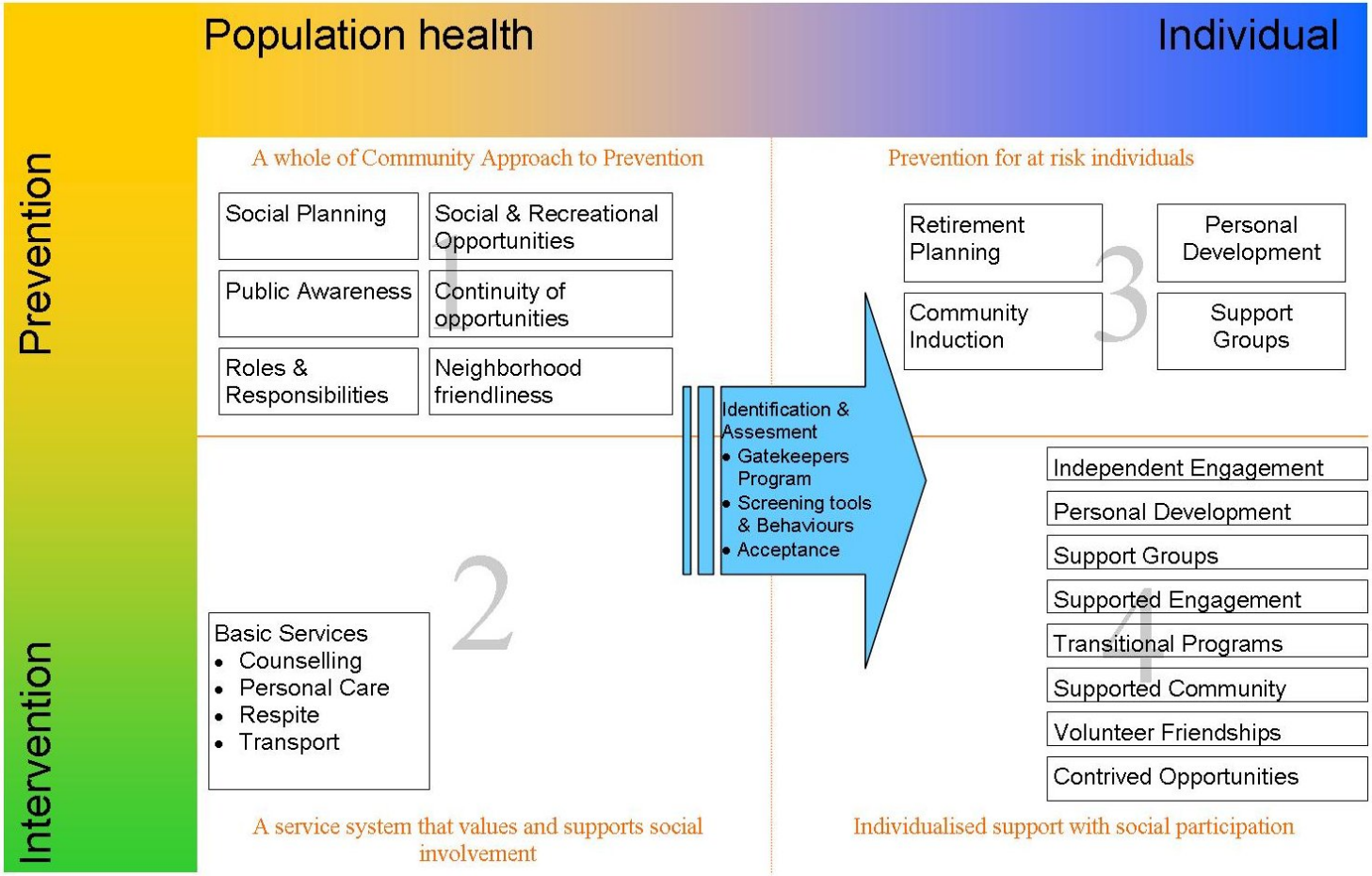
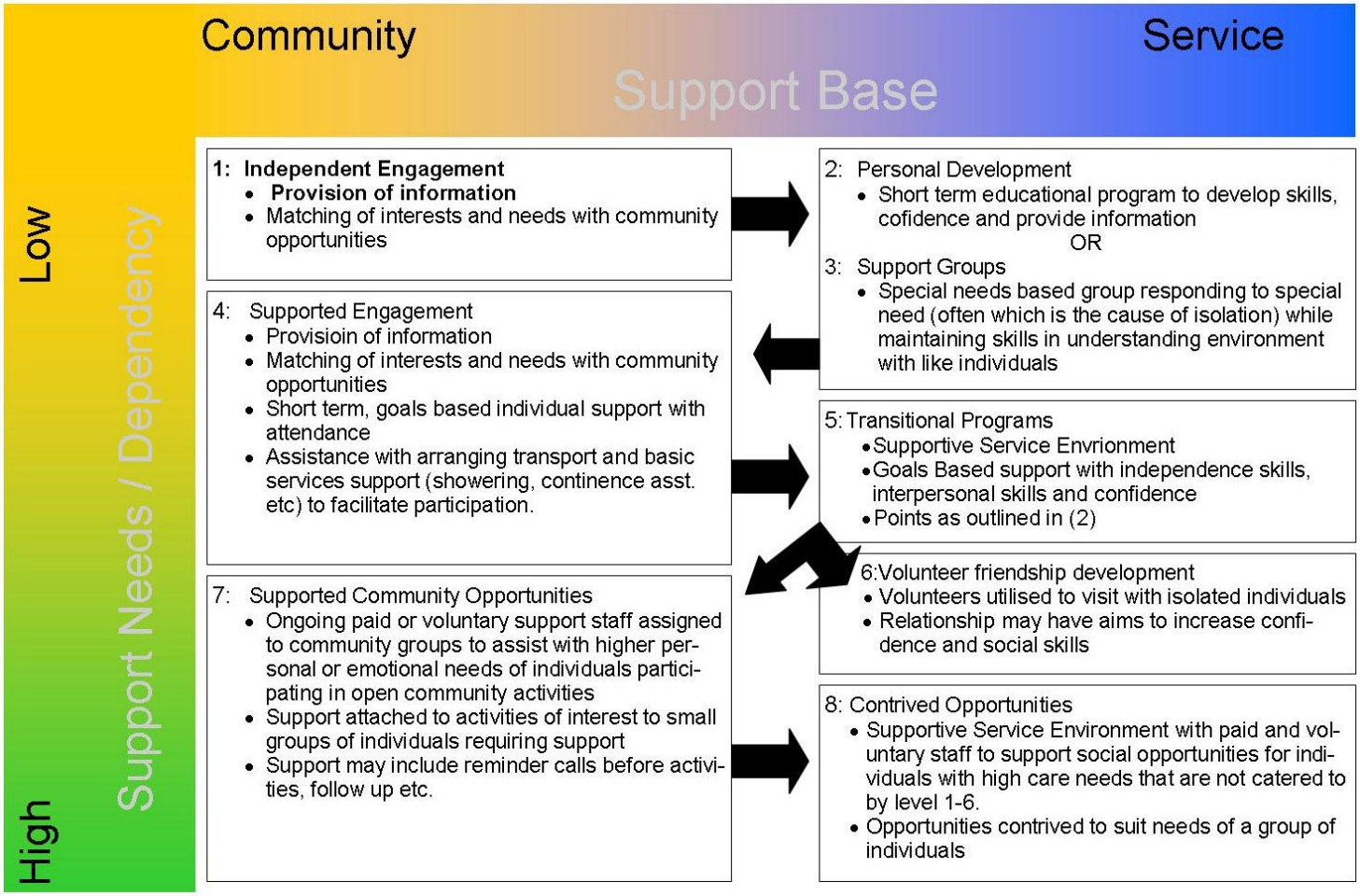


Chart 3: Social Connectivity Framework
A Planned and Coordinated System of Services and Supports Section 4—Individualised Support



A Population Health Approach – Prevention & Community Capacity

Reviews of practice & literature and consultations undertaken as part of this study have indicated a number of possible responses within a population health approach.

Social Planning

For some time the Southern Fleurieu Positive Ageing Taskforce has addressed issues of social planning in the region. This activity has promoted the suitable location and design of aged housing and access issues including footpaths, road crossings, access to shops, bus access, design of public spaces (signage, visibility), parking design and access, age appropriate recreation and open spaces, timely and appropriate public infrastructure, land use planning to facilitate access, transport and more.

These will all continue to have a significant impact on the independence of the older population, allowing older people to remain both physically active and active in their local communities and reducing costs associated with health and aged care. As such a holistic or framework approach to social isolation must include working across sectors to ensure that the independence of older people is considered in designing communities.

Public awareness (Education and Promotion)

There is an opportunity to raise community awareness of the value of social connectivity, its impact on health and wellbeing, opportunities for social participation and support for those who are isolated. Community awareness (conducted in the right way) could also assist in breaking down the stigma of loneliness and isolation, encouraging greater acceptance of help by those who are lonely or isolated.

Positive stereotyping of older people in our community and an increased awareness of the important contributions of older people will improve community attitudes towards ongoing roles for older people and increase the expectation of continued participation.

Roles and Responsibilities

Social participation has not necessarily been something sought by people but rather a side effect or even obligation arising from other obligatory aspects of life such as school, work and family responsibilities. As we get older, our children grow up and we retire, these roles and responsibilities can significantly diminish. Even more so when we move away from the local community which may reduce roles as grandparents or carers of our neighbours and friends. A community development approach to social isolation in older age should consider avenues for maintaining or reintroducing these roles and responsibilities…. Examples may include:

- Improving access to opportunities for flexible workforce participation
- Ensuring a range of volunteering opportunities that are broadly promoted, easily accessed, cater to a wide range of skills and physical capabilities and well supported.
- Recognising, valuing and supporting grand parenting. This might include ways to support long distance grandparents.

- Encouraging schools to seek volunteers from the older community to support learning assistance programs.

Social and Recreational Opportunities

By the nature of the community groups we spoke with, (Appendix 3) less isolation was often reported as a direct result of the individuals association with, and support from, these community groups.

Membership of a group or club can provide an ongoing 'supply' of new friends as the group naturally loses and gains members. As an individual gets older they will lose family members and friends from around them. Those who have relied solely on a core group of close friends and family will find themselves more at risk of isolation than those who are members of groups with replenishing memberships.

The Survey of community representatives and service providers identified that community groups currently offer activities from craft and games to conversation groups, meals, support groups and religious activities. Over the selection of 16 community groups surveyed there were more than 27 different social opportunities with a total of 765 individuals involved (Appendix 3). Community groups therefore are a critical component of the social isolation framework and must be encouraged and supported.

A lack of appropriate activities was identified by respondents to surveys or interviews of service providers and community representatives undertaken in this project (Appendix 3). We must be continually mindful of the need to provide a range of opportunities for social participation that meet the diverse interests and needs of the population. These interests and needs will continue to change over time, requiring the community's social resources to continue to develop in response to this change.

Churches

A supportive environment was identified by service providers and community representatives as critical in preventing and responding to isolation. It became obvious from this survey how much churches contribute to the range of 'supported' or 'supportive' social opportunities in the community. The principles and philosophies behind churches support the provision of more inclusive and nurturing social environments which are open to individuals other than their own "members". It is these groups that are particularly relevant to marginalised individuals who are at risk of isolation. As such the social isolation framework must recognise and address the vital role that churches play.

Lifelong Membership

Groups which are characterised by lifelong membership are generally not dependent on an individual's physical capacity (sports), circumstances (school) etc and may be associated with a significant cultural bond with which comes a sense of responsibility for its members.

Such groups include RSL, CWA and Churches. Even small rural townships and families can show the same characteristics of non-specific and lifelong membership, cultural bonds and a sense of responsibility for its members.

Membership of all these groups are changing. Groups are reporting declining and ageing memberships. Small towns reported a change in the nature of their community with more short term residents and families are more likely to be fragmented and geographically distanced. A framework for responding to social isolation must consider the affect of such changes on the future capacity of the community to support social participation.

Changing social and recreational needs

The recent study on current and future social and recreational needs of older people in the Southern Fleurieu Peninsula (Active Ageing 2006) reviewed a range of literature looking at trends in social and recreational preferences of older people. The literature indicated that older people will be seeking greater variety in social and recreational activities from communities. Chosen pursuits will be more suited to complex and flexible lifestyles and will be integrated with travel and tourism, natural location, intellectual stimulation and learning and good food and wine.

Continuum of opportunities

There is potential to prevent social isolation through identifying and supporting opportunities to create a continuum of social involvement at points in the existing structures where individuals are at-risk of losing social connection with the community. This risk may arise as a result of a change in health status and physical capacity or moving. A continuum may be developed in a variety of ways, some of which are:

- Diversification – increase the range of activities offered by a particular club. Examples include:
  - The local golf club creates a pool competition to diversify their activities so that members whose health may prevent them from playing golf can still participate in other club activities.
- Non Playing Roles – identify both playing and non playing roles within sporting clubs and take a broad view of who and how these roles might be filled. For example:
  - The local football club, finding it difficult to fill the positions of secretary and timekeeper advertise these positions at the local retirement village seeking interest from individuals who might have experience with other football clubs but might have no previous association with this club.
- Social Membership – encouraging people to be involved in the social aspects of the club. For example:
  - The local bowling club offers a social membership which enables people to attend the club for the range of functions, when the bar is open or for Friday night dinners. Members receive a copy of the newsletter, are able to be on the committee and have voting rights.
- Dual membership: - membership with one club may provide some playing rights or concessions at another club

- The local golf club offers dual membership with Thaxted Park Golf Course where a lot of local people played before they retired to the Southern Fleurieu.

Neighborhood friendliness and social initiation

Hawthorne and Griffith (Appendix 1 – Literature Review) identified Neighborhood friendliness as a barrier to social participation. Interviews with service providers and community representatives identified difficulties with 'how one becomes involved with a group of interest' and referred to difficulties with integrating individuals into community activities when they could not be sure of how supportive or friendly the group would be. While information is available on contact names and numbers for a range of groups, often these groups do not have processes for new membership, leaving potential members floundering, feeling unwelcome or unsure of themselves.

Organizations and groups should be encouraged to be aware of and able to communicate the types of roles and activities they offer, to have processes for how people can become a member, not only on paper but to become "initiated" into the group. This could include having a buddy system for new members or simply that an existing member has the role of welcoming and introducing new members. Where it is a community centre or group that have varied activities or roles it may involve an induction, guided tour or a handbook.

Interviews with community representatives, many of whom had a position within a community group, identified issues with waning membership and ongoing viability. In this environment community groups may be open to assistance in developing processes for new membership through a community development approach.

Population Health - Intervention

Basic Services

Individuals with care needs have a range of basic needs that, if unmet will prevent their participation in the community. This can include:

- Management or stability of chronic disease and it's symptoms
- Continence management
- Basic personal care such as showering
- Provision of mobility aids

Communities must ensure the availability of adequate basic services for all individuals who need them. These basic supports must be coordinated with the social needs of individuals such as:

- Providing information, mechanisms and promoting confidence in managing symptoms of chronic disease in different settings.
- Providing continence aids that are discreet
- Ensuring the timing of personal care support enables individuals to be ready in time for social outings
- Ensuring that mobility aids suit the needs of individuals within the home as well as within other social settings.

In doing this, communities will encourage community participation and realize the associated benefits.

When transport is not available as part of public infrastructure it becomes a necessity as a basic service. The Southern Fleurieu does not have a public transport service, rather transport options are personal, private industry or a community service. 72% of respondents to the survey undertaken as part of Background Paper 3 identified Transport as a key barrier to social participation. This was the single greatest barrier to social participation identified in this study.

Identification of At Risk and Socially Isolated Individuals

Moving from a population health approach to responding to individual needs requires the identification of at risk and socially isolated individuals. Social Isolation, by its very nature, can be very difficult to identify. One should not assume that all older people who are prone to social isolation have the skills to pick up the phone to ask for help and respond to information posted to them.

Gatekeepers Program

Most older people are in contact with their GP, the Pharmacist or hairdresser, even those who are isolated. Such individuals have the opportunity to identify people at risk of social isolation and refer them to appropriate resources.

The implementation of a 'gatekeepers' program based on a model that originated in Washington by the Spokane Community Mental Health Centre is one way of harnessing this opportunity. Private allied health services (pharmacists, physiotherapists & podiatrists) and other members of the community could be enlisted to identify older adults living alone and possibly at risk of isolation. Health events or life changes such as bereavement may bring them into contact with key people who are in a position to identify their needs and link them with support groups and other community resources that might reduce their social isolation

Screening tools & Behaviours

Existing service providers have scope to improve the detection of social isolation through incorporating screening tools in a holistic approach to general assessments. Two tools were identified in the Literature Review undertaken as part of this study (Appendix 1). These are the UCLA Loneliness Scale and the Friendship scale. Both are simple proven tools, the UCLA Loneliness Scale consists of 20 questions and the Friendship scale of 6 questions.

