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<tbody>
<tr>
<td>ACPR</td>
<td>Aged Care Planning Region</td>
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<tr>
<td>ACAT</td>
<td>Aged Care Assessment Team</td>
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<tr>
<td>AHA</td>
<td>Australian Healthcare Associates</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>CCSSI</td>
<td>Chinese Community Social Services Inc</td>
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<tr>
<td>CHSP</td>
<td>Commonwealth Home Support Programme</td>
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<tr>
<td>CVS/the scheme</td>
<td>Community Visitors Scheme</td>
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<tr>
<td>DCVS</td>
<td>Digital Community Visitors Scheme</td>
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<tr>
<td>the Department</td>
<td>The Commonwealth Department of Health</td>
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<tr>
<td>HACC</td>
<td>Home and Community Care</td>
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<tr>
<td>HCP</td>
<td>Home Care Package</td>
</tr>
<tr>
<td>LGBTI(Q)</td>
<td>Lesbian, Gay, Bisexual, Transgender, Intersex, Queer</td>
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<tr>
<td>MS</td>
<td>Multiple Sclerosis</td>
</tr>
<tr>
<td>NACAP</td>
<td>National Aged Care Advocacy Programme</td>
</tr>
<tr>
<td>RAS</td>
<td>Regional Assessment Service</td>
</tr>
<tr>
<td>YOD</td>
<td>Younger Onset Dementia</td>
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1. Executive Summary
1. Executive Summary

1.1. Overview

The Community Visitors Scheme (CVS, the scheme) was introduced by the Department of Health (the Department) in 1992 to recruit volunteers to provide friendship and companionship for recipients of Australian Government-subsidised aged care services who are socially isolated or are at risk of social isolation and loneliness.

Until 2013, the CVS provided one-on-one visits in residential care settings. The scheme was then expanded and now includes:

- Group visits in residential care
- One-on-one visits to consumers of home care packages (HCPs).

In August 2016, the Department engaged Australian Healthcare Associates (AHA) to review the CVS.

The Review included consideration of:

- The extent to which the scheme aligns with current aged care reforms
- The potential to increase the role of volunteer visitors to provide additional support to consumers
- Options for delivering CVS services to home care and residential care consumers, in the context of potential ongoing reforms to home care
- How the uptake of the CVS in the home care setting could be enhanced
- The extent to which the CVS is meeting the needs of people from special needs groups (as identified under the Aged Care Act 1997) and identification of models of good practice
- Other community visitor services addressing the social isolation of older people, across related sectors (e.g. disability), both domestically and internationally
- Opportunities for streamlining program management, funding allocation and service structure with a view to reducing red tape for both providers and the Department.

A mixed methods approach was used to conduct the Review and included:

- A literature scan
- Review of program documentation and data, including collated quantitative data from CVS service providers (known as auspices) relating to funding and performance, as well as qualitative data supplied by auspices
- Stakeholder consultation, including in-depth interviews, an online consultation paper, and telephone focus groups.

The Review generated considerable stakeholder engagement, including 163 submissions to the consultation paper. AHA is grateful to all contributors (see Appendix A for a full listing).
1. Executive Summary

1.2. Summary of key findings

1.2.1. Current operation of the CVS

The Review identified the following key points in relation to how the CVS is currently operating:

- The CVS is provided by 212 auspices with 325 agreements across the three visit types.
- Total funding for 2015–16 was $16.9 million (excluding GST), providing for over 11,000 visitor places.
- While funding amounts vary markedly, there is a relatively large proportion of low value grants.
- Referrals to the CVS are primarily made by aged care service providers. Referrals from other sources (e.g. family, health or other service provider, self-referral) are relatively rare.
- Auspices have developed tailored approaches to visitor recruitment and training, and devote considerable time to promoting the CVS to aged care service providers.
- Once a match is made between the volunteer visitor and consumer, both parties are noted to derive significant benefit from participating in the CVS.
- The Commonwealth has primary responsibility for administering CVS funding, monitoring performance and providing program oversight. Guidance provided by the Commonwealth has become less prescriptive in recent years, allowing auspices greater flexibility in how they deliver the CVS.
- CVS Network Members play an important role in training staff of other auspices, directing referrals and supporting collaboration within the jurisdictions (See Section 3.4.3 for a description of the Network Member role).
- While uptake of the CVS in the residential care setting is strong, auspices providing home care one-on-one visits have struggled to fill their funded places.
- Consumers from the Culturally and Linguistically Diverse (CALD) and rural/remote special needs groups appear to be more commonly involved with the CVS compared with other special needs groups.

1.2.2. Findings in relation to key Review areas

- While consumers can exercise choice within the parameters of the scheme, the extent to which the CVS supports choice and control (in the broader sense intended through the aged care reforms), is limited by suboptimal awareness of, and access to, the scheme.
- Inflexibilities in CVS funding arrangements mean consumers’ wishes cannot always be met (including during transition between home and residential care settings).
- Although there is currently significant variation in the roles and activities undertaken by volunteer visitors, there was little stakeholder support for explicitly expanding the role of the CVS visitor to include provision of information, support and advice about the aged care system.

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1 Based on funding and performance data to 30 June 2016, and qualitative data to December 2016.
1. Executive Summary

- A lack of awareness of the CVS and its operations (particularly referral processes) is a key barrier to uptake of the scheme in both home and residential care settings. This is exacerbated in the home care setting, with additional barriers (particularly risk management concerns and a competitive landscape) also noted.

- Improved networking and information sharing among relevant organisations (auspices, health and aged care service providers, organisations representing special needs groups etc.) was considered vital to improving uptake of the CVS through enhanced referral and visitor recruitment.

- Where appropriate visitor matches were made for individuals from special needs groups, good outcomes were reported. However, commonly-reported challenges included identification of special needs status and recruiting appropriate local visitors.

- Stakeholders felt program management could be improved through:
  - Potential rationalisation of the number of funding agreements in place (while maintaining equity of access), and combining ‘residential group’ and ‘residential one-on-one’ into a single visit type
  - Reviewing Key Performance Indicators (KPIs) and reporting templates
  - Providing feedback on performance reports.

- CVS auspice representatives noted that the level of involvement from the Department has diminished over recent years and suggest that greater Departmental input would support consistent implementation of the CVS and improve visibility of the scheme.

- Network Members play an important role in facilitating collaboration, information-sharing and training for staff in other auspices and could be further supported in this role.

- While a large variety of programs addressing social isolation in the elderly exists (both in Australia and internationally), there is little clear evidence available to define ‘best practice’. However, the CVS is seen as a long-running and highly successful scheme that brings substantial benefit to both visitors and consumers alike.

1.3. Options and considerations

Based on the Review findings, the following options for enhancing the CVS to ensure it can continue to deliver effective consumer support are presented for consideration by the Department. These are aligned to the review themes, noting that some options span multiple areas. More detail is provided in Chapter 5.

Alignment with aged care reforms

Expand eligibility

- Consider broadening eligibility criteria for the CVS to include recipients of the Commonwealth Home Support Programme (CHSP) (and HACC in WA), and those assessed as eligible for but waiting for a HCP. This would help position the CVS as key option for addressing social isolation, within an ‘integrated care at home system’ envisaged as part of future reforms.
1. Executive Summary

Consider a suite of approaches to addressing social isolation

- The CVS should be offered as part of a suite of programs available to consumers as they transition across the aged care system. These include individual and group social support activities provided through the CHSP as well as social/leisure activities provided by residential care providers or offered within home care packages.

- Consider expanding the Digital CVS (DCVS, currently provided by Nundah Activity Centre) as an effective and low-cost way to deliver the CVS to rural and remote consumers or those who are ‘hard to reach’ (or to match with an appropriate visitor in their local area) for other reasons.

- Continue to support other innovative approaches to CVS service delivery, such as the involvement of companion animals, and use of technology.

Expanding the role of volunteer visitors

Retain existing scope of the visitor role

- The primary focus of the CVS should continue to be the provision of friendship and companionship to consumers. Expansion of the visitor role to include information provision or other functions may compromise the CVS and as such, should be considered through separate programs.

- Consideration could be given to including standardised basic information on the aged care system as part of visitor training. However, care should be taken to ensure that training requirements do not become burdensome or overly demanding for visitors.

Enhancing uptake of the CVS

Improve promotion and enhance awareness

Promotion to service providers, consumers, and the wider public is critical to increasing the reach of the CVS and supporting consumer choice. Suggestions include:

- Develop Commonwealth-branded promotional and communications materials to augment localised promotional work undertaken by auspices.

- Create a stronger presence for the CVS on the My Aged Care website and the Service Finder.

- Develop tailored communications materials for HCP providers, outlining the responsibilities of auspices and service providers, and emphasising the consumer’s right to a CVS visitor of their choice.

- Include information on the CVS as part of the orientation process for:
  - Aged Care Assessment Team (ACAT) assessors
  - Aged care workers
  - National Aged Care Advocacy Programme (NACAP) staff.
1. Executive Summary

Facilitate national consistency

A more consistent national approach to implementation of the CVS could improve uptake and efficiency of the scheme. Suggestions to improve consistency include:

- Develop a clear yet flexible operational guide, similar to guidelines issued by the Commonwealth in the past.
- Enhance support for Network Members to facilitate collaboration and information sharing between auspices.
- Introduce mandatory basic training for CVS visitors, using the online package developed by Multiple Sclerosis (MS) Victoria as a basis.
- Ensure Department staff are responsive to auspice/Network Member queries to ensure consistent interpretation of the operational guide.

Improve coordination

Improved coordination of the CVS would support good practice and enhance cross-referrals. Suggestions include:

- Support Network Members and auspices to hold annual face-to-face meetings to raise awareness of other auspices’ delivery of the CVS and enhance cross-referrals.
- Develop a centralised accessible directory of CVS auspices (and potentially a dedicated CVS website) to assist with directing consumers, aged care providers and visitors to the most appropriate auspices. Information could include the following (noting that some information may be difficult to keep up to date):
  - Types of visits funded
  - Regions covered
  - Number of funded places (and number of vacant places)
  - Whether an auspice specialises in a particular special needs group (e.g. CALD, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI)).

Special needs groups

Optimise support for special needs groups

Consideration of the following options would enhance access and appropriateness of the CVS for people from special needs groups:

- Develop stronger linkages between auspices funded for special needs groups and other organisations/agencies involving those groups to support visitor recruitment.
- Source training from relevant peak organisations to support visitors engaging with people from particular special needs groups.
- Encourage broader awareness-raising within the sector regarding identification of people in special needs groups.
- Consider relaxing geographic boundaries for auspices funded for special needs groups in order to maximise access, and consider alternative models of service delivery (e.g. DCVS).
1. Executive Summary

Program management considerations

Improve reporting processes

The following options could improve efficiency, accuracy and usefulness of CVS reporting, and reduce administrative burden for providers and the Department:

- Review and simplify CVS KPIs.
- Revise the reporting template and consider introducing Smart Forms, pre-filled with auspices’ funding and contractual information, to improve ease of reporting and quality of data submitted.
- Develop an annual summary report of auspice performance against consolidated national performance data to enable auspices to benchmark their performance.

Streamline funding arrangements

The following options are suggested to improve CVS funding administration:

- Consider rationalising the number of low-value grants by minimising duplication of service provision (i.e. auspices serving similar consumer groups within the same geographical area), whilst ensuring that access is not compromised.
- Combine residential one-on-one and residential group visit types into a single ‘residential’ visit type so that all consumers can receive the visit type most appropriate to their needs (noting that this may change over time).
- Introduce a single funding agreement to cover all visit types to minimise administrative workload for auspices and the Commonwealth.
- Consider relaxing geographical funding restrictions that prevent consumers continuing with the same auspice (and visitor) as they transition from home care to residential care.
2. Introduction
2. Introduction

2.1. The CVS

The Community Visitors Scheme (CVS, the scheme) was introduced by the Department of Health (the
Department) in 1992 to recruit volunteers to provide friendship and companionship for residents of
Australian Government-subsidised aged care homes who are socially isolated or are at risk of social
isolation and loneliness.

The Australian Government funds organisations (known as CVS auspices) to recruit and train visitors,
who are subsequently matched with aged care consumers (referred by aged care service providers and
others). The CVS visitors set aside time, at least once a fortnight, to visit and befriend the consumer.
Additional funding is provided to seven CVS auspices across the jurisdictions (ACT/NSW is combined) to
undertake the role of Network Member in their respective state or territory (see Section 3.4.3 for details
of the role). An additional auspice is funded as a Network Member for people from CALD backgrounds.

Following an expansion in 2013, the CVS now delivers three types of visits:

- One-on-one visits in residential care
- Group visits in residential care
- One-on-one visits to consumers of HCPs.

<table>
<thead>
<tr>
<th>Stakeholder Group</th>
<th>Description</th>
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<tbody>
<tr>
<td>CVS auspice</td>
<td>An organisation funded to provide CVS services. Auspices may be funded to</td>
</tr>
<tr>
<td></td>
<td>provide any or all of the following service types:</td>
</tr>
<tr>
<td></td>
<td>- One-on-one visits in residential care</td>
</tr>
<tr>
<td></td>
<td>- Group visits in residential care</td>
</tr>
<tr>
<td></td>
<td>- One-on-one visits to consumers of HCPs</td>
</tr>
<tr>
<td>Aged care service</td>
<td>In the context of this Review, aged care service providers are organisations that</td>
</tr>
<tr>
<td>provider</td>
<td>deliver Commonwealth-subsidised aged care services, including residential aged</td>
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<tr>
<td></td>
<td>care and HCPs. A number of aged care service providers are also funded as CVS</td>
</tr>
<tr>
<td></td>
<td>auspices.</td>
</tr>
<tr>
<td>Consumer</td>
<td>In this Review, ‘consumers’ refers to recipients of Commonwealth-subsidised</td>
</tr>
<tr>
<td></td>
<td>aged care services.</td>
</tr>
<tr>
<td>CVS Network Member</td>
<td>An auspice that receives additional funding to:</td>
</tr>
<tr>
<td></td>
<td>- Facilitate links between the CVS auspices and the Australian Government</td>
</tr>
<tr>
<td></td>
<td>- Promote innovation and self-sufficiency among CVS auspices</td>
</tr>
<tr>
<td></td>
<td>- Provide an efficient and effective communication and consultation</td>
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<tr>
<td></td>
<td>mechanism between CVS auspices and the Australian government.</td>
</tr>
<tr>
<td></td>
<td>There is one Network Member in each jurisdiction (except NSW and ACT, which</td>
</tr>
<tr>
<td></td>
<td>is combined), as well as one CALD Network Member.</td>
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2. Introduction

Peak organisation

Peak organisations are groups/associations representing members with shared/allied interests. In the context of this Review, peak organisations refer to those representing the aged care sector, aged care consumers, or special needs groups, who have an interest in the CVS.

Volunteer visitor

Volunteer visitors provide CVS visits to aged care consumers. The term ‘visitor’ (or ‘volunteer visitor’) is preferred to ‘volunteer’ to avoid confusion with other volunteers of aged care service providers.

2.2. Purpose of the Review

AHA has reviewed the CVS to inform the Department on how the scheme can continue to effectively provide appropriate support to consumers of residential and home care services who are socially isolated or at risk of social isolation.

The Review has been undertaken during a time of widespread changes to the aged care system, which centre on enabling aged care consumers to exercise choice and control over the aged care services they receive, in a market-based system.

The scope of the CVS Review is to:

- Explore the extent to which the scheme aligns with current aged care reforms
- Explore the potential to increase the role of volunteer visitors to provide additional support to consumers
- Consider options for delivering CVS services to home care and residential care consumers, in the context of potential ongoing reforms to home care
- Explore how the uptake of the CVS in the home care setting could be enhanced
- Explore the extent to which the CVS is meeting the needs of people from special needs groups (as identified under the Aged Care Act 1997) and identify models of good practice
- Identify and compare other community visitor services addressing the social isolation of older people, across related sectors (e.g. disability), both domestically and internationally
- Identify areas for streamlining program management, funding allocation and service structure with a view to reducing red tape for both providers and the Department.

The Review findings have enabled the development of options for the Department in considering how the CVS can continue to deliver effective consumer support into the future.

2.3. Review method

The Review involved a five-phase methodology as shown in Figure 2-1, with additional details on key processes provided below. The Review was conducted between August and December 2016.
2. Introduction

**Figure 2-1: Review method**

2.3.1. Literature scan

A brief scan was undertaken of the Australian and international literature relating to community visitor services aimed at addressing social isolation and loneliness in older people. The literature scan informed the development of stakeholder consultation tools, and key findings are presented throughout the report.

A summary of the literature scan, including the search strategy and findings, is provided at Appendix B.

2.3.2. Data review

CVS funding data for 2013–14 to 2016–17 and performance report data for 2015–16, supplied by the Department’s National Aged Care Grants team, have informed the Review. A summary is provided in Chapter 3 with additional details in Appendix C.

Qualitative data provided with performance reports, addressing successes and challenges experienced by auspices, have been reviewed and summarised in Appendix D.

2.3.3. Stakeholder consultations

The Review involved extensive stakeholder consultation, including:

- 44 in-depth telephone interviews with key informants identified by the Department. These included a sample of 22 auspice representatives (Table A-1) (see Appendix E for a list of interview questions).
- 163 submissions to an online consultation paper (the consultation paper is provided in Appendix F and findings summarised in Appendix G).
2. **Introduction**

- six telephone focus groups with 23 participants to further explore themes and options for changes to the CVS (these were held instead of a stakeholder workshop in order to overcome barriers to participation) *(Appendix H)*.

A summary of stakeholder involvement is included in *Appendix A*.

The following methodological limitations are noted:

- The agreed method for the CVS Review did not include a mechanism for obtaining the views of end-users of the CVS (i.e. consumers and volunteer visitors). However, visitor perspectives were captured through qualitative information provided by auspices and service providers. In addition, 28 visitors responded to the consultation paper.

- Performance data supplied for the Review was self-reported by auspices and is not able to be verified. Due to a number of inconsistencies, detailed analysis has not been possible.

- While broad representation of CVS auspices has been achieved for the Review the level of input in some jurisdictions was less than ideal, despite multiple attempts at engagement.
3. Current operation of the CVS
3. **Current operation of the CVS**

### 3.1. Overview

This chapter presents an overview of current CVS structure and service delivery, based on:

- Funding and performance data provided by the Aged Care Grants team (to 30 June 2016)
- Stakeholder consultations
- Review of CVS program materials.

### 3.2. Introduction

The CVS is delivered by over 200 service providers (auspices) who are funded to provide the CVS within particular geographical regions (based on Aged Care Planning Regions (ACPR)). From its inception in 1992, the CVS has delivered one-on-one visits in residential aged care homes. In 2013, the CVS was expanded to include group visits in residential aged care and one-on-one visits in home care, in addition to placing stronger emphasis on engaging with consumers from special needs groups.

The CVS is delivered by many different types of organisations of varying size and complexity including:

- Aged care service providers (including those in the private, not-for-profit and local government sectors). Note that a number of aged care service providers are also funded as CVS auspices.
- Health and community services
- Religious organisations
- Continuing education providers and volunteering organisations
- Multicultural community groups and other organisations focused on special needs populations such as LGBTI
- Not-for-profit organisations with a social welfare focus.

### 3.3. Funding

Key findings in relation to funding and service structure are reported here. See Appendix C for additional detail and charts.

#### 3.3.1. Total funding

- Total CVS funding for 2015–16 was $16.9 million for (excluding GST).
- Funding is allocated on the basis of ‘active visitors’ (the equivalent of one visitor providing at least 20 visits per year). Funding is approximately $1,424 per active visitor, across all visit types. Current funding allows for more than 11,000 active visitors nationally.
- The majority of CVS funding is directed to residential one-on-one visits. Funding for residential group and home care one-on-one visits currently accounts for only 37% of total funding.
- NSW has the largest number of funded auspices, followed by Victoria and Queensland.
3. Current operation of the CVS

3.3.2. Funding per auspice

In 2015–16, a total of 212 auspices received funding, with agreements for 325 different visit types, including:

- 141 agreements for residential one-on-one visits
- 103 agreements for home care one-on-one visits
- 81 agreements for residential group visits.

CVS funding amounts vary considerably between agreements. The lowest amount was $7,122 (which equates to five active visitors), increasing to $1.36 million for one auspice that was funded for 926 visitors across multiple states. A high proportion of funding amounts for residential group and home care one-on-one agreements were less than $10,000 for the year (37% and 16% respectively).

3.4. CVS service delivery

Requirements for delivery of the CVS are set out in the CVS Policy Guide (2013–2016) and a set of Frequently Asked Questions (FAQs) available on the Department’s website2 and within individual funding agreements. In the past, the Department issued more comprehensive guidelines, however AHA understands that they have not been updated since 2004 (and therefore do not include information about home care one-on-one or residential group visit types). The Department indicated that these guidelines were withdrawn in order to provide auspices more flexibility in how the CVS is delivered. However, many of the more longstanding auspice coordinators still use the guidelines and associated templates, and encourage their more recently appointed counterparts to do likewise.

The following sections provide an overview of CVS service structure and delivery, structured according to the roles of key stakeholders involved in the scheme.

3.4.1. Auspice CVS coordinators

Typically, auspices employ a CVS manager or coordinator (part or full-time) whose role includes the following activities:

- Recruitment of volunteer visitors
- Induction and training of volunteer visitors
- Promotion of the CVS to aged care service providers and the broader community
- Matching of the visitor with a consumer: this may involve meeting and assessing the consumer’s suitability for the CVS, and participating in visits with the volunteer visitor to help establish the relationship
- Addressing any issues or concerns raised by the visitor or the aged care service provider regarding the relationship or the consumer’s care needs
- Developing internal policies and procedures
- Keeping records of visits

3. Current operation of the CVS

- Performance reporting to the Department
- Providing support to, and recognition of visitors through morning teas and other social events
- Communication and networking with other auspices, including on-referral of consumers where required.

While many auspice coordinators consulted for the Review have been in the position for many years, other auspices experience high levels of turnover. In cases where positions remain unfilled for some time, loss of volunteer visitors is not uncommon.

3.4.2. Volunteer visitors

Volunteer visitors provide a minimum of one visit per fortnight (on average) either in the consumer’s home, or on an individual or group basis within a residential aged care home, depending on the auspice’s contractual arrangements.

Recruitment

Attraction and retention of visitors is key to the success of the CVS. Auspices advertise for volunteers through a range of methods including SEEK and other volunteering websites, word of mouth, presentations at aged care facilities, newspaper promotion, radio advertisements and flyers/promotional materials. Some auspices use social media to promote the CVS.

Volunteers come from a range of backgrounds and vary in age from university students to retirees. Some organisations that deliver multiple services (aged care or other) have volunteer pools from which they can recruit to the CVS with relative ease. Smaller organisations that do not have embedded processes for volunteer recruitment have noted challenges in sourcing volunteers. For some auspices, supply of visitors is the limiting factor in filling their funded CVS places. Others report having a surplus of visitors but have difficulty attracting consumer referrals. In the latter case, an auspice may link the visitors with a different auspice that has an appropriate consumer on their waiting list. The complexities of matching volunteer visitors with consumers’ needs (including gender, culture, interests and location) can delay commencement of visits.

Motivations for volunteering for the CVS vary, but usually relate to a desire to ‘give back’ to the community by enriching the lives of socially isolated older people. Participation in the CVS brings important benefits to both visitors and consumers, and promotion of the benefits (through word of mouth or other activities) is an effective way of recruiting future visitors.

Role

The primary role of the CVS visitor is to provide friendship and companionship to the socially isolated consumer. A number of auspices provide a standard position description and require that their visitors sign a Memorandum of Understanding (MOU) which outlines a range of activities that the visitor should not undertake, such as providing nursing or personal care to the consumer, or monitoring standards of care provided by the aged care service. Auspice coordinators and visitors have indicated that in practice, the scope of the visitor’s role can vary, depending on the longevity and strength of the relationship and the visitors’ confidence to undertake additional activities (e.g. taking the consumer on outings). See Section 4.3 for stakeholder perspectives on the question of expanding the visitor’s role.
3. Current operation of the CVS

Induction and training

On-boarding of visitors is a thorough, and in some cases time-consuming process. According to some auspice coordinators, the amount of paperwork involved is similar to the recruitment of paid staff. Reference checks are routine and police checks are mandatory. Some auspice coordinators use the National Standards for Volunteer Involvement\(^3\) to guide their volunteer induction and management processes.

