Towards an enabling approach in community care

Empowering people, enhancing independence, enriching lives
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A pproaches to service delivery that enable people to build on their strengths have been shown to improve the independence and overall wellbeing of older people and younger people with a disability. The community care sector is continually working to achieve these outcomes so that people are able to participate in the community as fully as possible.

This paper describes an enabling approach. This is a relatively new approach and one way of supporting frail older people and people with a disability to live at home in their community. The purpose of this paper is to highlight how people can benefit from an enabling approach, encourage discussion and suggest some next steps for people and organisations interested in this approach.

In using an enabling approach, the individual requiring support becomes an active decision-maker in the planning and implementation of their community care support arrangements. As they become involved in identifying goals that are important and meaningful to them, and participating in decisions that affect their lives, their confidence and personal wellbeing is enhanced.

An enabling approach can improve physical functioning and mobility, social and emotional wellbeing, and community connectedness.

This paper aims to engage everyone involved in community care by raising awareness of the issues surrounding an enabling approach and opening the topic for discussion and debate.

The NSW Government acknowledges the valuable contribution of the community care sector and the many people who provided feedback throughout the development of this paper.

I am delighted to give you the opportunity to find out more about an enabling approach and I look forward to working together to continue improving the independence and wellbeing of older people and younger people with a disability.

Peter Primrose MLC
Minister for Ageing
Minister for Disability Services
Background

A national Home and Community Care (HACC) forum was held in Victoria in February 2008. The forum showcased innovative community care programs, evidence-based better practices and new models of service delivery that have demonstrated improved quality of life outcomes for individuals.

Following this forum a working group named IMPACT was formed in NSW. IMPACT comprises community care representatives from key consumer groups, carer bodies, service provider organisations, industry bodies, the HACC Development Officers Network, government agencies and local government.

IMPACT has played a vital role in stimulating discussion, promoting the exchange of ideas, and generating understanding and enthusiasm for better practices that put the person at the centre of service delivery by incorporating a ‘doing with’ as distinct from a ‘doing for’ or ‘doing to’ approach.

This paper and the enabling approach it describes, supports the person-centred, socially inclusive and culturally appropriate approach to providing community care services being advocated by IMPACT.

An enabling approach focusses on ‘doing with’ and supports the person ‘to do’ rather than ‘doing for’ or ‘doing to’ the person.
What is an enabling approach?

An enabling approach is a new way of supporting frail older people and people with a disability to live at home in their community. It is based on the following principles:

1. Frail older people and people living with a disability have the capacity to make gains in their physical, social, and emotional wellbeing.
2. The best outcomes for clients accessing community care occur when services are responsive to individual needs rather than being implemented on the basis of the types of services that are available.
3. An individual’s needs are best met when there are collaborative working relationships between the person, their carers and family, social networks, support workers and between service providers.

An enabling approach focuses on what the person can do and wants to be able to do, not just on what they are unable to do at present. It offers people the opportunity to be actively involved in identifying goals that are important and meaningful to them and to participate alongside their support worker to achieve their goals.

Evidence from around the world shows that when well targeted and implemented, an enabling approach in community care can benefit people by building their confidence and self esteem, empowering them by actively involving them in decisions about their care needs, enhancing their autonomy and independence and improving their personal wellbeing and quality of life.

Successful enabling programs may include a short-term restorative component. This is suitable for people who have recently entered the community care system, existing clients who have experienced a recent change in functioning or existing clients who identify goals around improving their functioning and independence.

An enabling approach is person-centred and uses where appropriate, a number of evidence-based better practices to achieve agreed goals and outcomes. These include practices around wellness, active ageing, early intervention and prevention, social inclusion, and short-term restorative care (also known as re-ablement).

An enabling approach is consistent with the aims of the HACC program. These aims are to:

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers
- support these people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to residential care
- provide flexible, timely services that respond to the needs of consumers.

This approach is consistent with the NSW State Plan which commits government agencies to embedding early intervention and prevention into service delivery and to reducing unnecessary hospital admissions. An enabling approach is also consistent with Towards 2030: Planning for our changing population, a whole-of-government strategy to actively plan for the ageing population in NSW.
2.1 What people have said about enabling practices

“When I first came, I was struggling to do 10 to 15 minutes of the exercises. After a couple of months, I was doing 30 minutes and after a couple more months, I was doing the whole class. I get a lot of benefit. So does my wife. She was having to do everything for me before. Now I do it all myself: my shower, getting dressed, everything.” Participant – Acacia Living Life, UnitingCare Ageing NSW and ACT Northern Sydney Region, Brooklyn, 2010.