Assessment

In the proposed framework for Social Isolation, an appropriate assessment focused on the skills and abilities of the individual will be very necessary in understanding what a satisfactory level and appropriate form of community involvement is to them, and assisting them to achieve it. The literature review undertaken as part of this study outlines an example of a tool that assists with this process. The "Personal Planning Tool" (Appendix 1) provides a mechanism for:

- understanding the person, their current and past networks and roles and roles, strengths, disabilities and their impact, losses,
- Considering and assessing options for responding to the individuals needs.
- Identifying and assessing how and by who the support or assistance could be provided

Accepting Help

Dominating the barriers identified by the service provider and community representative consultation in this project was the issue of individuals who do not consider or accept that they are isolated or may not be comfortable accepting or admitting they need help.

Addressing community attitudes is one way of improving acceptance of help by those who are isolated. In addition, adequate social participation (as the opposite of isolation) needs to be understood by service providers as having different meaning and intensity for everyone. It can mean being involved, feeling useful, having an interest, being appreciated by someone or something, being a part of something and many other things for different people.

The way social isolation is broached with individuals and the way social participation is described may influence acceptance.

- If social isolation is approached in the form of casual, well timed and individually tailored offers of relevant opportunities it may be less likely to be accepted as accepting a social opportunity rather than admitting to being socially isolated.
- Opportunities for social participation can be promoted as opportunities, fulfilment of a responsibility, offering something to others etc rather than being helped and as such may be more likely to be seen to be relevant.

Prevention for at risk individuals

Retirement Planning

Consultation with service providers and community representatives raised issues about the impact of retirement on individuals and poor retirement planning (Appendix 3 Community Representative and Service Provider Consultation). This particular at risk population could be targeted for educational programs aimed at promoting retirement planning. These programs might include planning for some level of workforce participation, volunteering or other social roles as well as looking at the implications of decisions such as retirement migration and the importance of maintaining or building social networks with the destination community.

Community Induction

The Southern Fleurieu Peninsula has a unique demographic including large numbers of older people who are relatively new to the area, having migrated in their retirement. This group has been identified as being more at risk of social isolation resulting from the loss of social networks through both retirement and moving, particularly if the move is followed by other changes to health, socio-economic or marital status (Appendix 1 Literature Review). Responses might include looking at the use of new residents packs or the conduct of induction programs, where new residents can participate in information sessions that introduce them to their local community, what it has to offer and what they might have to offer it.

Personal Development

Personal development can fit within either the prevention or service responses to social isolation. With respect to prevention, personal development is a broader concept of encouraging individuals to continue to challenge and reinvent themselves, to change and adapt to changing circumstances and environments. These skills will provide older people who are more resilient to the myriad of changes (health, loss) which often result in isolation.

Personal Development may focus on promoting:

- "Passion". Challenging people to think beyond the social stereotype of the older person, providing peer role models who are passionate and creative about their retirement pastimes….they may have taken up writing childrens books, have learned to belly dance, become involved in politics or volunteer with remote aboriginal communities. Passion, it seems can enable people to overcome what would otherwise be barriers to ongoing social participation.

Or

- 'Resilience". Encouraging people to adapt to their changing circumstances and see this adaptation as a challenge rather than a loss. Again peer role models can show how they have taken retirement or disability and used it to reinvent themselves or start new challenges in their life.

Support Groups (Including Carer Support)

Support Groups may prevent or intervene in social isolation. Support groups provide both a means of dealing with an issue which itself may be (or may become) a barrier to participation as well as an interest in common to encourage social interaction. Support groups are particularly relevant to individuals who are experiencing major life changes such as taking on a caring role, a major health event or loss of a partner. These people are also more likely to be at risk of isolation.

Often such individuals find it hard to give themselves permission to participate socially due to guilt or because they are consumed with the event they are experiencing. Others are concerned that they will not be understood (grief, caring) or that their appearance (i.e. paralysis) will not be acceptable.

Support groups provide an opportunity to meet with others in like situations. In this environment people may feel that they are more likely to be understood or accepted. The support group enables the person to maintain their focus on the major event in their life while maintaining or regaining social involvement confidence and skills.

Individualised support with social participation

Independent Engagement

Independent Engagement aims to identify and respond to individuals who are at risk of social isolation or who have been isolated for a short time generally as a result of a specific event such as a health incident or loss of a partner. This kind of early intervention may involve providing assistance with:

- Assisting individuals to identify existing relationships and ways to enhance them
- Assisting individuals to identify potential relationships and strategies to develop them
- information about social opportunities
- information about basic services and resources such as transport assistance, support groups or counseling
- Counseling with respect to matching individuals needs and interests with available opportunities.

Early intervention may be supported by self help or personal development opportunities. Such programs may focus on building social skills, confidence, motivation and awareness of social opportunities and the importance of social participation in health and independence. Similarly individuals may benefit from Support Groups which allow the special need (which may be causing the individual to be at risk of isolation) to be addressed while maintaining social interaction in a supportive, understanding and accepting environment.

Supported Engagement

Supported engagement involves the provision of a range of initial supports with the end goal being integration into community based opportunities. This might include:

- Identifying and providing support to maintain or enhance existing relationships
- Identifying opportunities and providing support to develop new relationships
- Provision of information about available opportunities as well as other factors which may affect capacity for participation such as costs, transport, accessibility etc.
- Assistance with matching interests as well as needs (supportive environments, disability access, costs) with community opportunities. This might include some level of counselling.
- Assistance with access to basic support services in order to enable the individual to focus on social needs or simply to participate. This might include services such as showering and dressing assistance to get ready for an outing, mobility or continence aids, transport or counseling for grief or loss.
- Education with respect to self management and the importance of social participation in health and independence.

- Short term, goals based individual support. This might involve the provision of paid or voluntary assistance for a short term based on goals such as:
    - Gaining confidence with in the ability to independently manage health and physical needs in the social environment.
    - Making social connections with other individuals within the group.
    - Gaining confidence in social interaction.

Transitional programs

Transitional Programs generally involve the provision of contrived social interactions controlled by service providers. These social interactions are intended to be time limited with individualised goals that may include development of independence skills, interpersonal skills, confidence and ultimately integration into community activities.

Review of current practice (Appendix 2) identified a range of transitional programs. Some were based on the development of relationships between an individual and a volunteer with the purpose being for the volunteer to provide a dual role of friendship and integration support. Other programs were based on contrived group social activities controlled by a service provider in which individual participants develop skills towards their own defined goals.

These programs differ from friendly visiting / relationship building programs and contrived opportunities in that they are intended to be time limited and transitional in nature, providing the groundwork for social integration. However the short term nature of the programs was not always observed to be successfully achieved. The difficulties were observed to be in the development of relationships between volunteer and individual or between individuals participating in a group program. Once relationships were developed, service providers found it difficult to withdraw the service or activity that supported this relationship, even if the aim of integration with community opportunities had been achieved. In this instance the service then became a longer term service and hence able to respond to a more limited number of people.

Transitional programs need to have very clear guidelines, parameters and goals. The development of relationships in transitional programs may be more appropriately focused on relationships between participants in a group than between participants and volunteers. Transitional programs need to include a very specific idea of the 'next step' for individual participants, this step also considering the possibility that meaningful relationships might have developed between its members.

Social opportunities or education offered by service providers should, wherever possible be conducted in community environments, surrounded by other social opportunities. Such environments will contribute further to potential social integration by improving awareness, familiarity, comfort and confidence in the social environment

Conducted successfully these programs will ultimately provide integration into community opportunities without further need for support, hence being quite sustainable.

Volunteer Friendship Development

Friendship and relationship building approaches can vary in their aims. Generally these programs utilise volunteers to visit with isolated individuals. The aim of this interaction can be to facilitate the development of a meaningful relationship between the volunteer and isolated individual. In some programs the purpose of this relationship is purely to provide friendship and social interaction. In other programs the purpose also includes increasing the individuals confidence and social skills – sometimes as a precursor to social integration or engagement.

It is the intention of these programs to provide long term meaningful relationships. In doing so they may be more successful than programs that provide opportunity for social participation without any guarantee of a meaningful relationship. While established relationships may require little ongoing support, a review of such services conducted in this study (Appendix 2) showed that service providers found it difficult to identify a point at which these relationships were no longer considered within the bounds of the service. As such these programs generally provide long term support and are less sustainable than community engagement models.

Contrived Opportunities

In the proposed framework Contrived Opportunities provide social opportunities developed and controlled by service providers to meet the needs of a group of people who cannot be assisted through any of the afore mentioned strategies.

Contrived Opportunities offer a supportive service environment with paid and voluntary staff to support social opportunities for individuals with high care needs. This may include behavioural or physical care needs that cannot be managed in community environments.

Where Contrived Opportunities are required, they are developed to suit needs of a defined group of individuals. These opportunities will change with the changing care needs of the target group. Where possible these activities will not be constrained by commitment to a set physical location or staffing structure.

Sustainability of programs offering contrived opportunities lies in a careful admission process that ensures only individuals, who cannot be supported via other less intensive models, access the service. This will also be highly dependent on the accessibility of those less intensive models.

Common Principles

The success of the proposed framework lies with the sharing of a common philosophy and implementation according to common principles. These principles are reflected throughout this document and include:

- A view of social isolation as a continuum in which the characteristics that define participation and the point defining isolation are different for every individual and are defined by their nature, circumstances and perceptions.
- An understanding that promoting social connectivity involves a whole of community response that goes beyond the provision of direct support to assist people to participate and responds both collectively to improve community capacity for social participation and individually to prevent or respond to isolation.
- A common commitment to prevention of social isolation as a priority.
- A focus on sustainability.
- Shared planning and coordination of capacity building activities, services and supports to promote social participation in the community.
- A service system that values and supports social involvement
- A broad view of social connectedness that may incorporate direct and indirect roles, relationships and participation.
- A common approach to working with individuals to enable them to enhance their social connections in ways that appreciate their needs, goals, skills and abilities, opportunities, inhibitors, social history and character.
- Minimising intervention and promoting independence, self-management and community engagement

Implementation

Parts 1 to 3 of the proposed Framework provide an environment that promotes social connectivity. Implementation of this framework should be based upon the assumption that prevention is better than cure.

Part 4 of the proposed Framework involves a system of interventions for responding to social isolation at different levels (levels 1-8). The intention is that individuals will receive support at the lowest possible level to realize their goals. This is aimed at providing the most satisfaction for individuals and sustainability of the framework.

Resource allocation will be very important in meeting the goals of providing support while minimising service intervention.

An inability to provide a lower level of support (where appropriate) will result in individuals receiving a higher level of support than needed. This can only serve to increase the individuals dependency and possibly decrease the value of social participation, not to mention the expected higher cost of providing a higher level of support.

To successfully implement this framework it will be necessary (particularly in relation to Part 4) to build the framework from the bottom up. If higher level supports are made available first, individuals with lower level support needs will be inappropriately provided with higher level supports in the absence of appropriate alternatives.

Appendices

1. Background Paper 1: Social Isolation Literature Review

2. Background Paper 2: Social Isolation Practice Review

3. Background Paper 3: Community Representative and Service Provider Consultation

4. Background Paper 4: Social Participation – Estimated Target Population

Background Paper 1

Social Isolation Literature Review

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Introduction

This background paper provides an overview of literature on the subject of social isolation. It provides different views on the definition, risk factors, identification, extent and impact of social isolation. It also provides an overview of government policy and service responses to the issue.

In 2002, the Australasian Centre on Ageing, (Robyn Findlay & Colleen Cartwright, 2002) compiled a Literature Review as an initiative of the Mental Health and Social Isolation Working Party of the Queensland Government's Ministerial Advisory Council on Older Persons. The Working Party commissioned the review as part of an investigation into the issue of social isolation among older people and possible responses to the problem.

Excerpts from this review, along with information from other referenced sources and commentary make up this Background Paper.

Definitions of Social Isolation

Social isolation has been variously defined in the literature. Day (1992) defined it as "the absence of satisfying relationships and a low level of involvement in community life" (p.7). Gardner et al. (1998) considered participants in their study to be socially isolated if they were experiencing a combination of factors that included low levels of social participation and levels of social activity that the older person perceived as inadequate. Cattan and White (1999) and Hall and Havens (1999) defined social isolation as the objective measure of having minimal interaction with others, and emotional isolation (or loneliness) as the subjective feeling of dissatisfaction with having a low number of social contacts.

Generally the approach taken is that "social isolation" encompasses both social and emotional isolation. However, Victor, Bond et al (2000) have included up to four concepts when defining social isolation: being alone (ie. The amount of time spent alone), living alone (ie. a lack of significant other), social isolation (as defined by low levels of social contact with others) and loneliness (the negative feelings held by individuals about their levels of social interaction) (Victor, Bond et al. 2000).

Risk Factors for Social Isolation Among Older People

Research undertaken by the Lincoln Gerontology Centre in the School of Public Health at La Trobe University from May 1996 to February 1998 (Gardner et al., 1998, p.6) showed health status to be the main factor associated with social isolation. A decline in social activity over the previous five years, and being a man, were also significant. Older male veterans (75 years and over) were more likely to report low social participation, that is, they were more at risk of social isolation. Also, a higher proportion of single people said they did not have enough social activity and reported the adverse consequences of unhappiness, boredom, and/or loneliness. A change in self-rated health had a strong association with movements into, and out of social isolation and low social participation .

In the development of "the Friendship Scale" in 2000, Hawthorne and Griffith reviewed 49 articles concerned with the predictors or determinants of Social Isolation. This review suggested that the correlates of social isolation are: geographic location including living alone or homelessness, the closeness of personal relationships, ethnic status, marital status, health status and mental health, employment status, socio-economic resources including income, age with accompanying communication losses, and network characteristics including neighborhood friendliness and social initiation.

Factors identified in other literature reiterate and add to these concepts and include loss (in its many forms), poor health, mental illness, being a carer, geographic location, communication difficulties (including being from a non-English-speaking background), place of residence, being male and single, and transport difficulties (Brennan et al., 1995; Edelbrock et al., 2001; Hall & Havens, 1999; Havens, 1989).

Loss

Losses contributing to social isolation include:

- loss of health and function, including hearing and other communication abilities; vision; mobility; and health generally;
- loss of relationships (loss of partner through death or divorce; loss of children when they leave home or through premature death; loss of grandchildren if the family move away or following divorce);
- loss of social networks (leave work, move to a new area in retirement; have financial restrictions on activities); and
- loss of transport options (having to give up a driver's licence or being unable to afford to run a vehicle; public transport not being available or not accessible). This is likely to be an even greater problem for older people living in rural & remote areas (especially, eg. farms in outlying areas).

Poor physical health

Gardner et al. (1998) found that poor health was the most important predictor of social isolation, followed by reduced social activity in the previous five years. Conversely, "social support and social network measures have been associated with improved health and well-being" (Edelbrock et al., 2001, p.19). However, the reverse is also of concern. That is, older people who are socially isolated are at increased risk of poor health (Hall & Havens, 1999).

Mental illness

A person who has a mental illness may suffer many of the losses listed above and may also lose the confidence to make new friends or undertake new social activities. The issue of depression is very important and one that can be easily overlooked or misdiagnosed in primary health care. Depression and social isolation are closely linked (Anderson, 2001) and in fact, it can be a circular problem. That is, a person may become depressed, which then causes them to withdraw from family, friends, society and to become socially isolated which in turn leads to further depression. The danger also is that it may be the social isolation per se, rather than the depression itself, which is the precipitating factor, that is, a person who becomes socially isolated, perhaps for some of the reasons listed

above, may become depressed which in turn may exacerbate the social isolation (as was the case above for health more generally). An additional problem with depression is that insufficient attention may be paid to the use of medications such as anti-depressants which can remove motivation and increase social isolation.

Being a carer

Providing long-term, full-time care to a spouse or other family member, especially where there are few other informal supports available, can cause an older person to be socially isolated.

The Carers NSW survey, which began in 2001 and ended this year, found up to a third of male carers were at risk of social isolation and were either dissatisfied with the support from their social network or using destructive methods of coping with caring. While the report conceded its results were biased because carers living in rural areas, the elderly, the unemployed and retired, and Australian-born carers were over-represented in the sample of 346, the results still clearly identify a high level of isolation.

Non-English-speaking background

Not having English as a first language has been identified as a risk factor for social isolation among older people, particularly those whose major migration groups came to Australia in the 60s and 70s and for whom there had been little or no follow-on migration. The numbers in their cultural groups are diminishing. Some of the older members of the groups have never learned English and, in many cases, their children do not speak their parents' original language (Williams et al., 1999). Even those who have learned English may lose this ability if they develop dementia.

Place of residence – rural/remote

Social isolation is closely associated with geographic location (Havens, 1989). Older people in rural and remote areas may be at risk of social isolation, particularly those who live at a distance from the town, no longer drive and whose families have moved away from the area. Lee (1983) found that older people living in inner -city Hobart had much more frequent contact with friends or relatives than those living in outer suburban areas. This was largely due to better public transport, to shorter distances making taxis affordable and even the convenience for family and friends of the older person being closer and so, easier to visit. Lee concluded that the inner city was actually a more amenable location for older people than outer areas, a point frequently overlooked when residential aged care facilities or retirement villages are being built.