Volunteer visitors receive training and support from their auspice coordinator. Training may cover:

- Information about the CVS
- The ageing process
- Rights and responsibilities of consumers and visitors
- Communication
- Assessing risk and ensuring safety (including in home care)
- Grief and loss.

There is no compulsory training program for volunteers, however approximately 25 auspices (primarily Victorian and NSW-based) use an online package developed in 2015 by MS Victoria (with funding support from the Department).\(^4\) This package is available to all auspices free of charge, or for a fee of approximately $150 per year for access to full functionality (including generation of certificates, email notifications etc.). This package has been promoted at CVS Network meetings and in a newsletter from the Department.

Some auspices source training on other topics from peak organisations (e.g. dementia training developed by Alzheimer's Australia). In addition, some aged care service providers invite CVS visitors to participate in their in-service training.

3.4.3. Network Members

CVS Network Members receive funding to represent and support CVS auspices within each state and territory. The role includes:

- Providing support, mentoring and informal training to auspice coordinators
- Maintaining lists of auspices' funding (including number of places, regions serviced and visit types provided)
- Disseminating information from the Department to auspices
- Collecting information from auspices and providing it to the Department
- Coordinating and attending regional meetings with auspice coordinators (in addition, some Network Members organise state CVS conferences)
- Handling enquiries from aged care service providers and the public.

\(^3\) Volunteering Australia, 2015, National Standards for Volunteer Involvement.

\(^4\) Available at [www.cvsonline.org.au](http://www.cvsonline.org.au).
3. Current operation of the CVS

Processes for electing Network Members vary between states. In some cases, the role is rotated biannually; in others, the incumbent Network Member continues in the role until another auspice coordinator agrees to take over.

3.4.4. Aged care service providers

In accordance with the User Rights Principles 1997, aged care service providers are required to identify and refer consumers who may benefit from a volunteer visitor to a CVS auspice, and support and welcome the volunteer visitors. Most residential aged care homes have a liaison person (e.g. leisure and lifestyle coordinator, diversional therapist or similar role) with whom auspice coordinators interact in order to obtain consumer referrals. In some cases, a single aged care service provider may engage with (or be approached by) multiple auspices.

Strong relationships between auspice coordinators and aged care service staff appear to be critical to the effective implementation of the CVS. Auspice coordinators invest heavily in promoting the CVS to service providers and explaining how the scheme operates. High levels of turnover in the liaison role means that this can be an ongoing process for auspice coordinators.

Aged care service providers usually provide an orientation to CVS visitors but are not required to organise or sight police checks (this is the responsibility of the auspice).

Since visitors are volunteers of the CVS auspice, rather than volunteers of the aged care service provider, very little is required of aged care service providers once a visitor-consumer relationship is established, beyond advising the auspice of relevant information regarding the consumer.

3.4.5. Consumers

Consumers eligible for the CVS are recipients of Australian Government-subsidised residential care or HCPs who have been identified as being at risk of social isolation or loneliness. People receiving services through the CHSP (or HACC in Western Australia), or who have been assessed as eligible for a HCP but are on the waiting list to receive one, are ineligible. The CVS Policy Guide encourages auspices to engage with people from special needs groups with a focus on those groups considered to be at particularly high risk of social isolation (see Table 3-1).

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3. Current operation of the CVS

### Table 3-1: Special needs groups

<table>
<thead>
<tr>
<th>Special needs groups (Aged Care Act 1997)</th>
<th>Priority group for CVS*</th>
</tr>
</thead>
<tbody>
<tr>
<td>People from Aboriginal and Torres Strait Islander communities</td>
<td>✓</td>
</tr>
<tr>
<td>People from CALD backgrounds</td>
<td>✓</td>
</tr>
<tr>
<td>People who live in rural or remote areas</td>
<td>✓</td>
</tr>
<tr>
<td>People who are financially or socially disadvantaged</td>
<td>✓</td>
</tr>
<tr>
<td>Veterans</td>
<td></td>
</tr>
<tr>
<td>People who are homeless or at risk of becoming homeless</td>
<td></td>
</tr>
<tr>
<td>Care-leavers (including Forgotten Australians, Former Child Migrants and Stolen Generations)</td>
<td>✓</td>
</tr>
<tr>
<td>Parents separated from their children by forced adoption or removal</td>
<td></td>
</tr>
<tr>
<td>LGBTI</td>
<td>✓</td>
</tr>
<tr>
<td>People of a kind (if any) specified in the Allocation Principles</td>
<td></td>
</tr>
</tbody>
</table>

* CVS Policy Guide 2013-2016

In the vast majority of cases, consumers are referred to the CVS by aged care service providers. Self-referral, or referral by family members or others (e.g. health or allied health professionals), is relatively rare.

Effective matching of consumers with visitors is essential to the success of the CVS, and is something to which auspice coordinators devote significant time. There are occasions where it is difficult to find a match for a consumer (e.g. if the consumer has significant cognitive or behavioural issues, or if they speak a language/dialect particularly uncommon in their community). In addition, it is not uncommon for consumers’ capacity to engage with the CVS to diminish over time as they age.

According to the vast majority of stakeholders consulted (noting that consumers were not directly involved in the Review), once an effective match is made, consumers experience significant benefit from the CVS, including decreased sense of loneliness and improved quality of life. This is consistent with evidence from the literature on social isolation in older people (see Appendix B).

### 3.4.6. Other stakeholders: Aged care assessment teams and other service providers

Referral to the CVS by ACATs, healthcare or other service providers or family members is relatively rare, largely due to low levels of awareness of the CVS, and a misconception that aged care service providers serve as the gateway to the program. Exceptions exist –there are instances where auspice coordinators have good relationships with local ACATs and referrals are made directly, but this is made more difficult if there are delays between ACAT assessment and receipt of a residential care place or a HCP. In some states, strong relationships between NACAP representatives and auspices have led to CVS referrals through that channel.

The day-to-day running of the CVS (aside from promotional work and some elements of volunteer training) does not appear to involve service providers or sectors other than the aged care service sector.
3. Current operation of the CVS

provider to any great degree. Generally, if a visitor has concerns about a consumer’s health or social situation they are encouraged to raise these with the auspice coordinator who will follow up with the aged care service provider. Rarely, auspice coordinators may seek advice from advocacy services through the NACAP if they have particular concerns about consumers’ rights.

3.5. CVS governance and management: role of the Commonwealth

This section provides an overview of the role of the Commonwealth in the governance and administration of the CVS.

3.5.1. Program governance

As noted in Section 3.4, over recent years the Department has afforded auspices a greater degree of flexibility in how they deliver the CVS, provided they comply with the requirements of the funding agreements and the intent of the Policy Guide 2013-2016.

The Department issues newsletters to auspices periodically. These newsletters respond to questions or concerns (e.g. around reporting requirements), publicise good news stories and promote training opportunities.

Network Members and other auspice coordinators have noted that the level of communication between the Department and auspices has diminished over the past two years. For example, in the past, Department representatives would commonly attend network meetings or conferences; this is now, reportedly, rare.

3.5.2. Promotion

The Department provides information about the CVS on its website and some information is also provided on the My Aged Care website. Responsibility for promotion of the CVS rests primarily with the funded auspices, and many aged care service providers and community members are unaware that the CVS is a Commonwealth-funded, national program.

3.5.3. Contract management

CVS funding has been administered by the Aged Care Grants Team within the Department since October 2015. The role includes:

- Administration and day-to-day management of all CVS grants (including management of deliverables, payments and data management)
- Risk management
- Liaison with CVS auspices.

Two different types of funding agreement for the CVS are in place, as shown in Table 3-2. Depending on what visit types are funded, auspices may be funded under one or two separate CVS funding agreements.
3. Current operation of the CVS

### Table 3-2: CVS funding agreements

<table>
<thead>
<tr>
<th>Visit types</th>
<th>Funding dates</th>
<th>Reporting required</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Residential</td>
<td>01/07/13 to 30/06/16 (all active contracts have been extended to 30/06/17)</td>
<td>• Yearly reporting on performance, income and expenditure</td>
</tr>
<tr>
<td>one-on-one</td>
<td></td>
<td>• Financial declaration required for 2016–17</td>
</tr>
<tr>
<td>• Home care</td>
<td>01/01/14 to 31/01/17</td>
<td>• Six-monthly or yearly reports on performance, income and expenditure (varies between years)</td>
</tr>
<tr>
<td>one-on-one</td>
<td></td>
<td>• Audited financial statement at contract completion</td>
</tr>
<tr>
<td>• Residential group</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3.6. Auspice performance reporting

Auspices are required to report against three Key Performance Indicators (KPIs). The indicators and a summary of auspice performance for 2015–16 are shown in Table 3-3. See Appendix C for details.

### Table 3-3: Key performance indicators

<table>
<thead>
<tr>
<th>KPI</th>
<th>Details</th>
<th>Target 2015–16</th>
<th>Performance&lt;sup&gt;6&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>KPI 1</td>
<td>Percentage of active visitors (relative to the number of active visitor places for which the auspice is funded)</td>
<td>90% for all auspices</td>
<td>• Residential one-on-one: 80% of auspices met or exceeded target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Home care one-on-one: 38% of auspices met or exceeded target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Residential group: unable to ascertain – data unreliable</td>
</tr>
<tr>
<td>KPI 2</td>
<td>Percentage of consumers who belong to special needs groups (relative to the total number of consumers participating in the CVS for the auspice)</td>
<td>20% for ‘mainstream’ auspices 80% for auspices funded specifically for special needs groups</td>
<td>• Across all visit types, 70% met or exceeded the target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 81% of auspices funded for special needs groups met or exceeded target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• 73% of mainstream auspices met or exceeded target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• CALD was the predominant special needs group, followed by rural/remote</td>
</tr>
<tr>
<td>KPI 3</td>
<td>Percentage of aged care providers in the relevant ACPR that are participating in the CVS (i.e. where consumers are receiving visits)</td>
<td>50% for all auspices</td>
<td>• Not assessed (out of scope for review). However it is noted that KPI3 is difficult to interpret and accurately report.</td>
</tr>
</tbody>
</table>

In addition to reporting against the KPIs, auspices provide a narrative report on the successes, highlights and barriers for the CVS. A summary of the narrative data is provided in Appendix D.

<sup>6</sup> Based on self reporting. Results should be interpreted with caution due to errors/inconsistencies in data submitted by auspices. Refer to Appendix C for detail.
4. Key Review areas: analysis and findings
4. **Key Review areas: analysis and findings**

4.1. **Introduction**

This chapter discusses the following key Review areas set out in the terms of reference:

- Alignment of the CVS in the context of the aged care reforms
- Expanding the role of volunteer visitors
- Options for enhancing the uptake of the CVS (with a focus on the home care setting)
- Meeting the needs of people from special needs groups
- Program management considerations
- Alternative approaches to addressing social isolation.

Discussion in this chapter is based on:

- Stakeholder feedback (including interviews, consultation paper responses and focus groups)
- Performance data (including narrative data provided with performance reports)
- A literature scan
- CVS program documentation.

4.2. **Alignment with aged care reforms**

4.2.1. **Background**

The current reforms to Australia’s aged care system centre on embedding a ‘consumer driven, market-based, sustainable aged care system’. Key features of the reforms of relevance to the CVS include:

- A strong focus on consumer empowerment, choice and control over the services received and the settings in which they receive them
- A continued emphasis on meeting the diverse needs of consumers (regardless of cultural or linguistic background, sexuality, life circumstances or location), and designing services around the preferences and needs of individuals
- A strong focus on supporting consumers with dementia
- A single, government-operated assessment process
- A single, market-based aged care and support system that enables seamless movement from care at home to residential care.

The following changes within the home care sector have important implications for the CVS:

- From 27 February 2017, funding for HCPs will follow the consumer, enabling consumers a greater level of choice of provider and services.

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7 Aged Care Sector Committee, 2016, Aged Care Roadmap.
8 Aged Care Sector Committee, 2016, Aged Care Roadmap.
4. Key Review areas: analysis and findings

- A shift towards a more integrated ‘care at home’ system, potentially blending the HCP program and the CHSP (pending further stakeholder consultation and agreement).[^9]

The following sections summarise stakeholder perspectives in relation to these features.

4.2.2. Stakeholder perspectives

Choice and control

Many stakeholders noted that CVS consumers have the ability to exercise choice and control (i.e. choice to participate, option to request a re-match of visitor, the types of activities undertaken during visits) within the parameters of the scheme and the routines and regulations of the aged care service providers.

However, many others considered that, in its current form, the CVS does not support consumers to exercise choice and control in the broader sense intended through the reforms. Three main reasons for this were provided:

- Sub-optimal awareness of the CVS (among service providers, consumers and the broader public) was consistently identified as a key factor limiting opportunities for consumers to engage with the scheme. Stakeholders commented that consumers (or their families) need to be aware of the scheme before they can choose to take part. Even if consumers wish to become involved with the CVS, it is difficult to find information about which auspices they could choose from or the process for self-referral.

- A misconception that referrals for the CVS can only be made by aged care service providers limits opportunities for consumers and their families to self-refer (even if they are aware of the scheme). The reliance on providers to refer consumers to the CVS is seen as inconsistent with the concept of consumer-directed care.

- The scope of the CVS, as originally envisaged, was focused around visitors providing friendship and companionship to consumers. As such, the extent to which visitors provide practical support or act as an information source to support consumers to exercise choice and control is limited (and, in most cases, actively discouraged by auspices).

Flexible service delivery

Restrictions within the funding arrangements for the CVS limit the extent to which the CVS offers flexible service delivery. These include:

- Region-based funding: CVS auspices are required to provide their services within designated ACPRs. This means that an auspice may not be able to continue providing the CVS to a consumer who moves out of the area, which threatens the continuity of the consumer/visitor relationship.

- Auspices that are funded for residential group visits (and not residential one-on-one) may not be able to provide the CVS to an isolated consumer for whom a suitable group arrangement cannot be made (e.g. in instances where there is only one resident within a residential home from a particular CALD group). Issues also arise if consumers who are initially part of a group

4. Key Review areas: analysis and findings

become no longer able to participate in group visits (e.g. due to deteriorating cognitive state or hearing).

- Capped visitor numbers: if auspices have reached their targets, they will often decline to take on additional referrals.

Despite these limitations, auspices (and Network Members in particular) have demonstrated strong willingness to ensure that consumers’ needs are met and will attempt to refer consumers to the most appropriate auspice. For example, if consumers who have identified as LGBTI are referred to a mainstream auspice, they will commonly be directed to an auspice that caters specifically to that group. This approach relies on auspice coordinators being aware of the other auspices in their jurisdiction, including what visit types they are funded for, and if they are likely to have places available — information which is not readily available.

In addition, the digital CVS (DCVS) is an example of an alternate service delivery mode which enables people who may not otherwise have access to the CVS to take part (See Section 4.5.3.)

Assessment process

Levels of awareness of the CVS among ACATs (responsible for assessing consumers for residential aged care and HCPs) vary between regions, but are considered to be suboptimal overall. Some ACAT staff refer consumers directly to the CVS upon assessment; others may recommend the aged care service provider refers the consumer to the CVS but do not have mechanisms in place to check whether these are acted upon.

Delays between being assessed as eligible for a HCP and commencing on a package also make it difficult for auspices to take up referrals from ACATs (as consumers do not become eligible for the CVS until the package is in place), even though some stakeholders highlighted that this is a particularly vulnerable time for those who are socially isolated.

Transition across the system

Auspice coordinators have cited some instances where a visitor been able to continue to visit a consumer when the consumer has moved from their home into residential care. Such instances appear to be rare, partly due to the low levels of CVS activity in the home care sector, but also because an auspice may not be funded for both home care and residential care visits in the same region, or because the residential care home is out of the auspice’s funded region. In such cases, the volunteer visitor may transfer across to a different auspice that can provide for the consumer, but it is clearly not a straightforward process for the relationship to continue through the transition. Increased travel distances can also present a barrier to visitors continuing their relationship with consumers when they transition from HCPs to residential care (and can also be a problem if consumers move between residential care homes).

A number of stakeholders noted the challenges to seamless transition that arise from having social support for consumers living at home provided under different programs. The following suggestions were made:

- The CVS should be available to CHSP consumers.
4. Key Review areas: analysis and findings

- Social support services (either individual or group) provided through the CHSP should continue to be available to consumers who transition from the CHSP to HCPs. In particular, services that are comparable to the CVS (i.e. volunteer-based ‘Friendly Visiting’ programs), should be supported under the HCP program so that consumers can continue with the same volunteer visitor.

- The period between assessment for, and receipt of, a HCP is a time during which consumers may be particularly isolated, so it would be ideal to introduce the CVS visits at that time.

There was support for the CVS to be provided as one of a suite of programs available to aged care consumers who are socially isolated, as part of a future single ‘care at home’ system.

4.3. Expanding the role of volunteer visitors

4.3.1. Background

Stakeholders were asked to consider the feasibility and implications of expanding the role of the visitor to encompass provision of information about the aged care system, consumer rights and options for accessing other services or supports. The intention of the proposed expanded role would be to better support consumer choice and control, in the context of the aged care reforms.

4.3.2. Stakeholder perspectives

While consultation findings revealed significant variety in the roles already being fulfilled by CVS volunteers (e.g. outings, shopping, transport to appointments, exercise, and skill development such as use of technology), overall there was minimal support for explicitly expanding the visitors’ role. Most stakeholders considered that the ongoing primary focus should be on being a “friend, specialising in the spending of time with people”, with any desired additional functions (information provision etc.) fulfilled through a separate program. As currently occurs, other appropriate assistance could take place on a mutually-agreed basis (and with the auspice’s support). The key reasons expressed for this view included:

- Potential conflict with friendship role: the visitor would be less a ‘friend’ and more like a carer, which may disrupt the power balance in the relationship.

- Concerns about the quality of information or assistance that could be provided by visitors, and a belief that the training, supervision and support required is beyond the capacity of auspices to deliver (at least without additional funding).

- Concern that increasing the level of responsibility for visitors would make the role more onerous and less attractive, making it more difficult to recruit and retain visitors (in an increasingly competitive environment).

- Some visitors may not have the capability or desire to take on an information-provision or other role (i.e. it may suit some, but not all).

One peak organisation suggested that CVS training could include an optional module for visitors, covering topics such as:

- What information is available on My Aged Care?
4. Key Review areas: analysis and findings

- The role of aged care advocacy services
- The role of the Aged Care Complaints Commissioner and the process for making complaints
- The rights and responsibilities of aged care consumers
- What ‘choice and control’ means in home care.

Such an induction could allow CVS visitors to act in the capacity of an ‘informed friend’, linking consumers with other organisations and additional supports where required. Stakeholders also spoke of other additional training topics that may be useful for CVS visitors, including the areas of dementia, depression and palliative care. Other stakeholders cautioned that training and induction is already time-consuming, and that adding to the process may deter visitors from following through.

A final, complex theme emerging from this discussion was that the notion that volunteers should ‘do what a friend would do’ (e.g. in relation to practical support or engagement with family) is interpreted differently depending on a number of factors including the strength and duration of the relationship. For example, one auspice coordinator spoke of the support provided by a visitor to the consumer’s family during the final stages of the consumer’s life. This support included having the consumer’s son stay at the visitor’s house (as he was from interstate). The visitor was subsequently invited to speak at the consumer’s funeral, demonstrating the strength of their bond. This is in contrast to advice from many auspices that visitors should avoid becoming involved with consumers’ families.

4.4. Enhancing uptake of the CVS

4.4.1. Background

The expansion of the CVS into the home care sector in 2013 has been challenging for auspices. Many auspices have struggled to achieve their targets as demonstrated in performance data (see Section 3.6). This section explores some of the barriers to uptake of the CVS generally before considering specific challenges in the home care setting.

4.4.2. Stakeholder perspectives: barriers to uptake

A broad range of barriers (or potential barriers) to the uptake of the CVS were raised. These included:

- Low levels of awareness of the CVS among aged care service providers.
- Suboptimal communication between auspices and aged care service providers, exacerbated by high levels of staff turnover and time constraints (several auspice coordinators reported occasions in which a consumer had passed away and the auspice was not notified, causing significant distress to the visitor when they arrived for their scheduled visit).
- Uncertainty among aged care service providers about:
  - Their role and responsibilities in relation to volunteer management and facilitation of visits
  - Referral processes (including which auspice to refer to, and what form was required, since referral forms can vary between auspices).
4. Key Review areas: analysis and findings

- Reliance on referral by aged care service providers, rather than other service providers or consumers/family members, exacerbated by a lack of clarity around who is permitted to refer to the CVS.
- Difficulties recruiting volunteers (factors include the broad range of volunteering opportunities available, travel requirements, and for some, the CVS on-boarding process).
- Difficulties retaining volunteers (factors include the visitor’s satisfaction with the role, change in visitor’s circumstances (e.g. moving out of the area, illness), consumer ill-health/death).

In the residential setting, doubling up of induction and orientation processes – i.e. residential aged care homes treating the CVS visitors as ‘one of their own’ – was a frequent frustration for auspices and their visitors. Confusion about requirements for sighting of police checks was a commonly-reported problem. In addition, the inflexibility of funding (i.e. for either group or one-on-one service delivery) meant that sometimes consumers’ wishes could not be met.

4.4.3. Barriers to uptake in the home care setting

Barriers to uptake in the home care setting were generally seen to be greater than in the residential setting, with issues including:

- Even greater lack of awareness of the CVS among home care providers, or misconceptions around the scheme (including the belief that the HCP provider is required to ‘approve’ CVS visits for their consumers, or that the HCP provider’s role in enabling visits is more complicated than it is).
- The home care landscape is changing rapidly because of the reforms and it is difficult for HCP providers to keep up with the developments, let alone consider other programs such as the CVS.
- Greater difficulty for providers in identifying the socially isolated.
- Concerns around both visitor and consumer safety (compared with the supervised, structured and secure environment of the residential aged care home) and the additional training and risk management measures required.
- Perceived competition between the CVS and HCP providers’ own social support services.
- Fear that the CVS auspice may ‘poach’ the consumer, if the auspice is also funded to provide HCPs.
- Lack of volunteer interest/comfort in visiting people’s homes (although, in contrast, some stakeholders noted this setting would be preferred by some, for example some CALD groups for whom the residential aged care setting is culturally ‘foreign’).
- Challenges of matching visitors and consumers in a given geographical area.
- Lack of eligibility for those assessed as eligible for, but not yet receiving, a HCP.
- Some HCP consumers (particularly those on Level 3 or 4 packages) have particularly complex behavioural and cognitive issues and care needs. Such consumers can be difficult to find an appropriate match for, and, if a match is found, it may be more difficult to coordinate visits given the number of other services in place.
4. Key Review areas: analysis and findings

4.4.4. Opportunities to enhance uptake

Stakeholders consistently nominated improved and consistent promotion of the CVS as a key to enhancing uptake across residential and home care settings. This included aspects such as:

- National promotion of the CVS and its benefits, along with representative ‘good news stories’.
- Centrally-developed promotional and communications materials for all stakeholders (especially aged care service providers, consumers and potential visitors) – including those for specific special needs groups and translated for CALD groups.
- Development of a clear and succinct Commonwealth-badged operational guide for auspices and aged care service providers outlining roles and responsibilities (the existing FAQs were considered to be a good starting point).
- A dedicated CVS website and central repository of CVS information (for consumers, auspices, visitors and aged care providers).

Improved networking and information sharing (e.g. between individual auspices, between auspices and aged care providers, auspices and other relevant agencies) was also considered vital to improving uptake of the CVS through enhanced referral and volunteer recruitment. In many cases, strong relationships between auspices and aged care service providers (including instances where they were the same organisation) were reported to be the key contributor to the success of the CVS at the local level.

4.5. Special needs groups

4.5.1. Background

Prior to its expansion in 2013–14, auspices were categorised as ‘generic’ (mainstream) or ‘ethnic/culture specific’. There was no explicit focus on other special needs groups as identified in the Aged Care Act 1997. The expansion of the CVS in 2013–14 was intended to improve the ability of the program to meet the needs of people from all special needs groups, with a particular focus on the following groups for which the prevalence of social isolation in the aged care setting may be particularly high:

- People from Aboriginal and Torres Strait Islander communities
- People from CALD backgrounds
- People who live in rural and remote areas
- Care-leavers
- Those identifying as LGBTI.