“Our goal is to make sure clients succeed in whatever it is they want to do.” Manager – Magnolia Cottage Dementia Day Therapy Centre, LivingCare, Nowra, 2010.

“I hadn’t been out for years socially, until this started. I’ve made contacts and friends and it has turned my life around. Stanley loves coming; he always gets up early on Coffee Club Tuesday.” Carer, Connections Coffee Club, Western Sydney Dementia Advisory Service, Blacktown, 2010.

“I can now do so much more for myself at home. I hope the Community Kitchen keeps going. If we weren’t here we’d be sitting at home getting melancholy.” Participant – Berridale Community Kitchen, Snowy River Home Living Support Service, Snowy River Shire Council, Berridale – NSW Snowy Mountains Region, 2010.

At the Berridale Community Kitchen

“Elders choose the activities they want to do and the coordinator enables and supports this process.” Manager, Multipurpose Allira Gathering Association Inc, Dubbo NSW, 2010.
2.2 An enabling approach in practice: a case study

Identifying needs and goals

Mrs C is 81 years old and lives alone. She had been actively involved in her church and local community before experiencing a stroke earlier in the year. Following the stroke, Mrs C stopped going out on her own, fearing that her poor balance could result in a fall. Within her house she has also cut down on the heavier housekeeping tasks like vacuuming, large cleaning jobs, laundry and gardening.

The assessor who saw Mrs C focussed on her strengths and abilities as well as her needs. Together they discussed what Mrs C would most like to achieve from a support plan. Mrs C’s expressed goals were to get stronger, resume her church activities, do more about the house and get back out in the garden.

Adopting enabling strategies to achieve Mrs C’s goals

Mrs C’s support plan was centred on her achieving her own goals. To help her do this, she agreed to:

- consult her GP and undertake a light home exercise program designed with an allied health worker
- when stronger, join a twice weekly exercise program at a local neighbourhood centre
- work with a domestic assistance service and divide housekeeping tasks into the following categories:
  - ‘too heavy for now’ (to be done by the service)
  - ‘I can do with help’ (to be shared with the service)
  - ‘I will do’ (to be done by Mrs C)
- review and re-negotiate these housekeeping tasks at least every three months
- receive assistance to identify and make contact with a person, eg a pastoral care team member, to discuss her continued interest in participating in church activities
- accept referral to an easy-care gardening service for discussion and planning on converting her garden to become low maintenance.

Outcomes

After mastering basic strength and balance exercises, Mrs C progressed from using a frame to a walking stick when out and was eventually able to walk unaided inside her home. A more confident Mrs C then arranged a ‘buddy’ to drive her to and from church activities in return for a home-cooked meal one night a week. After six months, some housework tasks were moved from the ‘I can do with help’ to the ‘I will do category’, meaning that Mrs C needed fewer hours of domestic assistance each week. She was delighted to find that the new raised garden beds, dry spell planting and better mulching reduced the amount of garden maintenance needed without affecting her enjoyment of the garden.
2.3 Comparing a traditional approach in community care with an enabling approach

The table below contrasts a traditional approach of providing a service to meet a person’s needs and an enabling approach whereby a person’s goals are identified, along with their potential to improve functioning, social connection, wellbeing and to the implementation of strategies to achieve these goals.

Table 1 below compares critical stages in both approaches. Ideally community care providers will have the skills and ability to use the best approach in order to achieve the desired outcomes for the individual.

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<th>Traditional approach</th>
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<tr>
<td><strong>Assessment</strong></td>
<td>Assessment focuses on what the individual is unable to do for himself/herself (eg unable to shower and dress without assistance; unable to prepare meals).</td>
<td>Assessment focuses on what the individual is able to do and wants to be able to do for himself/herself (eg wants to regain the ability to shower and dress themselves; wants to be able to prepare easy meals).</td>
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<td><strong>Care planning</strong></td>
<td>Care planning takes place in the context of what services the agency is able to provide (eg personal care, social support services).</td>
<td>Care planning focuses on what support the person needs to achieve their goals. This support is specific to the individual and may involve informal and other support (eg self care aids; strength-building exercise program; nutritional plan).</td>
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The plan focuses on what the service provider will do, identifying the broad areas and the specific type of formal services to be provided.