Fear and feeling vulnerable

Many older people may become isolated because they will not leave their homes at night and some will not even leave their homes in the daytime.

Gender/marital status

In the study by Gardner et al. (1998) "Men were much more likely to be isolated than women", p. 87. Edelbrock et al. (2001) also identified being male as a risk factor for social isolation.

In a focus group undertaken by Active Ageing in it's study of social and recreational needs, conducted for the Southern Fleurieu Positive Ageing Taskforce in 2006, participants identified that "widowers don't feel motivated to go out on their own".

Community attitudes

Community attitudes towards older people can have a detrimental effect on the ability of these people to have satisfying, meaningful interactions within their community.

Transport

Older people may have to give up their driver's licence due to health impairment or, in the case of many older women who never learned to drive, their transport options may significantly reduce if their husbands die. "Transport is critical for maintaining independence and quality of life. An inability to access transport can lead to social isolation and a deterioration in general health and well-being" (Department of Health and Ageing, 2000, p.23). Difficulty getting on and off public transport, resulting in loss of dignity, and poor design factors which impact on safety, such as lighting and steps, may result in older people not being willing to use public transport (ibid.; Peel et al., 2002; Sheehan et al., 1997).

Migration

In 2005 the Southern Fleurieu Positive Ageing Taskforce undertook a study on migration of older people in the area (Migration and Return Migration in the Older Population of the Southern Fleurieu Peninsula). The report showed that there is significantly larger movement of older people both into and out of the area. People who had lived in the area for shorter periods of time appeared to have fewer social connections with the area. The report concluded that social isolation (and the need to facilitate social connection) and a greater dependence on low level support services sooner in the ageing process is likely to result from the increased mobility, decreased social connectivity, reduced informal and family supports and possibly limited financial capacity and available options for this population.

In consultations undertaken by Active Ageing in it's study on current and future social and recreational needs for the Southern Fleurieu Positive Ageing Taskforce (2006), participants discussed problems of breaking into a new social group. Individuals reported feeling awkward entering a club where they don't know people and are on their own and fearful of 'who is going to speak to you?'.

Extent of Social Isolation

One of the early key studies in this area was Tunstall's (1963) study of the elderly in the UK which
showed that approximately 10% of the aged were lonely and 20% were socially isolated. Based on work since then, it is now widely accepted that the prevalence of loneliness is between 3–25%; it has become a stereotype of later life that there is a network of loneliness, social isolation and neglect (Victor, Bond et al. 2000). A study of loneliness and isolation in the UK in 2000 "revealed that nearly one million people aged 65 and over (12%) feel trapped in their own home" (Owen, 2001).

In Australia, a study of 2000 Veterans found that "approximately 10% of respondents were classified as socially isolated and another 12% were at risk of social isolation" (Gardner et al., 1998, p.6). The researchers concluded that, nationally, more than 34,000 veterans and war widows were socially isolated and an additional 41,000 were at risk of isolation. In addition, 16% of World War II veterans said they did not have enough social activity, and 15% re p o rted they were frequently or very frequently unhappy, bored or lonely.

Gardiner found that a significant proportion of World War II veterans, particularly those who are socially isolated, want to increase their social participation. Nearly three quarters of isolated World War II veterans said their usual social activity was not enough, and wanted more. While about a third of isolated older veterans said they were only interested in more contact with family, about 40% wanted more social participation independently of their family, or in addition to family contact

A study by Edelbrock et al. (2001) of social isolation/social support issues among older people in the Sydney area found very little difference between older veterans and older people in the general community. It is therefore likely that at least 10% of people aged 65 and over are socially isolated and a further 12% are at risk.

The 2005 study into migration undertaken by the Southern Fleurieu Positive Ageing Taskforce showed that the aged population in the area was highly mobile in comparison to the population across South Australia generally. There was also evidence that newer arrivals in the area had less connection with their local community. The report concluded that these factors were likely to result in a higher level of social isolation in this particular community.

Identifying Social Isolation

The Friendship Scale

The Centre for Health Program Evaluation was commissioned by the Whitehorse Division of
General Practice in 2000 to conduct a survey of the health status of patients attending their general
practitioners (GPs). From a similar survey conducted in 1998 and from general anecdotal evidence, the staff of the Division were aware that many GPs were reporting social isolation as a
concern. It was therefore determined that the health status survey should include a measure of
social isolation to quantify the extent to which the anecdotal evidence was a reflection of a
widespread issue across the Division.

Hawthorne and Griffith (2002) reviewed a range of instruments for measuring social isolation and found that none of the instruments from the literature reviewed seemed appropriate for inclusion in the survey: they were multidimensional, too long, or probed areas which did not seem essential in terms of the Whitehorse Division study. An instrument was needed which:

- Was very short. Respondents were being approached 'cold' (without any warning or obvious recruitment phase) and it was thought that the interview needed to be as parsimonious as possible;
- Was as friendly as possible. Respondents would be answering when they could be feeling vulnerable (ie. waiting to see a GP). To meet with this requirement all items were constructed from a positive perspective. They are presented from the point of view of having friends and social support;
- Covered the different domains of isolation. From the literature they defined these as personal intimacy, being lonely, getting on with other people, access to support when needed (i.e. contact with others) and being dependent upon others. In the interests of parsimony, as described above, we constructed just one item for each domain.
- Covered both the intensity and duration of isolation. This was achieved by setting the timeframe within which isolation occured as the previous four weeks. In addition, all item responses were couched in terms of isolation occuring "not at all" through to "always" within this timeframe.
- Was easily scored for the obvious practical reason of ease of use by the researchers. The scoring system was to be through summation

The six items of the friendship scale (2005) measure six of the seven important dimensions that contribute to social isolation and its opposite, social connection. The psychometric properties suggest that it has excellent internal structures as assessed by structural equation modeling (CFI = 0.99, RMSEA = 0.02), that it possesses reliability (Cronbach a = 0.83) and discrimination (Appendix 1).

UCLA Loneliness Scale

The UCLA Loneliness Scale was developed to assess subjective feelings of loneliness or social isolation. Items for the original version of the scale were based on statements used by lonely individuals to describe feelings of loneliness (Russell, Peplau, & Ferguson, 1978). The UCLA Loneliness Scale (Appendix 3) has become one of the most widely used measure of loneliness. Scores on the loneliness scale have been found to predict a wide variety of mental (i.e., depression) and physical (i.e., immuncompetence, nursing home admission, mortality) health outcomes in our research and the research of others.

Impact of Social Isolation

Social Isolation and Suicide

Social isolation has been identified in the literature as a risk factor for suicide. Rosenman (1998) found that, for older people, loneliness and physical morbidity may be risk factors for suicide and these factors also increase the possibility of older people becoming socially isolated.

The Australian national suicide prevention strategy (2000) acknowledges the contributory role of social isolation in suicidal behaviour. One of the strategy's stated aims is to "enhance resilience and resourcefulness, respect, interconnectedness and mental health in [the whole population], and reduce the prevalence of risk factors for suicide".

There is an association between communication and interaction with others and the maintenance of selfesteem, self-concept, and ultimately the mental wellbeing of ageing individuals. Social isolation may
adversely affect both mental and physical health (Queensland Health 2004, Bunker et al 2003, Hawkley &
Cacioppo 2002).

Health Related Behaviours

Social isolation and social interactions are determinants of health related behaviours (Hawkley & Cacioppo 2002). There is evidence that lonely individuals who are lacking social supports may engage in fewer health-promoting behaviours, more health-compromising behaviours and may not access appropriate and timely utilisation of healthcare (Hawkley & Cacioppo 2002).

Poor social relationships and a lack of community participation are seen to be as big a risk for health as cigarette smoking, high blood pressure, obesity and lack of physical activity (Driscoll & Wood 2002).

Ellaway, Wood et al (1999) revealed that loneliness was significantly associated with the frequency of general practice consultations.

Stress can increase your susceptibility to illness and disease. Mental distress as a result of social isolation and lack of social support has been shown to increase the likelihood of heart disease, complications in pregnancy and delivery, and suicide (Syme 1996). In order to cope with emotional stress, people often adopt strategies or behaviours such as smoking, drinking, illicit drug use, eating junk food, which in turn can have negative effect on their physical health (Orley 1998).

Admission to Residential Care

McCallum, Simons, Simons and Friedlander (2005) reported that the hazard of nursing home placement increased significantly with depression.

Dementia

There is some evidence suggesting a link between social isolation and dementia (Fratiglioni, Wang et al. 2000).

Health

- Social isolation and lack of community interaction are strongly associated with poorer health.(Driscoll & Wood 2002).
- The National Heart Foundation reports that depression, social isolation and lack of social support are significant risk factors for CHD (coronary heart disease) that are independent of conventional risk factors such as smoking, high cholesterol and hypertension and are of similar magnitude to these conventional risk factors (Driscoll & Wood 1999).
- Socially isolated people die at two to three times the rate of people with a network of social relationships and sources of emotional support (Brunner, E 1997).
- Participation in sport or recreational programs provides opportunities for socialising, building friendship networks, reducing social isolation and enhancing community wellbeing. This ultimately leads to improved physical and mental health (Driscoll, K & Wood, L.1999).
- Social networks are thought to have an influence on health through at least three mechanisms: the provision of resources and advantages (social capital); the wellbeing effects of social support; and the influence on behaviours (such as peer effects on smoking) (Berkman 2000)
- The Victorian Population Health Survey 2001 found that people with few social networks were more likely to report fair to poor health and to be experiencing some level of psychological distress. They were also less likely to feel valued by society.
- Civic participation, even more than participation in activities and recreational pursuits is very powerfully linked with wellbeing. Volunteers stand out from other workers in having the highest levels of wellbeing. Mostly aged over 55, they enjoy high levels of satisfaction with their lives, work and leisure, health, sense of community connection and religion or spirituality (Cummins et al 2002).
- Poor social relationships and a lack of community participation are seen to be as big a risk for health as cigarette smoking, high blood pressure, obesity and lack of physical activity (Driscoll & Wood 2002)

Socio-Economic

Social networks can act as a buffer between individuals and the general socio-economic, cultural and environmental conditions over which they have little control and are the most difficult to change. Unemployment, for example, is a major factor in lack of wellbeing.

There is a growing evidence base to suggest that community participation on various levels is a key element to an individual's sense of wellbeing and to the state of the health of the community generally. Well connected communities with strong social networks are more likely to benefit from lower crime figures, better health, higher educational achievement and better economic growth (Smith 2001)

Government Policies/Priorities

Federal Government

A stated priority of A National Strategy for an Ageing Australia (2002) is: The need for age-friendly infrastructure and community support (including housing, transport and communications) to enable greater numbers of older Australians to participate in and remain connected to society.
The National Strategy also highlights the role that access to health and aged care services, as well as recreation, tourism, leisure activities and life-long learning have in ensuring that older people do not become socially isolated.

State Government

In 1996, the Hon Dean Brown, Premier of South Australia launched "Ageing - a ten year plan for South Australia" (1996). The 10 year plan centres around the right and expectation of every South Australian to enjoy full citizenship from birth until death, irrespective of age or frailty. The plan identifies that limitations to citizenship and the loss of positive functions and involvements can lead to physical and social isolation.

"The major goal of the next 10 years must be to extend the duties and rewards of citizenship to all members of the South Australian Community – to replace the season ticket approach to citizenship with genuine life membership" (Ageing – A ten year plan for South Australia)

The plan is divided into three areas, Living in the Community, Participating in the Community and Independence in the Community. With respect to "Participating in the Community" the plan proposes that "Older People will take their place as citizens with access to the fullest possible range of activities, memberships and obligations. The plan addresses emerging needs including:

- recognizing and using the skills of older people
- supporting people with disabilities to retain access to a full range of community activities
- recognizing older people as a growing and specialized market
- education opportunities for vocation or enrichment
- ongoing leisure, recreational and educational activities
- opportunity to pursue artistic and cultural aspirations
- recognizing contributions made through volunteering

In 1999 "Moving Ahead: A Strategic Plan for Human Services for Older People in South Australia 1999-2004 provided a blue print for a more customer focused and integrated service delivery system with a strong focus on healthy ageing. The plan included such strategies as:

- "building a recognition in other areas of State Government activity (such as recreation, transport, education and employment) of the importance of developing strategies which facilitate the participation of older people in a full range of activities and interests"

- "Broaden the understanding of rehabilitation from physical function to include mental/emotional, environmental and social factors."

Improving with Age, Our Ageing Plan for South Australia was released in Februrary 2006 by the South Australian Government, providing direction to is ageing program. This document provides significant reference to isolation / participation including:

- 'being active, eating well and being connected to the community are essential to achieving a long, healthy life".
- "The primary responsibility for keeping active, taking sensible steps to look after their health and participating in communities lies with older people themselves. We will continue to support and encourage older South Australians to seize opportunities".

The Plan's priority for Health is to "have a greater focus on health promotion, illness prevention and early intervention to improve the well being of older people" this includes a range of actions around physical activity and "continuing to demonstrate the benefits of activity on good mental health, disease prevention and social connection". Actions around workforce development, as proposed in the Plan, include developing strategies to enable people to continue working beyond 65 years if they choose to do so.

Local Government

The Australian Local Government Association has become increasingly aware of and active in response to the ageing of the Australian Population. In 2005, the Australian Local Government Association produced a paper titled "Age-Friendly Built Environments, Opportunities for Local Government". This report identified that poor built environments can present significant obstacles to the independence of seniors and concludes that, in designing age-friendly built environments local government can achieve significant benefits. The paper then provides six fact sheets offering local governments initiatives that may be used to support age-friendly built environments. The six strategies covered by the fact sheets are:

- Promote age-friendly built environments
- Create safe and secure pedestrian environments
- Foster age-friendly community planning and design
- Improve mobility options for seniors
- Support recreation facilities, parks and trails
- Encourage Housing Choices

The City of Victor Harbor Community Services Policy identifies community services as an integral part of Council's responsibility. It identifies community services as those which enable individuals to improve, maintain or restore their well being and personal welfare and enables communities to improve, maintain or restore their sense of community and environmental amenity. The policy identifies some groups of residents as requiring special attention or assistance to access services or who need other services specific to their need. These groups include people who are geographically or socially isolated.

The Alexandrina Council Corporate Plan includes a number of references that, while not specific to social isolation, respond to a number of the risk factors associated with social isolation such as Transport (Strategy 27.2), holistic approach to positive ageing (strategy 28.1), respond to changing needs of older population (strategy 28.2), promote initiatives to enable independence (strategy 28.3), provision of facilities to promote physical exercise (strategy 29.1) and ensuring reasonable access to use of community centres, halls and other built facilities (strategy 30.1).

Interventions to address social isolation

Social isolation is one of the most difficult situations to resolve (Lachs, 2000; Russell & Schofield, 1999). At both a community and government level, numerous interventions to address social isolation have been tried, but very little information is readily available on evaluations of the effectiveness of these interventions both in terms of reducing social isolation and in terms of whether the interventions are worthwhile given the costs involved.

Assessment

Schulz offers an assessment tool that could be useful in assisting workers to think about the people needing support and how that support might be delivered in order to enhance the citizenship, roles and life strengths of the individual. It facilitates an assessment that is focussed on the person their skills and abilities. The "Personal Planning Tool" (Appendix 2) provides a mechanism for:

- understanding the person, their current and past networks and roles and roles, strengths, disabilities and their impact, losses,
- considering and assessing options for responding to the individuals needs.
- Identifying and assessing how and by who the support or assistance could be provided

Teleconferencing

Findlay and Cartwright (2002) reviewed evaluations of teleconferencing programs internationally and in Australia. Teleconferencing was shown to produce decreased support needs, diminished loneliness, and enhanced coping (Stewart, Mann, Jackson et al., 2001), to be a cost effective strategy for bringing people together, especially from geographically isolated areas (Shanley 2001) and to gain social networks and try new methods of communication (Swindell 2001). Evaluation of telephone interventions by Findlay and Cartwright (2002) showed both positive and indifferent outcomes. Findlay and Cartwright (2002) reported that telephone interventions are popular interventions aimed at reducing social isolation and their success was considered to be due, in part, to the quality of the training received by the telephone contact staff. They concluded that further research is needed to determine whether they actually achieve their purpose.

Computer networks

Conclusions drawn by Findlay and Cartwright (2002) from the few studies that have examined the efficacy of computer use in reducing social isolation and loneliness are equivocal. Seniors are certainly showing more interest in the internet. The fastest growing users of the internet are those over 55 years and the primary reason for older people becoming interested in the Internet is to keep in touch with their relatives and friends. Individual differences and types of program usage are important factors to consider when evaluating the effectiveness of computer usage. The best types of computer programs for reducing social isolation appear to be those such as Email that encourage interpersonal dialogue. Programs that encourage processes such as Web searching may in fact increase social isolation, depression and loneliness and decrease community participation. There is some evidence that Internet usage may increase

community involvement and decrease loneliness in extroverts, but that it may have the opposite effect on introverts. This may mean that socially isolated older people may not gain from Internet usage unless they are or were previously socially outgoing people.