While the lack of direct consumer engagement in the Review limits assessment of the extent to which the needs of people from special needs groups are being met, the perspectives of auspice coordinators and peak organisations, along with performance data, help to illustrate how the CVS is supporting people from these groups.
4. Key Review areas: analysis and findings

4.5.2. Stakeholder perspectives

Individuals from special needs groups are most commonly identified by the referrer – whether aged care service providers, family/friends or health care professionals. However, sometimes this information is not collected (non-disclosure) or not passed on to auspices due to privacy concerns.

The groups most commonly mentioned during consultations were CALD and LGBTI, with stakeholders noting that while individuals belonging to the former group are often readily identified, identification of the latter is reliant on self-reporting, often hindered by fear of discrimination. It was also suggested that care-leavers often prefer not to disclose this part of their background. It was noted that CVS auspices for Aboriginal and Torres Strait Islander people are not available in all jurisdictions.

Once individuals from special needs groups were referred to the CVS (and particularly to auspices specifically catering to their group), and an appropriately-matched visitor found, good outcomes were usually reported by stakeholders. However, it was these initial steps (referral with special needs identified and volunteer recruitment) that hindered access for these groups. Suggestions for improving the CVS for special needs groups therefore included:

- Better promotion in the community, including communications materials in languages other than English
- Raising awareness of the CVS (and focus on special needs groups) among aged care service providers
- Improving identification of individuals from special needs groups, and overcoming service providers’ privacy concerns
- Strong networking with relevant organisations representing special needs groups
- Visitor training (e.g. cultural safety training for ‘mainstream’ volunteers, dementia awareness training)
- Networking and sharing referrals and visitors between auspices as relevant
- Use of technology to enable matching of geographically-distant visitors and consumers
- Additional funding.

4.5.3. Models of good practice

A number of noteworthy examples of auspices supporting special needs groups were identified through consultations, three of which are described below.

Digital Community Visitors Scheme

The Nundah Activity Centre (NAC) provides HCP recipients in specific areas of Australia with a tablet (with internet connection and “generous” data allowance) to facilitate a digital CVS (DCVS). As with the standard CVS service, the DCVS involves a visitor contacting the consumer weekly via skype (audio-visual or audio-only communication). The DCVS also facilitates (digital) contact with consumers’ loved ones, HCP providers and health care providers.
According to the project’s performance report for 2015-2016, the service is designed to complement, rather than replace, face-to-face service delivery. The report also notes the potential for the tablet and internet connection to facilitate other initiatives that may benefit consumers (e.g. specifically-designed apps, specially designed radio, telehealth and virtual reality experiences aimed to address specific conditions such as dementia).

Digital delivery of the CVS is of benefit to geographically isolated consumers, but also those with, for example, social phobias. It can also be particularly useful for Indigenous consumers geographically or culturally disconnected from their ‘country’, and those from other special needs groups isolated through differences in culture and language. An LGBTI virtual visitors scheme has been developed as a partnership between Nundah Activity Centre and the National LGBTI Health Alliance Silver Rainbow (LGBTI inclusive ageing and aged care).  

The DCVS is said to:

- Expand the pool of potential volunteers
- Increase the likelihood of successful consumer/visitor matching
- Overcome problems associated with distance, cost and privacy issues
- Offer “a wide and ever-growing suite of customisable, stimulating and interesting computer applications to augment the visiting activity”
- Be cost-efficient compared to traditional face-to-face visiting models
- Enable consumers to become social supports for other consumers without needing to be willing or able to physically visit them
- Help consumers expand their own circle of social contacts
- Facilitate visitor support networks.

Switchboard Victoria ‘Out and About’ - LGBTI

Switchboard Victoria is a “telephone-based counselling, information and referral service” that operates for LGBTI individuals, family/friends and health and welfare professionals across Melbourne, regional Victoria and Tasmania. While it has been running for 25 years, Switchboard became a CVS auspice in 2013 (with the name ‘Out and About’) and is currently funded for 65 visitors in home or residential care.

Although visitors are not required to identify as LGBTI, the auspice recruits volunteers with genuine understanding and experience of what the consumer group has gone through – and some consumers will request a volunteer from a specific group – noting the importance of recognising “diversity within the diversity” for special needs groups.

Along with other auspices funded specifically to support LGBTI individuals, Switchboard became part of a LGBTI CVS network with monthly teleconference to “compare notes”.

11 From Nundah Activity Centre performance report
12 www.switchboard.org.au
4. Key Review areas: analysis and findings

Chinese Community Social Services

Chinese Community Social Services Inc (CCSSI) is a not-for-profit organisation that delivers HCP, HACC/CHSP, has a 120-bed residential care home and operates as a CVS auspice (home care and residential group).

As a CVS auspice, CCSSI reports high numbers of referrals in both the home and residential care sectors, and from ACATs directly. CCSSI provides informal support to those assessed until a HCP commences.

Their volunteer coordination program results in a good supply of volunteers, who undergo some online training (see Appendix B for information on other social support services provided by CCSSI).

The auspice notes that some consumers express a preference for a non-Chinese visitor (these are referred to another ‘mainstream’ auspice), while others – particularly in the home care setting – are more comfortable with telephone interaction, rather than face-to-face.

CCSSI uses volunteer drivers to assist in transporting CVS volunteers to consumers’ homes. CSSSI also offers volunteers the option of ‘job sharing’ the visitor role with another volunteer, so that consistent visits can be maintained if one visitor is on holidays, unwell or otherwise unable to visit.

4.6. Program management considerations

4.6.1. Introduction

In this section, opportunities to streamline program administration are considered.

4.6.2. Funding allocation and grant administration

The CVS is currently provided by 212 auspices, many of whom have two separate funding agreements covering up to three visit types. This creates difficulties for administration by auspices. In addition, the volume of funding agreements creates an administrative challenge for the Aged Care Grants team. Several stakeholders have suggested that consideration should be given to rationalising the number of auspices, provided equity of access is not compromised.

Reporting

Auspice representatives consider that CVS reporting is not particularly onerous, but have questioned how useful it is. Performance against KPIs can be difficult to calculate (particularly given that some coordinators are unclear on contractual details such as the number of funded places). KPI 3, which requires auspices to establish the number of aged care service providers in their region, is inconsistently interpreted and performance is poorly recorded.

Several auspices suggested that the reporting template be revised and simplified, and pre-filled where possible with details from funding agreements. A desire for feedback from the reporting process, to enable auspices to see how they were performing compared with their counterparts, was also expressed.
4. Key Review areas: analysis and findings

4.6.3. Role of the Commonwealth

CVS auspice representatives have noted with concern that the level of input from the Department has diminished over recent years. Examples include:

- Comprehensive guidelines and templates are no longer provided by the Department and have been replaced with the *CVS Policy Guide* and FAQs. While these latter documents are considered useful, auspice coordinators have expressed a desire for more guidance; other stakeholders were not aware that these resources existed.
- Departmental representation at CVS conferences and meetings has become increasingly infrequent.
- In the past, the Department has issued certificates for visitors’ long service. These have not been provided recently. High rates of turnover in the Department has been cited as a factor.
- CVS newsletters (issued by the Department) have been infrequent over the past year. The newsletters are considered particularly valuable by auspices, especially when they address administrative challenges, such as clarifying requirements around police checks.

Suboptimal awareness of the CVS was consistently acknowledged as a challenge for the scheme. In addition, low levels of recognition that the CVS is a national, Commonwealth-funded program was a further problem for auspice coordinators, who felt that a higher level of Commonwealth branding and promotion would aid in their efforts to ‘sell’ the CVS to aged care service providers by making it seem more credible and giving it more ‘clout’.

4.6.4. Role of Network Members

Network Members play an important role in facilitating collaboration, information-sharing and training for other auspices in their jurisdictions. Network Members demonstrate a passion for the CVS and, on the whole, devote considerable time to the scheme with relatively little funding.

Network Members report providing high levels of support to new auspice coordinators, and have suggested that introduction of standardised basic training, along with an updated operational guide (with templates e.g. referral forms), would simplify this process. Mechanisms for information-sharing between auspices (both online and face-to-face) are also considered important in supporting good practice.

Network Members have reported difficulty in getting responses to questions they have raised with the Department, which can impact the quality of the advice they provide to auspices. With more funding, Network Members can see opportunities for broadening promotion of the CVS beyond the usual audiences, to include a greater focus on (for example) NACAP providers, general practitioners and organisations supporting special needs groups.
4. Key Review areas: analysis and findings

4.7. Other approaches to addressing social isolation

While the evidence for befriending schemes is ‘equivocal’, they are often used both in Australia and internationally to prevent and ‘treat’ social isolation13.

A large variety of models exists, both in Australia and internationally – one-to-one and group models, some utilising technology for communication and connection, others providing transport for group activities. However, there is little clear evidence available to confirm the benefits of particular models or indicate which elements of a program contribute to, or hinder, its success. Therefore, the identification of “best practice” is not possible.

Throughout consultations, stakeholders named a wide variety of models that they considered ‘best practice’ (or to have elements of best practice). These are listed in Appendix B along with further information on a select few. Many suggestions referred to social support models similar to the CVS – including some operating in the same general ‘landscape’, such as those available through the CHSP (social support – individual and group). Others were clearly outside the scope of any ‘visiting’ scheme (e.g. intergenerational living programs).

More broadly, models and approaches that stakeholders felt could, or should be considered by the Department (to address social isolation among aged care consumers) included:

- Providing a greater variety of activities within residential aged care homes (including collaboration and transport to share resources)
- Intergenerational models (e.g. local school/pre-school and aged care home relationship)
- Providing café-style functions, activities and relevant (e.g. cultural) celebrations
- Extending community eligibility beyond HCP recipients
- Facilitating group outings (with transport provided)
- Funding for more visitors from CALD groups
- Maintaining community connections for residents who have recently moved into a residential aged care home
- Funding a pool of fully salaried people whose focus is entirely on visiting people in special needs groups and who work closely with the CVS
- Corporate models (e.g. employees supported to volunteer time)
- Utilisation of companion animals
- Group visitor models (e.g. groups of volunteers to visit where volunteer safety may be an issue)
- Art therapy programs
- Community choirs for residents of aged care homes
- University students living in residential aged care homes.

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13 Pate, A 2014, Social isolation: its impact on the mental health and wellbeing of older Australians, Melbourne.
4. Key Review areas: analysis and findings

Approaches utilising technology were considered beneficial by the stakeholders who mentioned them, and their particular benefits in linking well-matched but geographically separate consumers and volunteers were highlighted.

Overall, stakeholders were “supportive of exploring a wide range of options, given no singular model is likely to suit all aged care consumers or the particular characteristics of their local community”.

Discussion of other models also served to illustrate the elements unique or highly valued in the CVS: for example the continuity of a relationship with one person, the voluntary rather than paid role of the visitor (positively affecting power-balance and consumers’ sense of self-worth), the straightforward and uncomplicated objective of providing friendship and companionship.

Among all stakeholder groups consulted there was a very high level of support for the CVS. In the residential aged care context, it is seen as a long-running and highly successful scheme that brings substantial benefit to both visitors and consumers alike, and that engages people who are particularly isolated who may not be willing or able to participate in other social connectedness activities. As such, the strong consensus emerging from stakeholder consultation was that the CVS should be supported and expanded as a key service option for consumers amongst a suite of programs for addressing social isolation and loneliness.

4.8. Key findings

- While consumers can exercise choice and control within the parameters of the scheme, the extent to which the CVS supports choice and control (in the broader sense intended through the aged care reforms), is limited by suboptimal awareness of, and access to, the scheme.

- Inflexibilities in CVS funding arrangements mean that consumers’ wishes cannot always be met (including during transition between home and residential care settings).

- Although there is currently significant variation in the roles and activities undertaken by volunteer visitors, there was little stakeholder support for explicitly expanding the role of the CVS visitor.

- A lack of awareness of the CVS and its operations (particularly referral processes) is a key barrier to uptake of the scheme in both home and residential care settings. This was exacerbated in the home care setting, with additional barriers (particularly risk management concerns and a competitive landscape) also noted.

- Improved networking and information sharing among relevant organisations was considered vital to improving uptake of the CVS through enhanced referral and volunteer recruitment. Other key opportunities to enhance uptake include national promotion, guidelines, communications materials and a central repository of CVS information for auspices, aged care service providers, visitors, consumers and the general public.

- Where appropriate visitor matches were made for individuals from special needs groups, good outcomes were reported. However, commonly-reported challenges included identification of special needs status and recruiting appropriate local volunteers.

- Stakeholders felt program management could be improved through:
4. **Key Review areas: analysis and findings**

- Potential rationalisation of the number of funding agreements in place (while maintaining equity of access), and combining ‘residential group’ and ‘residential one-on-one’ into a single visit type
- Reviewing KPIs and reporting templates
- Providing feedback on performance reports

- CVS auspice representatives have noted with concern that the level of input from the Department has diminished over recent years.

- Network Members play an important role in facilitating collaboration, information-sharing and training for other auspices in their jurisdictions, and could be further supported in this role.

- While a large variety of programs addressing social isolation in the elderly exists (both in Australia and internationally), there is little clear evidence available to define ‘best practice’. However, the CVS is seen as a long-running and highly successful scheme that brings substantial benefit to both visitors and consumers alike.
5. Options and considerations
5. Options and considerations

5.1. Options for enhancing the CVS

The following options for enhancing the CVS to ensure it can continue to deliver effective consumer support are presented for consideration by the Department. These are aligned to the Review themes, noting that some options span multiple areas. These have been informed by the Review findings, and discussed with a number of stakeholders during telephone focus group sessions (see Appendix H).

Alignment with aged care reforms

Expand eligibility

- Consider broadening eligibility criteria for the CVS to include recipients of the Commonwealth Home Support Programme (CHSP) (and HACC in WA), and those assessed as eligible for but waiting for a HCP. This would help position the CVS as key option for addressing social isolation, within an ‘integrated care at home system’ envisaged as part of future reforms.

Consider a suite of approaches to addressing social isolation

- The CVS should be offered as part of a suite of programs available to consumers as they transition across the aged care system. These include individual and group social support activities provided through the CHSP as well as social/leisure activities provided by residential care providers or offered within home care packages.
- Consider expanding the Digital CVS (DCVS, currently provided by Nundah Activity Centre) as an effective and low-cost way to deliver the CVS to rural and remote consumers or those who are ‘hard to reach’ (or to match with an appropriate visitor in their local area) for other reasons.
- Continue to support other innovative approaches to CVS service delivery, such as the involvement of companion animals, and use of technology.

Expanding the role of volunteer visitors

Retain existing scope of the visitor role

- The primary focus of the CVS should continue to be the provision of friendship and companionship to consumers. Expansion of the visitor role to include information provision or other functions may compromise the CVS and as such, should be considered through separate programs.
- Consideration could be given to including standardised basic information on the aged care system as part of visitor training. However, care should be taken to ensure that training requirements do not become burdensome or overly demanding for visitors.

Enhancing uptake of the CVS

Improve promotion and enhance awareness

Promotion to service providers, consumers, and the wider public is critical to increasing the reach of the CVS and supporting consumer choice. Suggestions include:
5. Options and considerations

- Develop Commonwealth-branded promotional and communications materials to augment localised promotional work undertaken by auspices. Key messages could include:
  - The CVS is a national, Commonwealth-funded program
  - Referral of eligible consumers to the CVS can be made by consumers, families, health care providers and others, in addition to aged care service providers
  - The right of socially-isolated consumers to receive the CVS (consistent with the relevant quality standards and reflected in accreditation processes)
  - The benefits of the CVS (for visitors and consumers)
  - How to find an auspice (including for people from special needs groups).

- Create a stronger presence for the CVS on the My Aged Care website and the Service Finder.

- Develop tailored communications materials for HCP providers, outlining the responsibilities of auspices and service providers, and emphasising the consumer’s right to a CVS visitor of their choice.

- Include information on the CVS as part of the orientation process for:
  - Aged Care Assessment Team (ACAT) assessors
  - Aged care workers
  - National Aged Care Advocacy Programme (NACAP) staff.

Facilitate national consistency

A more consistent national approach to implementation of the CVS could improve uptake and efficiency of the scheme. Suggestions to improve consistency include:

- Develop a clear yet flexible operational guide, similar to guidelines issued by the Commonwealth in the past. These could include templates for auspices to adapt and use, such as referral forms and information for aged care service providers.

- Enhance support for Network Members to facilitate collaboration and information sharing between auspices

- Introduce mandatory basic training for CVS visitors, using the online package developed by Multiple Sclerosis (MS) Victoria as a basis. Auspices may augment this training with other modules depending on need. Consideration could be given to funding translation of the training into languages other than English.

- Ensure Department staff are responsive to auspice/Network Member queries to ensure consistent interpretation of the operational guide.

Improve coordination

Improved coordination of the CVS would support good practice and enhance cross-referrals. Suggestions include:

- Support Network Members and auspices to hold annual face-to-face meetings to raise awareness of other auspices’ delivery of the CVS and enhance cross-referrals.

- Develop a centralised accessible directory of CVS auspices (and potentially a dedicated CVS website) to assist with directing consumers, aged care providers and visitors to the most
5. Options and considerations

appropriate auspices. This directory could be updated by auspices on an annual basis (with all
information approved by the Department). Information could include:

− Types of visits funded
− Regions covered
− Number of funded places (and number of vacant places)
− Whether an auspice specialises in a particular special needs group (e.g. CALD, Lesbian,
Gay, Bisexual, Transgender and Intersex (LGBTI)).

Special needs groups

Optimise support for special needs groups

Consideration of the following options would enhance access and appropriateness of the CVS for people
from special needs groups:

• Develop stronger linkages between auspices funded for special needs groups and other
organisations/agencies involving those groups to support visitor recruitment.
• Source training from relevant peak organisations to support visitors engaging with people from
particular special needs groups.
• Encourage broader awareness-raising within the sector regarding identification of people in
special needs groups.
• Consider relaxing geographic boundaries for auspices funded for special needs groups in order
to maximise access, and consider alternative models of service delivery (e.g. DCVS).

Program management considerations

Improve reporting processes

The following options could improve efficiency, accuracy and usefulness of CVS reporting, and reduce
administrative burden for providers and the Department:

• Review and simplify CVS KPIs.
• Revise the reporting template and consider introducing Smart Forms, pre-filled with auspices’
funding and contractual information, to improve ease of reporting and quality of data
submitted.
• Develop an annual summary report of auspice performance against consolidated national
performance data to enable auspices to benchmark their performance.

Streamline funding arrangements

The following options are suggested to improve CVS funding administration:
5. Options and considerations

- Consider rationalising the number of low-value grants by minimising duplication of service provision (i.e. auspices serving similar consumer groups within the same geographical area), whilst ensuring that access is not compromised.

- Combine residential one-on-one and residential group visit types into a single ‘residential’ visit type so that all consumers can receive the visit type most appropriate to their needs (noting that this may change over time).

- Introduce a single funding agreement to cover all visit types to minimise administrative workload for auspices and the Commonwealth.

- Consider relaxing geographical funding restrictions that prevent consumers continuing with the same auspice (and visitor) as they transition from home care to residential care.
Appendix A. Summary of stakeholder consultation process
Appendix A. Summary of stakeholder consultation process

A.1. Stakeholder consultation approach

The CVS review included three stages of stakeholder consultations. This chapter outlines the approaches used in detail and the level of engagement achieved.

A.2. Telephone interviews

A total of 77 stakeholders, nominated by the Department, were contacted by AHA and invited to an in-depth telephone interview. Stakeholders included CVS auspices (including Network Members), aged care service providers, peak organisations and other groups/representatives as shown in Table A-1. The sample of auspices selected by the Department was intended to provide a mix of the following characteristics:

- Location (state/territory; metropolitan/rural)
- Auspices providing each of the three service types
- Service size (i.e. number of funded places)
- Auspices that also provide Commonwealth-subsidised aged care services (and those that do not)
- ‘Mainstream’ auspices and those funded for special needs groups.

Of the 77 stakeholders contacted, a total of 44 elected to participate, as shown in Table A-1. In many cases, multiple representatives from an organisation participated in the interview.
Appendix A. Summary of stakeholder consultation process

Table A-1: Summary of telephone interviews

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Number contacted</th>
<th>Interviewed</th>
<th>Opted for consultation paper only</th>
<th>Declined involvement or unable to contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>CVS Network Members</td>
<td>8</td>
<td>7</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other CVS auspices*</td>
<td>36</td>
<td>22</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Aged care providers</td>
<td>14</td>
<td>6</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Peak organisations</td>
<td>13</td>
<td>4</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Groups representing special needs group</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>NACAP providers</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Aged Care Grants team</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>HCP representative</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td><strong>77</strong></td>
<td><strong>44</strong></td>
<td><strong>19</strong></td>
<td><strong>14</strong></td>
</tr>
</tbody>
</table>

*At interview, a number of auspices were identified as also being aged care service providers. Categories used in this table are those originally provided by the Department.

In addition to those listed in Table A-1:

- One stakeholder was interviewed at the request of a CVS Network Member (because of her involvement with an innovative program involving pets as a means of reducing social isolation).
- The Department arranged group teleconferences with:
  - Department state and territory network representatives (three attendees with input from others via email following the meeting)
  - ACAT (four attendees with input from other teams via email following the meeting).

A list of participating organisations is provided at Section A.5.

Interviews were semi-structured in nature, using a tailored interview schedule for each stakeholder group. The average interview length was approximately 40 minutes. In some cases, following the interview, stakeholders were invited to consult with their teams and respond to the interview questions via email.

Interview questions are provided at Appendix E.

A.3. Online consultation paper and feedback form

A consultation paper was developed as an alternate or additional mode through which interested stakeholders could have input to the Review (see Appendix F). The paper was available on both the Department’s and AHA’s website from 21 October 2016 to 2 December 2016.

The consultation paper was promoted via the Department’s network of key stakeholders (including aged care service providers, peak organisations, CVS auspices, Departmental staff, ACAT and Regional Assessment Service (RAS) staff). The consultation paper was provided in Word and PDF format as well as on the SurveyMonkey platform in order to maximise accessibility.
Appendix A. Summary of stakeholder consultation process

The number of responses to the consultation paper far exceeded expectations, with 196 submissions received in total. Of these, 148 were submitted via SurveyMonkey (representing a total of 115 individuals after double entries and blank surveys were removed), 47 via email and one via post, resulting in a total of 163 submissions to be analysed.

Details of organisations who responded to the consultation paper are provided at Section A.6.

A summary of consultation feedback, with further information about respondents, is provided at Appendix G.

A.4. Stakeholder in-depth telephone focus groups

The Project Plan for the CVS Review included provision for one or more stakeholder workshops, to be undertaken depending on need and sufficient stakeholder interest. Following discussion with the Department, AHA sought expressions of interest for a workshop (to be held in Sydney in early December) from key stakeholders involved in the telephone interviews. Interest from stakeholders based outside NSW was low, so it was subsequently agreed that a series of in-depth telephone focus groups would be undertaken instead of a workshop, in order to overcome travel-related barriers.

The aim of the telephone focus groups was to build on the findings from the interviews and consultation paper feedback by enabling in-depth exploration of options for a future CVS model (see Appendix H for the focus group briefing paper).

AHA facilitated a total of six in-depth focus groups from 6 to 8 December. On average, eight individuals were invited to participate in each focus group, in an effort to maximise discussion while keeping participant numbers manageable. While the initial response rate to the focus group invitations was very high, total of 23 stakeholders subsequently participated.

Focus group participants included those that had already participated in the initial round of telephone interviews and who had expressed interest in further discussions. They included representatives from a range of stakeholder groups, including CVS Network Members, auspices and aged care service provider representatives and interested peak organisation representatives.