The plan has a joint focus on what the person receiving support will do and what the service provider will do to help achieve the person’s goals. Strategies can be either:
- **formal** (eg home support services; aids and equipment; adapting the home environment) or
- **informal** (eg connecting to social network supports and tapping into existing community resources).
<table>
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<th>Service delivery</th>
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<td>The focus is on outputs (eg four hours of personal care per week).</td>
<td>The focus is on achieving outcomes (eg goals that are important and meaningful to the person receiving support).</td>
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<td>Reviews occur when the situation or client’s needs change (eg the client’s health has declined and more support services are required).</td>
<td>Regular review is built into the care plan. The focus is on whether and to what extent the person’s goals have been achieved. New goals are established as needed.</td>
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<td>Service tends to be on-going until packaged care or residential care is needed or the client dies.</td>
<td>The program ends when the person has achieved their goals or dies. Support can be ongoing or provided on an episodic basis if required.</td>
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An enabling approach offers people the opportunity to be actively involved in identifying goals that are important and meaningful to them and to participate alongside their support worker to achieve their goals.
Why use an enabling approach?

There are a number of key drivers for innovation, better practice and new models of service delivery in community care which include:

- the needs and expectations of the people requiring support
- a growing evidence base that is confirming what better outcomes people are achieving and how
- the decreasing availability of carers
- challenges around recruiting and retaining skilled staff in the sector
- the need to effectively manage increasing demand for services due to the ageing population.

Key drivers for an enabling approach are:

- the needs and expectations of the people requiring support
- the evidence-base demonstrating the results achieved
- the need to effectively manage increasing demand for services.

3.1 The needs and expectations of people requiring support

People who are frail and/or living with a disability generally want and expect to live at home and be connected to their community. They place a high value on support that will help them live independently and avoid the necessity of moving to a residential care environment. Consumers today expect community care services to be coordinated, effective, efficient, flexible and responsive to their needs.

The community also expects this responsiveness to include services to assist people who may otherwise have more difficulty than most people in accessing services. Identified special needs groups include Aboriginal and Torres Strait Islander people, people from culturally and linguistically diverse backgrounds, people living with dementia and people living in remote or isolated areas.

With more people living longer, our attention has shifted over the last few decades towards improving quality of life. This has been accompanied by a shift in focus from the treatment of disease to early intervention and prevention, with special attention to: the role a healthy lifestyle plays in preventing disease, disability, and premature death, to improving quality of life, and to promoting successful ageing.

The needs of people requiring support to live at home and in their community vary; some have low needs, whereas others have very complex needs. Some people are able to manage with little or no support, and others are not. Some people require support from their social networks whereas others need formal support services.

While community care is targeted at people who are frail aged, those living with disability and their carers, the initial request for assistance can be brought about by either a sudden deterioration in function eg following a fall, or by a slow deterioration due to health problems or lifestyle factors. In some cases the person’s deterioration can be slowed or
reversed, whereas in other situations, the person will require support that is ongoing.

Many people needing community care support have the potential to gain tangible benefits by participating in low levels of physical activity, improving their diet, and nutrition, using aids and equipment to maintain their functioning, participating in activities that are meaningful to them, and building or re-building and maintaining social relationships.

3.2 The evidence base

A few key findings from the vast and growing evidence base in support of an enabling approach are summarised below.

- There are risk factors for cardiovascular disease, such as high blood pressure, obesity, and smoking, which have been shown to lead to premature death and disability. There are also protective factors, such as exercise, diet and nutrition, which have been shown to improve health, personal wellbeing and quality of life (Broe, 2010).

- Brief community care interventions that give a client the opportunity to regain their capacity to do things for themselves can arrest physical deterioration for a while and improve personal wellbeing (Aged Services Learning and Research Centre, Southern Cross University, 2009).

- Low level exercise such as shopping, cooking, doing housework, laundry and gardening can help improve functioning, build confidence and morale, and improve personal wellbeing (McWilliam et al, 2000).

