

Department of Health

health

Well for Life

Improving emotional wellbeing
for older people

At home

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March 2011

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About this resource

Well for Life started with a focus on improving the nutrition and physical activity of older people in a range of settings. The Department of Health has further enhanced Well for Life by including a focus on improving emotional wellbeing. Emotional wellbeing is essential to a happy and healthy life. Activities to enhance emotional wellbeing strengthen an individual's capacity to maintain their independence, autonomy and general wellness.

A combined focus on the three elements of **physical activity, nutrition and emotional wellbeing** supports the Victorian Department of Health's priority of promoting physical and mental health and wellbeing among older people. Well for Life is an integrated health promotion approach. Agencies use a range of interventions and partnerships to achieve positive outcomes for individuals and the community.

HACC Active Service Model

Well for Life activities build on the holistic, health promoting principles of the active service model being implemented by Home and Community Care (HACC) services. By identifying an individual's abilities and focusing on restorative care to build capacity, the HACC Active Service Model approach assists people to make gains in their general health and wellbeing. Support services play a key role in encouraging and assisting individuals to identify and act on opportunities for independence and self-management.

This information resource aims to promote Well for Life goals with a focus on **emotional wellbeing for older people living at home**. This includes older people living independently in private housing, assisted living or public housing. Some of these people may be attending HACC-funded planned activity groups or other group activities held in the community.

It is designed to support primary health and community service organisations implementing Well for Life, including HACC planned activity group (PAG) service providers. Service providers should note that this information resource does not replace or supersede program guidelines. For example, HACC program guidelines take priority if there appears to be a conflict between the information in this resource and in HACC guidelines.

Physical activity and nutrition

The information resource complements the physical activity and nutrition sections of the *Well for Life: Improving nutrition and physical activity for older people at home* resource kit (Department of Human Services 2005). The resource has been reviewed and tested by Well for Life projects funded to implement physical activity, nutrition and emotional wellbeing strategies.

This information resource includes:

- practical guidelines for identifying barriers to people's emotional wellbeing
- suggestions about how to recognise opportunities to encourage emotional wellbeing
- a series of help sheets with practical strategies
- an education package.

Service providers are encouraged to make full use of the information resource as an easy-to-use, practical and effective tool for supporting the emotional wellbeing of older people living at home.

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Section 1: Introduction

1.1 Purpose

Used in conjunction with *Well for Life: Improving nutrition and physical activity at home*, this information resource will assist primary health and community service organisations to promote nutrition, physical activity and emotional wellbeing opportunities for older people at home and their carers. This includes older people living independently in private housing, assisted living or public housing.

The intention of the information resource is to generate discussion about emotional wellbeing and focus on ways in which the emotional wellbeing of older people can be actively enhanced through service provision.

The information resource provides a self-assessment and continuous improvement process to enable service provider staff and managers to:

- recognise the benefits of engaging in discussion about emotional wellbeing
- better understand the benefits of emotional wellbeing
- identify and consider current emotional wellbeing practice
- gain experience in applying self-assessment and continual improvement tools and checklists
- generate ideas and action to improve opportunities for emotional wellbeing
- develop and implement strategies to enhance the emotional wellbeing of older people.

1.2 Resources

This document contains the following resources:

- An introduction and overview of the **principles** of emotional health and wellbeing for older people living at home.
- A **facilitator's guide** to use in leading discussion about emotional wellbeing for older people living at home. The facilitator's guide includes: **case studies** to illustrate key issues; a **good practice checklist** for physical activity, nutrition and emotional wellbeing for self-assessment and planning; and an **action plan** template for recording agreed actions.
- A series of **help sheets** outlining key issues and practical considerations for the emotional wellbeing of older people living at home, which can be used in conjunction with the facilitator's guide and educational resources. All or some of the help sheets can be selected for use depending on the service setting and context.
- **Educational resources** including a session format, PowerPoint presentation, handouts and speakers notes. **Module one** provides an overview of emotional wellbeing for older people, its principles and practice; and **module two** explores the issue of ageism.