Focus group discussions informed the development of the options and considerations outlined in this report (see Chapter 5).
Appendix A. Summary of stakeholder consultation process

A.5. List of stakeholders who participated in in-depth telephone interviews

**Auspices**
- All Aged Care (QLD)
- Anglicare Southern Queensland (QLD)
- Australian Red Cross Society (ACT)
- Burnie Brae Centre (QLD)
- Chinese Community Social Services Centre Inc (Vic)
- Co.As.It- Italian Association of Assistance (NSW)
- Communites@Work (ACT)
- Community Care (Tas)
- Community First International Ltd (SA)
- Ella Community Centre (NSW)
- Gay and Lesbian Switchboard Inc (Vic)
- Lifeline (Tas)
- Melbourne City Mission (Vic)
- New Hope Foundation Inc (Vic)
- People Who Care Inc (WA)
- Southcare Inc (WA)
- St Basil’s Aged Care Services (WA)
- The Centre for Continuing Education Inc (Vic)
- The Corporation of the City of Norwood, Payneham & St. Peters (SA)
- The Whiddon Group (NSW)
- UnitingCare Wesley Bowden (SA)

**Aged Care Service Providers**
- Anglican Retirement Villages (NSW)
- BaptistCare (NSW)
- Benetas (Vic)
- Novacare Community Services Ltd (NSW)

**CVS Network Members**
- City of Unley (SA)
- Melville Cares (WA)
- Multiple Sclerosis (Vic)
- Queensland Community Care Network (QLD)
- Red Cross (Tas)
- Royal Prince Alfred Hospital (NSW)
- YMCA (NSW)

**Peak Organisations**
- Council of the Aging (COTA)
- Leading Aged Services Australia (NSW)
- National LGBTI Health Alliance (NSW)
- Uniting Care (Clayton Homes) (NSW)

**Special Needs Groups**
- Australian Nursing Home Foundation Limited (NSW)
- Multicultural Communities Council of Illawarra (NSW)

**Departmental**
- Director, Home Care Reform Branch
- National Aged Care Grants, Department of Health (Tas)

**Other**
- RSPCA (SA)
Appendix A. Summary of stakeholder consultation process

A.6. Organisations who responded to the consultation paper

- AEPL Eremeran Study Centre
- ACON Health
- Age Concern
- Aged and Community Services Australia
- Alzheimer’s Australia
- Amberlea Aged Care Drouin
- Anglican Parish of Glenelg
- Anglicare Southern Queensland
- Australian Multicultural Community Services Inc.
- Australian Red Cross
- Baptistcare WA
- Barongarook Gardens Aged Care
- BlueBross Community and Residential Services
- Brightwater
- CatholicCare Diocese of Broken Bay
- Catholic Community Services
- Catholic Healthcare Ltd
- CatholicCare Sydney
- Centre for Participation (formerly Wimmera Volunteers Inc)
- Chaffey Aged Care
- Chester Hill Neighbourhood Centre Inc.
- Chinese Australian Services Society
- Chinese Community Social Services Centre
- CHSA Riverland
- Churches of Christ Community Care
- City of Charles Sturt
- City of Unley
- Co.As.It. Community Services Inc
- Co.As.It. Italian Association of Assistance
- Combined Pensioners and Superannuants Association
- Community First International
- COTA Australia
- Creston College
- Cura In-Home Care
- MS Victoria
- Diversicare
- Dubbo Neighbourhood Centre
- Enfield Baptist Church
- Esperance Home Care
- Estia Bentleigh
- Fraser Coast Multicultural Support Services
- Fronditha Care
- HammondCare
- Hastings McCleay CVS
- Horton House (Twilight Aged Care)
- Hunter Volunteer Centre Inc
- Hunters Hill Ryde Community Services
- IMPACT Community Services
- Kew Gardens Aged Care
- Latrobe Community Health Service
- Leading Age Services Australia
- Lexington Gardens Aged Care
- LGBTI CVS Network
- Lifeline Tasmania
- Lions Club of Redcliffe Kippa-Ring Inc
- Logan Area Committee on the Ageing Inc
- Lutheran Community Care
- Macarthur Diversity Services Initiative
- Mackay Community Visitors Association
- Manning Support Services
- McKenzie Aged Care Group
- Melbourne City Mission (MCM)
Appendix A. Summary of stakeholder consultation process

- Melville Cares
- McKenzie Aged Care Group
- MiCare
- Migrant Resource Centre South Tasmania
- Mooraleigh Hostel - Monash Health
- Mornington Peninsula Shire
- Mount Gambier & District Uniting Church
- MS Australia
- MS Victoria
- Multicultural Aged Care
- MultiLink Community Services Inc.
- National LGBTI Health Alliance
- National Seniors Australia
- Neighbourhood Central
- Nepean Volunteer Services Inc
- New School of Arts Neighbourhood House Inc.
- Northern Volunteering SA Inc
- Nuhra Life enrichment Centre Inc.
- Older Persons Advocacy Network (OPAN)
- People Who Care
- Phoenix Westgate Migrant Centre
- Princes Court homes
- Queensland AIDS Council
- Queensland Community Care Network
- Red Cross - VIC
- Regis Milpara Lodge
- Regis Onatrio nursing home
- Riverina Community College
- Riverview Community Services
- SkillCentred Queensland Inc
- South West Do Care
- Southern Cross Care
- Southern Migrant and Refugee Centre
- Southern Volunteering South Australia (SVSA)
- Springwood Neighbourhood Centre Cooperative Ltd
- St John Of God Hospital Bunbury
- St Jude's Community Visitors Scheme (Brighton SA)
- St Vincent's Prague House
- Switchboard Victoria Inc
- Sydney Local Health District
- The Centre for Continuing Education Inc. (The Centre)
- The Golden Retriever Club of SA Inc (Caring Canine Companions)
- The Mews Aged Care (Sapphire Care)
- Toukley Neighbourhood Centre
- Trinity Manor Aged Care
- UCWB
- Umbrella Multicultural Community Care Services Inc
- Uniting AgeWell Noble Park
- Uniting In Care Salisbury
- Vasey RSL Care
- Victorian Arabic Social Services
- Villa Maria Catholic Homes
- Volunteering Central Coast
- Volunteering Coffs Harbour Inc
- Wesley Community Services Ltd
- Wintringham
- Wynnum Baptist Church Community Visitors Scheme
- YMCA NSW
Appendix B. Literature scan findings
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A.7. Introduction

Community visitors schemes, also known as ‘buddy’, ‘home visiting’ or ‘befriending’ services, are run in many countries under various models. Befriending can be defined as “a voluntary, mutually beneficial and purposeful relationship in which an individual gives time to support another to enable them to make changes in their life” (National Council for Voluntary Organisations 2015).

In order to inform AHA’s Review of the Australian CVS, programs with essential similarities were examined through a brief literature and internet scan.

A key common element of most models identified include the use of volunteer visitors, who are trained and matched to an appropriate consumer based on factors such as common interests, personality and expectations regarding visits.

While the Australian CVS aims to prevent social isolation among those in receipt of government-funded aged care, these types of services (both in Australia and internationally) also cater for other populations, including those with disabilities or mental illness.

There is a large number and variety of befriending programs in existence, even when limiting the target group to the socially isolated elderly, and it is difficult to identify particular strengths and weaknesses of individual models due to a lack of (at least publicly-available) evaluation data as well as the different contexts in which programs are delivered.

The key elements and differences between the services identified are discussed in this document, to inform the evaluation of the CVS and identify potential alternative models of service delivery.

A.8. Evidence for benefit

The literature highlights the lack of robust evidence relating to interventions aimed at reducing social isolation (including befriending programs) perhaps because of the wide variety of models implemented (Grenade & Boldy 2008).

For example, they may be:

- Group-based or one-to-one
- Delivered face-to-face or through other means (e.g. telephone and internet)
- Stand-alone interventions, or part of a package of interventions to address social isolation and related issues
- Designed to be an ongoing activity, or one that aims to help the individual engage (or re-engage) with community networks
- Short or long term
- Delivered by volunteers or paid staff
- Provided to people living in the community or in residential aged care (Devine 2014).

In addition, although most commonly delivered to provide companionship and emotional support (Devine 2014), it is sometimes unclear exactly what the desired outcome of such programs might be.
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(e.g. lowering incidence of depression, improving quality of life, delaying need for residential care). There may also be a different focus for programs – e.g. some may be designed to prevent social isolation, rather than ‘treat’ it (Windle et al. 2011).

There is some evidence that befriending can reduce the effects of social isolation and improve life satisfaction, social integration and self-perceived health status (Chal 2004). It is also suggested that such programs may enable consumers to remain in their own home for longer and even have an effect on mortality. A 2010 systematic review (of befriending programs across settings and populations) found that befriending had a modest effect on depressive symptoms and emotional distress, but that the ‘active ingredient’ in such programs is difficult to define (Mead et al. 2010).

Conversely, a 2014 review found that “ineffective intervention [to combat social isolation] involved...one to one interventions conducted in people’s own homes” (Pate 2014, p. 15).

Although the literature scan identified a large number and variety of models, it is not possible to identify whether these were effective, and what elements represented strengths and weaknesses within each model, as few evaluations were publicly available, and those that were seldom reported clear outcomes.

Despite the lack of robust evidence, consumer satisfaction, where reported, appears universally high (Chal 2004, Age Concern New Zealand 2015).

Although not within the scope of this scan, benefits for volunteer befrienders – and the importance of the perceived benefit for volunteers – is also noted (Chal 2004).

A.9. Aims/roles of programs

Providing company, assistance and activity

Particularly in schemes targeting the elderly, the provision of companionship and social opportunities is the key purpose. This can entail one-to-one visits, outings or group activities.

In some cases, the visit may involve mutually-agreed activities such as walking, and/or practical assistance such as shopping, cooking or transportation.

While a large proportion of elderly people who could benefit from a befriender may also require assistance with daily activities, this is often out-of-scope for volunteer befrienders. However, it is interesting to note that those receiving home support may also benefit from a befriender, and differentiating these roles (and providing both to an elderly person) may reduce the burden on both befrienders (to help with tasks) and support workers (to provide companionship) (Chal 2004).

Information provision

In some models, the role of the volunteer extends beyond simple company/friendship to broader efforts at encouraging social inclusion – for example, supporting them “to increase their social activity in their own way, at their own pace” (Age Concern New Zealand 2015). They may help individuals to maintain links or re-engage with community, for example by improving their access to information and other services (AgeUK 2011).
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It has been suggested within the Australian context that there are many programs in existence that target social isolation in older people, but there may be suboptimal awareness of these among the target population (Bond et al. 2014). This implies a potential role for befrienders to be aware of and provide information to aged care consumers about such other opportunities. The Befriending Scheme in the UK recruits volunteer ‘information ambassadors’ to ensure users of a group program has access to relevant information and understands how it might benefit them (The Befriending Scheme 2016a).

Screening/issue identification

While not often articulated as a primary aim of befriending programs, in some cases volunteers are trained to identify any emerging issues or concerns and facilitate appropriate referrals – particularly in the community setting (e.g. Call in Time in the UK (Jopling 2015)). Conversely, in other programs befrienders do not undertake this role, as a matter of organisational policy (Chal 2004).

Advocacy

In some models, advocacy on behalf of an older person is the role of a volunteer visitor. For example, in a UK program, volunteer visitors have been able to help care home residents raise important concerns that they were uncomfortable raising directly with care home staff, leading to benefits for the individual and other residents (Jopling 2015). In a home-based model over the course of a year, five volunteers had taken up quality of care issues with relevant agencies and two ‘Safeguarding Vulnerable Adults Alerts’ had been raised with social services as a result of issues identified by volunteer visitors (NCVO Mentoring and Befriending 2015).

Learning/skills development

While perhaps less common in the aged care sector, volunteers in other sectors may play a role in upskilling consumers – for example those with learning disabilities – often to better equip them for employment (The Befriending Scheme 2016b).

In the aged care context specifically, the concept of life-long learning is relevant, potentially leading to decreased social isolation and improved wellbeing (Adult Learning Australia 2016). A frequent focus of learning for the elderly is use of technology (see below).

Watchdog function

While out of scope of this literature scan, it is noted that in many states of Australia, ‘volunteer visitors’ are engaged to undertake an advocacy and watchdog role (as ‘independent community observers’) in sectors including disability, mental health and justice.

A.10. Funding/cost issues

Throughout the scan, there was little to suggest ‘user pays’ models of service provision, outside of transport. As noted in a 2004 review, “while incentives, like transport or small payments may encourage greater numbers of befrienders, service users should not have to pay as this does not embrace the reciprocal nature of friendship” (Chal 2004, p. 48).
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However, the same review noted that various funding models existed for both large and small befriending services in New Zealand, including government contracts, grants, trusts and user payments. While 9% of providers utilised this latter source as their main source of funding, it was noted that the cost to the user was extremely low, usually less than $5 per activity/outing (Chal 2004). The vast majority of resources scanned suggested various funding models including various levels of government, charities and trusts – and often a combination of these or funding through collaborative partnerships.

There is some suggestion that befriending programs may be ‘cost effective’, with overall potential savings outweighing the costs of program delivery (Social Care Institute for Excellence 2012) – however, such a finding is clearly context-dependent.

In the 2004 review of services in New Zealand, 52% of providers reported running costs of NZD$30,000 or less (Chal 2004). The review found that while ‘formal’ services (i.e. those whose primary source of funding is government) had higher costs than other services compared with those relying on grants, bequests, donations and trusts), they enjoyed better infrastructure and avoided the uncertainty of funding and sustainability encountered by other organisations that could lead to discontinuation of services. Outcomes achieved by befriending services, however, appeared to be similar across models.

A.11. Governance and management

A 2004 evaluation of befriending services in New Zealand noted that responsibility for population-based initiatives to promote the health and wellbeing of older people lies with not only the national government, but also local authorities and community-based services (Chal 2004). Similar sentiments were expressed by stakeholders in other countries. For example:

- A Canadian investigation noted that volunteer-based outreach programs “could be done within the context of small service agencies...or could involve larger provincial or national efforts by government or other suitable organizations” (p. 40)

- In the UK it is recognised that all levels of government, professional bodies and regulators, and adult social care and health providers across all sectors are involved in supporting independence and improving community connectedness for the elderly (AgeUK 2011).

In many cases, befriending services are run by charities and non-profit organisations, with paid staff coordinating a volunteer ‘workforce’. For example, in New Zealand, while the majority of face-to-face befriending services are provided by volunteers, “almost all providers had a paid, full time or part time coordinator/manager” (Chal 2004, p. 68).

Some organisations may run a number of programs/service models relevant to the same target audience (e.g. one-to-one, group, and telephone services). In other cases, (e.g. The Befriending Scheme in the UK) an organisation might run programs relevant to a number of different groups (in this case ‘adults from vulnerable groups’ including those with mental health issues and learning disabilities as well as the elderly) (The Befriending Scheme 2016b).

In the UK, mentoring and befriending projects can apply for accreditation against a national quality standard comprising 10 requirements across four key areas (management and operation, service users, mentors and befrienders and the mentoring/befriending relationship).
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Umbrella organisations

In one (Scottish) model, a national umbrella organisation (and registered charity), ‘Befriending Networks’, provides subscription-based information and support and broad advocacy for new and existing befriending projects, helping them to “develop effectively and efficiently by sharing experience and practice between projects”. Befriending Networks also produces resources and sets guidelines and recommendations for best practice in program management (Befriending Networks 2016a). Similarly (but with a broader focus), the UK’s NCVO Mentoring and Befriending Network provides training, resources and networking opportunities as an accreditation process supported by an ‘Approved Provider Standard (NCVO 2015).

A.12. Process

To create a successful befriending service, three key enablers are the referral of appropriate consumers, recruitment (and retention) of appropriate volunteers, and “clear friendship boundaries between befriender and service user”.

As articulated by Age of Concern (NZ), the process of becoming a volunteer often involves steps such as:

- Interview
- Police and reference check
- Training
- Matching
- Providing records of visits
- Regular reviews with coordinator
- Ongoing training/support (Age Concern New Zealand 2015).

A.13. Volunteers

Characteristics

A 2004 review of New Zealand services found that most befrienders were older, female volunteers (Chal 2004).

While there is suggestion in the literature that volunteers belonging to the same generation as the consumer (along with other factors in common) may aid relationship-building efforts, it was also suggested that intergenerational contact may be ‘more effective’ in addressing loneliness (AgeUK 2011, Windle et al. 2011). Programs may involve younger people from primary school through to university age (Friends of the Elderly Ireland 2016), with examples including schemes that encourage children to be involved in visiting (with their parent guardian or teacher) or writing letters (Love for the Elderly 2016). Although different in nature to a befriending service, initiatives such as Timehelp utilise elderly volunteers in school-based support. Although a key aim of this program is to support schools (students and teachers), the benefits for volunteers in terms of physical, emotional and social health are noted (Bond et al. 2014).
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Recruitment and retention

As mentioned above, there is evidence that volunteer befrienders do benefit from the relationship. However, little information about methods of improving volunteer recruitment and retention was found.

Many programs provide information for potential volunteers on their website, and in some cases a downloadable brochure outlining the process and commitment required (e.g. Age Concern New Zealand). Advertising through print media, radio and flyers, along with recruitment through volunteer centres, word of mouth, and ‘shoulder tapping’ were reported by coordinators in New Zealand, but the same report noted that many coordinators were struggling to recruit sufficient numbers to provide for all referrals (Chal 2004). Half of the befrienders interviewed had found out about the opportunity though advertising (although the modality is not specified).

Most programs are delivered by volunteers – and it is suggested that paid models (particularly where the user pays for the service) may be inappropriate, as it may make such a service inaccessible for financially-challenged older people as well as undermining the concept of ‘befriending’. However, reimbursement of costs incurred (e.g. travel) may assist with recruitment and retention of volunteers (Chal 2004).

The appropriate matching of volunteers and consumers allows reciprocity within the relationship, and is an important consideration in the success of a program (Chal 2004). Matching may take into account age, common interests and activities, expectations regarding visits, background and life history and personality, although compatibility may be hard to define (Chal 2004).

Benefits and risks

The most commonly articulated benefit of utilising a volunteer workforce to deliver befriending services was the creation of a genuine emotional (rather than commercial) relationship (Chal 2004).

Little information was found about risks of using a volunteer workforce. However, there are inherent risks in situations in which an individual volunteer is visiting an individual (particularly in their own homes). Befriending Networks in Scotland dedicates a web page to issues around insurance specifically for befriending services (Befriending Networks 2016b).

A 2004 review of New Zealand befriending services did identify clear role definition/friendship boundaries as a key issue to be addressed (along with appropriate referral and recruitment and retention of volunteers). Even when trained, the nature of the relationship may mean that volunteers undertake – or are asked to undertake – unintended roles and tasks (Chal 2004). This can result in the loss of a volunteer if he/she feels overburdened or uncomfortable.

A.14. Reach and recruitment of consumers

In many programs, potential consumers are referred by the health, allied health, and community care providers with whom they have contact (e.g. GPs, community nurses, social services). Other sources of referral include potential consumers themselves or concerned relatives or neighbours, police and government agencies (Chal 2004).
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Many programs have a website that provides basic information and encourages self or relative referral for services, and in some cases a downloadable brochure. It is unknown (but possible, if not likely) that many of these organisations may provide hard copies of these pamphlets for distribution to aged care services, health care services etc.

However, a Canadian investigation into social isolation among seniors noted the importance of communicating to the broader community about available support services, as the target population itself may not be in a position to know about, or act on knowledge of existing services (British Columbia Ministry of Health 2004).

Similarly, a UK report highlighting promising approaches characterised ‘foundation services’ that must be provided before any particular intervention (including befriending schemes) could be implemented: reaching lonely individuals, understanding and responding to their individual context and needs and supporting them to take up the services that would “help them make meaningful connections” (Jopling 2015).

Suggested approaches include screening for known risk factors of social isolation, training of community members with whom older people are likely to have contact (to facilitate identification and referral), and integration of interventions with existing health care services (especially primary care) (Jopling 2015).

From the literature scan, it seems that self-referral (or even family/neighbour/friend referral) is unlikely to optimise the reach of CVS to individuals in need. However, broader community awareness and the screening/targeting of individuals through existing processes and relationships may be most effective.

A.15. Other models

Given the wide variety in characteristics of socially isolated elderly people, it has been suggested that best practice may involve supporting individuals to access the type(s) of interventions that best meet their needs (Jopling 2015). While many of these may be outside the scope of this literature scan (not being directly relevant to the CVS), it is useful to highlight those that could be captured in a future CVS model.

Group models

While group visits already occur in Australian residential aged care settings under the CVS, alternative group models may be of particular relevance to the home care setting, where those in receipt of HCP are likely to be more independent and mobile. Indeed, there is some evidence to suggest that group activities (and those in which consumers are ‘active’ participants) may be more effective than one-to-one interventions (Dickens et al. 2011).

Examples include regular tea parties (with volunteers hosting and providing transport) or meals in volunteers’ homes or cafes and restaurants. The ‘Eating with Friends’ program in Tasmania, funded primarily through the HACC Program, evolved out of the ‘meals on wheels’ program, as volunteers noted the issue of social isolation among consumers. While there is no fixed format for running the program, it provides social eating opportunities for elderly people (Eating With Friends 2014).

Transportation may be of particular importance in facilitating group activities, especially for those living in the community, or, for those living in residential aged care, for activities held outside of these
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facilities (Pate 2014, ‘Eating with friends’: is it addressing social eating needs of older Tasmanians? 2013).

Telephone and online models

Social isolation interventions utilising technology appear to be becoming more common.

For example, ‘care calling’, as identified in a New Zealand evaluation, entails daily telephone calls to an older consumer. Another model (St John Caring Caller) provides a free, national, long-term befriending service for housebound people (St John New Zealand n.d.).

In the UK, the Silver Line Helpline is available 24 hours a day, seven days a week to provide information, friendship and advice to older people, link them to relevant local groups and services and support those suffering from abuse or neglect (The Silver Line 2013). Although the helpline is manned by paid staff, the service also offers phone and mail-based volunteer befriending services (Jopling 2015).

Other models include the Call in Time program in the UK, in which organisations volunteer their workers’ time (e.g. half an hour per week during work time) to call an older person. The provider notes that the model allows delivery of a cost-effective service that has little problem recruiting volunteers (Jopling 2015).

Telephone services also exist in Australia – for example the Red Cross Telecross service, in which volunteers call isolated older people in the community daily to check on their wellbeing and respond appropriately if there is no response (Bond et al. 2014). However, the focus of this service is welfare, rather than addressing social isolation.

Similar to telephone-based services, online models allow frequent contact between volunteers and consumers even where geographical barriers exist, or where consumers have difficulties or concerns about meeting with people face-to-face (Devine 2014). The Australian Enmesh project involved providing iPads and a specifically-designed application provided to older adult participants, and reported positive effects on wellbeing and social isolation, through participants’ ability to share photographs and messages (Bond et al. 2014).

While there are some concerns that internet use may contribute to – rather than help to alleviate – social isolation, it may be a useful tool in maintaining existing networks and as an adjunct to broader initiatives addressing social isolation (Bond et al. 2014).

Special needs groups

A number of models were identified that specifically targeted special needs groups. Relevant information and examples identified in the literature scan are outlined below.

Aboriginal and Torres Strait Islander people

No specific information was found in the literature relating to befriending services for Australian Aboriginal and Torres Strait Islander people. However, in New Zealand, Maori service providers ensure that befriending services are provided in a culturally-appropriate way (“developed by Maori to meet the needs of Maori”) and that individual communities can be catered for (Chal 2004, p. 97). The programs identified in the 2004 review:
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- May be offered to people as young as 45, if deemed a ‘Kaumatua’ (elder) by their community
- Providers may be tribally-based, or ‘pan-tribal’
- May involve group meetings and/or traditional activities (e.g. flax weaving, formal or informal speeches, prayers and blessings)
- Can involve practical assistance (e.g. shopping, transport, even support for attendance at funerals)
- Are generally holistic models, providing support for spiritual, emotional, physical and mental health.

Culturally and linguistically diverse

Some research undertaken in the ACT highlighted the fact that while mainstream services are not always able to meet the needs of those from CALD backgrounds, culture-specific services are limited in capacity and can’t necessarily provide what is needed or wanted (Cultural and Indigenous Research Centre Australia 2009).

The ‘Multilingual Senior Surfers Pilot Project’, undertaken in Melbourne, targeted older CALD adults. Volunteers, utilising training materials in languages other than English, facilitated access to, and training for, the target audience on computers and the internet. Increased social connection was reported as an outcome (Bond et al. 2014).

Lesbian, gay, bisexual, transgender and intersex

In one example, a 2012-13 pilot program in Queensland trained volunteers to regularly visit older isolated or housebound LGBTI adults and undertake activities such as reading, listening to music, or going on outings (Bond et al. 2014). Consumers and volunteers could choose to meet in the consumer’s home or in a public place such as a local café, library or shopping centre (LGBT seniors community visiting service n.d.).