Support groups & Structured group interventions

Structured group interventions may have some success. Stewart et al. (2001) examined the impact of support groups on widowed seniors' loneliness, affect, and perceived support in Canada. While the number of participants was too small to show significant outcomes, widows reported that one important impact of the support group was decreased loneliness and isolation. Those for whom the intervention was most effective were those for whom it was an early intervention. Other research also points to the need for early intervention (Faberow et al., 1992; Ott, 1999). The results of Stewart et al's study suggested that beneficial effects may not appear for some time and that most participants thought that interventions needed to last around 20 weeks to be effective.

Andersson (1985) in a Swedish study cited in Stevens (2001) used a randomised control trial to evaluate a structured group intervention for older women. Intervention consisted of four meetings led by home health aides. Topics such as leisure activities and the neighbourhood were discussed. Six months after these meetings, participants demonstrated more frequent social contacts, an increase in participation in organised activities, and a decline in loneliness. There was however, no change in the availability of a close friend or confidante.

While there was no research to support their assumption Findlay and Cartwright (2002) proposed that support groups may be a more effective intervention for women. In addition, a study in the UK by Killeen (1998) reported that it is usually only people who are already socially competent who attend such groups. Thus, isolated, socially incompetent people may not benefit from the establishment of the typical support group. The implication is that when planning is being undertaken to develop support group projects, energy may need to be invested in developing strategies for enhancing some older people's feelings of self worth, self esteem, social confidence and other associated characteristics if such groups are to be a successful targeted intervention.

Community initiatives

Findlay and Cartwright (2002) reviewed a variety of community initiatives including 'Adopt-a-Granny', the 'Gatekeepers program', 'homeshare', and retirement living. In Australia, the ***Adopt-a-Granny*** scheme usually involves a young family who has no grandparents or the grandparents live a long way away. The family is linked with an older person in the local community for mutual benefit (eg "grandparenting" of children in return for company and social inclusion for the older person). There is no available evaluation of this scheme.

Gatekeepers program (especially for early intervention for older people at-risk) is a service-linking community outreach program that originated in Washington by the Spokane Community Mental Health Centre. It enlists mental health professionals, postmen, and meter readers to identify older adults living alone and possibly at risk for a serious health problem such as dementia or suicide (Raschko, 1990). The model has been

adopted (and adapted) elsewhere. The results of this program are difficult to measure, but findings in Canada suggest its success. "Specifically, increases have occurred in the community health centre's caseload of these under-served and hard-to-reach older adults; nursing home bed shortages are no longer experienced in the county, and 40% of the referrals to a related in-home case management program are the result of the gatekeeper system" (Dyck, Mishara, & White, 1998). Because disadvantaged older people do not as a rule self refer in times of need (Raschko, 1990), the gatekeeper model may be particularly effective for targeting older people at risk. Major life changes such as bereavement, discharge from hospital and entry into public accommodation may bring them into contact with key people who are in a position to identify their needs and link them with support groups and other community resources that might reduce their social isolation (Moyer, Coristine, Jamault et al., 1999).

Homeshare was launched in Adelaide in 1997. It has been established in a number of countries to help older people stay in their homes longer. It helps to address social isolation by bringing together older people, who need some help around the home, and younger people who need accommodation. The latter do
10 hours of agreed work in exchange for free accommodation. Evaluation has shown that the matching process requires dedicated coordinators with a caseload of a maximum of 30 matches. The program receives HACC funding, but the restrictions inherent in this are an ongoing source of frustration (Squires,
2001).

Retirement village living is another accommodation option that may have a beneficial effect. Buys (2001) in an evaluation of retirement village living in Queensland found that living in close proximity with other older people in congregate accommodation influences informal contact with others and is beneficial for those who seek alternative accommodation due to isolation or loneliness. However, there is some debate around whether this type of accommodation does in fact reduce loneliness or has no effect at all.

***International initiatives*:**

- **Canada** has been very active in developing programs to address social isolation and there the focus has been very much on community-based support programs, Teleconferencing has also had some success in Canada.
- **Sweden** and **The Netherlands** have used structured group interventions and educational programs,
- in **Italy** a privately-run tele-check program has been effective in reducing suicide rates among older people.
- More recent projects in the **UK** to address social isolation among older people have included support-group models have been found to attract older people who are already socially competent and thus these programs may not be meeting the needs of those most at risk.
- The **Australian** focus has been on community-based support groups, including social clubs and illness-specific groups, there has also been early acceptance of teleconferencing, tele-check and other telephone-based information and support services. Computer-linked projects are becoming more accessible through community-based organisations and local government libraries. In addition, innovative projects such as Homeshare have attempted to address social isolation.

Social and Recreational preferences and opportunities

According to the 2002 General Social Survey, conducted by the ABS, 29% of women and 24% of men 65 years and over participated in church or religious activities during the three months prior to interview.

The ABS conducted a survey on the sports and physical activities in which people participated during a 12-month period prior to interview in 2002. This includes participation in sports or physical activities organised by a club or association as well as those undertaken for recreation or exercise, which may not be organized. The survey found 62.4% of the population aged 18 years and over participated as a player (rather than in a support role) at least once during the 12-month period in one or more sports or physical activities. Participation rates declined steadily with age. The rate for persons aged 65 years and over was 45.6%.

The 2002 ABS Sports Attendance Survey indicated 48% of all people aged 18 years and over, attended a sporting event (excluding junior and school sport) at least once in the previous 12 months. Attendance rates steadily declined with age. Among men aged 65 years and over, the attendance rate was 27%, while for women in this age group it was 16%.

The ABS study of Attendance at Selected Cultural Venues and Events, Australia, (2002) showed that attendance at the performing arts for people over the age of 65 years at 11.58%. Musicals and operas were most popular with 16.6% attending these in the 12 months prior to the interview. Theater performances and other performing arts were more popular in this older age cohort than popular or classical musical concerts and dance performances. Attendance was lower in the over 65 age group than for the total population at 17.18%.

The 2002 Survey of Attendance at Selected Cultural Venues and Events showed that 35.7% of individuals over the age of 65 attended a library in the 12 months prior to the survey. The 2002 survey showed that 42.1% of the persons aged 18 years and over attended a library at least once in the 12 months prior to interview compared with 36.8% in 1999 indicating an overall increase in the proportion of the community accessing this resource.

The recent study on current and future social and recreational needs of older people in the Southern Fleurieu Peninsula (Active Ageing 2006) reviewed a range of literature looking at trends in social and recreational preferences of older people. The literature indicated that older people will be seeking greater variety in social and recreational activities from communities. Chosen pursuits will be more suited to complex and flexible lifestyles and will be integrated with travel and tourism, natural location, intellectual stimulation and learning and good food and wine.

This study surveyed older people in the Southern Fleurieu about their social and recreational preferences. There were 155 responses to this questionnaire.

- 10% were in the paid work force, half indicated their work was regular, half indicated occasional
- 7% were interested in being in the paid work force
- 15% indicated swimming as an activity they would like to be involved in
- 14% indicated that they would like to be involved in physical activities (exercise class, walking, sport)
- 155 respondents were regularly involved in more than 80 different activities, 53% in clubs, 32% in social activities, 28% in physical activities, 28% in church, 13% in mental or learning activities, 10% in arts and crafts and 5% in volunteer work.

In drawing together the literature and results of local consultation the study concluded that:

- The creation of supportive environments for social and recreational activities should be a planning priority.
- Activities with a social/community aspect will be more popular and sustainable
- Many of the favourite activities are characterized by minimum organization and basic facilities
- Organised sport has a lower priority for older people than leisure/social/recreational activities

Age Friendly Built Environments

A 2003 report on promoting healthy ageing in Australia stated that consideration of the built environment is essential to the achievement of increased healthy life expectancy. The built environment has a powerful impact on mobility, independence, autonomy and quality of life in old age and can also facilitate or impede the quest for a healthy lifestyle at all ages.

The Australian Local Government Association's Age-Friendly Built Environments – Opportunities for Local Government discussion paper reported;

> "In Australia, low density urban development, a characteristic of many communities, is not particularly age friendly. Features such as rapid suburbanization, dispersed development patterns, the lack of footpaths, separation of land uses and automobile dependency all present significant obstacles to the independence of seniors."

The report goes on to describe good urban design including a safe pedestrian environment, easy access to shopping centres, a mix of housing choices, nearby helath centres and recreational facilities and concludes that such design will have many benefits including:

- improved health and overall wellbeing,
- allowing seniors to age in place
- allowing seniors to remain active – both physically active and active in their local communities.
- increased independence
- making neighbourhoods more liveable for all ages,
- reducing costs associated with health and aged care

- a range of social and economic benefits by extending and expanding seniors' contribution to community life.

Vocational Participation

In recent years, the retention of mature age workers (for the purpose of this article, mature age workers are defined as employed people aged 45-64 years) in the labour force has been highlighted as a possible solution to the potential shortage of labour, and has been the focus of certain public policy goals. These policies include gradually increasing the age at which women can access the age pension, ongoing increases to the minimum age for accessing superannuation benefits, and the introduction of incentives for workers who stay on in employment beyond the Age Pension age (e.g. the Pension Bonus Scheme).

In 2003-04 most men (87%) aged 45-54 years were participating in the labour force, as were 73% of women in this age group. Participation rates were lower for older age groups. For those aged 60-64 years the participation rates for men and women were 51% and 28% respectively. Participation rates for 45-64 year olds increased from 57% to 68% between 1983-84 and 2003-04. This has been driven largely by the increased participation of women in the labour force (60% in 2003-04 compared with 36% in 1983-84) while the participation rate for men aged 45-64 years remained stable (77% in 1983-84 and 2003-04).

"We need to tap into the experience of our mature age workers, value their contribution, challenge the concept of early retirement and remove discrimination and other barriers to ongoing involvement in working life. The right incentives, such as choices and flexibility in work, life and learning opportunities are key to encouraging mature age workers to stay on in the workforce" (Improving With Age 2006)

Strategies for Developing a framework

According to research, certain strategies have been demonstrated to be more effective than others. These include:

- **Community Based:** Developing a framework for action on social isolation within specific communities and involving older people in all levels of planning, implementation and evaluation; and encouraging the ready pool of volunteers within the older population to engage in the process. Communities need support to establish their own projects rather than have them imposed on them (Joseph Rowntree Foundation, 2001). Older people need to be engaged in the planning process and allowed some level of control over the implementation of interventions (Cattan & White, 1999; Joseph Rowntree Foundation, 1999). Given that approximately one in five Australians aged 65 years and over undertake voluntary work each year (Department of Health and Ageing, 2000), there is a ready pool of skill, knowledge and enthusiasm that can be utilised for mutual benefit.
- **Local Needs:** Interventions need to be tailored to meet the needs of the target group in terms of location, transport, safety and personal confidence issues, timing, content, existing services, and existing budgets (Cattan & White, 1999; Joseph Rowntree Foundation, 2001).
- **Training:** Ensuring interventions have well-trained and appropriately supported facilitators and/or project co-ordinators;
- **Health Promotion**: Promoting healthier living in old age, poor health being strongly related to social isolation;
- **Inter-Sectoral Collaboration:** Involving all levels of government in the dissemination of information related to ageing and social isolation to all communities. Overcoming social isolation needs to be an integral part of a whole of Government approach. Encouraging social activity, especially through a preventive health approach, potentially can result in better health and lower use of health services. Improving health, through preventive as well as treatment and rehabilitation programs, will enable more social participation and assist in overcoming isolation (Gardiner et al 1998).
  The South Australian Strategic Plan for Human Services for Older People (1999) identified the strategies that facilitate participation of older people in a full range of activities and interests was the responsibility of a range of areas of State Government Activity including recreation, transport, education and employment.
- **Special Needs:** including multicultural and Indigenous communities, and encouraging seniors' groups or influential community elders to lead the dissemination process;
- **Single Point of Access:** Isolated people need to be provided with a single point of entry to all services and help. Complex systems of access will deter most people. Therefore, all services need to be linked (Owen, 2001).
- **Public service systems**: Public Services that cater for the needs of older people (eg transport, especially when the person no longer has a driving licence) must be provided. There needs to be greater public spending on services that have a socialising function such as accessible transport, user-friendly road crossings, good street lighting, and appropriate housing (Department of Health and Ageing, 2001;

Hall & Havens, 1999; Joseph Rowntree Foundation, 1999; Minichiello, 1992; Newman, 1991).

- **Awareness:** Promoting awareness among the general public of older people's important contributions to society, and discouraging negative stereotyping;
- **Skill Development** (Self Help): Implementing programs that focus on skill development (eg social competence – confidence, self esteem, and the skills to form social relationships) to potentially address the needs of particular persons who may not otherwise be covered by programs that rely on these personal skills for participation. One should not assume that all older people who are prone to social isolation have the skills to: pick up the phone to ask for help; respond to information posted to them; and/or be comfortable to accept services or visits or assessments from care professionals – this can be very stressful (Owen, 2001).
- **Service Support:** there is a need for specific services and information that are available, accessible, and affordable for older people if we are to help overcome social isolation (Findlay and Cartwright 2002).
  The South Australian Strategic Plan for Human Services for Older People (1999) identified a need to broaden the understanding of rehabilitation from physical function to include mental, environmental and social factors.
- **Individual responses**: Merely bringing older people who seek new contacts together in structured group interaction is not sufficient to alleviate loneliness for some people. Studies of older persons matched through such a process have found that few lasting relationships develop and loneliness persists (eg Bodden, 1994; Jerrome, 1981, 1983; cited in Stevens, 2001), what these people have in common, that is, loneliness, is not necessarily enough to make them relationship partners (Stevens, 2001).
- **Choice and Self Determination**: A trap that is easy for well-meaning people to fall into is to assume that all older people have a desire to participate in community life and activities (eg The National Strategy for an Ageing Australia, 2002). This is not always the case and people who do not participate do not necessarily feel socially isolated (Gibson, 2000). Forcing people into social situations may result in these people isolating themselves even further (Killeen, 1998). A better strategy is to visit them at short frequent intervals to acclimatise them to the interaction (Acorn & Bampton, 1992).
- **Prevalence and Cause**: When developing interventions to reduce social isolation, it is important to take the time to understand the extent of isolation and loneliness amongst older people within a community, and the associated factors (Victor et al., 2000).
- **Flexibility:** Services that are inflexible, bureaucratic and impatient with older people are generally ineffective because isolated older people may need proper time and support to regain control of their lives.
- **Targeting:** Interventions are more effective if they target specific groups, such as women, the widowed or those at risk of serious mental health problems (Cattan & White, 1999).
- **Encouraging existing social networks:** In the USA, Cohen (1992) found that community-based senior support programs, that is, services that provide one-on-one support such as preparing meals and bathing might lead to greater isolation by

discouraging older people from engaging their social network (i.e. family, friends, neighbours who in the past have provided these services).

- **Market Response:** The 1996 10 year plan for Ageing in SA identified the need to recognize older people as a growing and specialized market. The provision of social, recreational, cultural, artistic, and educational opportunities for older people is a potential market for commercial ventures and need not be seen as the realm only community services or groups.

Evaluation

Although there has been a range of projects developed to address social isolation, evaluation of the projects, in Australia and elsewhere, has been limited. Of the interventions that have been evaluated, a factor underpinning the success of many of them is the quality of the selection, training and support of facilitators or coordinators of the programs.

Because there is limited understanding of what constitutes effective interventions for social isolation, it is important that:

- Evaluation is built into community-based projects from their inception, and
- projects are preferably preceded by the trial of pilot programs;
- Evaluations of government-funded programs and interventions, including their sustainability and long-term benefits, are promoted and appropriately funded;
- Networking between communities, university researchers and policy makers is developed to provide the technical expertise and financial support necessary for thorough evaluation of interventions, and to prevent duplication of efforts, to share experiences, and to serve as think tanks.

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Appendix 1: The Friendship Scale

During the past four weeks:

Hawthorne G. 2005 Measuring Social Isolation in older adults: Development and Initial Validation of the Friendhsip Scalre. *Social Indicators Research*

During the past four weeks:

1. It has been easy to relate to others:
□ Almost always
□ Most of the time
□ About half the time
□ Occasionally

2. I felt isolated from other people:
□ Almost always
□ Most of the time
□ About half the time
□ Occasionally

3. I had someone to share my feelings with:
□ Almost always
□ Most of the time
□ About half the time
□ Occasionally

4. I found it easy to get in touch with others when I needed to:
□ Almost always
□ Most of the time
□ About half the time
□ Occasionally

5. When with other people, I felt separate from them:
□ Almost always
□ Most of the time
□ About half the time
□ Occasionally

6. I felt alone and friendless
□ Almost always
□ Most of the time
□ About half the time
□ Occasionally

Notes:
1 = Almost always
2 = Most of the time
3 = About half the time
4 = Occasionally
5 = Not at all

Scoring involves reversal of items 1, 3 and 4 followed by summation across all items. The score range is 0–24. A high score represents social connectedness and a score of ‘‘0’’ complete social isolation. scores can be categorised into five levels. Those who are very socially isolated will obtain scores in the range 0–11 because they will have endorsed at least 1 item at level 1 or lower (i.e. have reported an isolating condition ‘‘most of the time’’ or ‘‘almost always’’). Isolated or low level social support respondents are those with scores of 12–15, which require endorsement of at least two items at or lower than level 2. Some social support refers to the range 16–18, because in this range at least two items at level 3 or lower must be endorsed. The socially connected range is between 19–21 because at least one item at level 3 or lower must be endorsed. The very socially connected will score within the range 22–24. This requires endorsement of at least four items at level 4. A person obtaining a score in this range cannot have endorsed any item at levels 0 or 1.