Section 2: Emotional wellbeing concepts and principles

2.1 Concepts and definitions

Well for Life defines emotional wellbeing in the same way the World Health Organization and VicHealth define mental health.

World Health Organization 'Mental health is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community.'

VicHealth 'Mental health is the embodiment of social, emotional and spiritual wellbeing. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just.'

Social, emotional and spiritual wellbeing for Aboriginal people recognises the importance of connection to land, culture, spirituality, ancestry, family and community that serve as sources of strength and resilience. Social and emotional wellbeing problems cover a broad range of issues that can result from, for example, unresolved grief and loss and removal from family (Cooperative Research Centre for Aboriginal Health 2009).

The adoption of the concepts of *active ageing* and *positive ageing* by service providers and the wider community can counteract some risks to an older person's emotional health.

Active ageing

Active ageing is a term used by the World Health Organization (2002) and relates to 'the process of optimising opportunities for health, participation and security in order to enhance quality of life as people age.' In a practical sense, active ageing is about recognising and supporting older people to realise their potential, and continue to engage with families, peers and the wider community in a social, economic, cultural, and spiritual way. Therefore a key goal for service providers is supporting independence and autonomy for all older people no matter how frail, disabled or in need of care.

Positive ageing

Positive ageing is about being valued by and contributing to the community as we age, which benefits both individuals and society (Office of Senior Victorians 2005). The HACC Active Service Model reflects the concept of positive ageing as it promotes a wellness or active ageing approach that emphasises optimal physical and mental health and acknowledges the importance of social connections to maintain wellness. Adopting a HACC active service model approach requires service providers to actively involve an individual in goal-directed care planning and encourages participation in health promoting activities, including strengthening social supports.

Well for Life seeks to enable active and positive ageing through promoting physical activity, nutrition and emotional wellbeing. The information and help sheets included in this information resource provide strategies to assist staff in their day-to-day work with older people. They are based on research evidence and expert opinion and reflect the concepts of active ageing, positive ageing and the HACC active service model approach.

2.2 Guiding principles for emotional wellbeing

The guiding principles are based on a range of approaches that uphold active ageing and positive ageing including person-centred care, a HACC active service model approach and health promotion. These principles underpin the information contained in the help sheets.

Service providers can use these principles in their day-to-day work. For example:

- when communicating with older people
- in considering the key messages conveyed to older people, including through written, verbal and non-verbal communication
- as part of a practice review
- in planning or thinking about how to enhance the services provided to older people
- in updates of organisational policy and procedures
- including emotional wellbeing information in workforce development and training activities.

Emotional wellbeing guiding principles for staff

- 1 Support **autonomy** and **independence** by 'doing with' rather than 'doing for' and actively involve clients in setting goals and making decisions about their care.
- 2 Encourage and foster social connections within and external to the service.
- 3 Focus on **strengths, abilities** and **improving capacity**, rather than disabilities.
- 4 Promote **personal responsibility** for activities of daily living and engagement in activities of personal interest.
- 5 Provide **person-centred services** that are **flexible and responsive** to changes in an older person's health and wellbeing, and are based on their goals.
- 6 Create **relationships** with the older person to explore their interests and strengths and to develop their goals.
- 7 **Respect** an older person's decision-making ability and incorporate their wants in decisions about care they receive and types of services provided.
- 8 Work in **partnership** with other local services and agencies, and with the person's carers and family, but recognise that in some cases a person may not want other parties consulted when making decisions about their future.
- 9 Respect **privacy and dignity** in relation to consulting friends, families, neighbours, relatives and service providers when making decisions about a person's future.

Principles

2.3 Understanding diversity

The *Victorian Charter of Human Rights and Responsibilities (2008)* represents a commitment that all Victorians are treated with equality, fairness and respect. It encompasses the diversity of the Victorian community and acknowledges that barriers to accessing services are experienced by many individuals and groups who are marginalised or disadvantaged.