Rural and remote

While it is sometimes suggested that social isolation may be closely related to geographical isolation, and less of an issue in metropolitan areas, a recent study found that social isolation among older people was most prevalent in the largest Australian cities as well as the most sparsely populated areas (Beer et al. 2016).

As outlined above, telephone and online models of befriending may be of use in this context.

Other

While not defined as a special needs group under the Aged Care Act 1997, befriending services are also described for specific populations that intersect with the elderly population, such as those with mental illness, disability or at end of life (Gardiner & Barnes 2016, People First n.d.).

The value of reciprocity in volunteering was raised by a number of international agencies. While those receiving aged care services may have limited ability and mobility, in some cases being befriended by a volunteer can motivate people to volunteer themselves, either as a ‘befriender’ or in other ways. A UK report into ‘promising approaches’ in reducing social isolation and loneliness among the elderly noted several case studies in which this had occurred, including aged care, and migrant and refugee mentoring.
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initiatives (Jopling 2015). This is also echoed in other programs such as Timeshare in Australia, where older people volunteering in school-based positions noted benefits in terms of their own physical, mental and social wellbeing (Bond et al. 2014).

A.16. Novel initiatives funded by the CVS

Through the process of the Review, several initiatives already funded through the CVS were noted for their novel models of delivery, three of which are described below.

**Digital Community Visitors Scheme**

The Nundah Activity Centre (NAC) provides HCP recipients in specific areas of Australia with a tablet (with internet connection and “generous” data allowance) to facilitate a digital CVS (DCVS). The DCVS is profiled in Section 4.5.3 as an innovative approach to providing the CVS to special needs groups.

**Caring Canine Companions**

This service, operated under the CVS by the Golden Retriever Club of South Australia, involves volunteers visiting residential aged care facilities with their dogs (that have been assessed to ensure appropriate behaviour, attitude and presentation) to provide companionship and the “therapeutic value of having a pet to cuddle” (Golden Retriever Club of South Australia Inc n.d.).

**Switchboard Victoria**

Switchboard Victoria is a “telephone-based counselling, information and referral service” that operates for LGBTIQ individuals, family/friends and health and welfare professionals across Melbourne, regional Victoria and Tasmania. Switchboard Victoria provides the ‘Out and About’ service for older LGBTIQ consumers, funded through the CVS. This program is profiled in Section 4.5.3.

A.17. Initiatives identified by stakeholders

Throughout the Review consultation process, a number of initiatives were mentioned by stakeholders as being ‘promising’ or ‘of interest’ in terms of the scope of the Review. Although limited information was available on the internet regarding these, some (for which information could be sourced) are summarised below.

**Wesley mission**

Wesley mission runs several social support services for older people or those with disabilities, all supported by funding from Commonwealth and state governments. These programs operate in various parts of Melbourne.

**Do Care**

Established 1977 and operating in Melbourne’s eastern, southern and north-western areas, Do Care pairs volunteers and consumers (one-to-one or group) for flexible activity options (e.g. meet for a chat,
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play board games/cards, coffee outings, local walks/drives, movies, craft, shared meals, pet companionship).

**Telelink**

A free service that groups up to 10 people to get together via phone link (from their own homes) once per week to chat about shared interests for 45-60 minutes (a program outlines topics for particular days/times).

**Melba club**

Melba Club provides social opportunities for older people in the Yarra Valley area, including small day group activities, a home visit program, men’s group and radio program.

**Chats program**

Designed for older people living independently, the Chats program is managed and run by Lifeline Tasmania (also a CVS auspice providing home care and residential group and individual services) and funded by the Australian Government Department of Health and Tasmanian Government.

Those aged 65 years and over (or aged 50 years and over if you’re Aboriginal or Torres Strait Islander), need to be assessed by via My Aged Care to determine eligibility. However, younger consumers can contact Chats directly (Chats Tasmania 2016).

The program is focussed on “helping older Tasmanians to create and sustain improved quality of life by developing a sense of belonging through participation and inclusion in activities, social engagement and community connections”. Consumers identify goals, and activities are chosen to reflect consumer needs, interests and abilities, and commit to attending at least two activities per month. Services include day trips, social phone calls, a monthly newsletter, links to community organisations and events and special interest groups.

The organisation can also provide transport to their own events, with a participant co-contribution of $5 per activity charged (Lifeline Tasmania 2014).

**Australian Red Cross**

Like a number of organisations (including existing CVS auspices), the Australian Red Cross provides a number of services for older people who live alone (including those with HCPs or living in an aged care home), older people with few social connections outside their home, people with disabilities and people recovering from mental illness.

These services are funded through the NDIS and My Aged Care, and include home visits, social outings, group activities, peer support and social phone calls (TeleCHAT and TeleYARN for Aboriginal and Torres Strait Islander people). Many match consumers with volunteers based on interests and values (Australian Red Cross n.d.).

The Telecross service – a daily welfare check (phone call) – is also available across Australia (Australian Red Cross n.d.).
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Volunteer Buddy Program (Tasmania)

Alzheimer’s Australia has explored various innovative approaches to address the common issues of social isolation that a lot of people diagnosed with Dementia face. One such project is the Volunteer Buddy Program in Tasmania, which is designed to enhance the quality of life of people living with Younger Onset Dementia (YOD) by reducing social isolation and providing meaningful activity.

The program, funded through the National Quality Dementia Care Initiative, matches people based on similar interests, skills, culture, personality and hobbies. This matching process helps form genuine connections between volunteers and people with YOD. This relationship is the foundation for change and benefit to people’s lives. People with dementia feel a sense of connection and have something to look forward to when involved in the program. They have better mood and a sense of being valued. Carers enjoy seeing their loved one being happy and participating in their community. Carers also receive respite from their caring role by being a part of this program.

The best-practice model developed for volunteers engaging in a buddying service with people with YOD is successful due to its flexibility and consumer-directed nature. The program also has the potential to change dementia stereotypes in the community through partnerships with community providers which involves education and awareness raising about YOD. The program is relatively inexpensive, simple in its design and could easily translate across service providers in different states and territories.

*Note: text above provided by Alzheimer’s Australia in their response to the consultation paper.*

Chinese Community Social Services Inc

As well as being a CVS auspice (see Section 4.5.3), this organisation delivers other social connectedness programs in Victoria.

Joyful line is a tele-support and counselling service that aims to help provide homebound and frail Chinese seniors who experience social isolation (and their carers) with social connection and emotional support. The service includes:

- A weekly social tele-support group with consumers grouped by dialect, background and interests
- A phone counselling service (individual and group) for those with emotional problems (e.g. depression) (Chinese Community Social Services Centre Inc. n.d.).

The service is offered free of charge, funded by the Australian Government Department of Health and Ageing and the Victorian Government Department of Health (Chinese Community Social Services Centre Inc. n.d.).

In addition, the ‘Active and fulfilling ageing’ project, funded by the Australian Government Department of Social Services, aims to:

- Promote social inclusion for Chinese-speaking seniors, and encourage them to contribute to the community with their skills, to make friends, to learn new knowledge, and to be more confident.
- Enhance their capacity and independency to cope with ageing, to stay active and socially connected, and lead an active and fulfilling retirement life.
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The program includes: Active Learning, Life Coaching, and the Championship program (providing recognition of achievement to Chinese seniors) (Chinese Community Social Services Centre Inc. n.d.).

Companion Animal Support Service (SA)

The City of Charles Sturt (SA) initiated a pilot project in 2015 to match volunteers with older consumers who need assistance walking their dog. Volunteers commit to visiting once a week to walk a consumer’s dog for up to an hour.

The aims of the project (as stated in an information brochure for prospective volunteers) are “improve both the quality of life and health for the dogs involved and increase the older person’s socialisation and access to other services within Community Care” (City of Charles Sturt n.d.).

In addition to walking consumer’s dogs, volunteers are asked to:

- provide records of dates and times of visits
- report any perceived needs for additional assistance to the program’s coordinator.

While the program’s online brochure states that “other tasks may be negotiated if identified and approved by the coordinator”, it also advises that “volunteers involved in the project will however not be able to assist you in any other tasks (i.e. shopping, cleaning etc.)” (City of Charles Sturt n.d.)

The service is free for consumers, and volunteers can be reimbursed for out-of-pocket expenses.

Other

A number of other programs or organisations were mentioned by stakeholders (in particular through responses to the consultation paper, with variable levels of detail provided). These included:

- A home That Fits (Finland)
- Age UK
- Anglicare
- Befriend.org.au
- Blue Care
- Brightwater
- Catholic Community Services
- CHSP programs (including Legacy, Neighbourhood Visitors)
- City of Boroondara Community Recreation Outreach Program (CROP) activities
- Community Circles (UK): community-circles.co.uk
- Community Navigators (UK): http://involve.community/navigators.php
- Companionship for disability – WA Blue Sky
- Compeer Friendship Program run by St Vincent de Paul society
- Contact the Elderly tea parties (UK)
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- Country Women’s Association
- Cycling Without Age
- Dementia-friendly communities
- Dust and chat
- Gippsland Multicultural Services
- Greek Welfare
- Independent Transportation Network
- Joseph Rowntree Foundation’s ‘Neighbourhood approaches to loneliness’ program
- Lifelinks/Eastern Region SRF Program
- Links program run by the local churches
- Loneliness Project in the UK
- Mansfield Mates (mental health sector)
- Melbourne City Mission
- Men’s Sheds
- MS Society
- National Seniors Australia
- New Hope Foundation
- Opening Doors (LGBTI program, UK)
- Orange Sky Laundry.
- Organisation in Queensland called ‘Social Visitors’ (a fee-for-service program)
- Oxfordshire Befriending at End of Life (OxBEL) run by AgeUK
- Personal Helpers and Mentors (PHAMs), South Australia mental illness sector initiative
- Probus
- Rise and Shine
- SAGE – LGBTI (sageusa.org)
- Share and Care – Home share international
- Silver Alliance (Queensland)
- St John Community Care
- Telecross, Telechat and Mates programs (Red Cross)
- The AMA Peer Visitor program (specific to retired doctors)
- The City of Charles Sturt
- The Companion Animal Project (Age Concern)
- The Dutch model of care
- The Eden principles/Eden Alternative
A.18. Conclusion

While the evidence for befriending schemes is ‘equivocal’, they are often used both in Australia and internationally to prevent and ‘treat’ social isolation (Pate 2014).

A large variety of models exists, both in Australia and internationally – one-to-one and group models, some utilising technology for communication and connection, others providing transport for group activities. However, there is little clear evidence available to confirm the benefits of particular models or indicate which elements of a program contribute to, or hinder, its success. Therefore, the identification of “best practice” is not possible.

Despite the variety of models and lack of robust evidence for benefit, consumer satisfaction with befriending schemes (where reported) appears universally high (Chal 2004, Age Concern New Zealand 2015), and reciprocal benefits for volunteer befrienders are also noted (Chal 2004). There is some suggestion that befriending programs may be ‘cost effective’ (with overall potential savings outweighing the costs of program delivery) (Social Care Institute for Excellence 2012) – however, such a finding is clearly context-dependent.

In Australia and internationally, the importance of collaboration and integration between small, community-based agencies, larger organisations, other relevant sectors and governments is noted. For example, a Canadian investigation into social isolation among seniors noted that volunteer-based outreach programs “could be done within the context of small service agencies…or could involve larger provincial or national efforts by government or other suitable organizations” (British Columbia Ministry of Health 2004, p. 40), with government support of smaller agencies an important element of “community-specific programming”. Similarly, in the UK it is recognised that all levels of government, professional bodies and regulators, and adult social care and health providers across all sectors are involved in supporting independence and improving community connectedness for the elderly (AgeUK 2011). In the context of the CVS, there is also the “need for health and social care statutory services to successfully work alongside the voluntary sector” (Windle et al. 2011, p. 7).
Appendix B. Literature scan findings

A.19. Cited references


Appendix B. Literature scan findings


Cultural and Indigenous Research Centre Australia 2009, Comparative social isolation amongst older people in the act: final report, Department of Disability, Housing and Community Services, Sydney.

Devine, P 2014, One-to-one befriending programmes for older people, ARK Ageing Programme.


Eating with friends: is it addressing social eating needs of older tasmanians? 2013, Report to ‘Eating with Friends’ Steering Committee.


Jopling, K 2015, Promising approaches to reducing loneliness and isolation in later life, AgeUK.


Appendix B. Literature scan findings


Appendix C. CVS funding and performance data
Appendix C. CVS funding and performance data

A.20. Introduction

This appendix includes information on CVS funding, service structure and auspice performance. This information is summarised in Chapter 3.

Total funding

Figure C-1 shows the total funding amounts from 2013–14 to 2016–17, by jurisdiction. Funding increased from $12.7 million in 2013–14 to $15.9 million in 2014–15, coinciding with the expansion of the CVS to include home care one-on-one and residential group activities.

Figure C-1: CVS funding per year, by jurisdiction

Note: National funding relates to a single service agreement, administered in Victoria but with services provided across multiple states.

Funding by visit type

The majority of CVS funding is directed to residential one-on-one visits, as shown in Figure C-2. Funding for residential group and home care one-on-one visits was made available following the expansion of the CVS in 2013–14, but currently accounts for only 37% of total funding.
Appendix C. CVS funding and performance data

Figure C-2: Funding by visit type, by year

Note: Percentages may not total 100% due to rounding.

Funding per auspice

CVS funding amounts varied considerably between agreements. The lowest amount was $7,122 (which equates to five active visitors), increasing to $1.36 million for one auspice that was funded for 926 visitors across multiple states.

Figure C-3 shows the distribution of funding amounts for individual auspices across each visit type for 2015–16. A high proportion of funding amounts for residential group and home care one-on-one agreements were less than $10,000 for the year (37% and 16% respectively).
Figure C-3: Distribution of funding agreements by funding amount and visit type, 2015–16

- Residential group - % within funding band (Total of 81 agreements)
- Home care one-on-one - % within funding band (Total of 103 agreements)
- Residential one-on-one - % within funding band (Total of 141 agreements)
Appendix C. CVS funding and performance data

Distribution of funding

*Figure C-4* shows the number of auspices by jurisdiction, for each activity type. For 2015–16, NSW had the largest number of funded auspices. It is not possible, from the data available, to determine the geographical coverage of the CVS.

*Figure C-4: Number of auspices providing activity types by jurisdiction 2015–16*

Performance against KPI 1: Percentage of active visitors

*Figure C-5* shows performance against KPI 1 for 2015–16. While the target for all auspices was 90%, only 38% of auspices funded for home care one-on-one met or exceeded this target, compared with 80% for residential one-on-one.

Note that the residential group data are considered unreliable due to inconsistencies in reporting by auspices. The high proportion of ‘exceeded’ targets for residential group visits is not necessarily indicative of the true position. Also note that 30% of performance reports for residential group visits did not record any activity.
Performance against KPI 2: Special needs groups

KPI 2 assesses the extent to which visits are occurring with people from special needs groups. Due to a number of inaccuracies with reporting of these data (e.g. double counting of consumers who belong to multiple special needs groups) it has not been possible to analyse performance on this indicator in detail.

Figure C-6 shows performance against KPI 2. Across all visit types, more than 70% of auspices met or exceeded their target. A greater proportion (81%) of auspices funded for special needs groups met or exceeded their target compared with mainstream auspices (73%), as shown in Table C-1, however this result should be interpreted with caution due to a number of records with incorrectly assigned targets and a large number of records that recorded zero or did not enter data. In addition, inconsistent recording of special needs group status on auspice referral forms, and non-identification by consumers, means that this data is unlikely to be a true reflection of the number of people from special needs groups participating in the CVS.
Appendix C. CVS funding and performance data

Figure C-6: KPI 2 performance

<table>
<thead>
<tr>
<th>% of auspices meeting KPI 2 Target</th>
<th>0% Achieved or No Data Recorded</th>
<th>Not Met (&lt;50% of target%)</th>
<th>Not Met (&gt;50% of target)</th>
<th>Met (&lt;10% above target)</th>
<th>Exceeded (&gt;10% more than target)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home care one-on-one</td>
<td>0%</td>
<td>0%</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Residential group</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Residential one-on-one</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Table C-1: KPI 2 performance: mainstream and special needs group auspices

<table>
<thead>
<tr>
<th>Funding type</th>
<th>KPI 2 target</th>
<th>Number of useable records*</th>
<th>% of agreements meeting or exceeding target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mainstream</td>
<td>20%</td>
<td>98% of 268 records</td>
<td>73%</td>
</tr>
<tr>
<td>Special needs</td>
<td>80%</td>
<td>96% of 49 records</td>
<td>81%</td>
</tr>
</tbody>
</table>

*There are an additional 8 records for which the target (20% or 80%) could not be established. These have been excluded.

Figure C-7 shows the predominant special needs group recorded by auspices for 2015–16 (i.e. the special needs group for which the greatest number of consumers was recorded). Across all visit types, CALD consumers were more consistently engaged, followed by rural and remote consumers. CALD consumers were more strongly represented in residential group visits compared with the other visit types, which is unsurprising since group visits tend to engage consumers who speak a common language or dialect. Consumers identifying as LGBTI, Aboriginal and Torres Strait Islander or care-leavers featured less prominently, a finding that may be partly attributable to non-disclosure.
Figure C-7: Predominant special needs groups engaged by CVS

<table>
<thead>
<tr>
<th></th>
<th>Home care one-on-one</th>
<th>Residential group</th>
<th>Residential one-on-one</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of agreements per visit type</td>
<td>102</td>
<td>81</td>
<td>142</td>
<td>325</td>
</tr>
</tbody>
</table>
Appendix D. Themes from CVS performance reports
Appendix D. Themes from CVS performance reports

A.21. Key themes from CVS performance reports

A total of 163 auspice performance reports for 2015–16 were scanned for the information provided under three headings: program highlights, benefits and difficulties. These are summarised below by visit type (residential one-on-one, residential group and home care one-on-one).

Where auspices were funded for more than one visit type (and reporting did not specify which comments related to which type), these have not been explicitly included. However, brief review of these confirmed that thematic saturation had been reached.

A.22. Highlights

Residential one-on-one

The most common highlights reported related to volunteer visitor get-togethers and recognition events (both internal and external). The commitment and enthusiasm of visitors was noted as a highlight, along with good consumer/visitor matches.

Visitors attending events with their consumers (e.g. residential aged care home Christmas parties), individual ‘good news stories’, and positive feedback received (from consumers, staff and family members) also featured as program highlights.

Other highlights included organisational elements, such as:

- Visitor recruitment (especially those with particular skills/interests to share, or men to visit male consumers)
- Visitor training
- New internal processes (e.g. online induction)
- Program promotion (e.g. newsletters, representation/presence at relevant expos, speakers at relevant forums).

Residential group

As with residential one-on-one programs, visitor recognition events were very often cited as program highlights, as were visitor recruitment and training achievements. Again, numerous ‘good news stories’ were shared, highlighting the experiences of individual consumers and/or visitors, and positive feedback was received from residential aged care home staff, residents and visitors.

Residential group services appeared particularly to support CALD residents. Again, visitors were reported to be attending events at residential aged care homes with their consumer (e.g. culturally-themed morning teas, Christmas parties), and helping them (and staff) to celebrate days of cultural significance.

Home care one-on-one

Highlights identified by auspices delivering the CVS in the home care setting were not dissimilar to those captured in residential setting reporting (as described above). These included visitor get-togethers and
Appendix D. Themes from CVS performance reports

recognition events, and visitor recruitment success. Individual ‘good news stories’ also featured strongly, often focused on good consumer/visitor matches or increased social connection through visitor support to attend community activities or increased consumer confidence to become more engaged. Visitors also shared special events (e.g. birthdays, Christmas, Hanukkah) with their consumers. Opportunities to promote services and assist with visitor recruitment were also noted as highlights, along with internal staffing and procedural improvements (e.g. new positions to support delivery of the CVS, development of volunteering manuals, updated policies, database etc.).

A.23. Benefits

Residential one-on-one

The primary benefit of the program reported through the performance reports was the genuine, lasting friendships developed between visitor and consumer – with many auspices noting the reciprocal nature of the relationship and benefits for both parties, particularly where language or key interests and activities could be shared. In particular, residents enjoyed having a visitor ‘just for them’, improving their sense of worth.

For the consumer, reduced isolation and cognitive stimulation was felt to be a key benefit, particularly among non-English speaking consumers and those suffering from cognitive decline (or both). The CVS was reported to give residents something to look forward to and increased confidence was related, in particular, to having a friend outside of the residential aged care home. In many cases, this external friend was highly valued, making residents feel like part of the “real world”. For CALD consumers, having a friend with whom they can communicate in their native language brings a connection to their community and an opportunity to reminisce.

The companionship and support offered by volunteer visitors was sometimes noted to translate into improvements in consumers’ physical and mental health, general wellbeing and overall ‘disposition’, with the latter noted to be a benefit of the program to residential care staff.

“A resident who did not have any family or friends to visit had stopped going to the dining room to eat with other residents. Since we have been involved with visiting her weekly, she has now resumed going to the dining room”.

This support to interact with other residents was noted in a number of reports.

Visitors also brought specific ‘teaching’ skills to the relationship – for instance, where younger generations taught their consumer how to use an iPad.

Anecdotally, visitors report social and emotional health benefits related to their CVS role: a sense of achievement, of ‘making a difference’ and ‘giving back to community’. The team culture among visitors was also noted as a key benefit, relating strongly to the highlights (e.g. visitor get-togethers) noted above. Several auspices noted that many visitors are themselves seniors who may be living on their own, and potentially at risk of social isolation or mental health issues (e.g. depression or anxiety) in their own right. The CVS provides them with not only the opportunity to engage with their consumer(s), but also other members of the visitor team.

In some cases, more tangible benefits to visitors were noted, for example where international university students or new migrants were recruited as visitors. Their interactions with consumers gave them...
Appendix D. Themes from CVS performance reports

Contact with the elderly (e.g. for those missing their grandparents overseas) and a chance to practise their English. Similarly, for those seeking or working towards a career in aged care, involvement with the CVS provided significant insight into aged care issues and professional development opportunities, as well as a positive experience to include in their CVs. More generally, communication and interpersonal skills are developed through visitors’ involvement in the program.

Many individual “good news stories” were shared through the reports to highlight the benefits of the program, in particular to consumers and visitors. Benefits for family members of the consumers were also noted.

“Families are sometimes more relaxed to know that they have a community visitor visiting their loved one and that they have someone outside the family to talk to”.

Residential group

Again, the key benefit of the CVS in the residential group setting was the development of a lasting friendship and shared participation in activities, with the common language and culture shared by consumers and visitors from particular backgrounds playing an important role in many instances.

“We believe the benefits for residents of CALD background are unquestionable: psychological and emotional wellbeing, cultural connection, community sense, identity validation…”

Visitors also supported residents to take part in activities (e.g. bingo), and drew residents out of their rooms to make social connections and friendships with other residents. One auspice noted “a one-on-one visit with some of these people would not have the same effect”. Another reported training its visitors to incorporate music therapy into their group visits.

Decreases in loneliness and depression were reported, along with increased social engagement from consumers. In some cases, the group format enabled consumers to provide support to each other (e.g. after the death of other members of the group).

“Regular visits from bilingual volunteers were of great benefit in increasing the residents’ social support network and sense of ‘belonging’ within their residential aged care facility”.

For visitors, their own wellbeing was enhanced by their involvement with the CVS, and feelings of achievement and contributing to community were noted.

Home care one on one

Benefits to consumers and visitors involved in the home care setting were similar to those reported in residential care settings. Consumers looked forward to volunteers’ visits, and they bolstered consumers’ self-esteem and sense of worth. Reduced isolation was particularly noted for those from CALD backgrounds and those for whom ‘complex barriers’ prevented them from leaving their homes.

“Participation in the CVS and socialising with a volunteer visitor can be the only social interaction some clients have each fortnight (aside from Home Care Workers attending to deliver mostly domestic and personal care type services)”.

“These little excursions and connecting socially with someone has given them the confidence to stay in their home and maintain their independence.”
Appendix D. Themes from CVS performance reports

Again, the reciprocal benefits to both parties were noted. Beyond the valued friendships developed, visitors benefitted from training and development and enjoyed a sense of ‘making a difference’ and ‘giving back to the community’.

Family members were also said to be appreciative of the service, which lessened consumers’ constant reliance on them for companionship and support.