- Improvements in a person’s health and functional capacity are necessary but not sufficient to achieve wellbeing. Measures to (re)connect people to their communities and social networks are essential (McMurray, 2007).

- In many cases, it is possible to reverse or slow down deterioration in functioning, improve capabilities, and improve wellbeing with modest low cost interventions such as encouraging low-level exercise, and improving diet and nutrition and the use of assistive technology (eg aids and equipment such as canes and walkers) (McWilliam et al, 2000).

- It is possible to improve individual functioning by modifying the home environment
eg by adding ramps, lowering cabinets, and removing rugs (O’Connell, H. 2007).

- It is possible for frail older adults participating in short-term restorative care programs offering multi-disciplinary intervention, to improve their ability to perform activities of daily living, reduce the likelihood they will fall and injure themselves, increase feelings of independence, autonomy, and self-efficacy, and increase involvement in the management of their health and abilities including self-care (Lewin et al, 2006; Kent et al, 2000; Tinetti et al, 2002).

- Research over the last 10 years suggests that community care that places an emphasis on completing tasks (eg doing the shopping, doing the laundry), and generally ‘doing for’ may be unintentionally creating dependency and working against the goal of enhancing the individual’s autonomy and independence (Ryburn et al, 2007).

- When successfully targeted and implemented, an enabling approach that includes short-term restorative intervention can delay, reduce, or remove the need for longer-term ongoing support from the community care service system (Victorian Government Department of Human Services, 2008).

- An enabling approach has the potential to improve staff satisfaction (Victorian Government Department of Human Services, 2008).

In short, an enabling approach has the potential to enhance individual autonomy and independence and to improve personal wellbeing and quality of life. It also has the potential to improve staff satisfaction and to assist service providers to free up capacity to support more clients.

Appendix 1 provides additional information about key references that support an enabling approach.

**3.3 The need to effectively manage increasing demand for services**

Today, at age 60 an Australian man can expect to live on average, to age 84; and at age 60, an Australian woman can expect to live, on average, to 88 years. Life expectancy for Aboriginal and Torres Strait Islanders is 15 years lower than for non-Indigenous Australians, and the Australian Government has determined that: “Closing the gap in life expectancy between Indigenous and non-Indigenous Australians is a matter of national priority”.

By 2021, almost one in four Australian adults will be aged over 65 years. Over the next 40 years, the 85 year and over age group will quadruple in size (Productivity Commission, 2010). The National Health and Hospitals Reform Commission (NHHRC 2009) forecasts that the number of aged care places will need to at least double by 2030 to meet projected demand (Ibid).

These are compelling reasons for us to adopt evidence-based better practices and to pilot new models of sustainable service delivery.
3.4 Who will benefit from an enabling approach?

Feedback from pilot projects in Victoria and from demonstration projects in NSW suggests that, in addition to frail older people and people with a disability, other groups will benefit from an enabling approach. These groups include carers, family members, staff, provider organisations, local communities, and government at all levels.

Even if there is no potential to restore or improve function, people can benefit from accessing services that use better practices associated with wellness, active ageing, early intervention and prevention, and social inclusion. Individuals being supported to live at home and in their community can be encouraged and supported to actively participate in the development and delivery of their services, even if this is limited.

An enabling approach is based on the individual’s goals. The person directs the direction of enabling strategies, meaning they are more likely to be actively engaged and feel that enabling is done with them rather than to them. For many individuals this will not be a short-term intervention; however an ongoing service can help prevent unnecessary deterioration.

It appears at this stage that an individual’s diagnosis is not a reliable indicator of success when participating in an enabling program. Positive results have been reported by people with complex needs, people receiving palliative care services, people in the old-old (over 75 years) age group and people with dementia in the early stages.

Organisations that are using an enabling approach report that this approach is likely to get the best results in the following circumstances:

- when both the recipient of the service and the provider of the service understand and value the approach
- the person has the capacity to make gains in their personal wellbeing, functioning and socialisation
- family members and carers support the approach
- the individual is a willing participant
- the holistic needs of the individual are addressed
- staff are skilled in implementing evidence-based better practice
- the goals are developed with the person and they have meaning for that person
- when enabling interventions are evidence-based and targeted to meet the individual’s needs.
The Better Practice Project

In October 2009, Ageing, Disability and Home Care (ADHC) initiated The Better Practice Project for HACC in NSW. This project aims to strengthen the capacity of community care to adopt evidence-based better practices that will enhance the autonomy, independence and quality of life of people requiring support to live at home and in the community.