The Charter prompts services to plan for and address the needs of all people, taking into account diversity in age; gender and sexual identity; physical and cognitive ability; emotional, spiritual, religious and cultural background and beliefs; ethnicity; Aboriginality; refugee status; language; and socio-economic circumstances and needs. The Charter encourages us to recognise the commonality between people as well as the difference within groups, and respond to this difference.

Aboriginal people

For the purposes of this document Aboriginal refers to people who identify as Aboriginal, Torres Strait Islander or as both Aboriginal and Torres Strait Islander. An Aboriginal person is defined as a person who is a descendant of an Indigenous inhabitant of Australia, identifies as an Aboriginal, and/or is recognised as Aboriginal by Aboriginal members of the community in which they live.

Each Aboriginal community is unique. Aboriginal people conceptualise good health as inclusive of social, spiritual, emotional and physical wellbeing. Cultural identity, self-determination, and connection to land, family and community are critical to the emotional wellbeing of Aboriginal people.

People of culturally and linguistically diverse backgrounds

The interplay between culture and health is significant for many Victorians from culturally and linguistically diverse (CALD) backgrounds. Health and wellbeing issues for CALD Victorians differ depending on factors including gender, age, cultural background, health and wellbeing prior to their arrival in Australia, settlement experiences, family reunification and length of time settled in Victoria.

The various traditions practiced by CALD Victorians may impact on their experience of health and wellbeing, and also on the way in which they access the human services system. Sometimes these traditions are successfully recognised through mainstream practice but at other times they may be in conflict. Furthermore the interplay between culture and health may continue for subsequent generations and can result in intergenerational conflict. Research also clearly shows the ill-health effects of discrimination and social exclusion.

Being culturally informed and providing sensitive support is an integral component of service provision. It is important that health and human service workers provide support with an understanding of culture beyond their country of origin.

A lack of spoken English and/or literacy skills also impacts on some CALD Victorian's access to human services. Additionally, it is recognised that as people age, it is not unusual to lose proficiency in speaking a second language. As a result older people with conditions affecting memory tend to revert to speaking their first language. When working with people from a CALD background who do not speak English well, workers should use a professionally qualified interpreter to help overcome these issues.

Gay, lesbian, bisexual, transgender and intersex people

It is important that aged care service providers support the sexuality of clients, whether they are heterosexual, gay, lesbian, bisexual, transgender or intersex. Many older people grew up in an era when homosexuality, other non-mainstream sexualities and transgender identities may have been considered criminal, unnatural, deviant or the basis for societal discrimination. This can mean that older people might not feel comfortable or safe to 'come out', or talk about their needs. This may have a range of impacts from limited expression of their sexuality or gender identity to social isolation that, in turn, can have negative consequences on emotional wellbeing.

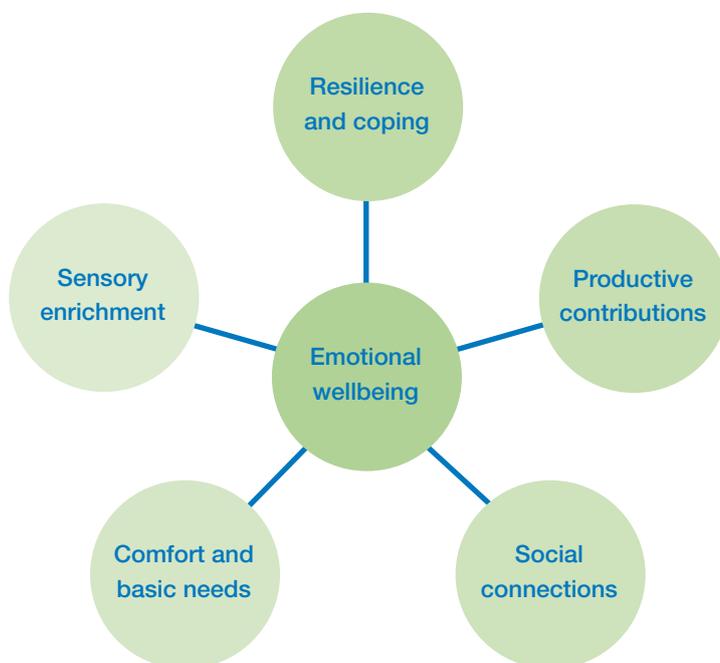
Gay, lesbian, bisexual, transgender and intersex (GLBTI) older people want understanding, empathy, non judgement, acceptance, sensitivity and awareness. Cultural competency training, advocacy and respect by service providers are important in providing safe, high-quality services appropriate to their needs.