A.24. Difficulties

Residential one-on-one

Lack of notification from residential aged care home staff when a resident is not well enough to receive a visit, is in hospital, or dies was highlighted for its impact on both the resident’s visitor (in particular, not feeling valued) and the CVS coordinator (if the visitor then takes time out or resigns from the program). More generally, communications between residential aged care homes and CVS auspices were often reported to be less than ideal.

Turnover in visitor workforce and staff also has an impact on the smooth running of the CVS. Visitor turnover appears not to be uncommon, often related to visitors discovering the role is ‘not for them’, the death of a consumer (for long-serving visitors), personal or family illness or death or gaining employment/returning to study. One trend identified by a number of auspices was prospective visitors seeking involvement with the service in order to fulfil the criteria for unemployment benefits, or solely to improve their own language skills. These visitors (with personal motivations driving their involvement) were found to be less reliable, or shorter-term, than other visitors.

While in some cases recruitment of visitors is a challenge (particularly among CALD groups and men), in others finding suitable consumers – or gaining funding for waiting visitors – was reported as an issue, with auspices noting that staff were not identifying suitable residents for visitor visits or particularly helpful in matching residents and visitors. This may be at least partially due to the evolving nature of residential aged care home residents (i.e. increasing frailty, cognitive decline as healthier seniors stay at home longer). Conversely, some auspices find that residential aged care homes do refer consumers with high levels of physical frailty or dementia/behavioural issues without noting these on the referral form, often resulting in unsuccessful matching of consumer and visitor. Identification of special needs groups could also be problematic, sometimes felt to be due to privacy concerns of lifestyle coordinators at the residential aged care homes.

The turnover in staff presents difficulties for awareness and promotion of the program, with CVS coordinators having to constantly ‘educate’ key staff about the CVS and its role. A general lack of awareness and, in some cases, a lack of trust of the CVS was mentioned. Some auspices noted that residential aged care homes had their own volunteer programs with their own systems, training and procedures, so that visitors had to fulfil two sets of requirements (and in some cases, apply for separate police checks) in order to visit their consumer.

Issues surrounding boundaries were not prominent – however one did note an issue where a visitor “was being used to work as a Diversional Therapist” and another reported an instance in which a resident requested “a large amount of money” from his visitor.
Appendix D. Themes from CVS performance reports

Reporting was seldom mentioned as a difficulty, although several auspices did note the need to follow up visitors for time sheets/other records. The time taken for the induction process (and specifically the police check requirement) sometimes presented challenges for auspices.

Residential group

Visitor recruitment was again noted as a difficulty, especially where specific language and cultural backgrounds had to be found. Where suitable visitors were found, sometimes these same characteristics meant that the visitor him/herself needed additional support from auspices (e.g. to complete necessary paperwork and understand auspice and residential aged care home policies/procedures).

Visitor turnover was noted to be related to the sometimes challenging nature of the role (especially in dealing with consumers requiring high-level care), visitors attaining employment or entering full-time study, and personal illness, family commitments or other circumstances. Again, it was noted that some visitors sought involvement with the CVS primarily as work experience or to satisfy government benefit requirements. Besides this, some auspices found the groups were not ‘stable’ over time, with residents coming into and leaving the group, making group cohesion challenging.

A lack of interest from residential aged care homes, if not a level of hostility, was reported by a small number of auspices, and several reports noted that residential aged care homes were unable to identify more than one resident suitable for group visits. In addition, some residents did not wish to participate in group activities/visits, with reasons including privacy concerns, personality clashes with other residents, a preference for one-to-one conversations, hearing impairment, and a perceived lack of even attention from the visitor in group contexts. Some auspices noted that, even where group visits were initiated, consumers subsequently expressed a wish for one-on-one visits. This presented a particular challenge in cases where the auspice was not funded for one-on-one visits.

Organisational change, both within auspices and residential aged care homes, sometimes presented challenges for the CVS, and paperwork delays (especially in undertaking police checks) and competition between auspices were also noted as challenging.

One auspice noted that, because of the nature of the cultural group, most of their visitors had previous connections with the residents they visited, and this had the potential to raise issues of boundaries for the visitor in delivering the CVS.

Home care one on one

A lack of referrals from HCP providers appears to be a common difficulty encountered, often reported to be related to a lack of awareness of the CVS and high staff turnover. In a few cases, HCP providers were reported to be uncooperative.

In addition, a small number of auspices noted that referrals through My Aged Care/ACATs could be problematic and time-consuming. More generally, the entire process of HCP assessment, and the perceived need for family approval of CVS referrals could also be lengthy, affecting the smooth operation of the CVS in this setting.

Those funded to provide the CVS to specific cultural groups reported struggling to find appropriate consumers to fulfil their quotas, and consumer and family concerns around privacy and safety were also
Appendix D. Themes from CVS performance reports

felt to be impacting on referrals. There also appears to be significant turnover in consumer numbers in the home care setting, due to changes in health status, moving out of town to be with family or in to residential care, cancellation of HCPs, and consumer death. For auspices only funded for home care one on one visits, a consumer’s transition into residential care created barriers to the ongoing relationship and was reported to cause distress to both parties.

In some cases, a lack of consumers (due to the issues noted above) was reported to lead to visitors losing interest in the CVS, or volunteering their available time elsewhere.

In addition to these issues related to consumer recruitment and retention, recruitment and retention of suitable (or reliable) visitors could also be challenging, particularly for consumers with dementia.

Although boundaries were not often raised as an issue for the CVS in the home care setting, one auspice did note “It can be very difficult sometimes to ensure all volunteers are working within their capacity or scope as a CVS volunteer only”. Another mentioned that consumer expectations sometimes caused a problem – for example, where consumers wished their visitor to drive them somewhere or perform other duties around the home.

A.25. Summary

Overall, the highlights, benefits and challenges reported by auspices providing the CVS in each of its three modalities were similar.

While the special friendship between visitors and consumers was valued by both, across all settings auspices reported that involvement in the CVS often resulted in broader social engagement for individual consumers – e.g. through increased confidence and willingness to participate in activities (residential care one-on-one), development of other friendships (residential group) and ability to attend outside community events (home care one-on-one).

While auspices were overwhelmingly positive about the experience for both consumers and visitors, challenges were encountered in recruitment of both groups and successfully matching individuals. However, successes in these areas were also consistently reported as ‘highlights’.

Communications between the relevant agencies (e.g. residential aged care homes, HCP providers, My Aged Care) were felt to be sub-optimal across the CVS, often resulting in both a lack of referrals to the CVS and ongoing issues affecting the smooth delivery of the CVS.

The key differences reported were directly related to the settings in which the CVS was delivered – for example, not all residential care consumers were interested in group visits, and home visits are subject to privacy and safety concerns of consumers and families.
Appendix E. Stakeholder interview questions
Appendix E. Stakeholder interview questions

A.26. Questions for CVS Network Members and auspices

How CVS is currently operating? (CVS Network Members and auspices)

1. Please provide an overview of your organisation’s role, and your role, in relation to the CVS:
   a. Approximate size of service?
   b. How many FTE working on the CVS program?
   c. Mainstream or special needs group-specific organisation?
   d. What types of service delivery (Residential one-on-one, Residential group, home care one-on-one)?

2. How is the CVS currently operating?
   a. How do consumers access the scheme?
   b. Any issues with awareness/willingness to refer consumers by aged care service providers?
   c. How is it promoted?
   d. How are volunteers recruited?
   e. What policies, procedures, training and orientation processes are in place?
   f. Is ongoing support provided to volunteers once their relationship is established?
   g. If volunteers have difficulties establishing relationships, what happens?
   h. What are your processes for dealing with any potentially adverse events reported by volunteers?
   i. What are your processes for dealing with any conflict that may arise between visitor and consumer?
   j. Is demand for the CVS being met?
   k. How do auspices determine if they are meeting the needs of the consumers (i.e. measures of success)?

3. How is the program administered?
   a. What records are kept by your organisation?
   b. How do you measure success?
   c. What reporting do you provide to the Commonwealth regarding the CVS?
   d. Is the reporting reasonable?

4. Do you feel that the CVS supports consumers to exercise choice and control? If so, in what ways? If not, why not?

5. How do auspices support consumers as they transition across the system (e.g. from HCP to Residential care)?

6. Can volunteers follow a client during the transition from home to residential care?
   a. Have there been any issues related to facilitating this?

7. What interactions does your organisation have with the health sector and other services/providers?
   a. Are there established referral pathways?
Appendix E. Stakeholder interview questions

b. Does the success of service delivery depend on networks with other services?

Role as a Network Member (for Network Members only)

1. For how long has your organisation been a CVS Network Member?
2. What does the role involve?
3. Does information sharing occur between Network Members? Is this formal/ad hoc?
4. How could the Network Member role (or coordination of CVS more generally) be enhanced (e.g. with more funding)?
5. Are there processes for ongoing training and support?

Role of volunteers (CVS Network Members and auspices)

1. To what extent do CVS volunteers currently provide information and support to consumers (i.e. beyond friendship/companionship role)?
2. Would it be possible to expand the role of volunteers to take on more of a role in providing information (e.g. about other services) and support?
   a. What are the barriers to this being undertaken?
   b. What training/resources would be required?
   c. What monitoring processes would need to be in place to ensure that this expanded role was achieved successfully?

Service delivery to Home care and residential care (CVS Network Members and auspices delivering CVS in home care settings)

Note: clarify that this organisation delivers across both settings before asking these questions

1. What are the key differences in delivering CVS services to home care and residential care consumers?
   a. What additional support is required to effectively deliver the CVS in the community setting? Prompt: are volunteers equally willing to visit in home care setting (compared with Residential care)?
   b. Are there barriers to effective implementation of the CVS in the home setting?
   c. How is risk to visitors managed in the home care setting?

Enhancing uptake in the home care setting (CVS Network Members and auspices involved in delivering CVS in home care settings)

1. How do you promote the availability of the CVS for home care to consumers/service providers/broader community?
2. What is the current level of demand for the CVS in the home care setting?
3. Are there barriers to uptake?
Appendix E. Stakeholder interview questions

Special needs groups (CVS Network Members and auspices)

**Note to interviewer:**

**Special needs groups as per Aged Care Act 1997:**
- a) people from Aboriginal and Torres Strait Islander communities
- b) people from culturally and linguistically diverse backgrounds;
- c) people who live in rural or remote areas;
- d) people who are financially or socially disadvantaged;
- e) veterans;
- f) people who are homeless or at risk of becoming homeless;
- g) care-leavers;
- h) parents separated from their children by forced adoption or removal;
- i) lesbian, gay, bisexual, transgender and intersex people; and
- j) people of a kind (if any) specified in the Allocation Principles

1. Is your service specifically funded to address special needs groups? (If so, which?)
2. What approaches do you use to engage with people from special needs groups?
3. Do you feel that the needs of people from special needs groups are being met?
4. Are there particular barriers to getting more people from special need groups involved in the service? (noting that people may not necessarily disclose special needs group affiliation)

Opportunities for improvement (CVS Network Members and auspices)

1. In your view, what could be done to improve the CVS? Prompts:
   - a. Promotion
   - b. Efficiency
   - c. Reporting/program governance
   - d. Communication and networking

2. Are there other models for providing volunteer support to consumers to address social isolation that you think the Commonwealth could consider? (Prompt: other social connectedness activities; not specifically one-on-one)

A.27. Aged care service providers

How is the CVS currently operating?

1. Please provide an overview of your role within your organisation
2. Please describe your organisation: size, geographical location, types of service provision (Residential care, HCPs, any particular special needs group etc.)
3. Please tell me about your understanding of/involvement with the CVS:
   a. Estimate of how many consumers are engaged with the CVS
   b. What is the process for referring consumers to the CVS?
   c. Are there ever delays in matching consumers with volunteers?
Appendix E. Stakeholder interview questions

4 Do you feel that the CVS supports consumers to exercise choice and control? If yes, how? If not, why?

5 What are the benefits of the CVS for consumers?

Role of volunteers

1 How would you describe the support provided to your consumers? (prompt: companionship? other types of support? Do volunteers act as a source of information for consumers?)

2 Do you think it would be reasonable to broaden out the role of the volunteer to provide more information to consumers about other services/referral options available to them?

3 How much support (if any) do you need to provide to the volunteer visitors?

4 Are there any issues with having CVS volunteers in your residential care facilities (or home care settings, if relevant)?

Service delivery to home care and residential care settings

Note: Clarify that this organisation delivers across both settings before asking these questions

1 What are the key differences in delivering CVS services to home care and residential care consumers?

Enhancing uptake in the home care setting

1 How is the CVS promoted to home care consumers?

2 Are there any barriers to uptake of the CVS in the home care setting?

3 Do you have any concerns about how the CVS is functioning in the home care setting (prompts: risk to consumers/volunteers)?

Special needs groups

1 Do you have any comments in relation to how well the CVS is meeting the needs of people from special needs groups?

2 Any suggestions for how the CVS could improve in relation to meeting the needs of people from special needs groups?

Opportunities for improvement

1 In your view, what could be done to improve the CVS? Prompts:
   a. Promotion/uptake
   b. Efficiency
   c. Reporting/program governance
   d. Other?

2 Are there other models for providing volunteer support to consumers to address social isolation that you think the Commonwealth could consider? (Prompt: other social connectedness activities; not specifically one-on-one)
Appendix E. Stakeholder interview questions

A.28. ACATs

Note: The following questions were sent to ACAT representatives via email (rather than by teleconference), in order that they could seek feedback from their colleagues and respond by email.

1. What level of understanding and interaction do you have with the CVS program and CVS service providers (auspices)?
2. Do you refer consumers directly to CVS? If yes:
   a. What is the process for making referrals?
   b. Do you refer HCP as well as Residential Care consumers to the CVS?
   c. Do you undertake any follow up to check if the consumer has engaged with the program?
3. Are there opportunities for the ACATs to assist consumers to engage with the CVS or to support uptake of the program (particularly in the home care setting)? How could this occur?

A.29. Peak organisations (representing aged care sector/consumers/special needs groups) and other relevant stakeholders

How is the CVS currently operating?

1. Please provide an overview of your role within your organisation
2. Please tell me about your understanding of/involvement with the CVS
3. Do you feel that the CVS supports consumers to exercise choice and control? If yes, how? If not, why?
4. What are the benefits of the CVS for consumers?

Role of volunteers

1. What is your understanding of the type of support provided to consumers? prompt: companionship? other types of support? Do volunteers act as a source of information for consumers?
2. Do you think it would be reasonable to broaden out the role of the volunteer to provide more information to consumers about other services/referral options available to them?

Service delivery to home care and residential care settings & enhancing uptake in home care setting

NB: some informants may not be able to provide this level of detail

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14 Initially, Regional Assessment Service (RAS) staff were included in the list of stakeholders to be interviewed. It was subsequently decided that, given their (likely) limited involvement with the CVS, RAS staff would be invited to respond to the consultation paper instead.
Appendix E. Stakeholder interview questions

1. What do you see as the key differences in delivering CVS services to home care and residential care consumers?
2. Are there any barriers to uptake of the CVS in the home care setting?
3. Do you have any concerns about how the CVS is functioning in the home care setting? (prompts: risk to consumers/volunteers)

Special needs groups

NB: If the peak organisation is focused on a particular special needs group, spend more time on these questions

1. Do you have any comments in relation to how well the CVS is meeting the needs of people from special needs groups?
2. Any suggestions for how the CVS could improve in relation to meeting the needs of people from special needs groups?

Opportunities for improvement

1. In your view, what could be done to improve the CVS? Prompts:
   a. Promotion/Uptake
   b. Efficiency
   c. Other?
2. Are there other models for providing volunteer support to consumers to address social isolation that you think the Commonwealth could consider? (Prompt: other social connectedness activities; not specifically one-on-one)

A.30. Internal Departmental program and policy areas (including State and Territory networks)

How is the CVS currently operating?

1. Please provide an overview of your role in relation to the CVS. Prompt: how much involvement do you have with the CVS?
2. Are you aware of any particular issues/problems with how the program is operating? Prompt: barriers to referral of consumers/issu with recruiting volunteers?
3. Do you feel that the CVS supports consumers to exercise choice and control? If yes, how? If not, why?

Role of volunteers

1. Do you think it would be reasonable to broaden out the role of the volunteer to provide more information to consumers about other services/referral options available to them?
Appendix E. Stakeholder interview questions

Service delivery to home care and residential care settings & enhancing uptake in home care setting

1. What do you see as the key differences in delivering CVS services to home care and residential care consumers?
2. Are there any barriers to uptake of the CVS in the home care setting?

Special needs groups

1. Do you have any comments in relation to how well the CVS is meeting the needs of people from special needs groups?

Opportunities for improvement

1. In your view, are there opportunities to reduce red tape in relation to the administration of the CVS?
2. Are there other ways in which the CVS could be improved? Prompts:
   a. Promotion/Uptake
   b. Efficiency
   c. Other?

Other models of volunteer support

1. Are you aware any other promising/innovative models of volunteer support (e.g. offered by CHSP providers) that would be worth exploring as part of the CVS Review?
Appendix F. Consultation paper
Appendix F. Consultation paper

A.31. The Community Visitors Scheme

The Community Visitors Scheme (CVS) was implemented by the Commonwealth Department of Health (the Department) in 1992 to recruit volunteers to provide friendship and companionship to consumers of Australian Government-subsidised aged care services who are socially isolated or are at risk of social isolation and loneliness.

The Australian Government funds organisations (known as CVS auspices) to recruit and train volunteer visitors, who are subsequently matched with aged care consumers (referred by aged care service providers). The CVS visitors set aside time, at least once a fortnight, to visit and provide friendship to the care recipient.

Following its expansion in 2013 (as part of the Aged Care Reform Agenda), the CVS now provides three types of visits:

- One-on-one visits in residential care
- Group visits in residential care
- One-on-one visits to consumers of HCPs.

The CVS aims to enhance the lives of aged care consumers through the contact they have with CVS visitors, with benefits such as increased self-esteem or general feeling of wellbeing, feeling cared for and/or connected to the community, and reduced feelings of loneliness or isolation.

A.32. Review objectives

Australian Healthcare Associates (AHA) is reviewing the CVS to inform the Department on how it can continue to effectively provide appropriate support to consumers of residential and home care services who are socially isolated or at risk of social isolation, in the context of ongoing reforms to the aged care system.

The scope of the CVS Review is to:

- Explore the extent to which the program aligns with current aged care reforms
- Explore the potential to increase the role of visitors to provide additional support to consumers
- Consider options for delivering CVS services to home care and residential care consumers, in the context of potential ongoing reforms to home care
- Explore how the uptake of the CVS in the home care setting could be enhanced
- Explore the extent to which the CVS is meeting the needs of special needs groups (as identified under the Aged Care Act 1997) and identify models of good practice
- Identify and compare other community visitor services and programs promoting social connectedness to address social isolation of older people, within the CHSP and across related sectors both domestically and internationally
- Identify areas for streamlining program management, funding allocation and service structure with a view to reducing red tape for both providers and the Department.
Appendix F. Consultation paper

The findings of the Review will enable the development of options for a future volunteer service delivery model, for consideration by the Department.

A.33. This consultation paper

This consultation paper has been developed to explore and seek stakeholder feedback on a range of themes relevant to the future of the CVS. It is available on the websites of the Australian Government Department of Health and AHA, and promoted to relevant stakeholders to provide an opportunity for input to the review process.

A.34. Have your say

We would like to invite you to respond to this consultation paper.

You are welcome to respond to this consultation paper anonymously. However, if you feel comfortable doing so, it would be appreciated if you could provide some background on your role and organisation in Section 2 of this paper. Consultation questions are listed under each heading in Section 3. Please respond to these questions using the spaces provided. Note that not all questions may be relevant to all stakeholders.

Please email your responses to cvs@ahaconsulting.com.au or send to:

CVS Review
Australian Healthcare Associates
Locked Bag 32005, Collins Street East
Victoria 8003

The closing date for submissions is 2 December 2016.

If you:

- have any questions about the consultation paper or the feedback process
- would like to receive a paper copy of the consultation paper and feedback form
- would prefer to provide feedback via telephone

please contact Jill Waddell or Greer Edsall at Australian Healthcare Associates on 03 9663 1950 or cvs@ahaconsulting.com.au.
Appendix F. Consultation paper

A.35. Summary and next steps

This consultation paper highlights the objectives of the CVS Review.

Stakeholder responses to this consultation paper will be analysed and incorporated into a final report to be provided to the Department.

In addition, a brief summary report of key findings and themes will be produced and sent to all respondents who provide their name/email address for this purpose.

AHA thanks all stakeholders for their contribution to this Review.

A.36. Response form

About you

While you are welcome to respond to this consultation paper anonymously, please provide as much information as you feel comfortable to, in order to clarify your interest in and perspectives on the CVS.

Name: ............................................................................................................................................................

Position: ........................................................................................................................................................

Organisation: ..................................................................................................................................................

Are you a representative of (please tick all that apply):

☐ A CVS auspice

☐ A CVS network member

☐ A peak body

Please specify the group you represent: ........................................................................................................

☐ An aged care service provider (please specify type and setting below):

☐ residential

☐ community-based

☐ metropolitan

☐ regional

☐ rural

☐ A CVS volunteer

☐ Other – please specify:
Appendix F. Consultation paper

Please provide an overview of your organisation’s role and/or your personal role in relation to the CVS.

Would you like to receive a summary of feedback received from this discussion paper?

☐ If yes – please provide your email address:

A.37. Consultation questions

Current operation of the CVS

Background to the CVS is provided in Section 1 of this document. The current operation of the CVS is guided by the CVS Policy Guide (2013-2016). For more information you can access Frequently Asked Questions that are available online at the Department of Health website.

1. From your perspective, how is the CVS currently operating?

   • How is it promoted (to potential consumers, potential volunteers and the broader community)?
   • How is it accessed (e.g. what is the process for referral)?

2. Are there any issues in matching volunteers and aged care consumers? If yes, please provide details.

How does the CVS support aged care consumers?

The CVS is designed to provide friendship and companionship for recipients of Australian government-subsidised aged care who are socially isolated or are at risk of social isolation and loneliness. It was expanded in 2013 in line with the Aged Care Reform Agenda, which aimed to create a seamless and flexible aged care system in which consumers could exercise choice and control in the way they access and use a broad range of services.

3. What are the benefits of the CVS for consumers?
Appendix F. Consultation paper

4. Is demand for visitors being met? If not, please provide details.

5. Does the CVS currently support aged care consumers to exercise choice and control? If so, how? If not, why?

6. Does the CVS support consumers as they transition through the aged care system (e.g. from home care packages to residential aged care)? How is this achieved?

7. What interactions occur between the CVS and other sectors and organisations to support aged care consumers (e.g. health sector and other service providers)?

CVS in residential and home care settings

Following its expansion in 2013, the CVS currently delivers one-to-one and group visits in residential aged care settings and one-to-one visits to consumers of Commonwealth-funded home care packages.

8. What are the key differences in delivering CVS services to home care and residential aged care?
   - What are the barriers to effective implementation of the CVS in each of these settings?
   - What are the barriers and facilitators to uptake of CVS services in each of these settings?
   - Do you have any concerns about how the CVS is functioning in either of these settings? If so, please provide details.

CVS volunteers’ role

There are a number of community visitor models in place, both in Australia and overseas, with different objectives and modes of service delivery. In some models, the role of the volunteer extends beyond simple companionship to broader efforts at encouraging social inclusion – for example, supporting aged...
Appendix F. Consultation paper

care consumers “to increase their social activity in their own way, at their own pace” (Age Concern New Zealand 2015)\(^{15}\) or providing information about and referrals to other relevant services and events. In other models, visitors might assist with daily activities (e.g. shopping, cooking, transportation), provide advocacy or act as ‘independent community observers’ to uphold service standards. In the CVS, the primary role of the volunteer is intended to be as a friend or companion for the consumer.

9. What is your understanding of the type of support provided to aged care consumers through the CVS?

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10. What type or level of additional support for aged care consumers could reasonably be expected of volunteers delivering the CVS?

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11. What support do volunteers need to provide this additional support in residential aged care and home care settings?

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12. What barriers exist to volunteers providing additional support?

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Meeting the needs of special needs groups

There is a connection between increased experience of loneliness and belonging to a special needs group, in particular for migrant and refugee populations, older lesbian, gay, bisexual, transgender and intersex (LGBTI) people, people living in rural and remote areas and those in residential care (Pate 2014).