The Better Practice Project has an enabling approach at its foundation, and has four components described in Sections 4.1 to 4.4.

4.1 Mapping innovation and better practice initiative

In March 2010, a call for nominations was issued, inviting the HACC sector in NSW to nominate service providers adopting better practices in service delivery that were aligned with an enabling approach.

This resulted in development of A handbook for community care services. This will be available from November 2010 online www.adhc.nsw.gov.au > Doing business with us > Home and Community Care Program.

The handbook includes practice ideas, case studies, and client and carer stories from 50 services, large and small, across NSW. This resource provides fact sheets and essential information about available resources.

4.2 Awareness-raising education

ADHC has partnered with the Aged & Community Services Association of NSW and ACT (ACS) to develop an awareness-raising program to be offered across NSW. The program is designed for care coordinators, case managers and HACC development officers who want to learn more about an enabling approach by participating in a small interactive program.

The awareness-raising education program will be independently evaluated and the results of the evaluation will inform decisions about future programs.

4.3 Demonstration projects

Four demonstration projects are now underway, supporting individuals who are eligible for HACC services, using an enabling approach. The projects will run for 12 months until June 2011 and are located in:

- Clarence Valley in Northern NSW
- Singleton in the Hunter Region
- Northern Sydney
- Eastern Suburbs Sydney.

These projects are offering short-term early intervention and support to approximately 400 older people who are willing and interested in participating.
The demonstration projects will help us to learn more about:

- how an enabling approach can help individuals improve their functioning, their social networks and their personal wellbeing
- the characteristics of people who benefit most from this approach
- the costs and benefits of this approach
- the impact on staff, participating service providers, and the local community.

*Enable Me Demonstration Project, Northern Sydney*

### 4.4 Independent project evaluation

Independent consultants have been engaged to evaluate the results of the demonstration projects, the mapping initiative and the awareness-raising education program.

The consultants will gather quarterly feedback on the demonstration projects, including client feedback, and client and carer stories. They will also gather feedback from staff and service providers and will facilitate shared learning from the projects during the year. The outcome of the evaluation will contribute to informing the direction of future service delivery.
In NSW, the HACC Program has entered a period of transition. Under the National Health and Hospitals Network Agreement endorsed by the Council of Australian Governments (COAG), there will be a split of responsibilities for aged care and disability programs. The Australian Government is to assume full responsibility for aged care services for people aged 65 years of age and over (50 years of age and over for Indigenous Australians) from 1 July 2012.

As part of its commitment to a smooth transition, the NSW Government is keen to support and facilitate a state-wide consultative process with the community care sector. Aged and Community Services Association of NSW and ACT Inc (ACS) will play an active role in communicating the changes and assist in building future sector capacity through consultation and facilitated forums on transitional planning.

ADHC will make findings from The Better Practice Project available to the Australian Government and will apply these findings in planning and developing community care services for people under 65 years of age.

ADHC will continue to engage the sector in how best to implement an enabling approach as a viable support option for people requiring support to live at home in their community. This process of change is likely to take time.
Next steps: How you can be involved

If you want to know more or become involved in this exciting new direction for community care the following information provides some options.

1. Read about the evidence related to an enabling approach. Refer to the references and appendix for details.

2. Participate in regular IMPACT forums facilitated by:
   - Aged and Community Services Association NSW and ACT Inc (ACS)
     Email: mail@agedservices.asn.au
   - Council of Social Service of NSW (NCOSS)
     Email: info@ncoss.org.au


4. Attend the awareness-raising education programs being conducted by ACS and suggest interested co-workers also attend. For information about the awareness-raising education program contact ACS via email on mail@agedservices.asn.au.

5. Participate in regional forums and networking events that are focussing on this approach and exchange information and ideas.

6. Share your enabling better practices and achievements with others by speaking at upcoming forums and conferences.

7. Attend the 2011 HACC and Community Care Conference being run by ACS to be held in Darling Harbour, Sydney from 2–3 May 2011. Contact ACS via email on mail@agedservices.asn.au.
References


Appendix

Definitions

‘Active Ageing’

“Active ageing is the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age. It applies to both individuals and population groups. Active ageing allows people to realise their potential for physical, social, and mental well-being throughout the life course and to participate in society, while providing them with adequate protection, security and care”.