2.4 Individual emotional wellbeing

Well for Life identifies five elements crucial to maintaining an individual's emotional wellbeing:

- 1 Resilience and coping
- 2 Being productive and making a contribution
- 3 Social connections
- 4 Basic needs and comfort
- 5 Enjoying sensory enrichment.

Figure 1: Five elements of emotional wellbeing



Element	Description	How organisations and staff can support this
Resilience and coping	This is the ability to cope with life events and stresses associated with changes in circumstances. Effective coping skills give people better control over their lives and adds to their sense of emotional wellbeing.	Develop an awareness of when the person is not managing, and what is important to them which will assist in developing, with the person, practical solutions. Positive communication is required.
Being productive, making a contribution	Staying active and happy and enjoying what life has to offer. Maintaining self-esteem, feeling productive and having a meaningful role in daily affairs.	We can challenge ageism. Get to know the person, their interests and respect their roles in life, past and present. Show respect and incorporate their wishes in their care. Encourage independence and autonomy and participation in purposeful activities.
Social connections	Having meaningful relationships with family, friends, peers, the wider community, and staff/workers. Receiving and giving affection.	Encourage individuals to be involved in positive social activities. Support individuals to engage with social and cultural networks and the local community, their peers, families and friends.
Being comfortable	Fulfilment of basic physical needs and the absence of health problems. Having a sense of privacy, security and safety. Being comfortable in your environment.	Encourage nutritious enjoyable meals, good healthcare, appropriate lighting, temperature control and a safe environment. Provide assessments and equipment to support independent living. Implement HACC Active Service Model principles and goal setting.
Sensory enrichment	Having one's senses stimulated and enjoying habitat ambience. Having a pleasant amount of activity and arousal to convey emotional support, affection and respect.	Be aware and inventive in finding sources of sensory enrichment for individuals whose emotional wellbeing is at risk. Resources for this include group activities catering for individual tastes and interests. Ensure noise, lighting and access to sunshine are appropriate and do not irritate. If appropriate, offer hand and hair treatments or massages.

The help sheets contained in section 4 provide strategies and suggestions for implementing these elements in practice.

Section 3: Facilitator's guide

3.1 Responsibilities

Facilitators or nominated change leaders can use this guide to plan and conduct a productive group discussion about emotional wellbeing.

To effectively implement and sustain increased opportunities for emotional wellbeing for older people at home and their carers, **service providers** must be committed to delivering best practice and continuous improvement.

Facilitators or nominated change leaders need to ensure that:

- the process and tools for assessing the organisation's practices in promoting emotional wellbeing are related to existing organisational systems for improving the quality of services
- clear explanations are provided to staff about how to use the good practice checklist and help sheets
- ongoing opportunities are provided for participants to read, engage with and discuss the emotional wellbeing information
- there are opportunities for reinforcement and practice.

Participants in discussions on emotional wellbeing may involve practitioners in direct service delivery, assessment or program coordination roles, providing in-home or centre-based services and activities. Participants may range from very experienced to inexperienced and/or from highly qualified to having minimal formal education.