More broadly, special needs groups (as identified in the \textit{Aged Care Act 1997}) include:

- People from Aboriginal and Torres Strait Islander communities
- People from CALD backgrounds
- People who live in rural or remote areas
- People who are financially or socially disadvantaged
- Veterans

\(^{15}\) Please refer to Appendix B for references
Appendix F. Consultation paper

- People who are homeless or at risk of becoming homeless
- Care-leavers
- Parents separated from their children by forced adoption or removal
- LGBTI people
- People of a kind (if any) specified in the Allocation Principles.

The current Funding Agreement between the Australian Government and CVS auspices mandates a minimum percentage of services to be delivered to individuals from the identified special needs groups.

13. How are individuals from special needs groups identified and/or targeted?

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14. How well does the CVS support individuals from special needs groups?

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15. How could the CVS better support individuals from special needs groups?

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16. Are there other vulnerable groups that are, or should be, catered for through the CVS (e.g. those with cognitive or other impairment)?

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Exploring other community visitor models

A large number of community visitor programs exist (both in Australia and overseas) targeting social isolation in older people and other groups such as those living with disability or mental illness. These include group models, those that are delivered remotely (via telephone or online), or those that cater to specific populations (e.g. special needs groups).

The CVS may benefit from good practice examples and/or lessons learned through the implementation and delivery of these programs.

17. Are you aware of any other community visitor services in Australia or overseas that aim to reduce social isolation or support social connectedness?

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Appendix F. Consultation paper

18. Can you identify any particular ‘good practice’ examples?
   • What are the key benefits of the model?
   • What are the key elements contributing to the model’s success?
   • How do they meet the needs of special needs groups?

19. Are there other models for providing support to aged care consumers to address social isolation that the Department could, or should, consider? Please provide details.

Summary

Please provide any other information or views you feel are relevant to the review of the CVS.

20. In your view, what could be done to improve the CVS (in terms of promotion, efficiency, governance and reporting, communication and networking or other aspects)?

21. Do you have any other comments or suggestions you want included in the review of the CVS? Please provide details.

Thank you for providing your feedback on this discussion paper.
Appendix G. Consultation paper findings
Appendix G. Consultation paper findings

A.38. Introduction

This chapter provides a summary of consultation paper findings. See Appendix F for the full consultation paper.

The consultation paper could be completed online (through Survey Monkey), or a Word document downloaded and returned via email or post to AHA. A copy of the consultation paper is included at the end of this Appendix. The consultation period ran for six weeks from 21 October to 2 December 2016.

A.39. Respondents

A total of 115 individuals completed the online paper (after double entries and blank surveys were removed). A further 47 responses were received via email and one via post. Respondents included:

- 141 individual representatives of auspices (including representatives of all Network Member auspices except for the Northern Territory) and a representative of the National LGBTI CVS Network
- 28 volunteers
- 30 representatives of residential aged care providers
  - 10 represented providers that are also auspices
- 20 representatives of community-based aged care providers\(^{16}\)
  - 14 represented providers that are also auspices
- 8 representatives of peak organisations
  - Older Person’s Advocacy Network
  - Leading Age Service Australia
  - Aged & Community Services Australia
  - National Seniors Australia
  - COTA Australia
  - Alzheimer’s Australia
  - The National LGBTI Alliance
  - Migrant Resource Centre South Tasmania.

Note that many respondents indicated they belonged to several of the categories listed. Not all respondents answered all questions. In cases where no responses were received from a particular stakeholder group (e.g. volunteers), they are not included in the following summary.

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\(^{16}\) Note that some respondents were providers of both community and residential aged care. While many also indicated that they were ‘Network Members’, their personal/organisational details did not match with the list provided by the Department, indicating confusion about the term.
Appendix G. Consultation paper findings

A.40. Current operation of the CVS

Auspices

Promotion and access

Auspices noted that awareness and promotion of the scheme was a particular issue, with responsibility primarily falling on individual auspices. This included promotion to aged care providers in particular (with one auspice noting particular ‘roadblock’ issues with HCP providers), but also to potential consumers and volunteers and the community more generally.

“I am sure that Lifestyle Directors/ diversional therapists etc. forget that the CVS exists in their busy schedules unless we are consistently making contact”

Auspices suggested that a significant amount of effort goes in to local promotion activities, including:

- Developing and maintaining communications and relationships with staff of relevant aged care services providers
- Promoting the CVS (direct to potential consumers) within residential aged care homes – e.g. at resident and/or family meetings
- Developing brochures, posters and fliers for distribution/display
- Attracting volunteers (e.g. through employment channels, volunteer organisations and resource centres, brochures, radio advertising, attendance at expos etc.)
- Raising general community awareness (e.g. advertising through community networks, stories in local newspapers, auspices’ own websites, newsletters, television etc.). In some cases, special needs groups were targeted through promotion via specific channels (e.g. multicultural or LGBTI radio stations).

Word of mouth was often mentioned as an important channel for recruiting both consumers and visitors.

Some explicitly suggested that greater support from the Department in terms of promotion and clarifying roles and procedures (e.g. Network Members’ role in receiving and ‘sharing’ referrals) would be helpful.

Most consumer referrals are facilitated through aged care providers (e.g. diversional therapists or lifestyle coordinators in residential aged care homes, or HCP providers), whether in the residential or community setting. Sometimes referrals came from other sources, such as My Aged Care/ACAT, doctors or allied health services and, seemingly rarely, directly from consumers’ families.

While most auspices receive referrals that are then matched to a visitor, at least one auspice suggested the reverse process occurred, in which residential aged care homes provided matches for the auspice’s available visitors.

Matching visitors and consumers

The most common difficulties reported in matching consumers with visitors centred around the complex needs of the target population, with auspices noting that many have dementia, behavioural issues, poor
Appendix G. Consultation paper findings

physical health and/or other complex needs. These cases were sometimes referred to as ‘inappropriate referrals’, but in other cases were noted as challenges in ‘finding the right visitor’ and providing appropriate training. Auspices noted that confidentiality concerns sometimes prevented referrers from providing all relevant information to the auspice, hampering matching efforts.

Finding the ‘right’ visitor for consumers could be challenging, especially where a visitor is requested with particular language skills, culture, gender, age or interests. This difficulty was exacerbated in special needs groups, where language (and dialect), culture and background became more specific. Also, in smaller communities, consumers may not want a visitor from their own area, or there may not be a suitable match (e.g. for special needs groups).

Respondents reported ‘mismatches’ occurring for a variety of reasons, noting that in some cases the matching process was one of trial and error.

It was suggested that the home care setting offered additional challenges in matching consumers and visitors. This was, in some cases, related to a geographical mismatch of available consumers and visitors, or consumer confusion around whether they have to pay for the service or miss out on others. Other issues were also reported:

“I declined to match a volunteer with a home care client due to the overbearing odours (cat urine) in the client’s home. The provider was having difficulty in removing the smell. I declined to match a volunteer with a home care client who became angry when I met him (the client) for the first time.”

Other issues raised included:

- Lack of referrals to the CVS
- Visitor recruitment and retention
- Transport for (often senior) visitors in the home care setting
- Length of recruitment/training/matching process
- Family concerns
- Consumer and visitor expectations.

Aged care service providers

Representatives of providers who were also auspices tended to answer the consultation paper from the perspective of CVS service provision, and therefore their responses are summarised above.

Among those who were not CVS auspices, comments of note include:

- It is sometimes challenging finding visitors, particularly for consumers from CALD backgrounds or with mental health issues.
- CVS does not feature strongly on websites, and it is difficult to find relevant information when searching on the web.
- Some noted good communication between auspice and provider, and two-way matching processes (i.e. auspice contacts residential aged care home if they have a visitor looking for a consumer, and vice versa).
Appendix G. Consultation paper findings

- Generally, the referral process was said to be ‘quick and easy’ (residential).
- There is a ‘scatter gun’ and inconsistent approach to promotion, referral and implementation of the scheme: success or failure is determined by chance and goodwill of those involved (community).
- There is a lack of awareness and implementation of guidelines among visitors and coordinators.
- Often the process starts with a volunteer who is then matched to a consumer. The process should be the reverse in order to realise consumer-directed care.

While most respondents were very positive about the CVS and their interactions with auspices, one noted:

“In all our dealings with CVS, we have only been able to get a match with one of our residents in the last 4 years. There are a lot of restrictions within our organisation, with security and staffing levels. So it is very difficult to organise and liaise with each other. Also, we do not have a co-ordinator in this facility, and only have 3 part time staff, who are pressured to their limits, so we are extremely time poor.” (Residential aged care provider)

However, another stated “Access seems simple once the correct auspice is discovered” (residential and community-based aged care provider).

Peak organisations

General aged and aged care peak organisations noted significant variation in the operation of the CVS across the country, and identified similar themes to those described above, including:

- Deficiencies in promotion/information access (particularly direct-to-consumer and through My Aged Care)
- Lack of national consistency in implementation (with ‘success’ dependent on the quality of individual relationships between relevant organisations)
- Difficulties matching consumers and visitors (“limited inclusion for a wide range of people”)
- Lack of volunteers and lengthy delays in matching consumers and visitors.

There was concern that most referrals are currently facilitated through aged care service providers rather than through ACATs, other community sources (e.g. health and allied health professionals) and ‘direct’ through individuals themselves and family and friends. Particular issues of access were noted in the home care setting, and for those with cognitive impairment, disability or palliative care needs.

CALD

Finding visitors matching consumers’ CALD backgrounds can be challenging.

LGBTI

Where LGBTI-specific CVS services are available, it is operating well, though many providers are still unaware of the scheme, or are still reluctant to identify and support LGBTI consumers in accessing the
Appendix G. Consultation paper findings

CVS. There are also difficulties in promoting LGBTI CVS to LGBTI consumers as they are isolated and may not feel comfortable in identifying themselves as LGBTI.

Where there may be sufficient numbers of willing visitors, matching people based on location can take time, and it can be difficult to recruit, train and support visitors in some areas.

Visitors

All visitors who responded to the consultation paper spoke highly of the scheme and the benefits it offered for both visitor and consumers. Several suggested that the CVS should be promoted more widely because it may be an attractive option for people looking for volunteering options that are straightforward and that don’t require a large time commitment.

In relation to matching, a shortage of male visitors was noted. One respondent also noted that geographical distance/transport barriers may also make matches more difficult.

A.41. Benefits for consumers

Auspices

The benefits of the CVS for consumers were felt to be many and varied. In line with the aims of the scheme, some reported reduced social isolation. However, it is clear that this benefit includes many important facets, including:

- Companionship, conversation and mental stimulation
- Personal connection between consumer and visitor
- Connection to community
- A relationship based on mutual interests
- Decreased feelings of loneliness
- Contact with people with shared language or cultural background, or from the same special needs group (e.g. LGBTI)
- Emotional support.

The regular nature of volunteers’ visits was felt to be a key benefit, giving consumers’ something to look forward to.

Broader benefits for consumers’ physical and mental health, wellbeing and quality of life were also reported, along with increased interest and engagement in other aspects of their lives or notable improvements in behavioural patterns (e.g. among those with dementia). In particular, increased confidence, self-esteem and feelings of worth are among the perceived benefits of the CVS.

The ‘independent’ nature of the visitor (i.e. not family, not aged care staff) was mentioned by several auspice representatives as a key benefit, allowing consumers to talk about subjects they may be unable to raise with family members, or telling often-repeated stories to a new listener.
Appendix G. Consultation paper findings

Aged care service providers

The benefits for consumers, as reported by aged care providers, did not differ significantly from those noted by auspices.

“A relationship develops based on mutual interests. The consumer knows that the visitor is there voluntarily. Consumers are able to reconnect to community thereby reducing risk of social isolation. Consumers have given feedback that these visits often become the highlight of their week.”

Peak organisations

Again, the perceived benefits of the CVS were consistent across stakeholder type, with social connection, increased wellbeing and reductions in loneliness frequently cited.

Preventing premature entry into residential aged care homes was noted as a potential benefit by one peak organisation, and another mentioned social outings (e.g. shopping for personal needs, attending appointments) as a benefit, along with acquiring/regaining skills.

Visitors

Perceived benefits for consumers were again consistent among this stakeholder group. Visitors reported helping the residents feel happy through the warmth of the personal contact, which in turn brings benefits to the visitor:

“I bring her joy.”

“LGBTI consumers are saying that they are very happy to have a visitor that ‘understands them’ and that they don’t have to act ‘straight’ for.”

A.42. Meeting demand

Auspices

When asked whether demand for visitors is being met, auspices’ responses were mixed. There was a relatively even spread of those who explicitly answered ‘yes’ or ‘no’. Auspices noted that both demand and supply of visitors fluctuates over time.

It should be noted that ‘meeting demand’ was interpreted differently by respondents. It could be (and was) taken as providing the active visitors for whom they were funded, being able to respond to referrals. In some cases a broader view was taken, with respondents hypothesising about the potential pool of aged care consumers who could benefit from the CVS (e.g. if they knew about it, if they were referred etc.).

A couple of respondents noted that while demand was being met in the residential care setting, this was not the case in the home care environment – although this appeared to be measured against perceived need in the community, rather than referrals.

Issues noted to affect auspices’ ability to meet demand included:

- Increasing demand
Appendix G. Consultation paper findings

- Recruitment and retention of visitors (especially with CALD or other specific backgrounds and qualities)
- Lack of funding to provide appropriate training and support to visitors
- Geographical mismatch of consumers and visitors
- ’Inappropriate referral’ of consumers with complex needs (e.g. dementia, behavioural issues, poor physical health and/or other).

Aged care service providers

Representatives of community-based aged care service providers generally felt that demand was being met, although challenges remained meeting demand from CALD consumers and those with mental health issues. Lack of knowledge of the CVS also meant that true levels of demand may not be realised.

In the residential setting, responses were mixed. Several felt that more volunteer visitors are required to meet demand, and some noted that the process could be slow due to paperwork and the time taken to find an appropriate visitor.

It was noted that in some cases group visits were not feasible, due to lack of numbers of residents belonging to a given language group. Where cluster requirements were not met, residents “missed out”.

Peak organisations

Several peak organisations noted that they were not necessarily in a position to comment on supply/demand issues related to the CVS.

However, a number felt that a lack of available or appropriate visitors meant that demand was not being met, particularly for specific consumer populations (e.g. Aboriginal and Torres Strait Islander and CALD groups). It was noted that LGBTI-specific CVS services are not available nationally.

One noted that meeting of demand varied greatly – while some auspices have problems meeting demand, others have a surplus of visitors without the consumer referrals to match them with.

Visitors

Few visitors responded to this question. Those that did felt that there is always a need for more visitors because social isolation is so common amongst the elderly.

A.43. Supporting consumers to exercise choice and control

Auspices

The vast majority of respondents representing auspices felt that the CVS did support consumers to exercise choice and control. This was primarily related to decisions specifically concerning participation in the CVS, such as:

- Whether to participate
Appendix G. Consultation paper findings

- Requesting particular characteristics in a matched visitor (language, background, gender, age, interests etc.)
- Choosing when visits would occur, and what activities would be undertaken
- Choosing to be matched to a different visitor, or withdraw from the scheme.

“There is now potential for about five different auspices to be operating in one facility - mine (general); CVS with dogs; CALD CVS; Aboriginal CVS; groups CVS. This might be more complex for staff of facilities being required to work with different organisations, but for the resident it should provide more options and more appropriate outcomes.”

Of the few auspices that did not feel the CVS supported consumer choice and control:

“Volunteers are not allowed to know a client’s medical history, so it is encouraged that they restrict activities to companionship rather than choice of activity.”

“Not that is recognisable with the actual residents but the nursing home facilities often make arbitrary decisions about whether a CALD person with dementia will benefit from a friendly visitor in their own language. If the person cannot communicate in English how do they make these decisions?”

Even within this limited context, it was highlighted that potential consumers could only exercise this control and choice if they were aware of the CVS. A couple of respondents reported that on (rare) occasion, family members intervened to stop a consumers’ participation in the scheme.

Several respondents answered in a broader context, noting that CVS visitors were not able to assist consumers in making decisions about their care, nor fulfil roles that are outside the scope of the CVS.

Aged care service providers

Providers generally also felt that the CVS supported consumers to exercise choice and control, as outlined in auspices’ feedback above. However, as mentioned previously, a lack of awareness sometimes meant that consumers were unable to exercise choice and control, and the availability of visitors could also limit true choice.

Peak organisations

Improving consumers’ ability to ‘exercise choice and control’ was not necessarily seen as a function of the CVS, although stronger links with other relevant bodies (e.g. Aged Care Complaints Commissioner, NACAP-funded organisations) could assist this.

One peak organisation noted that ‘choice and control’ would be better facilitated through direct (individual, family and friends) and other indirect (e.g. GPs, pharmacists) referral to the CVS, rather than requiring referrals through aged care service providers.

Another suggested more broadly that “involving aged care consumers in the evaluation of the CVS and in future planning and delivery of the services will be necessary to enhancing choice and control”.

Visitors

Visitors agreed that the CVS supports consumers to exercise choice and control, within the limits imposed by the structure and routine of the residential aged care home.
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A.44. Supporting consumers through transition

Auspices

Most respondents felt that the CVS does support consumers as they transition through the aged care system, with the majority reporting visitors ‘following’ consumers as they moved from home care to residential care.

“Volunteers follow consumers who move from private home to a nursing home facility. CVS Expansion is a great program that assists seniors to maintain their independence and connect with the community.”

Three barriers to this occurring were raised:

- When auspices had limited funding agreements (e.g. funding for home care, but not for residential, or only residential group visits)
- When consumers moved out of the area
- Misguided concerns about confidentiality meant that some aged care providers would not share information about where a consumer had moved to with auspices. It was recommended by this stakeholder that the Department develop a policy to help service providers “negotiate this situation with confidence”.

More broadly, several respondents noted that even if a consumer hasn’t had a visitor while in the community, having a visitor when they move to residential care can ease that transition and provide/maintain links with the ‘outside’ community.

Aged care service providers

Some service providers recalled instances where visitors had ‘followed’ consumers from home to residential aged care, although many did not have full visibility of this process (especially if they worked in only one setting). Although many felt this would be ideal, actual experience of this happening was limited.

A.45. Interactions with other sectors and organisations

Auspices

Respondents often noted that strong liaison was required between auspices and aged care service providers.

Beyond these interactions, auspices were actively sharing information, networking, promoting the CVS and being supported by a range of external organisations and sectors.

“Our auspice staff attends community initiatives, forums, information days and networking meetings to foster relationships between other service providers and members of the health community”

Interactions reported included those with:
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- Other individual auspices (information sharing, referral sharing)
- Regional CVS groups (through Network Members)
- Community organisations and other HCP service providers
- The health sector (GPs, hospitals, mental health providers)
- Peak organisations (CVS promotion, visitor recruitment, training and support for visitors)
- NACAP organisations
- Department of Health.

Aged care service providers

Providers who were not also auspices had limited knowledge of the CVS’ interactions with other sectors and organisations (other than their own).

Peak organisations

While few peak organisations commented specifically on these interactions, one noted the general importance of appropriate linkages in “improving the social characteristics of a local community”.

Visitors

The sole visitor who responded to this question felt that the auspice for which he volunteered had good networks with other service providers.

A.46. The CVS in residential and home care settings

Auspices

A number of respondents from auspices did not feel that they were in a position to comment on the key differences in delivering CVS services in residential and community settings, as they were funded for one or the other.

Some ‘universal’ facilitators of effective functioning of the CVS were identified, primarily around effective promotion of the scheme (to service providers, potential consumers and their families), regular communication with aged care service providers and the availability of well-trained, committed and supported volunteers. A barrier identified across both settings was a lack of referrals from service providers, although a number of auspices felt that this was even more difficult in the community setting, where there was a “competitive commercial culture” that prevented HCP providers – particularly those who offered their own social support services – from referring consumers to the CVS. On the other hand, several respondents noted that residential aged care homes own induction and orientation processes were lengthy and, where followed, resulted in a great deal of ‘doubling up’ for the visitor. In the residential setting, a couple of respondents noted that separate funding arrangements for one-on-one and group visiting was restrictive – for example where an appropriate group could not be gathered or where another resident wanted to join in an activity currently provided under one-on-one funding.
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Many of the differences cited between providing the CVS across the two settings were related directly to the nature of these environments, the lives of consumers within each, and their relationship with their service provider. In particular:

- Risk management, visitor safety and duty of care issues were raised in the context of volunteers visiting consumers’ homes, and the vast difference in the level of ‘on the ground’ support noted between settings. One respondent noted that the vulnerability of consumers in the home care setting was an issue. This contrasts significantly with the “secure, structured environment” of the residential aged care home.

- HCP Providers do not have as intimate a knowledge of their consumers and their lives, and therefore may not easily identify those who are socially isolated.

- HCP recipients were sometimes overwhelmed by the number of carers visiting, and did not want another. In addition, home visiting required greater flexibility from visitors to schedule visits around other providers and ad hoc appointments and outings.

- The process of matching consumers and visitors in the home care setting was felt to be more lengthy, and there were sometimes problems matching pairs in geographical proximity.

- Potential consumers assessed as eligible for a HCP but currently on the waiting list for services are not eligible for the CVS, but may represent an extremely isolated cohort (i.e. before services begin).

- Record keeping was more difficult in the home care setting (e.g. recording/confirming visits).

  “The key difference in delivering CVS service to home as opposed to residential aged care settings, is the time taken to effectively implement the service, when one takes into account required risk assessments, the number of ‘issues’ that arise in-home that don’t arise in the facility, and the extra communication that needs to take place with the provider regarding issues that happen in the home.”

Aged care service providers

One service provider (of both residential and community-based services) noted that both settings depend on staff to assist and encourage consumer participation, while another commented “the efficacy of the service is dependent on the character of the coordinator” (residential). One noted that visitors from CALD backgrounds with limited English skills may feel more comfortable making home visits, as they may find it difficult to communicate with residential aged care home staff.

Again, the greater support for visitors in the residential setting was noted, along with increased risks in home care.

Peak organisations

Peak organisations suggested that key differences lay in the available pool of visitors, additional training and safety measures required for home visits. While some noted that CVS visitors felt safer and more supported in the residential aged care home environment, others felt that some visitors felt less comfortable in this ‘institutionalised’ setting.
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The safety of both consumers and visitors was highlighted in relation to both settings, but particularly in home care, where a lack of supervision, support and processes might compromise safety for both parties.

Aged care peak organisations also noted:

- Perceived competition for social support services in the home care sector.
- A perception that CVS visitors are paid or have other agendas driving their participation in the scheme – and a lack of awareness among HCP providers that the CVS is free.
- Perceived barriers of including ‘external volunteers’ – e.g. residential aged care homes treating CVS visitors as their own (doubling up of induction processes etc.) and/or restrictive policies/procedures within service providers.
- Sub-optimal awareness and promotion of the scheme across both settings.
- Lack of understanding around the role of the CVS (and sometimes ‘service refusal’) among service providers.
- Mismatched expectations between consumers and visitors (e.g. relating to undertaking house work in the home care setting).

CALD

A perceived barrier to recruitment of volunteers in the residential care setting is a negative perception of aged care. Also, consumers in residential aged care homes are often in palliative state and/or have more complex needs.

LGBTI

“It is only in 2016 that LGBTI CVS providers were able to expand their program into residential aged care facilities. This has resulted in an increase in referrals. However residential providers don’t consider a referral to the program a priority when they have their own work to do in providing care. In addition, some residential providers have expressed concerns about using external volunteers.”

Visitors

The sole visitor responding to this question noted that the home setting may be more challenging for visitors, and it is important that visitors feel comfortable.

A.47. CVS visitors’ role

Auspices

Overwhelmingly, auspices reported that the role of CVS visitors was primarily to provide friendship and companionship. While a few noted that visitors and consumers went on ‘outings’ together (e.g. to the shops or a café), for others this was explicitly outside of the scope of the CVS.

“My understanding is that it is intended to be as a friend or companion for the consumer - advocacy is a ‘no no’, cooking is a ‘no no’ and shopping for them or having anything to do with
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their money is a ‘no no’. It would be nice if our visitors had the time to do a little more but the guidelines are there for everyone’s protection’.

In residential aged care, supporting consumers to participate in group activities was also a common role. Where advocacy was mentioned, it was indicated that there were clear processes for this to occur through the auspice.

Most respondents expressed a desire to keep the visitor role as it is (focusing on friendship/companionship), noting that while other assistance (e.g. outings, shopping, accompanying to medical appointments) already took place on an individually-agreed basis, it should not become a core feature of the CVS.