‘The Wellness Approach’

“The Wellness Approach is a philosophical change in the thinking behind the delivery of Home and Community Care (HACC) services in Western Australia (WA). It supports a move within the WA HACC Program towards developing and implementing service models that have the potential to build capacity by actively working with the client to:

– prevent loss of independence by focusing on the retention of existing skills and where appropriate
– focus on regaining skills and a subsequent increased level of independence and well being, as opposed to a continuing or increasing dependence on services being provided by others”.

CommunityWest

‘Re-ablement’

“This new model, known under various terms, emphasises a capacity-building restorative approach. Its principal aim is to maintain and restore, to the extent possible, an older person’s capacity to live as independently as possible”.

“Most of the re-ablement type projects/programs reviewed which demonstrated positive outcomes included similar essential components or features, including goal setting; comprehensive assessment; and having multi-disciplinary teams”.


‘Person-centred planning’

“Person-centred planning is a process for continual listening and learning, focusing on what is important to someone now and in the future, and acting upon this in alliance with their family and friends. It is the foundation of self-directed support. Put simply, person-centred planning is a way of assisting people to work out what they want, the support they require and helping them get it”.

Helen Sanderson, http://www.helensandersonassociates.co.uk/

Literature reviews – evidence base


This report was funded by ADHC’s Northern Region and summarises the experience of teams in the UK, New Zealand and Western Australia. The report provides a comprehensive overview of the Australian and international peer-reviewed and ‘grey’ literature, exploring:

• multi-component re-ablement programs
• evidence-based single component interventions for re-ablement programs
• common features/approaches in re-ablement programs (including the use of assistive technologies, physical therapy, mobility and strengthening exercises, social rehabilitation, and health education, including chronic disease self-management, continence promotion and nutrition)
• key issues for implementation of re-ablement programs.
Appendix

The research showed that the provision of brief service interventions that give a client the opportunity to regain their capacity to do things for themselves can arrest physical deterioration for a while and improve personal wellbeing.

The paper also reflects a series of consultations with service providers on the NSW Far North Coast, with general consensus reached amongst participants that the evidence clearly supports the benefits of adopting a re-ablement approach for the provision of HACC services. It was noted this requires a philosophical change.


This is a review of Australian and international literature about person centred planning practices (PCP) and approaches. Literature was reviewed with the intention of illuminating the features of PCP and practices, the outcomes of PCP, and the issues that need to be considered in the development of person centred practices. The literature review demonstrates that person centred approaches can achieve significant outcomes for individuals with disabilities. It also demonstrates that it is an approach that requires fundamental changes in the way that service systems relate to people with disabilities.


This literature review was commissioned by the Victorian Department of Human Services in order to provide an evidence base to inform the development of the Active Service Model (ASM) within the Victorian system. It comprises a comprehensive international review of the literature, including a review of conceptual and theoretical underpinnings, current international practice and empirical research utilising an ASM-type approach.


In this text, the authors highlight that adopting strategies for wellness wherever possible is advantageous for all types of prevention, and argue that it is often possible to rehabilitate or re-enable occupational and social functions in frail older adults with chronic illness.


This paper highlights a study conducted in the United Kingdom by Davies, B., A. Bebbington and H. Charnley (1990), Resources, Needs and Outcomes in Community-Based Care: An Evaluated Demonstration of a Long-Term Care Model, Avebury, Aldershot. The study examined the impact of employing some simple targeting criteria, such as regular reassessment on a population eligible to receive home care. The study found that after regular six monthly reviews, a modest proportion were estimated to no longer require assistance and were taken off assistance. While some reapplied later and were readmitted to services as their condition indicated, the results of simply introducing regular reassessments of all clients were shown to be very significant. After five years, the cost of serving the population without reassessment was approximately one and a half times that of assisting the population remaining after regular reassessment. The reassessments demonstrate that decline is not inevitable and dependence on services is not a life sentence. Reassessments helped many clients regain their independence.