3.2 The process

The key steps

- 1 Plan and convene a staff meeting to discuss the emotional wellbeing of older people.
- 2 Explain your role and the aims of the discussion.
- 3 Discuss a range of emotional wellbeing topics, issues or areas of interest to participants. The help sheets and educational resources can be used to inform and stimulate discussion.
- 4 Discuss and self-assess current practice in relation to supporting emotional wellbeing. The good practice checklist and program standards can be used.
- 5 Define an area or topic for further investigation and continual improvement.
- 6 Discuss and generate possible ideas, approaches and solutions.
- 7 Agree on action to be taken and timelines.
- 8 Conclude the discussion.
- 9 Reflect.

Further information about each step is provided below.

Step 1: Plan and convene a staff meeting to discuss the emotional wellbeing of older people

Discuss with your manager the desire to focus on the emotional wellbeing of older people. Suggest that a staff meeting is convened to discuss the topic. The discussion may occur at regular staff meetings or at meetings convened specifically for the purpose. Allow two hours for the meeting if possible.

Schedule the meeting and discussion to occur over two or more sessions.

This allows time for participants to reflect, review their work practices and develop enhanced problem-solving skills.

Prepare for the meeting and familiarise yourself with relevant resources:

- the help sheets contained in this information resource
- the education package, PowerPoint presentation and speakers notes contained in this information resource
- *Well for Life: Improving nutrition and physical activity for older people at home*, including the checklist and help sheets.

Make enough copies of the help sheets and other resources to use during or following the discussion. Before commencing the group discussion, make sure that:

- management supports the meeting—consider having invitations endorsed by management to encourage participation
- participants are able to take time off from their regular duties
- management will be interested and supportive of ideas generated by participants
- a room is available for the meeting that is comfortable and free of interruptions
- seating can be arranged around a table or in a circle to encourage interaction
- there is adequate advance notice and promotion of the meeting
- someone has been organised to record and write up the results of the discussion and the plans
- the resources and equipment needed for the discussion are readily available
- refreshments have been arranged for participants.

Step 2: Explain your role and the aims of the discussion

Commence the meeting and explain your role to the group, which is to help them identify, discuss and work through issues about emotional wellbeing. Inform the group that your role is to facilitate the discussion, ask questions, provide access to information and resources, and generate ideas and solutions to the issues they identify.

Introduce participants to the concept of emotional wellbeing. Explain the aims of the discussion and the outcomes that will be achieved, that is: to identify improvements to current organisational practice and outcomes to enhance older people's emotional wellbeing.

Step 3: Discuss a range of issues or areas of interest to the group

After setting the scene, begin a free-ranging discussion of aspects of current practice relating to the emotional wellbeing of older people. Ask the group to think about how they define and understand emotional wellbeing.

Use workplace examples to highlight the concept of emotional wellbeing, such as an incident that has occurred, discussions a staff member has had with a colleague, or something staff would like to do better. The following prompts may be useful:

- A carer or relative expresses concern about an older person's change in behaviour
- A person's behaviour has changed quite abruptly
- A person seems sad, withdrawn or anxious
- A person is not communicating with others when their usual behaviour is to do so

- A person wants to speak about their emotional wellbeing
- A person expresses a sense of hopelessness or is negative towards others
- A person's confidence and self-esteem appears to be declining.

You can communicate to the group information you have read in current literature or industry journals in relation to the emotional wellbeing needs of older people. Prompting questions can be asked such as:

- Is that an approach our organisation could adopt or something our program could be doing?
- Is that a possible solution to an issue we have been experiencing and discussing?
- The literature does not seem to address [x] ...could we look at that problem in our agency and come up with some answers?

Step 4: Self-assess against the good practice checklist

With the group, assess the agency's strengths and opportunities for improvement in supporting the emotional wellbeing of older people.

For example, using:

- the good practice checklist in this information resource
- other relevant program standards applicable to your agency.

Step 5: Define an area for further investigation and continual improvement

Based on your assessment of current practice, identify an area for further discussion and investigation. In selecting this area, consider the following issues:

- Has a broad range of issues been raised?
- Did the group reach consensus on the primary area for further discussion and investigation?
- Is the issue relevant for the needs of the group and the agency?
- Is the identified area of practice improvement achievable?