Appendix 2: Personal Planning Tool

The following questions could be useful in assisting workers to think about the people needing support and how that support might be delivered in line with Better Practice Principles. This tool needs to be used in association with the core knowledge. It is proposed that some summary theoretical material could be developed as an adjunct to the planning tool. (see list following for potential resources in developing such material)

It is important that this exercise be conducted with a focus on the person and their needs, and considering an ideal future free of the constraints of funding or other external factors. A later exercise can then examine what compromises may be required to take these factors into account.

1. Understanding the person

1.1 Describe the characteristics of this person that make up their unique identity:
eg gender
age
cultural & religious background
work history
family
income
housing

1.2 What are their current community networks?

1.3 What are their past and current interests?

1.4 What are their past and current roles?

1.5 What are their strengths?

1.6 What is the person's disability or health issue?

1.7 What have been their life experiences as a result of their ageing or disability?
What have they lost?
How do people view them differently?

1.8 What are their needs? Why have they sought assistance?
Consider needs that are universal to all people (eg home, friendship, purpose)
Consider needs specific to their disability or the ageing process.

2. Impact

What has been the impact of the changes in this person's life resulting from the onset of ageing or disability?

3. Assumptions

3.1 What are some of the assumptions that you and others are making about this person?

3.2 What is your assumption about "the problem" that this person has?

3.3 What do you assume to be the "solution"?

3.4 What do you assume to be the most important issue in the person's life?

3.5 What do you consider are society's expectations for this person?

4. Life areas

4.1 What are the areas of this person's life in which they could benefit from assistance/support?
Is it in the area of:

- Health & physical well-being
- Relationships and belonging
- Sense of security
- Maintaining and enhancing valued roles
- Autonomy and control
- Protection of rights
- Life enrichment
- Independence
- Economic security
- Self-expression

4.2 What are the person's strengths that need to be acknowledged and developed?

4.3 In what areas do they require some compensation for their losses and vulnerabilities?

4.4 What are the risks for this person?
What are the areas of support that could address these risks?

5. How should the support or assistance be provided to this person?

5.1 Consider the main life areas in which this person needs support. How many different ways can you think of to address this need?

(eg, if a person is not getting adequate nutrition, how could this be addressed?

Possible options: meals on wheels
Assistance with shopping
Assistance with meal preparation
Going out to eat at local pub or café
Employing a chef
Go to cooking classes
Buying frozen meals at the supermarket)

5.2 What do you consider the best option amongst these?

5.3 Consider your choice against the following criteria:

- Will it convey a positive image about the person?
- Will it maintain or develop the person's skills?
- Does it use the person's time well?
- Does it promote the maintenance and development of meaningful relationships?
- Does it promote the person's real inclusion in the community?
- Does it utilise the person's strengths?
- Does it maintain or develop valued roles and contributions to the community?
- Is it a typical way that other people in the community have that need met?
- Is it an individualised response?
- Does it promote choices?
- Is it in a grouping that the person would normally choose to be in?
- Does the grouping promote this person's image and skill development?

6. Who is the best person or people to provide the support?

6.1 Is the support best provided by a paid worker or a family member or informal support person?

6.2 What are the particular knowledge and skills required to provide this support?

6.3 What are the qualities or characteristics that deliver the support in the most appropriate way?

6.4 Are there any unique requirements this person may have regarding the people who support them? Eg cultural, gender, presentation, age.

7. Summary of the ideal response to this person's needs

Summarise the major needs, life areas that can be addressed, and best methods and people to provide the needed supports.

8. Safeguards

How will you protect the quality of support for this person?

Barriers and constraints:

Consider the issues that may present barriers to delivering the ideal supports:

Funding
Occupational Health & Safety
Legislation
Organisational Policy
Risk to the person
Community attitudes
Staff knowledge of the options

How many of these present real barriers and how can the program respond flexibly to work around some of these issues? What compromises are required in relation o the ideal supports for this person?

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Appendix 3: UCLA Loneliness Scale

UCLA Loneliness Scale (Version 3)

Instructions: The following statements describe how people sometimes feel. For each statement, please indicate how often you feel the way described by writing a number in the space provided. Here is an example:

How often do you feel happy?

If you never felt happy, you would respond .never.; if you always feel happy, you would respond always.

NEVER	RARELY	SOMETIMES	ALWAYS
1	2	3	4

____ 1. How often do you feel that you are .in tune. with the people around you?
____ 2. How often do you feel that you lack companionship?
____ 3. How often do you feel that there is no one you can turn to?
____ 4. How often do you feel alone?
____ 5. How often do you feel part of a group of friends?
____ 6. How often do you feel that you have a lot in common with the people around you?
____ 7. How often do you feel that you are no longer close to anyone?
____ 8. How often do you feel that your interests and ideas are not shared by those around you?
____ 9. How often do you feel outgoing and friendly?
____ 10. How often do you feel close to people?
____ 11. How often do you feel left out?
____ 12. How often do you feel that your relationships with others are not meaningful?
____ 13. How often do you feel that no one really knows you well?
____ 14. How often do you feel isolated from others?
____ 15. How often do you feel you can find companionship when you want it?
____ 16. How often do you feel that there are people who really understand you?
____ 17. How often do you feel shy?
____ 18. How often do you feel that people are around you but not with you?
____ 19. How often do you feel that there are people you can talk to?
____ 20. How often do you feel that there are people you can turn to?

Items 1, 5, 6, 9, 10, 15, 16, 19, and 20 should be reversed.

Higher scores indicate greater degrees of loneliness.

Russell, D. W. (1996). UCLA Loneliness Scale (Version 3): Reliability, validity, and factor structure. Journal of Personality Assessment, 66, 20-40.

Background Paper 2

Social Connectivity Practice Review

Lisa Sparrow – Southern Fleurieu Positive Ageing Taskforce

March 2006

Introduction

The following background paper provides information on a range of current services designed to address social connectivity in the community. The intent is to provide examples of the different approaches, their philosophies, implementation and administrative aspects, outcomes and experiences.

Life Links

This is an example of a "Transitional Program" as defined in the Framework for Social Connectivity on the Southern Fleurieu Peninsula

Life Links is a project that assists men and women living in supported Residential Facilities to participate in their wider communities in ways they desire, with the support of volunteers. This enables them to:

- Extend their social networks and supports
- Link into socially and culturally appropriate recreational and social groups and/or to pursue their individual social interests
- As the name suggests, continue these links as part of their life

LifeLinks is a collaborative project with the Cities of Unley, Mitcham, Marion and Holdfast Bay. Funding was achieved in 2003 through HACC under the auspice of the City of Unley.

The LifeLinks Model

The model encourages the uniqueness and social development of each person who chooses to participate. It addresses the barriers that can occur due to poverty, mental illness, disability and reduced social supports and limited independent living skills by problem solving. It engages the involvement of agencies, churches and community groups. These community links will assist in the building of longer term support networks to sustain the outcomes for the recipients.

Volunteers are key to the model. A small team visits these men and women fortnightly in their home (Supported Residential Facility). Volunteers offer their friendship and provide guidance and encouragement. On the alternate week or at other times, volunteers create opportunities for people to explore new environments in the community and build support networks. They go out with individual residents to help them achieve and sustain their personal, social or recreational goals. Activities can vary widely such as going for a walk, visiting the library, joining a club, or attending a local fixture.

Volunteers are carefully selected, trained, supported and supervised to ensure quality of service delivery. People who are non-judgmental and possess the skills and empathy to work with this group in a creative way, are most suited. Volunteers need to commit at least to the fortnightly visiting and preferably to a weekend contact of 2-3 hours. Use of own transport is desirable and reimbursement of out-of-pocket expenses is available.

The careful matching of volunteers to particular persons and facilities is important. For this reason volunteer teams need a mix of personalities, experiences and in particular, genders.

Volunteers (often supported by the program coordinator) get to know participants in the program through the regular visiting program. Rather than try to link volunteers with individuals, the volunteers visit the facilities as a group and friendships find themselves. This has been found to be particularly beneficial for volunteers and participants also as conversation often flows better with more than two people, in a situation where the participant is not used to or not skilled at making conversation. Sometimes the participant begins by mainly observing a conversation and contributing when they feel comfortable. This is a much more natural and less threatening way to gradually develop these skills. According to the Program Coordinator, this visiting enables the development of interpersonal skills, it provides an opportunity to get to know the person, their desires and goals and work through those "rote" responses about what they are interested in (i.e. those activities which they may have been involved in, in an institutional setting). This takes time and trust and can be instrumental in "keeping the relationship and the outcome natural".

After a relationship is built, the volunteer(s) begins to build a web of support. This occurs in two ways

- Building supports around the Supported Residential Facility that will provide ongoing links between the facilities and the communities. An example is arranging for local service clubs to "buddy up" with a facility. These groups may then participate in or organise activities at the facility or invite residents to participate in activities in the community.
- Building supports around an individual. This can involve linking an individual with activities, resources, opportunities, clubs or groups that meet an interest or goal. This can involve significant reconnaissance by the volunteer and/or program coordinator before a participant is included.

Case Study

"A Story about Peter" is told by a LifeLinks volunteer

When we first went to the Supported Residential Facility Peter (not his real name) pretty well didn't want anything to do with us. If we would invite him to join us in bingo or scrabble or anything else we were doing he just wasn't interested but as its often the case we did notice that he was sitting in close vicinity to us and actually reacting to what was going on, laughing at the funny bits and correcting our mistakes.

Eventually he did come into the group just as an observer, and very quickly he was actively participating. One thing that was interesting to me was that after we had been coming for about the fifth visit when we walked into the big lounge room where the T.V. is on – where it is very difficult to have a conversation with anyone when the T.V. is on. We indicated that we couldn't really hear and that would they like to leave the room and talk. Instead Peter got up and said "I'm going to turn the T.V. off", and several of the residents said, "Oh, I don't think we are allowed to do that". And Peter said, "Well I am, because its important and I want to hear what they have got to say". So he stood up and

turned the T.V. off. Since that happened almost every time when we come in the majority vote to have the T.V. off.

I was really impressed with Peter. That led me to ask Peter to take a more active role in supporting the residents there as their spokesperson. Peter is now on the Advisory Group for LifeLinks, which meets every two months. He acts as a representative for the hostel where he lives.

That possibly in some way has led to him to put his hand up in asking for more help with literacy and numeracy classes so we have organised that as well.

Peter is actually starting to blossom and believe a lot more in himself. I think he is looking to broaden his life because I think he has a very active mind and he is currently thinking about where and what he can do. So currently its numeracy and will be literacy and I wouldn't be surprised if there were other things that he would like to do in the future.

We will certainly be helping him because he has helped us a lot as volunteers in his being a bit more pro-active and outspoken as a resident.

Resources, Administration and Outputs

The program is currently running across the 4 Council areas with 1.5 FTE staff providing support to approximately 50 volunteers as well as directly supporting a number of the more complex individual arrangements. In total it involves approximately X participants.

The program has recently received ongoing funding to support 3 FTE staff, with an aim to work with X volunteers and involve approximately 200 individuals across the 4 Councils and 10 Supported Residential Facilities. The nature of the target group assumes that participants will primarily be significantly isolated with complex needs.

Volunteer recruitment training and support is significant and includes:

- Interview to screen
- Police check
- Orientation folder
- Provision of a copy of the Better Practice book
- A 2 day course
- Ongoing information / training sessions
- Volunteer meetings and team meetings

Volunteers are required to keep a record of hours and receive reimbursement for:

- mileage to and from the work place and carrying out volunteering duties
- meal allowance when volunteer work necessitates a meal or snack between 11am-2pm or 4pm-7pm
- Public Transport allowance
- Parking allowance
- Telephone allowance

- Support expenses including cost of materials, food, entry fees etc required to undertake an activity with individuals or groups.

Volunteers are provided with resources to use in developing relationships. These can include games, craft supplies, sporting, cooking or gardening equipment etc.

Participants "register" to be involved in the program rather than being "assessed". This involves the participant completing a registration form themselves (or assisted to do so). The form identifies name, sex, date of birth, country of birth, ATSI, language spoken at home, pension and consent. It then requests information about the individuals interests and goals as well as health, mobility, communication or memory issues and what help the participant currently has with going out.

Comment

The LifeLinks program works hard to make relationships natural "because it is contrived, no matter how you look at it". This provides a number of challenges around then meeting the responsibilities of a service provider and accountability to a funding source. These include:

- Knowing where volunteers are and what they are doing at all times
- Registering the volunteers. Do they continue to be registered volunteers even if they form a lifelong bond with an individual?
- The registration of participants
- The collection of necessary data on individuals.
- Advising participants of their rights
- The requirement for paperwork to be completed and care needs to be understood if individuals are supported in activities outside of the facility.

All of these requirements contribute to the relationships formed through the program being experienced as "service" rather than "natural" relationships and the program continually struggles to find an appropriate balance.

Healthy Lifestyles, Towards Community Inclusion (Helping Hand Aged Care)

This program provides an example of a "Transitional Program" of "support groups" and "supported community integration" as defined in the Framework for Social Connectivity on the Southern Fleurieu Peninsula

Towards community inclusion services are available to individuals over the age of 60 years, living in the Northern metropolitan area who feel that "life is passing them by", would like to develop new interests, meet new people and become more involved in their community and require assistance to access community activities or groups. Services include:

- Providing information on community activities and groups
- Developing community supports
- Creating opportunities for community participation
- Reconnecting to community activities
- Working with groups and individuals to talk about the barriers to participating in the community
- Looking at what the social isolation issues are for older people living in the north
- Working together with the community to find creative ways to solve problems and make things happen

Focus Groups

Over time, the program has concentrated more and more on focus groups. This involves bringing together groups of people with similar interests or needs. This interest or need can provide a basis for developing relationships.

Focus groups also enable the program to reach more people with limited resources.

At times the nature of the focus group offers people the opportunity to be involved because of what they can offer the group rather than what the group can offer them – an empowering approach that enables the participant to be the "expert" rather than the "victim".

Focus Groups can include mens groups, relinquished carers groups, early intervention chronic disease groups etc.

Venue

The Program Coordinator has found that where groups have been developed by the Community Inclusion Service, the location has been very important to integration of participants into the broader community.

Venues which offer a range of activities or provide lunch etc encourage people to continue to participate outside the bounds of the group activity. Such venues include the local Vietnam Vets centre as a venue for a mens group. Meals, a pool table, darts etc and

a continual movement of people through the centre for reasons other than the mens group provides a range of opportunities for people to continue to socialise.

Individual support

Staff and/or volunteers support individuals to integrate into community activities. Activities or groups are always "checked out" by staff or volunteers before the participant is involved.

The Program Coordinator noted that there are risks with setting up relationships that may not work. However he also notes that "that's life" and it could be seen as patronising to participants to protect them from such risks that people take every day.

Resources, Administration and Outputs

The program has forged strong partnerships with other groups such as local government, RSL and carer support programs. These relationships provide assistance with venues, transport etc.

Promotion is a very important part of the program. It increases the awareness of social isolation and its relationship to poor health and identifies community groups that may be welcoming of including program participants.

Participants complete an enrolment rather than referral or assessment form. This is in keeping with the person being a participant in the community rather than recipient of a service.

A full time program coordinator will generally support around 100 individuals and coordinate 8 volunteers. 70 participants are supported through groups such as focus groups while another 30 receive support with integration into community activities individually.

Comment

The program coordinator reflected on the intensive nature of integrating individuals into the community and the capacity for contrived groups to increase confidence and facilitate community integration while assisting a much larger group of people.

Ageing Disgracefully

This is an example of a "Personal Development" program as defined in the Framework for Social Connectivity on the Southern Fleurieu Peninsula

The idea of this WEA course, initially supported by an aged care provider, was to encourage older people to break out of the box and move beyond stereotypes that determine how they live in the community as older people.

Over several weeks the program covered stereotypes, recognising your own uniqueness, developing goals, identifying opportunities to contribute or to learn, how to get motivated and stay positive. The program introduced role models and mentors in the form of inspirational (older) peer speakers such as older individuals volunteering overseas or in remote Australia.

While the course was initially run by an employee of an aged care organisation, it was supported by an older person who then ran future courses. It was seen as most appropriate, given the subject matter for older people themselves to be 'mentoring' others in how to 'age disgracefully'.