This Policy Framework was developed to inform discussion and the formulation of action plans that promote healthy and active ageing. It was developed by WHO’s Ageing and Life Course Programme as a contribution to the Second United Nations World Assembly on Ageing, held in April 2002, in Madrid, Spain.

Evaluating practice


This paper is an evaluation of three ‘Promoting Independence’ pilot projects in Leicestershire, United Kingdom. The intention of the pilot projects was to enable people to remain living in their own homes as long as possible by providing intensive packages of support and rehabilitation. All pilot projects aimed to help people to look after themselves rather than ‘do’ for them. The report highlighted the importance of close involvement and support of multi disciplinary colleagues with occupational therapy and physiotherapy backgrounds, as well the need for training and development opportunities for home care staff.


This study compared the outcomes for individuals who participated in the Home Independence Program (HIP) with those of individuals who received “usual” home care services. The (HIP) is a short term restorative programme targeted at older home care clients. The results of this study supported the hypothesis that older individuals referred for Homecare who did not have a diagnosis of dementia and participated in programs to promote their independence had better individual and service outcomes than similar individuals who received usual Homecare.


This study reviews potential of restorative approaches towards home care for frail older adults, which aim to go beyond traditional home care goals of ‘maintenance’ and ‘support’ towards improvements in functional status and quality of life. The authors cite a range of positive outcomes, including improved quality of life and functional status and reduced costs associated with a reduction in the ongoing use of home care services post-intervention.


The primary aim of the Health of Older People Strategy (2002) in New Zealand was to develop an integrated approach to health and disability support services that is responsive to older people’s varied and changing needs. Ageing-in-place services – that give older people the ability to make choices in later life about where to live, and to receive the support needed to do so – are a key component of meeting the aims of the Strategy. The ASPIRE project was set up to evaluate the effectiveness of three of the more significant ageing-in-place programmes:

- the Coordination of Services for the Elderly (COSE), Christchurch
- the Promoting Independence Programme (PIP), Lower Hutt
- Community FIRST (Flexible Integrated Restorative Support Team), Hamilton

The results of these programmes found that “the three services reduced the risk of entry to residential care and caregiver stress levels did not appear to rise, despite older people with high and complex needs remaining in their own homes” (Kathy Spencer, NZ Ministry of Health http://www.moh.govt.nz/moh.nsf/by+unid/672F0E6427851E4DCC2571F5000F8ECE?Open).
v) Commonwealth Department of Health and Aged Care, (1999) Targeting in the Home and Community Care Program, Aged and Community Care Service Development and Evaluation Reports No. 37, Commonwealth Department of Human Services and Health), AGPS, Canberra

This study reviewed the effects of different targeting strategies in the HACC Program, including targeting to improve functioning and support independence in the community. The review found that there are circumstances in which early, basic and general assistance has beneficial outcomes. These circumstances can be seen as presenting ‘windows’ of opportunity for secondary prevention, that is, interventions aimed at preventing loss of function and deterioration in individuals who already have established disabilities. Three broad sets of circumstances in which targeting to restore and maintain function applies can be distinguished, including clients needing ongoing but low levels of assistance, post acute care and supporting carers.

The NSW context

i) NSW IMPACT Forum - IMPACT principles

The five key principles developed by the IMPACT Working Group and background about IMPACT are available at: http://www.impactnsw.com/principles-details.html


The report introduces the first NSW whole-of-government strategy to actively plan for demographic change. The document identifies a range of ways that NSW Government agencies can respond to the ageing of the population, with a focus on early intervention to support people to maximise their health and quality of life as they move into older age.

Other Australian jurisdictions


The Victorian HACC Active Service Model Seminar was a 1-day follow on event to the National Forum, including some of the Forum’s keynote speakers, along with presentations and evaluation findings from a number of HACC Active Service Model Pilot Projects. Nearly 700 people attended the event.

Presentations from the day are available at the website above.


The discussion paper provides an overview of the evidence base and trends that have led to the development of the Active Service Model (ASM) initiative, describes the principles, objectives and key components that underlie the ASM, raises issues for implementation and outlines possible actions that could be part of an implementation plan.


This resource provides an overview of the WATCH (Wellness Approach to Community Home Care) project in Western Australia, including its aims and objectives, key workplace changes, essential principles. More information on the Wellness approach is available at http://www.communitywest.com.au/index.php?option=com_content&view=article&id=74&Itemid=105