Step 6: Discuss and generate ideas, approaches and solutions

Ask questions to assist the group to identify strategies to address any gaps in emotional wellbeing knowledge or practice that could be changed. For example:

- In your experience, how often does this issue occur?
- How many older people, their carers or staff members are affected?
- What would you need to help resolve the issue or bring about quality improvement?
- Could you use help sheets in this process?
- Would an education session help?
- Which people within or external to the agency could help to address the issue?
- What other initiatives are targeted to older people and their carers in the local community that you could build on or make links with?
- Is the strategy or action achievable and realistic?

Ensure that for each question posed, the group is able to agree on an appropriate course of action, if the question is applicable for their situation.

- Help participants generate the solution that will work for them.
- Use the help sheets to explore possible actions in more detail.
- Look at the example of how you could manage this part of the discussion—see the case study ‘Improving emotional wellbeing of PAG participants’.

To document the outcomes of the discussion and proposed actions, take notes on a whiteboard or butchers paper. This will be useful for later reference to review progress and outcomes.

Step 7: Agree on action to be taken and timelines

Discussion participants need to know that some action will be taken as a result of the meeting. Therefore, it is important for the group to agree on the next steps. Participants should be able to contribute ideas about the actions to be taken. This could be to arrange another meeting, circulate help sheets, invite a guest speaker, trial a new practice, or draft an organisational policy.

Actions arising from the agency’s self-assessment of their practice using the good practice checklist can be formally recorded using a format similar to the Action plan template. Record the action you intend to take, when this will occur and who is responsible.

Ensure management support for the action. The *Integrated health promotion resource kit* (Department of Human Services, 2003) provides examples of strategies that reflect management support and commitment to integrated health promotion. This provides a useful framework for considering ways you can engage management support for group discussions and, potentially, ideas generated by participants. Suggestions include to:

- incorporate specific health promotion tasks, such as emotional wellbeing into performance plans
- seek opportunities to promote and showcase achievements to senior management and board members.

Step 8: Conclude the discussion

As facilitator, you will have guided the discussion through a series of stages:

- discussion of general issues related to emotional wellbeing
- deciding on a particular area of concern or issue on which to focus
- working through a series of questions to highlight gaps in knowledge or areas where changes in practice may be required
- reaching agreement about what should happen next.

End the discussion at a point that is agreed by the group, ensuring that you have taken the group through these discussion stages. Reinforce and summarise the agreed action, timeframe and responsibilities.

Step 9: Reflect

Following the meeting reflect on your skills and performance as a facilitator.

As a skilled facilitator, you will have:

- ensured that the group members know each other and their roles prior to commencing the discussion
- facilitated, rather than directed, the discussion
- encouraged the group to find the answers to their own questions and issues
- encouraged the group to use the good practice checklist and help sheets to assist them to work through issues
- ensured that the group has developed an achievable plan for continuing to broaden their knowledge on their selected topic or issue. This does not have to be formal; it can be an agreement to continue the discussion at another meeting. Alternatively, you can use the Action plan template included in the educational resources section of the manual.

3.3 Good practice checklist for emotional wellbeing

The following is a good practice checklist for emotional wellbeing which has been informed by the HACC Active Service Model practice review and planning tool. It complements the existing Physical activity and nutrition Well for Life checklist and is designed for self-reflection, to prompt team discussion or for individual supervision discussions.

Good practice checklist for emotional wellbeing

This checklist can be used for self-reflection, to prompt team discussion or for individual supervision discussions.

Rating system

Not met: Those aspects you do not currently do.

Partially met: Those aspects you sometimes do well, but there is scope for improvement.

Fully met: Those aspects you currently and consistently do well.