Comment

The notion of stereotypes, rote responses etc have been raised numerous times during my discussions with providers of social integration or participation programs. This concept returns to the Positive Ageing Taskforce's focus on Current and Future Social and Recreational opportunities. While people's rote responses to the question "how do you see yourself keeping busy in retirement" may prompt a limited range of answers such as "Golf", "Lunch", "Bowls" etc do we need to encourage people and provide opportunities to develop a passion, follow their dreams and think outside the box. Will this passion then fuel the type of community involvement that will keep people fitter for longer? Do older people really want to play golf, bowls, lunch, volunteer for meals on wheels and do craft or would they like to do bellydancing, learn to surf, do a wine appreciation course or volunteer with a remote aboriginal community?

The possibility of preventing rather than curing social isolation is obviously be preferrable and the above approach seems to be an exciting way to do this. However this approach as an opportunity advertised to the general community may not attract the desired audience. I would imagine that this opportunity would attract active older persons who may gain the benefit of heightening their sense of adventure or passion. However these individuals are less likely to be those who are at risk of becoming isolated. It might have greater benefit if such an opportunity was also linked with a process which identifies individuals who may be at risk of becoming isolated.

Encounter Centre

While historically this is an example of a "Contrived Opportunity" (as defined in the Framework for Social Connectivity on the Southern Fleurieu Peninsula), Encounter Centre increasingly become a vehicle for increasing the range of "social and recreational opportunities" and for providing opportunities for people of all ages and abilities to take on "roles and responsibilities" within the community.

Historically Encounter Centre's mandate was to provide support and opportunities to younger adults with disabilities. Programs were developed for this target group and included woodwork, painting, pottery and wood burning.

These programs were supported by a large group of volunteers. Given the local demography of the Victor Harbor area, these volunteers were primarily older people. Over time, these volunteers have become older and needing of some level of support themselves. With the ageing of the volunteer group and the sale of goods made by people attending the centre has come a blurring of the lines between volunteer and participant. Hence few people see themselves as being there to receive a service, rather they are there to provide their community with a service. With this comes a sense of purpose and value to the community.

More recently the board has agreed to expand their target group to include older people.

Movement into a new larger and purpose built centre a few years ago has seen a number of new programs developed. Some of these are "outreach" activities, where Encounter Centre offer a venue to a group who are self managed. Other activities are organised and run by Encounter Centre. Activities may run on an ongoing basis or be offered for a limited time. These activities include:

- South Talk Conversation Group
- Bridge
- Knitting
- Floral Art
- Wood Burning
- Garden Club
- Teddy Bear Making
- Card Making
- Languages
- Computing

Volunteering roles are available in supporting

- Woodwork
- Paint shop
- Reception
- Pottery
- Nursery

- Kitchen

Resources, Administration and Outputs

The Encounter centre employs a full time Manager and 0.7 financial officer and 0.8 workshop supervisor and a 0.4 cleaner. Approximately 100 people are involved in the range of activities offered as "outreach" programs or organised by the centre. Approximately 75% of these participants would be over 65 years of age.

There are 200+ volunteers involved at the centre with more than half being over 65 years of age and some being over the age of 80 years.

While volunteers and participants are aging, few have care needs.

A unique characteristic of Encounter Centre is that a large part of its program caters to men.

The centre owns a bus which is used to provide transport to its younger disabled target group but generally is not offered to volunteers and other participants.

Comment

The true value of community participation is the sense of belonging, of being valued and having purpose. The value of being seen as having something to offer rather than being provided with a service has also been a recurring theme in my observations of successful programs. A true relationship between two people, in and of itself will provide these outcomes - participating in an activity may not. However opportunities for individuals to "offer something" to a situation provides these outcomes while also providing the empowerment and the sense of worth that enables people to feel an equal and worthy partner in a relationship and therefore will be more conducive to the development of real and lasting relationships.

Caring Neighborhood

Caring Neighborhood provides an example of both "volunteer friendships" and "supported community opportunities (lunch groups)".

Caring Neighborhood provides friendship and companionship for isolated or alone HACC eligible individuals with limited capacity to link into the community or establish friendships.

Aproximately 50% of participants in the program are frail elderly people, a further 25% are younger people with disabilities and 25% are individuals with a mental illness.

Approximately half of all referrals come from service providers with a further 35% from other clients, 15% from volunteers and 5% from individuals or their representatives.

The Coordinator visits all prospective participants, talking with them and getting to know them. Often issues are identified such as grief and loss. While the program does not provide support for the express purpose of providing assistance with specific tasks, sometimes the link made with the participant is task oriented such as walking the dog. This task is defined by the client and is seen by the client as less threatening than the idea of making conversation and developing a relationship. Over time trust and then a relationship develops in a more natural, more relaxed way (see case study).

Accepting or admitting that they are lonely is difficult for many prospective participants. The term "lonely" is avoided when discussing the client's situation, needs and preferences. Acceptance of help can also be difficult when individuals feel that family will reduce their visits if they feel someone else is doing this.

The Coordinator seeks to understand the interests of the individual and links people with volunteers and/or opportunities that might satisfy these interests. Sometimes it is a matter of individuals gradually regaining their confidence and an awareness of what they have to offer a relationship or the community. In some cases participants themselves become volunteers either within the Caring Neighbourhood program or with other services.

Connections between volunteers and individuals with the support of Caring Neighbourhood are seen as ongoing. Relationships can develop to the point where the line between a personal relationship and one of volunteer is unclear.

Group situations offer an opportunity to establish connections between participants that may result in participants continuing to see each other outside of the contrived group situation. Caring Neighbourhood facilitate 4 lunch groups with more than 70 people and 10 volunteers involved.

Case Study

Mrs Jones (not her real name) didn't want to be involved in a club and didn't want a friend. However she was happy to accept help from a volunteer with tasks with which

she as experiencing difficulty. It was agreed that the coordinator would seek a volunteer to walk Mrs Jones' dog. Mrs Jones slowly developed a relationship with her 'dog walker' this trust extending to Mrs Jones becoming involved with a "lunch club" that the volunteer was also involved in.

Resources Administration and Outputs

Caring Neighbourhood operates with a 0.6 FTE Coordinator, approximately 40-44 volunteers and supports 50 participants individually as well as around 70 individuals participating in the lunch groups.

Volunteer induction is undertaken in groups or with individuals. This includes an overview of the information contained in the Volunteer Handbook including:

- Rights and responsibilities
- Occupational Health and Safety
- Values and attitudes
- Police Clearance
- Volunteer Policy
- Expenses claims process
- Use of personal vehicle agreement

Assessment forms are not used, instead the program has a 'registration form' filled out by the participant or with assistance of the volunteer. This includes only basic necessary information.

This program is limited in it's capacity to meet the personal care needs of individuals with limited mobility who wish to undertake activities outside of their home.

Comment

Like other programs observed in this study this program reflected the role that volunteer / participant relationships, while contrived, play in increasing the confidence, skills and self efficacy that in turn enables the individual to develop further, natural relationships.

The level of skill required of the volunteer in ensuring that the relationship developed is one of development, rather than developing dependency, is something that we may not have investigated adequately in discussions with these providers and may need further discussion.

ACPA – Community Connect

Community Connect provides an example of "volunteer friendship" and "transitional programs" as defined in the Framework for Social Connectivity on the Southern Fleurieu Peninsula.

Community Connect matches socially isolated older people with volunteers to offer companionship and assistance to participate in the community.

The program focuses on the individual, recognising and utilising the participants capacity to contribute (see Case Study 1). It is acutely aware that individuals don't wish to be labelled or stereotyped as isolated or lonely and that this label can have a disempowering affect on the individual. The program has gradually changed the way it describes itself to ensure that the way the program is communicated does not adversely affect its outcomes.

In some cases the coordinator has capitalized on commonalities between participants. Linking participants with similar interests.

The Coordinator has observed a natural tendency for both the participant and volunteer to focus on the participants medical problems. Training for volunteers has had a focus on assisting volunteers to focus on the person.

Case Study

Mrs Smith (not her real name) has limited mobility and did not feel comfortable leaving her home. She is a local person who has a lot of knowledge about local history. Mrs Jones is a volunteer with Community Connect. She is new to the area and is interested in the local history. Mrs Jones started visiting Mrs Smith and talking about local history. After some time Mrs Smith found it difficult to explain without showing Mrs Jones the sights so they began to take outings to see the buildings and sites they had been discussing. On one such outing the two ladies came across and started a conversation with Mrs Jones' friends. Later Mrs Jones' friends said how interested they were in Mrs Smiths stories and asked if they could come for afternoon tea. This relationship has developed through Mrs Smith feeling that she has something to offer the people who visit her – her knowledge of the local area.

Resources Administration and Outputs

Approximately half of all referrals have been received through the Alexandrina Centre for Positive Ageing, 15% from the health service and the remainder from ACAT, GP's, self referral and others.

The program expects to receive 2-3 referrals per month with a turnover of only 1 participant per month. While originally the program expected that after some time participants would no longer need the program/volunteer, this has not been the case and it is now envisaged that connections made between two people will be lasting.
The program is limited in it's ability to support people with high care needs who are wanting to participate in activities outside of the home.

The program is staffed by one Coordinator, working 20 hours per week and funded by Home and Community Care at around $27,000

ACPA – Centre Based

ACPA provides an example of a mixture of "Contrived Opportunities", "support groups" and community development approaches covering "social and recreational opportunities" as defined in the Framework for Social Connectivity on the Southern Fleurieu Peninsula.

The Vision of Alexandrina Centre for Positive Ageing is to be a "progressive centre providing quality services that promote positive ageing within the Alexandrina Council area". It aims to provide services aimed at preventing social isolation and enable older people to be valued and active members of the community, to provide respite and support for Carers, to encourage older people to be responsible for their own health and independence, to assist in the integration of members into community activities.

ACPA offers a range of centre based activities and services in the Goolwa centre, programmed over a 6 day week. This program includes podiatry, hand waxing for arthritis, heat therapy, massage, conversation group, relaxation, keep fit, craft, cards & games, leatherwork, walking, folk art, marching ladies, carer support group, osteoporosis support group, mens social cards and a monthly scenic drive. A one day program operates from the RSL club one day per week in Port Elliot and includes hand-waxing, heat treatment, walking, keep active, Tai Chi, lunch and games.

ACPA also runs a number of short term or one off programs. These are generally educational, based on health promotion or skill development.

ACPA experiences some "overlap" between participants and volunteers. A number of volunteers are becoming frailer and themselves need some level of support, however they continue their voluntary roles.

ACPA Model

ACPA services two groups of people. This has been reflected in their model, particularly over the past couple of years.
The frail older group of participants requires a higher level of support. The role of ACPA in their care often includes respite for Carers, monitoring, social support, referral etc. These individuals often attend ACPA for a longer part of the day over which they participate in a range of activities.

Often isolated individuals become involved in ACPA through a referral for health or therapeutic reasons. This seems to be a more acceptable purpose for individuals who may have become withdrawn, who lack confidence or do not acknowledge or want others to acknowledge their isolation. This participation often has the additional benefits of social contact, which, with increased confidence, comfort and trust; develops into a greater involvement in more of the social aspects of the Centres activities.

On the other hand, the more active participants are more likely to attend specific activities of choice and require limited additional support. ACPA is now taking more of a community development role in meeting the needs of this client group. ACPA is

involved in the development of groups which it then facilitates to become self sufficient and community based.

A community exercise group was started 2 years ago with a small grant. This group was assisted by ACPA with referrals and support but was encouraged to operate in a community venue. This group has since grown to around 4 classes and has transferred to be part of the local Gym. The original group was made up of ACPA participants, a number of whom no longer attend ACPA, participating in these self sufficient community based programs instead. This type of community development activity is in line with ACPA's determination not to create dependency on ACPA for social participation. Goolwa Skill is a project whereby older individuals pass on their skills to younger people with an interest. Seniors computing teaches basic computing skills, initially focussing on older people but recently expanding this to 35 years+. These projects were similarly developed through a community development model, now being independently managed through their own committee's.

A community development approach to these activities has been one way that ACPA has been able to keep up with demand for services in an environment of significant population growth and minimal funding increases. Finding the right people to take responsibility for these activities is one of the biggest difficulties with this approach. People need to be passionate about what they are doing. Those who offer to take on a role are generally more successful than those who are approached. Community based programs are only as successful as the people leading them and can be person-dependent. As a founding supporter of these programs ACPA can tend to become re-involved if the independent management of these groups falters.

Case Study

Mr Smith was quite frail and was invited to participate in leatherwork at ACPA as a break for his Carer. Mr Smith mentioned this to his neighbour who was very interested and himself began coming to the leatherwork group. Now Mr Smith and his neighbour are firm friends and the neighbour provides Mr Smith with support.

Resources Administration and Outputs

In 2005 the centre provided over 31,000 services. Over 100 volunteers provided more than 12,000 hours of service. The centre based service is staffed by 1 administration officer, 1 assistant coordinator and 1 coordinator.

ACPA's centre based program is funded by Home and Community Care and the Alexandrina Council. Funding, covering staff, building maintenance and costs is around $240,000.

A small fee of around $2 applies to most activities.

Southern Onkaparinga Seniors Access – ACH

This service offers a mixture of "Contrived Opportunities", "supported community opportunities" "support groups" "transition programs" and "volunteer friendships" as defined in the Framework for Social Connectivity on the Southern Fleurieu Peninsula.

Southern Onkaparinga Seniors access provides social opportunities, support and respite for HACC eligible individuals in the McLaren Vale, Willunga and Sellicks Beach areas.
Coastal Capers is a program facilitated by ACH but predominantly organised by participants. It links people with similar interests together. Interested individuals are asked to a meeting in which individuals identify their interests. These interests are promoted via newsletters and notice board and others can add their name to a list. When there are enough people the activity is organised by the group with support (different levels depending on the group) from ACH. Service provider input has been particularly helpful in managing group dynamics and encouraging the group to be inclusive. Volunteer support and transport are provided for the activity. This program involves around 38 people.
Day programs operate at:

- McLaren Vale 2 days per week with 44 participants
- Sellicks Beach every second week with 30 participants
- and Willunga half a day per week with 15 participants. Being a smaller group this is often more appropriate for those less confident isolated individuals.

These programs usually experience a turnover of around 15 people per year with new referrals around 40. They offer support to the more frail members with limited capacity to provide personal care. There is a lifter on site. There is a high level of depression among participants (as much as 30%), low level dementia is present in around 40% of participants with 10% suffering from other mental illness including panic, anxiety and schizophrenia and 6% requiring assistance with personal care.
Coastal Seniors Access Program is a monthly meeting of people to hear a guest speaker on topics of health or education. It provides opportunity for lifelong learning as well as a social environment that offers an 'inbuilt topic for conversation'. Approximately 40 people attend each month from a mailing list of 116.
Short term educational programs are also offered by Southern Onkaparinga Seniors Access on topics such as 'memory' or 'living with arthritis'.
A Carer Support Group operates with ACH support for around 50 Carers.
Out and About links volunteers and clients on a 1 to 1 basis. Volunteers may home visit or go out with participants, depending on their interests and abilities. This program is aimed at people who are not suitable for group situations. The program aims to improve the confidence and skills of participants with the goal of improving community participation. Volunteers may initially be involved in very small ways, 'popping in' on the participant for a specific and short purpose. The volunteer's involvement may grow as their confidence and trust in the volunteer grows. While people can be linked back into communities it has not been seen as appropriate to withdraw volunteer support as this arrangement is based on a real offer of friendship. Turn over of participants is very small for this program. While this program fills a significant gap by meeting the needs of individuals who do not suit group programs it is very limited by it's size (funding).

Riverside Artists is an art group for frail (very) older people held weekly for 5 hours with approximately 14 participants.

Resources Administration and Outputs

Southern Onkaparinga Seniors Access is based in a stand alone purpose built Council owned centre in McLaren Vale. The service operates with 0.8 Coordinator, 0.8 Assistant Coordinator, and 11 hours of program assistant time per week.

The program budget is around $160,000 with Council providing venue and some maintenance.

Comment

This program offers predominantly centre based activities and community outings supported by paid staff. The level of support provided by staff varies significantly with the target group of each program. While they are not truly community based activities or opportunities, there is a high level of participant involvement in the operation of some programs and some programs are developed around the specific interests of participants.

The involvement (at some level) of ACH enables programs to receive that management support that so many community groups struggle to maintain with depleting membership on management committees. It also enables groups to be supported with respect to managing the dynamics of the group and maintaining the principles on which the programs are based. The community development style of some activities also contributes to the capacity of the service to support a wide range of activities with minimal resources.

Elder Friendly Communities

The Elder Friendly Communities Program is an example a community development approach covering "social and recreational opportunities" and "roles and responsibilities" as defined in the Framework for Social Connectivity on the Southern Fleurieu Peninsula.

The Elder Friendly Communities program builds on the fact that older people will make up a larger proportion (around one quarter) of our population and the understanding that these seniors will act as the vital core of day-to-day life. While some older adults may be frail and require assistance with daily living, the vast majority will be active and healthy. These healthy active older adults are ripe in character and life experience, rich in available time, many of them highly motivated to become active and involved in their neighbourhoods.