However, others identified a range of additional roles that could be undertaken, including identifying needs not being met, providing information about other services and events and (for auspices where this did not already occur) outings, shopping, transport, exercise, skills training (e.g. iPad) etc. This was balanced by risk management concerns, for example where outings might be requested by a frail consumer, placing too much responsibility on the visitor. Some expressed the view that visitors would be put off the role if it was perceived as being too onerous, risky or time-consuming.

While transport was often mentioned as a beneficial component, it also created significant concerns for risk-averse auspices or those without sufficient policies and protocols to facilitate this. One noted that visitors and consumers used ‘Access Cabs’ to enable outings for wheelchair-bound people (although the funding source for this was not stated).

Some examples may be specifically relevant to the residential group service delivery, where in some cases visitors are specifically trained to incorporate particular aspects into the visit (e.g. music therapy).

“Any additional support that will be provided to aged care consumers will likely dilute the effectiveness of the Community Visitors Scheme providing social support for volunteers as it would change the way that clients see the visitors. It would replace the ‘friendship’ with a client-worker relationship”.

Implications of extending the visitor role in relation to visitor training, supervision and support and auspices’ policies and processes were also noted, potentially requiring a cut in visitor numbers or an increase in funding. The training mentioned by auspices covered a wide variety of topics including aged care, manual handling, palliative care, first aid and other relevant areas. The increasing complexity of consumers and the importance of boundaries were also highlighted.

The potential need for reimbursement for visitors’ travel or other out-of-pocket expenses was raised.

There was concern among some that the visitor’s role should not replace that of paid carers, and that in taking on some of these sorts of roles the aim of the CVS would be diminished or lost (for both consumer and visitor).

Aged care service providers

Aged care service providers had a similar basic understanding of the role of the visitors to the auspices’.

In terms of additional roles visitors might play, one provider of residential and community-based services noted the potential role of the CVS in supporting consumers through their “transition period
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and adjustment”, with another suggesting “a skilled group of palliative care visitors would be useful”. Some visitors “draw on skills from work or hobbies to enhance their resident such as helping with art, bringing in a laptop or tablet, actually helping a resident learn to email etc.” (residential). Another mentioned that “it would be good if CVS visitors had the training to provide consumers with some gentle exercises, in accordance with consumers’ individual needs and [auspice’s] authorisation”.

Several providers felt that additional visitor training would be of benefit, for example in dementia, dealing with behaviours, depression in the elderly etc. Further training was also felt to be a key consideration if the role of the CVS visitor were to be expanded, as well as reimbursement for fuel expenses (if transport was added).

Apart from training, issues of confidentiality and time constraints were perceived as key barriers to expanding the role, and risk management and insurance implications were raised.

In the residential setting, one respondent noted that additional roles had the potential to “step on workers’ toes”, but a small number of others felt that outings, shopping, etc. would be useful additional roles.

Peak organisations

Aged care services peak organisations were generally keen to see the role of the CVS visitor retained as it is, with desirable additional functions fulfilled through a separate program. In particular, concerns were raised around personal care, administration of medication, financial advice and counselling.

Expanding the role could also lead to a decrease in volunteers willing and able to participate, as well as a decreased focus on companionship and social support.

However, it was noted that visitor training (e.g. the aged care system generally, referral pathways) should allow CVS visitors to act in the capacity of an ‘informed friend’, linking their consumers with other organisations and additional supports where required. It was suggested by one peak organisation that this could be achieved through “a national, 30-minute online (or off-line self-directed booklet) training session” and further nationally-consistent training modules for use by CVS auspices.

Visitors could also “link consumers with local community groups and activities to encourage independence and social connectedness”. One noted the particular potential value of the CVS in supporting consumers through transitions (e.g. from home to residential care).

Enabling visitors to broaden the scope of their services (e.g. to shopping or providing transport, accompanying to community activities etc.) may be considered useful by consumers, and it was noted by several respondents that this did occur in some (but not all) instances. In addition, the ability of the CVS to contribute to quality improvement in aged care (through observation and feedback) was noted through one response – e.g. through ‘unannounced visits’ or visits from small teams.

Overall, a number of peak organisations noted the variation in services provided under the CVS, and a level of confusion among key stakeholders about what was in and out of scope in relation to the scheme.

Appropriate induction, orientation and ongoing training and support for visitors – as well as CVS coordinators – were seen as key necessary supports, whatever the particular role of the scheme.
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Visitors

One visitor was open to the idea of taking the consumer to appointments or to the shops. Others expressed reluctance to take on any additional tasks, and said they would not continue with the CVS if the role became more onerous.

Training, time commitment, cost (e.g. for transport) and regulations (e.g. in relation to using private vehicles for transport) were listed as barriers to the provision of additional support.

A.48. Supporting special needs groups

Auspices

Targeting and identification

Special needs groups are often identified by the referrer – whether aged care service providers, family/friends, health care professionals etc.). However, sometimes this information is not collected or not passed on to auspices due to privacy concerns. Sometimes special needs status is only disclosed, or becomes apparent, after the consumer has already commenced with the CVS.

“In practice, older LGBTI people need to come out to their aged care provider in order to access our service. However, fear of discrimination from staff or other residents makes it unlikely that they will.”

Sometimes there is more specific communication between auspices and service providers to identify individuals from special needs group, and educate them about the importance and availability of the CVS for special needs groups and in some cases prioritising these people on waiting lists.

Broader promotion of the CVS (in the community, specific populations and residential aged care homes) is used to target special needs groups, along with networking and awareness-raising activities through specific relevant community groups and clubs.

Supporting individuals from special needs group

Many auspices felt that the needs of special needs groups were being well met by the CVS. In particular, this occurred through appropriate matching of consumers and visitors and by networking/seeking advice from relevant organisations or groups to provide training and support to visitors or seeking appropriate visitors through these external organisations.

“The auspices work together with specialist providers (where possible) to provide appropriate support and also training and support for the visitors.”

A small number mentioned a lack of referrals for (or identification of) consumers from special needs groups, but in other cases demand could not be met, resulting in waiting lists.

Some noted difficulties in meeting the KPI for special needs group:

“I do think it is unrealistic to ask all CVS auspices to meet the 20% KPI and target all special needs groups. It makes more sense that 20% of auspices funded are special needs specific, than requiring all auspices to meet the 20% target.”
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One auspice noted that veterans are ineligible for in home CVS due to not being eligible for a HCP, with another suggesting that the CVS does not take into account rural/regional areas where towns have very small numbers of people and available visitors.

Suggestions for improving the CVS for special needs groups included:

- Better promotion in the community, including communications materials in languages other than English
- Raising awareness among aged care services providers
- Improving identification of individuals from special needs group, and overcoming service providers’ privacy concerns
- Strong networking with relevant organisations
- Visitor training
- Networking and sharing referrals and visitors between auspices as relevant
- Additional funding.

A number of additional vulnerable groups that are, or could be supported if CVS eligibility criteria were extended to them, included:

- Those under the age of 65
- Those living in the community who are socially isolated but not eligible for a HCP
- Those with dementia
- Those with physical or intellectual disability or communication difficulties
- Those with mental illness
- Refugees
- Centenarians
- Carers.

Aged care service providers

Aged care service providers reported identifying special needs through their assessment and intake processes and conversations with family and friends, but noted many consumers may not disclose this information. In some cases, staff actively encourage individuals who are in special needs groups to consider having a visitor or being involved in the programs.

Most who provided an answer to how well the CVS supports individuals from special needs groups (which was few), were positive, although again it was noted that the CVS auspices may have difficulty matching consumers with dementia with visitors.

Visitor training, ensuring sufficient visitors to match to special needs consumers, and providing funding for special events or outings were all suggested ways the CVS could perform better in this space. One provider noted that CVS run by ethno-specific organisations would help to engage those groups.
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Additional vulnerable groups included those with a disability, those with dementia including young-onset), those with mental health issues and older carers.

Peak organisations

Aged care services peak organisations reinforced the importance of targeting special needs groups through the CVS and promotion of these specific services.

Additional populations identified included:

- Those with mental health concerns, acquired brain injury, dementia and other cognitive impairments – particularly where these resulted in communication difficulties
- Those at risk of homelessness
- Those with physical impairment and/or reduced mobility/access to transport
- Those receiving CHSP/WA HACC support or those on a waiting list for HCPs (or otherwise not eligible for the CVS – e.g. veterans)
- Younger people with disabilities or age-related illness (i.e. under 65).

Identification (or lack of disclosure) was a common challenge in targeting special needs groups (particularly in the home care setting), as was (subsequently) finding an appropriately-matched visitor within the local area (e.g. the “recruitment, training and matching of a gay community member with Auslan fluency”).

“In Tasmania very few identify as being CALD and seek CALD specific support. Difficult due to demographics e.g. rural, semi-rural, isolation. Keeping quiet.”

However, others noted that rural and remote and CALD groups are somewhat self-evident, identification may be more difficult for “cohorts of older Australians who may have been born in Australia or into an English-as first-language household, but still maintain a cultural connection to their heritage”.

LGBTI individuals are likely to face additional challenges, either through lack of self-identification or through discriminatory barriers within residential aged care homes or from family members (i.e. where guardianship applies).

“It is difficult to promote directly to LGBTI consumers as they may or may not be ‘out’, if within residential aged care, or they may be isolated or living within rural communities where they may not have access to information about CVS. Therefore promotion tends to happen through LGBTI networks, media and organisations.”

Improved identification of special needs groups (e.g. through initial assessment) was felt to be vital to supporting these populations, and better promotion (including through My Aged Care) of specifically-targeted CVS services could also assist. However, for some populations, inherent barriers made provision of CVS difficult – for example in rural and remote areas, where there is sometimes “an indirect reliance on other services [e.g. Meals on Wheels, Blue Nurses] to provide social connectivity”.

Linkages between relevant organisations (e.g. auspices and peak organisations) were felt to be important in providing the CVS to special needs groups, and expanding eligibility for the CVS in the
Appendix G. Consultation paper findings

Community (beyond HCP recipients) was again raised as a suggestion. A marketing drive to recruit bilingual visitors was also suggested.

The use of technology (e.g. phone and online models) might help the CVS in matching consumers and visitors regardless of geographical isolation from appropriate visitors, and training of ‘mainstream’ visitors – as well as service provider staff – in interacting with special needs groups could also assist.

A number of peak organisations noted that where consumer/visitor matches were able to be made, they worked very well.

A.49. Exploring other community visitor models

A number of other community visitor programs were mentioned by stakeholders, including those they were simply aware of and those that were felt to represent ‘good practice’ examples. These have been reviewed by AHA and, where most relevant, information has been included in the literature review (Appendix B).

Models that stakeholders felt could, or should be considered by the Department included:

- Providing a greater variety of activities within residential aged care homes (collaboration and transport to share resources)
- Residential aged care homes adopting a local school and develop pen pal arrangements with children
- Café-style functions, activities and relevant (e.g. cultural) celebrations
- Extending community eligibility beyond HCP recipients
- Group outings with transport provided
- Funding for more visitors from CALD groups
- Maintaining community connections for residents who have recently moved into a facility
- A pool of fully salaried people whose focus is entirely on visiting people in special needs groups and who closely cooperate with CVS
- Intergenerational models (e.g. local school/pre-school and residential aged care home relationship)
- Corporate models (e.g. employees supported to volunteer time)
- Use of companion animals
- Group visitor models (e.g. groups of visitors to visit where visitor safety may be an issue)
- Art therapy programs
- Community choirs for residential aged care home residents
- Those at risk of homelessness being ‘matched’ to share housing
- University students living in aged care.

It was also noted that elements of perceived ‘best practice’ were currently operating within individual CVS auspices (although not necessarily in a consistent manner).
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A.50. Improving the CVS

Auspices

While many suggestions were made on ways to improve the CVS, it should be noted that auspices were overwhelmingly positive about the scheme. As articulated by one, “Expansion of [the] CVS at a national level should build on the existing networks of current CVS auspices to ensure that the current wealth of experience and knowledge is retained”.

Better promotion of the CVS was the most common suggestion for improvement from auspice representatives. This included:

- Centralised information resources (including translated information for CALD groups)
- Centralised promotion to aged care service providers, potential visitors, potential consumers and the community about the availability of the CVS and its benefits
- Dedicated CVS website (both for general promotion and information-sharing between auspices)
- Marketing of the many ‘good news stories’ available.

A number of other suggestions for improving the CVS were received, covering the following themes:

- Networking and information sharing
  - Clarity and accountability around the roles and responsibilities of the Network Member, particularly in balancing organisational efficiency and streamlining of administrative arrangements while maintaining local relevance and connections
  - Transparency in how referrals through Network Members are managed
  - More networking/increased funding for this
  - Regular local forums and national conferences
- Governance issues
  - Annual reporting (rather than 6-monthly)
  - Reconsideration of KPIs (especially for home care setting) and restructured reporting template
  - Update of the CVS policy and procedures document
  - Broadening eligibility to others (e.g. CHSP) and allowing ongoing access to previous activities (e.g. undertaken through CHSP) through the CVS
  - Clarification of requirements for visitors in residential aged care homes to avoid duplication (police checks etc.)
  - Fostering an expectation that aged care service providers will participate in the CVS (and link to KPIs or reward for participation)
  - Better inclusion of the CVS in My Aged Care system
  - An effective evaluation tool to measure success/outcomes
  - One manager per state with “hands on” role in facilitating the CVS
- Funding
Appendix G. Consultation paper findings

− Increased funding (for auspices, administration duties, additional visitors, supporting visitors’ travelling expenses, transport for outings)
− Longer-term (e.g. three-year funding, with three months’ notice of continuation)
− Elimination of funding distinction between one-on-one and group visits in residential care
− There were mixed views on the relative merits of funding small auspices (who were perceived as being more “connected to community”) and larger organisations (who could perhaps deliver the CVS more efficiently)

• Greater sector support from the Department for individual auspices, including:
  − Training for CVS coordinators
  − Ongoing communication (e.g. newsletter)
  − Feedback on reporting
  − Staff turnover in the role responsible for CVS in the Department was identified as an issue.

• Visitor training and support
  − Centralised or group training
  − Regular ongoing training for volunteer visitors
  − Reducing paperwork for visitors
  − Attracting visitors (including younger).

Aged care providers

Few additional suggestions were noted beyond those summarised above. A couple of respondents who represented residential care providers (but not auspices) were keen to have regular education about and promotion of the CVS in their services. Another noted that it would be useful to have an overview of how the system is coordinated and managed, who the auspices are in each area and who are the key contacts (i.e. a central repository).

Peak organisations

Most of the recommendations from peak organisations are captured through responses to earlier questions on the consultation paper.

Improved integration was recommended – for example a shared understanding of services provided by the CVS and CHSP-funded social support programs, such as ‘Friendly Visitors’ (or extension of CVS eligibility criteria to encompass those consumers), as well as strengthened/formal relationships between the CVS and other relevant peak organisations.

Other comments included:

• National consistency (promotion, training, implementation in general)
• More training and targeted funding, CPI indexation
• Better promotion (to potential consumers and potential visitors)
• Greater flexibility within KPIs to allow focus on consumer demand
• Expanded eligibility (e.g. CHSP, WA HACC, Veterans Home Care Program)
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- Mandatory participation in the scheme by aged care service providers
- A greater focus on preventing social isolation
- Greater government support (e.g. visitor recruitment and retention support, potentially through grant funding for CVS state volunteer coordinators and a local Departmental contracts manager)
- Ensure alignment with other relevant policy (e.g. LGBTI ageing, CALD ageing strategies)
- Review of existing CVS ‘good practice’ processes.

Networks of auspices with shared interests (not just shared locality) may also be useful:

“The LGBTI CVS have formed a national network that is working well and provides them with a great opportunity to discuss issues, learn from each other, collaborate and share costs, for example in placing advertising in LGBTI publications.”

As noted by one peak organisation, “We are supportive of exploring a wide range of options, given no single model is likely to suit all aged care consumers or the particular characteristics of their local community”.

Visitors

Suggestions provided by visitors included promotion through social media, clearer guidelines on what visitors can and can’t do, and access to online training.
Appendix H. Focus group briefing paper
Appendix H. Focus group briefing paper

A.51. Introduction

The Community Visitors Scheme (CVS) was implemented by the Department of Health (the Department) in 1992 to recruit visitors to provide friendship and companionship for recipients of Australian Government-subsidised aged care services who are socially isolated or are at risk of social isolation and loneliness.

This paper has been developed to support a series of telephone focus groups for the Review of the CVS. It provides participants with some high level feedback from consultations undertaken for the Review to date, and outlines the key areas for discussion in the focus groups.

A.52. Review Terms of Reference

The scope of the CVS Review is to:

- Explore the extent to which the program aligns with current aged care reforms
- Explore the potential to increase the role of visitors to provide additional support to consumers
- Consider options for delivering CVS services to home care and residential care consumers, in the context of potential ongoing reforms to home care
- Explore how the uptake of the CVS in the home care setting could be enhanced
- Explore the extent to which the CVS is meeting the needs of special needs groups (as identified under the *Aged Care Act 1997*) and identify models of good practice
- Identify and compare other community visitor services addressing the social isolation of older people, across related sectors (e.g. disability), both domestically and internationally
- Identify areas for streamlining program management, funding allocation and service structure with a view to reducing red tape for both providers and the Department of Health (the Department).

A.53. Aims of focus groups

The aims of the focus groups are to:

1. Provide an overview of key findings from the Review consultation process to date
2. Build on these findings by discussing possible options for enhancing the CVS
3. Provide participants with an opportunity to explain their perspectives in more detail.

Note: the focus groups are not intended as a means of making definitive decisions about changes to the CVS service delivery model. Rather, the aim is to gather further stakeholder input in order to guide decision-making by the Department.
Appendix H. Focus group briefing paper

A.54. Review findings to date

The Review process has included a series of in-depth interviews with key stakeholders and distribution of a consultation paper. The following preliminary high-level findings have emerged through the consultation process to date.

Overarching impressions

- The CVS is viewed positively by stakeholders, who identify a range of important benefits for consumers and visitors.
- The Residential one-on-one service is well established and, in the majority of cases, valued by residential aged care providers and consumers. There is also support for the residential group service, although it is noted that this option may not be appropriate for some consumers.
- The expansion of the CVS into the home care setting has proven challenging. Many auspices have had difficulty engaging with HCP providers and awareness of the CVS appears to be low in this setting.
- Auspices devote considerable time to:
  - Visitor recruitment, training and retention
  - Promotion of the CVS to aged care service providers. This is an ongoing activity because of high levels of staff turnover in the aged care sector.
- There are low levels of support for expanding the role of the CVS visitor to provide information (about aged care and other services) and other assistance to consumers. Stakeholders have argued that:
  - To expand the role may risk compromising the friendship relationship which is at the core of the CVS
  - Challenges may arise in ensuring that consistent, high quality information is provided by visitors.

Enhancing the uptake of the CVS in the home care setting

- A number of opportunities were suggested for improving the uptake of the CVS in the home care setting, including better promotion of the CVS within the aged care sector (e.g. by ACAT and through My Aged Care).
- Many stakeholders suggested that more consistent branding of the CVS as a Commonwealth-funded program, along with associated guidelines and promotional materials, would boost the profile and credibility of the CVS among HCP providers and potential consumers (this also applies to the residential care setting).

Special needs groups

- The extent to which the CVS caters to the needs of people from special needs groups appears to be variable, and is difficult to ascertain due to reported issues with disclosure and documentation of special needs group status. Auspices that are specifically funded to provide the CVS to special needs groups (in particular, CALD groups) tend to do well in terms of meeting their targets.
Appendix H. Focus group briefing paper

Other programs addressing social isolation

- A number of different community visitor services and other programs addressing social isolation have been identified by stakeholders. These include those funded through the CHSP, which include group activities, telephone support and face-to-face befriending programs.

- Many stakeholders suggested that a consistent suite of programs/services should be offered to aged care consumers across the continuum of the aged care system (including the CHSP, the HCP Program and residential care) so that consumers may choose the option that works best for them as they transition through the system.

Program management, funding allocation and service structure

- A greater level of guidance from the Department in relation to CVS requirements (e.g. in relation to police checks) would be useful for auspices and aged care service providers.

- Many auspices have multiple funding agreements covering different aspects of the program, creating administrative challenges.

- The CVS reporting template should be reviewed and simplified.

- Greater promotion of the CVS at a national level could reduce the effort that individual auspices devote to promotion and awareness-raising activities.

- CVS Network Members play an important role in linking and supporting auspices, on a limited budget. Stakeholders suggested that opportunities to expand the Network Member role be explored, in order to further enhance coordination and sharing of ideas and resources.

A.55. Discussion topic 1: Increasing the effectiveness of the CVS (20 minutes)

While stakeholders noted the valuable role that CVS Network Members play in facilitating communication between auspices, it was agreed that there is scope to enhance this role (potentially with additional funding) to increase the effectiveness of the CVS. In addition it was agreed that there are opportunities to improve coordination of the CVS in relation to:

- Sharing of innovation and examples of good practice

- Training opportunities

- Facilitating referrals between auspices.

Discussion prompts:

1. What key roles could the Network Members be funded to undertake? (consider: networking/information sharing, volunteer training, coordinator training/professional development, CVS promotion, referrals between auspices etc.)

2. Could any of these roles be undertaken at a national (rather than state/territory) level?

3. What other approaches could be considered to improve the effectiveness of the CVS in reducing social isolation?
Appendix H. Focus group briefing paper

A.56. Discussion topic 2: Enhancing the CVS in the home care setting (20 minutes)

A number of reasons have been suggested for the relatively low levels of uptake of the CVS in the home care setting. Key reasons arising from consultations are:

- Lack of awareness and understanding of the program among HCP providers, consumers/family members, and other aged care stakeholders (e.g. ACATs)
- A reluctance of HCP providers to refer consumers to other programs/services that are not offered as part of their package (noting that many HCP providers include social connectedness activities within their service offering)
- Under-recognition of social isolation in HCP consumers by HCP providers
- Complex health, care or behavioural needs of consumers, which may mean that a volunteer visitor may not be appropriate or may be difficult to coordinate.

Discussion prompts:

1. Options for improving uptake of the CVS in the home care setting include:
   - Improving the profile of the CVS on My Aged Care
   - Improving awareness among ACATs
   - Improving awareness of the CVS and the issue of social isolation among HCP providers
   - Improving awareness among potential consumers and the general community (e.g. family members).

   How would you prioritise the options above to improve uptake in the home care setting? What other options could/should be considered?

2. Is the current model of CVS service delivery in the home care setting appropriate and attractive to potential consumers? Are there other models that could be considered (e.g. group activities with transport provided?)

A.57. Discussion topic 3: Special needs groups (20 minutes)

Currently, the CVS is delivered to people from special needs groups through mainstream auspices and those funded specifically to target people from special needs groups. The extent to which the CVS caters to the needs of people from special needs groups is mixed. Some auspices find it difficult to attract referrals for consumers from special needs groups, while others find it difficult to match consumers with a volunteer from (or otherwise sensitive to) the same group.

Discussion prompts

1. How could aged care consumers from special needs groups be best supported through the CVS? Options include:
   - Stronger referral pathways to CVS auspices specifically funded to provide the CVS to that group?
Appendix H. Focus group briefing paper

- Increased support for mainstream auspices (e.g. volunteer training through relevant peak bodies?)
- Other?

2. What other service delivery models could be further explored or expanded to meet the needs of consumers from special needs groups (e.g. telephone/online models)?

A.58. Discussion topic 4: Program management, funding allocation and service structure (15 minutes)

Note that this topic will not be discussed in focus groups with participants for whom the questions are not directly relevant.

Several options have been proposed for streamlining program management, funding allocation and service structure. We are interested in your views on the following options:

- Develop updated guidelines outlining the roles and responsibilities of the volunteer, auspice volunteer coordinator and aged care service provider in supporting the CVS.
- Merge the residential one-on-one and residential group services into a single ‘Residential’ service type, to provide auspices with flexibility in meeting the needs of residential care consumers and reduce the number of funding agreements in place.
- Review and update the reporting template for the CVS. This could include the use of smart forms (pre-filled with agreed KPI targets) for easier and more accurate completion.

Discussion prompts

1. Do you agree with the options proposed above?
2. Are there other priority changes to the CVS that should be made to streamline program management and administration and to reduce red tape?

Thank you for your participation in this focus group.