The Elder Friendly Communities Program is one innovative approach to engage seniors to build and strengthen supportive neighbourhoods and to ensure their sustained vital involvement in community life. This focus on neighbourhood life means that the seniors involved in the program have a commitment to improving life for each other and for their communities.

The program engages older adults to define and lead community development initiatives in their neighbourhoods. Like all community development efforts, the Elder Friendly Communities Program is based on the belief that the "population", seniors, have many untapped skills, gifts and capacities. This potential can be tapped to enrich the life of the community as a whole.

The program aims to change the approach to aging from one where older adults are considered as users of services to one where they are contributors. By focusing on the potential of older adults, the Elder Friendly Communities Program is developing a program approach that is critical to our successful and productive shift towards a vibrant, healthier, society.

While this project is being implemented in the Western suburbs of Adelaide, the project originated in Canada. The Canadian project provides part time community development workers (total just under 3 FTE) to support seniors' community efforts in eight neighbourhoods.

Community development activities emphasize the participation and empowerment of seniors in the identification of strategies and interventions aimed at creating supportive neighbourhood environments.

The projects were initiated with a neighbourhood level needs assessment. The findings became the basis for the beginning of community development activities. Later meetings discussed how they would like to address the issues that they had identified. Generally, sub-committees focus on a particular issue and report back to the main group on a monthly basis.

Today, in four of the original pilot neighbourhoods seniors gather regularly to plan and implement neighbourhoods initiatives. Current initiatives include affordable yard care and snow removal projects, a seniors' conference, unique projects to involve isolated seniors, multi-cultural sharing and celebration events, social gatherings, approaches to ensure access to local services for seniors, and advocacy initiatives.

Comment

This program focuses on the individual as a provider rather than a recipient of services. This contributes significantly to the individuals sense of self worth, value and independence. Furthermore this encourages a new level of volunteerism, a challenge to which the older population, being mostly fit and well and a source of immense skills and experience, will be ready for. It involves the volunteer as the driver, decision maker and manager as well as the worker.

3R's

The 3R's program fits within the concept of "Transitional Programs" as defined in the Framework for Social Connectivity on the Southern Fleurieu Peninsula.

the 3R's program is available to individuals living in the Eastern Suburbs of Adelaide who are (or are the carer of) over 65 years of age or a younger person with a disability. The program includes individuals with memory loss but does not cater for people requiring personal care.

The three R's stands for Respite, Recreation and Revitalisation.
Respite: the aim is to offer a regular planned break for Carers throughout the week with peace of mind knowing the person is participating in meaningful activities.
Recreation: the aim is to assist individuals to access a range of activities that will help them remain independent in the community. Facilitated support is offered in both a group setting and individually.
Revitalisation: is the benefit of the improved quality of life.

3R's currently runs 6 groups across the Eastern Metropolitan suburbs (Campbelltown, Payneham, Burnside). One is specifically targeted at frail aged persons, another at individuals with acquired brain injury, two are composite groups for frail aged and individuals with memory loss and one is specifically for those with memory loss. Groups run weekly with a duration of between 3 and 4 & ½ hours.

Key to the philosophy of the 3R's program is the integration of individuals into the community. This philosophy is not necessarily applied to individuals with significant cognitive impairment as the goals of memory loss groups are slightly different. These groups aim to maintain cognitive skills and participation for as long as possible in a supported environment.

During assessment the transitional nature of the program is explained. Each participant is assisted to set their own goals for participation in the program. Attendance to the program may be for a short or long time depending on the goals each individual set. Goals are revisited 3 monthly to evaluate progress and strategies to meet the goals. Staff work individually with people within a group setting with a focus on assisting them to meet their goals. The group setting serves a purpose of offering a supportive environment in which to build confidence and skills. The focus of the support worker on individual goals and the supportive nature of the group lends itself to group sizes of no more than 10 people with 2 support staff.

Groups provide primarily centre based activities such as board games and general socialisation. There are sometimes underlying therapeutic goals, particularly for individuals with memory loss. A lifelong learning or educational is also common in activities undertaken by the groups. Groups may go on outings once or twice a month.

3R's was designed to provide short term intervention to facilitate integration. However the program has found that, even when individuals gain confidence and become reconnected with the community, they do not want to sever their ties with the 3R's program, or more specifically, the friends they have made through the program. The program is currently addressing this issue with the potential to increase the independence of more confident groups.

The coordinator reports that a large number of people referred to the program, having been identified by a service provider or other individual as socially isolated, do not wish to participate in the program. People are rarely inappropriately referred although often transport is the main issue.

The program is a partnership of several agencies sharing information, expertise and resources. Workers are brokered from within these partner organisations and specifically trained within the philosophy of the 3R's program. The aim of this is to spread the philosophy and culture of the 3R's program throughout the partner organisations.

Case study:

Bill had been a manager of a supermarket until he suffered a brain injury resulting in significant memory deficit. He became very unsure of himself, refused to talk and had a very low self esteem. Through the support of 3R's Bill regained his confidence and now, after 5 years, speaks publicly about brain injury and volunteers talking with other brain injury victims.

Resources, Administration and Outputs

The program operates with recurrent funding of $170 000 per annum. There is a full time co-ordinator, 0.2 Admin assistant and about 72 hours per week from support staff. Capacity is to cater for around 60 participants per week with an average of 4 hours per person. This supports a population of around 223000 people of which around 36000 are over the age of 65 (note this program also caters for younger disabled). The program currently has no waiting list.

Comment

The concept of goal setting for isolated individuals responds to the idea that isolation and participation mean different things for different people in different circumstances and the need for each individuals specific needs to be acknowledged whether participating in a group based or individual intervention. This could be a powerful tool which promotes self awareness and self determination and a partnership between the service provider and the individual.

Once again common themes identified in this review of current practice arose within the 3R's program. These common themes included:

- The view that some groups of more marginalised older people require social opportunities that provide a supportive environment achieved only within a contrived and controlled environment.
- That responses to social isolation are aimed at building relationships and by this very nature do not lend well to being short term. The experience of a number of agencies

involved in this review was that, all going to plan, individuals will develop real relationships within somewhat contrived situations. In doing so the arrangement must be ongoing, whether this be between a volunteer and a participant of between a participant and a group. This then poses issues with turnover of participants and the capacity for the program to respond to larger numbers of people. Should a program withdraw it's support from groups or volunteers when relationships are well developed and at what point and how can this occur.

— There are a large number of people that are viewed by service providers as being isolated but who will not accept help.

Background Paper 3

Community Representative and Service Provider Consultation

Lisa Sparrow – Southern Fleurieu Positive Ageing Taskforce

April 2006

Methodology

A range of community groups (employee, chairperson or contact person) and service providers were interviewed personally via written survey or over the telephone and asked to comment on social isolation among older people in the community.
Individuals were asked:

- To provide information on the types of activities they offered which might respond to the needs of or come in contact with socially isolated people.
- To comment on the characteristics of social isolation in the community ie the profile of isolated individuals, causes, barriers to participation or special needs.
- To estimate the number of socially isolated people they are aware of and the number affected by a range of identified barriers.

By nature of the target group of individuals surveyed, some respondents were able to provide more information than others. Responses reflect differences, between respondents, in their perceptions, understanding and awareness of social isolation.

Anecdotal information and comments provided were found to be the most useful.

Community Groups Surveyed

1. St Augustines Anglican Church – Victor Harbor
2. Assemblies of God Victor Harbor / Oasis Care
3. Church of Christ Victor Harbor
4. RSB Victor Harbor
5. Port Elliot Uniting Church
6. Victor Harbor Telecross
7. Combined Christian Churches Community Care (Yankalilla)
8. Newland Memorial and Yilke Uniting Church
9. Happy Wanderers (Newland Memorial UC)
10. Myponga CWA
11. Yankalilla Senior Citizens
12. Hindmarsh Valley CWA
13. Yankalilla RSL
14. Yankalilla Meals on Wheels & Cape Jervis resident
15. Goolwa Church of Christ
16. University of the Third Age

Service Providers Surveyed

1. Southern Fleurieu Health Service – Community Support Service
2. Southern Fleurieu Health Service – Dementia Services
3. Southern Fleurieu Health Service – South Coast Carer Support
4. Southern Cross Care – Community Services
5. Lovell HCS – CACP's
6. Victor Harbor Community Therapy Service
7. Alexandrina Centre for Positive Ageing
8. ECH Independent Living Units

Table 1: Community groups surveyed by LGA and township:

LGA	**Township**	
Yankalilla	Yankalilla	4
	Cape Jervis	1
	Myponga	1
Victor Harbor	Victor Harbor	7
	Hindmarsh Valley	1
Goolwa	Goolwa	1
	Port Elliot	1

Table 2: Service Providers surveyed by LGA and township serviced:

LGA	**Township**	
Yankalilla	Yankalilla	4
	Cape Jervis	4
	Myponga	4
Victor Harbor	Victor Harbor	6
	Hindmarsh Valley	5
Goolwa	Goolwa	7
	Port Elliot	7

Analysis:

Prevalence and characteristics

Social Isolation is difficult to identify. The time and resources available to this study only permitted that the prevalence of social isolation be estimated by service providers and community representatives. The difficulty we soon discovered was in the inability of one person to judge the isolation of another individual without objective tools. This was particularly so given our acknowledgment that social connectivity is a continuum, along which there is a different point where each individual would express feeloings of isolation. However it was seen as important to our capacity to implement the proposed framework for social isolation, to have a broad understanding of the possible number of socially isolated people to whom the framework will need to respond.

Over the 16 community representatives and 8 service providers interviewed there were estimations of 605 isolated individuals across the Southern Fleurieu. While this figure can be used as an indication of the prevalence of isolation in the community, however:

- Are were estimations only of the 24 individuals interviewed
- Isolation was a subjective measurement, defined by each interviewee's own understanding of isolation and of the individuals they are involved with.
- Truly isolated people are likely to be unknown by all of the people interviewed.

An interesting slant on this estimation comes from 33% of all respondents to the community consultation, who identified that while they perceived an individual as isolated the individual either did not acknowledge this or would not accept help (Table 5). This raises the possibility that while the respondent may perceive that individuals social connectivity in the traditional sense to be limited, the individual themselves may not concur with this (and therefore perhaps is not isolated).

Respondents identified that this characteristic could be attributed to 58% of the total population identified as isolated (Table 6). While it is entirely possible that some of this 58% are in fact isolated, some might also be attributed to an inaccurate judgment of the individuals isolation.

A range of studies were reviewed as a part of this project. These studies (Literature Review Background Paper 1) gave a fair indication that at least 10% of people aged 65 and over are socially isolated and a further 12% are at risk. This provides one basis for estimating the current prevalence of social isolation in the Southern Fleurieu Peninsula (see Table 3(a)). Using this method it is estimated that there are currently nearly 700 isolated individuals across the Southern Fleurieu. Interestingly this figure is close to that identified by the community consultation (605).

Table 3(a) identifies a further 800 individuals are at risk of becoming isolated and that these figures could be expected to increase by around 50% in the next 15 years.

As shown in table 3, respondents reported that socially isolated people were more likely to be female (although this may be due to females being more likely to admit they are isolated and be affected by their isolation), and/or over the age of 75 and/or living alone and/or have no close family. Anecdotal information received indicated that people who had limited connection with the community or had no interests or passions were more likely to become isolated. These are all characteristics that might assist with the identification of 'at risk' individuals and the development of early intervention or prevention approaches.

Support Needs

Physical support needs, while identified by more respondents than any other support need was seen to affect a relatively small number (31%) of socially isolated people.

On the other hand emotional support was identified by 90% of service providers as a support need affecting a larger proportion of isolated individuals (43%). Depression and anxiety were seen to affect 27% of isolated individuals. Grief and Loss was identified by a relatively small number of respondents. However those that did identify grief and loss as an issue felt that this affected a large number (more than 50%) of isolated people. Overall there is some indication that emotional / psychological support needs are the more prevalent need of socially isolated individuals.

Community representatives saw a smaller percentage of people as having support needs than service providers. This could be viewed in two ways:

- Community representatives do not see the more isolated people and therefore do not see those with higher support needs
- Service Providers may be more aware of an individuals limitations. If this is the case it may be that the community representatives perspective is more accurate and that Service Providers may underestimate the abilities and overestimate the support needs of individuals in the community.

Barriers

The lack of connection with the community found in newcomers to the area was reflected in 3 out of 7 interviews with service providers. Community members also observed a loss of contact with community and family in retirement migrants. Interestingly one community representative referred to people "not knowing how to retire". The perception was that many people don't think about their retirement, they don't plan it and don't understand the implications of their retirement decisions. Service providers also identified that "Men can lose their identify and sense of usefulness when they no longer work".

Respondents generally felt that individuals who were "truly" isolated required quite intensive support to re-connect with the community. This involved responding to:

- a lack of awareness or acknowledgment in people that they have actually become isolated and how it is affecting them
- individuals acceptance of help

- the stigma associated with being lonely
- grief
- poor social skills
- behavioural problems
- hearing impairment
- finding relevant, appropriate, challenging or intellectually stimulating activities or interests
- depression
- a need for someone to lean on and to motivate.

Incontinence and sensory loss were identified as significant issues in 3 out of 7 interviews with service providers. Sensory loss was also identified by community representatives. In two interviews service providers reported individuals who were isolated as a result of embarrassment about the physical appearance of their disability (ie. paralysis and eating).

Service providers also identified cases where social isolation resulted from an inability to meet ones basic needs for personal care. The focus on these needs then detracted from meeting any next level needs such as that for social participation. Similarly service providers identified individuals who were unable to participate socially due to daily living activities being entirely time and energy consuming.

Other factors raised included lack of appropriate activities, carers duties, confidence, death of a partner, information about available opportunities, financial issues, geographical isolation, psychological issues and retirement.

Service providers in particular reported that unclear and unsupported pathways into groups or activities could make it quite difficult for people to become involved, particularly when the individual has low confidence. Service providers reported that, while individuals may be interested in a particular activity, the group may not have defined roles for new members or may not have procedures for greeting and inducting new or potential members. Potential members then feel that they are not welcome or needed.

Social Opportunities and Service Responses

Table 7 gives a good understanding of the range of activities offered by local community groups. Of 16 community groups interviewed activities offered included: craft, games, visiting, lifelong learning, support groups, outings and more, catering to more than 765 people.

Man local community groups offer social opportunities within ‘supported’ or ‘supportive’ environments. The principles and philosophies behind churches, in particular, support the provision of more inclusive and nurturing social environments which are open to individuals other than their own “members”. Any framework addressing Social Isolation must recognise and address the vital role that community groups, and in particular churches play.

A brief audit of opportunities for community connection listed in the local community guide identified 191 different activities that could be grouped into around 20 different categories including: bus trips, cultural, friendship, history, service clubs, sport, support group, art, educational, environment, food, games, hobby, IT, literary, music, politics and radio.

Table 9 gives an indication of the range of service responses for social isolation currently operating in the area. A range of different levels of support were. The services reported cater to an estimated 362 individuals and are most heavily weighted at either end of the Social Connectivity Framework, being a community development approach to ensuring a range of social and recreational opportunities to the provision of social opportunities in contrived environments.

Results

Prevalence and Characteristics of the Socially Isolated

Table 3: Reported Prevalence and Characteristics of the Socially Isolated

Group	Total service providers	Total community	total
# Isolated	498	107	605
General			
Male %	120 (24%)	30 (28%)	151 (25%)
Female%	367 (74%)	77 (72%)	443 (74%)
Under 65 %	58 (12%)	0 (0%)	58 (10%)
65-75 %	190 (38%)	20 (18%)	210 (34%)
75+%	250 (50%)	95 (88%)	344 (56%)
Live alone %	153 (31%)	80 (75%)	234 (39%)
have local family %	155 (31%)	18 (17%)	173 (29%)

Table 3(a): Prevalence of Social Isolation in the Southern Fleurieu (Statistical Basis)

	2005	2010	2015	2020
Alexandrina				
Population 65+	2366	2730	3219	3760
Socially Isolated	236.6	273	321.9	376
At Risk	283.92	327.6	386.28	451.2
Victor Harbor				
Population 65+	3830	4338	5017	5706
Socially Isolated	383	433.8	501.7	570.6
At Risk	459.6	520.56	602.04	684.72
Yankalilla				
Population 65+	781	908	1097	1259
Socially Isolated	78.1	90.8	109.7	125.9

At Risk	93.72	108.96	131.64	151.08
Total				
Population 65+	6977	7976	9333	10725
Socially Isolated	697.7	797.6	933.3	1072.5
At Risk	837.24	957.12	1119.96	1287

Support Needs of the Socially Isolated

Table 4: Support Needs and the Socially Isolated

Support Needs	% service providers identifying this need	% community representatives identifying this need	Total % identifying this need	Estimated % of isolated individuals with this need
Physical support	80%	60%	68%	31%
emotional support / confidence	90%	20%	48%	43%
cognitive / behavioural	60%	13%	32%	19%
depression/anxiety	80%	20%	44%	27%
chronic disease impact	20%	20%	20%	45%
grief and loss	56%	7%	25%	56%

Barriers

The following were identified as barriers by service providers and community representatives:

Table 5: Barriers Identified by Respondents

Barrier	**Percentage of respondents identifying this as a barrier:**
Transport	72%
Social Skills	36%
Relevant activities	35%
Acknowledging own need, accepting help	33%
Support needs	32%
Financial	16%
Access (resource limitations) of existing programs	12%
Eligibility for existing programs*	4%

* note: the only person identifying eligibility for existing programs as a barrier to participation was the provider of Extended Aged Care At Home Packages. This Australian Government Funded Service is funded such that it's the eligibility of recipients for Home and Community Care services is limited

Of those that identified these barriers, service providers and community representatives estimated that the barrier affected the following proportion of isolated people.

Table 6: Number of isolated individuals affected by barriers

Barrier	Estimated percentage of isolated persons affected by this barrier
Acknowledging own need, accepting help	58%
Transport	45%
Support needs	41%
Relevant activities	20%
Social Skills	12%
Financial	9%
Access (resource limitations) of existing programs	4%
Eligibility for existing programs	6%

Anecdotal Information received:

Community Groups

- Really isolated people need someone to take an interest in them, need one on one support from someone
- Church groups wanting to provide support (to i.e. isolated) have to worry about insurance and all sorts of legalities
- People need someone to follow up, to make the contact, make the effort to break the cycle.
- Men are less likely to open up and admit they are lonely – they are also less likely to feel it. Women will open up – they also feel it (loneliness) more.
- Lots have moved and lost their families, they may have no family or be the last one left (everyone around them has passed away.
- Isolated people often don't want to make a fuss or be an imposition, it is easy to forget about them.
- Grief is often associated with people withdrawing
- We are going in and out of peoples homes, they have needs but don't accept help
- Men are independent and don't accept they need help
- Poor social skills and behavioural issues are a problem, you need to think about the rest of the group
- Some people can't hear whats going on in a group environment, they feel very isolated because they can't participate
- This lady needs activities which are more intellectually stimulating, most (people/groups) are just not what she needs
- Some have never been interactive in groups and don't want to be
- The church has a carers system, everyone in the church has a carer – they can ring their carer any time of the day or night, they build a relationship with that person over time. There is a directory – we can let the Carer know if Mrs X is in hospital.

- We are not big enough communities to offer the range of activities (of Adelaide) to meet everyone's needs ie intellectually stimulating activity.
- Loss of licence is a major factor (in social isolation)
- Some people just don't know how to retire, they think they retire and just sit around
- People don't want to admit their family don't see them, there is a stigma attached to anyone whose family don't love them to death.
- Some people are just private
- People will get out if they have someone to organise things for them, to pick them up, to motivate them.
- Some people just don't know about what's available.
- There's not a lot happening in the area for those who are not physically active (Yankalilla).
- Not having their drivers licence is a problem
- Not knowing what help is available is a problem (Yankalilla)
- If people have interests all their life this keeps them going….if they just stayed home and looked after their husband they become isolated as they get older.
- Some people just don't have the right mentality – depression is pretty common however that generation mask it well – they can be very private and don't talk about their personal problems.
- There are new people moving into the area and losing their partner, they aren't really involved with the community and we wouldn't know if they were isolated or who they are.
- In a small town, particularly if you've lived here for years, if youre at risk the community rallies around.
- RSL are in a tough spot – we are going to combine ladies auxillary and men which will help.
- In Yankalilla we are pretty well cared for, everyone is getting along ok, there are no complaints, there is senior citz, probus, churches and we have the ACH nursing home.
- Members are aware of the help they can get, we have speakers from the aged care support people, we pick each other up, some of our members are 95, 87 years old.
- Farms change hands so much now we don't get them to CWA anymore.
- Some people live with their family and their family go to work – this can be lonely.
- People don't want to join senior citizens because they perceive them as being boring and inactive. We give people active things but just give them more time to do it – that's why we have so many members, lots in their 90's.
- There's probably a lot out there we don't know about
- Everyone looks out for each other, it's a good community out there, the community club is open for meals Thursdays and Saturdays (Cape Jervis)
- Everyone knows everyones business, if someone is sick we know it (Cape Jervis)
- Theres lots of men there on their own – they may need friendship (Cape Jervis)
- Lots of people have family in the city
- Most couples are fine. While they have a spouse they are ok, then the spouse dies they become lonely.

- Pride has a lot to do with it – people don't want to be charity cases.

Service Providers

- there is a lack of opportunities that "turn them on"
- There is no one there to help them (at the other end)
- lack of confidence
- Poor physical appearance (ie after stroke, with eating etc)
- safety concerns
- lack of independence
- transport
- Incontinence can be a major barrier for people participating
- Many don't know the town well and what is available
- Lots of people are resistive to help
- Transport and loss of licence are issues
- financial considerations - taxi costs $16 to get to camera club
- Eyesight
- There are small windows of opportunity to be involved with daily living activities taking up most of the day
- transport
- Many find it too tiring to get out
- Depression and anxiety
- Incontinence can be a major barrier for people participating
- New people to the area have no local connections
- Lack of basic support often results in isolation, package of services to meet basc needs provides confidence to socialise (heirachy of needs)
- Vision impairment
- Physical limitations
- Carers often lose their social connection or find their situation distances them from people who don't understand
- Cost
- Geographical isolation - cape jervis
- Who gives a rats about socialisation when theres so much stuff going on in your life (heirachy of needs)
- Hearing impaired
- Transport
- Some people move to the area when they are already frail or not long before and don't make connections
- Death of a partner
- frailty and health
- Men can lose their identity and sense of usefulness when they no longer work
- Embarassed because of disability - self conscious of image, wheelchair, eating etc.
- Continence
- People lose contact due to health episode
- sometimes people choose to be isolated
- There are lots of isolated people we just don't know about

- Use 75+ health assessments to identify isolated
- It is hard to think of who is isolated - tend only to think of those very severe cases
- We often get asked for check visits and this is often related to isolation
- Male caree's may be more controlling and demanding and as a result female carers more isolated
- Male carers not as isolated
- Relinquished carers need somewhere to go - they are clogging up carer support
- Half of identified isolated persons have no family support
- Many isolated people don't want to be more involved
- Half of identified isolated persons don't drive
- Most isolated people are in private homes
- Carers feel they are giving back by being involved in carer support
- If a social outlet is invovled with SCCS this gives permission for person to participate as it relates to their role as carer.
- Domestic violence are the ones we don't see
- Family not close by
- For some people the only person they see is their cleaner
- Small towns have a sense of community - not Victor Harbor
- Migrant retirees are putting the pressure on community resources but not contributing towards them
- It is not just physical support needs but that the physical disability makes it exhausting to go out
- Small issues can become bigger than life
- People are isolated but don't want to do anything
- Some people have intensive support needs ie 2 staff visiting 3 x per day
- Coping with chronic conditions is full time job
- Many people find it just 'all too hard' to participate - choose to be isolated
- Don't want to segregate people
- who defines what is appropriate or 'normal' participation
- While most would need emotional support and some physical support intially, once comfortable this support may be able to be gradually withdrawn
- Security of having someone there to be company & assist is most needed, this needn't be a paid carer
- Need to feel safe, encouraged, social support
- Supportive environment
- Carers need to feel that they are the focus of a relationship not the person they care for
- Need a warm, welcoming and understanding environment
- People feel like they are contributing, doing something for rather than having something done for them
- Something is needed to "get them in" ie massage
- Groups not always open to newcomers, particularly those who have needs
- Groups with sole purpose of social interaction can be quite daunting for people who lack confidence or skills, bhetter to have activity based opportunities with shared interest ie gardening.

- Sometimes don't refer to existing programs because of perceived ability of this service to respond
- Need to link people into existing activities and services
- What about a new residents package that provides information on whats available
- it is hard to 'get in' to encounter centre - there is no process of referral or membership, no process for new members. Volunteers are uncomfortable because of concern of having to care for frail or disabled. They need to define the "different roles" that new members could have and how they can become involved.q
- Need to establish familiarity and trust with a person before they might open up to more social contact
- Need someone to be motivator, almost to do it for you, someone you really trust, they need to be pushed
- It's a matter of breaking the barrier - getting that first success
- Activity based socialisation around topic of interest would be most successful ie community garden or mosaic
- All people would probably respond if there was adequate support
- Available supported activities are suitable for younger people with an intellectual disability or frail aged. There is not much for 50-70 year olds with a disability ie acquired brain injury.
- Motivation, courage and social skills re impairments, people need a mentor to encourage them
- Transport would have to be the biggest barrier
- It is very difficult to integrate people with antisocial behaviours into community activities
- Cost can be a problem for many people.
- A supportive environment is very important
- Once the activity becomes routine it is much easier (to facilitate or maintain)

Social Opportunities and Service Responses

Both service providers and community groups were also asked to describe the social opportunities or responses to social isolation that they offer.

Community Groups

Community groups offered activities from craft and games to conversation groups and religious activities. They also offered support groups and occasionally activities including a shared meal. Some groups provided a range of activities within the one program and other groups did not report the number of participants. Hence over the 16 community groups surveyed, there were more than 27 different social opportunities with an average of 28 participants per group and a total of 765 individuals involved (see Table 2).

Table 7: Activities offered by community groups (Survey)

Group Type	# groups	# people involved
Craft / Games etc	6	149
Individual support / visiting	3	200
Ladies group	2	30+
Lifelong learning	2	120
Support Group	2	24
Disabled	1	30
Religious Activity (other than Church)	3	
Conversation	1	20
Outings	3	70
Speaker / Meeting	3	72+
Meal & social	1	40
TOTAL	**27**	**765**

An audit of written resources outlining social and recreational opportunities offered across the Fleurieu Peninsula was conducted. This audit was not exhaustive and did not include those provided by formal service providers. However the audit is indicative of the range and number of social opportunities available across the region with a total of 191 activities identified.

Table 8: Activities offered by community groups (Audit)

Activity Type	Number Offered
bus trips	3
cultural	19
friendship	8
history	8
service clubs	31
sport	45
support group	10
special interest (art)	13
special interest (educational)	4
special interest (environment)	10
special interest (food)	1
special interest (games)	11
special interest (general)	2
special interest (hobby)	6
special interest (IT)	1
special interest (literary)	7
special interest (music)	7
special interest (politics)	2
special interest (radio)	2
special interest TOTAL	67
Total Activities Offered	**191**

Service Providers

The following table provides an overview of the type of service currently operating in the area, which respond to various aspects of isolation.

Table 9: Services offered by service providers

Activity Type	Number of individuals supported
Social and Recreational Opportunities (Comm Devt)	64
Supported Integration	4
Transitional Programs	30
Supported Community Opportunities	70
Volunteer Friendships	80
Contrived Opportunities	106
TOTAL	362

Background Paper 4

Social Participation Estimated Target Population

Lisa Sparrow – Southern Fleurieu Positive Ageing Taskforce

July 2006

Method

Alexandrina Centre for Positive Ageing (ACPA) was used as a benchmark for determining the possible target population for services supporting social participation in Victor Harbor and Alexandrina.

Different ACPA activities offer different levels of support and meet the needs of a wide range of individuals. ACPA provided data on participants in the range of support services and activities offered at the centre by level of dependence and age cohort (60-69, 70-79, 80+). Categories used were:

1. Independent
   - Does NOT require any support from staff
   - Communicates easily with others
   - Does NOT require assistance with transport
   - Would participate easily in ANY activity within the community
2. Transport Dependent Only
   - Requires assistance with transport
   - Does NOT require any physical support from staff
   - Communicates independently with others (strangers and friends)
   - Initiates involvement in activities him/herself
   - Would participate easily in ANY activity within the community (given transport needs are met)
3. Low Level Supportive Environment
   - May require assistance with transport
   - Participates independently <u>when environment is familiar and/or comfortable.</u>
   - Does NOT require any physical support from staff
   - Communicates independently with others who are familiar.
   - With assistance would potentially participate well in any environment once familiar and/or comfortable.
4. Moderate Level Supportive Environment
   - May require assistance with transport
   - Looks for some encouragement or invitation to participate "Come on X – join us over here" on ongoing basis.
   - Requires encouragement to communicate with others (does not easily initiate conversations even with familiar others)
   - Does NOT require any physical support from staff
   - Would potentially participate well in any supportive environment (ie church group)
5. Low Level Physical Support
   - May require assistance with transport (with some assistance ie getting mobility aids into and out of vehicle)
   - Require low level physical support. This is predominantly stand by assistance & conducive environment (no significant steps, disabled toilet, no large distances)
   - Communicates independently with others (strangers and friends)

- Initiates involvement in activities him/herself

6. Moderate Level Physical Support
   - May require assistance with transport (with assistance into and out of vehicle)
   - Require moderate level physical support. 1 person assist (in and out of vehicle, standing/sitting, toileting) & conducive environment (no significant steps, disabled toilet, no large distances)
   - Communicates independently with others (strangers and friends)
   - Initiates involvement in activities him/herself
7. Mixed Low Level Support
   - May require assistance with transport
   - Participates independently when environment is familiar and/or comfortable.
   - Require some physical support from staff (mainly standby assistance & conducive environment).
   - Communicates independently with others who are familiar.
8. Moderate Level Mixed Support
   - May require assistance with transport (& assistance into and out of vehicle)
   - Require moderate level physical support. 1 person assist (in and out of vehicle, standing/sitting) & conducive environment (no significant steps, disabled toilet, no large distances, raised chairs)
   - Looks for some encouragement or invitation to participate "Come on X – join us over here" on ongoing basis.
   - Requires encouragement to communicate with others (does not easily initiate conversations even with familiar others)
9. High Level Support
   - Significant anxiety, Mental Illness, high emotional dependence.
   - Behaviours: repeated questioning, requires repeated prompting
   - High personal care needs: i.e. assisted toileting

The data provided by ACPA was then divided by the total population for that age cohort (ABS projections for 2005) in the Alexandrina Coastal area to identify the percentage of that age cohort receiving each level of support. These percentages were then multiplied by the relevant age cohort populations in Victor Harbor and Yankalilla to indicate the number of people that would require assistance in order to provide services in these areas commensurate with that offered in Alexandrina Coastal Statistical Local Area.

Limitations

The limitations of ACPA as a benchmark must be considered in using this data. It cannot be assumed that this service provides an adequate level of services to meet the needs of all individuals in that community. However ACPA is used as an example of best practice in the region.

These projections do not account for differences between the three areas (Alexandrina Coastal, Victor Harbor andYankalilla) with respect to other community infrastructure, resources and services that support social participation within these communities. These differences will impact on the amount and type of services required to support equivalent levels of social participation.

Results

TABLE 1: Percentage of Alexandrina population receiving social participation support by age cohort and level of dependence:

Level of Dependence	60-69 years	70-790 years	80+ years
1. Independent	4.9%	3.8%	1.4%
2. Transport Dependent Only	0.7%	0.6%	2.4%
3. Low Level Supportive	0.6%	2.3%	0.6%
4. Moderate Level Supportive Environment	0.9%	1.9%	0.4%
5. Low Level Physical Support	0.1%	0.5%	0.6%
6. Moderate Level Physical Support	0.1%	0.2%	1.2%
7. Mixed Low Level Support	0.1%	0.2%	1.8%
8. Moderate Level Mixed Support	0.3%	1.4%	1.6%
9. High Level Support	0.1%	0.8%	0.4%

TABLE 2: Summary of actual (Alexandrina) and projected (Victor Harbor and Yankalilla) number of individuals requiring social participation support by age cohort and level of dependence:

Level of Dependence	Alexandrina Coastal # Total	Victor Harbor # Total	Yankalilla # Total
Independent	125	171	44
Transport Dependent Only	30	50	10
Total Low Level support	61	101	21
Total Moderate Level Support	74	120	25
High Level Support	13	21	4
TOTAL	**303**	**463**	**104**

TABLE 3: Detailed Actual (Alexandrina) and Projected (Victor Harbor and Yankalilla) number of individuals requiring social participation support by age cohort and level of dependence:

	Alexandrina Coastal				Victor Harbor				Yankalilla			
Level of Dependence	#60-70 yrs	#70-80 yrs	#80+ yrs	# Total	#60-70 yrs	#70-80 yrs	#80+ yrs	# Total	#60-70 yrs	#70-80 yrs	#80+ yrs	# Total
1. Independent	76	42	7	125	88	67	15	171	27	14	2	44
2. Transport Dependent Only	11	7	12	30	13	11	26	50	4	2	4	10
3. Low Level Supportive Environment	9	26	3	38	10	41	7	59	3	9	1	13
5. Low Level Physical Support	2	6	3	11	2	10	7	18	1	2	1	4
7. Mixed Low Level Support	1	2	9	12	1	3	20	24	0	1	3	4
4. Moderate Level Supportive Environment	14	21	2	33	16	34	4	54	5	7	1	13
6. Moderate Level Physical Support	1	2	6	9	1	3	13	18	0	1	2	3
8. Moderate Level Mixed Support	4	16	8	28	5	26	18	48	1	5	2	9
9. High Level Support	2	9	2	13	2	14	4	21	1	3	1	4