See also the *Good practice checklist for physical activity and nutrition in Well for Life: Improving physical activity for older people at home* (Department of Human Services, 2005)

Good practice checklist for emotional wellbeing

Element of good practice	Not met	Partially met	Fully met
I/we offer an integrated approach combining the three Well for Life elements of physical activity, nutrition and emotional wellbeing in care plans and activities.			
I/we are aware of and able to recognise, observe, monitor and discuss aspects of emotional wellbeing for older people through training, discussion, observation or surveys.			
I/we use a person-centred approach to consider the five key dimensions of emotional wellbeing for older people: productive contributions, social connections, comfort/basic needs, sensory enrichment, resilience and coping. In practice this means talking supportively with the older person about their emotional wellbeing and together identifying goals and interventions to enhance their emotional wellbeing (in care plans and activities).			
I/we acknowledge, understand and respect the diversity of older people including: gender and sexual identity; physical and cognitive ability; spiritual, religious and cultural background and beliefs; ethnicity; Aboriginality; language; and socio-economic circumstances.			
I/we promote autonomy, independence and use a HACC active service model approach with the older person. (See Help sheet 20)			
I/we actively support an older person's social connections and facilitate interaction with family members and friends. (See Help sheets 21 and 34)			
I/we actively support the older person to access a range of community facilities and events and develop new friendships . (See Help sheet 21)			
I/we acknowledge and respect the older person's past roles and support them to feel productive and accomplished. (See Help sheet 22)			
I/we are aware of the connection of physical activity to emotional wellbeing and use the Well for Life physical activity recommendations to inform care plans and activities. (See Help sheet 23)			
I/we are aware of the connection of nutrition and hydration to emotional wellbeing and support the older person to ensure they are well nourished and hydrated. (See Help sheets 24 and 25)			
I/we assess aspects of the physical environment and how they suit the older person. (See Help sheet 26)			
I/we provide opportunities for the older person to engage in sensory activities which they enjoy. (See Help sheet 27)			
I/we acknowledge and support the person's sexuality, sexual and gender identity as essential aspects of emotional wellbeing. (See Help sheets 28)			
I/we observe and support the resilience and coping skills of the older person, including how they look and the quality of communication with others. (See Help sheet 29)			
I/we acknowledge and support the person's spiritual, cultural or religious beliefs. (See Help sheet 30)			
I/we actively support a person through grief or bereavement . (See Help sheet 31)			
I/we use positive and respectful communication and actively address communication barriers. (See Help sheets 32 and 33)			

Section 4: Help sheets

A series of 19 help sheets are included in the existing *Well for Life: Improving nutrition and physical activity for older people at home* resource kit (Department of Human Services, 2005).

The help sheets included in this information resource focus specifically on emotional wellbeing.

All or some of the help sheets can be selected for use depending on the service setting and context.

Help sheet number	Topic
20	Promoting independence and autonomy
21	Social relationships and connections
22	Purposeful activities
23	Physical activity and emotional wellbeing
24	Food and emotional wellbeing
25	Hydration
26	Understanding sensory changes and the impact of the environment
27	Using sensory stimulation
28	Sexual expression
29	Resilience and coping skills
30	Spirituality and wellbeing
31	Loss and grief
32	Communication and emotional wellbeing
33	Strategies to combat ageism
34	Involving family members, carers and friends
35	Benefits and emotional wellbeing of staff

Help sheet 20: Promoting independence and autonomy

Older people typically wish to retain and improve their independence and autonomy. This means keeping or improving physical and cognitive function to fulfil the tasks of independent living, maintaining social connections, and making decisions about their care.

Traditionally, support services have been delivered in a task-oriented way that comes from a 'do to or for' approach rather than a 'support to do' or 'do with' approach. Service delivery has often focused on a person's weaknesses and what they are unable to do, rather than using a strengths-based approach focused on capacity building and restorative care.

Emerging research suggests that service delivery models with a health-promoting, capacity building approach can have positive and long-reaching benefits. This means focusing service delivery on optimising an individual's functional and psychosocial independence.

Strategies for supporting independence and autonomy include to:

- do with and provide support to do, rather than doing to or for
- acknowledge the roles, both past and present, of the older person
- find out about what the person values in their lifestyle and what they would like to change if they could 'turn back the clock' (metaphorically speaking)
- identify client abilities using strengths-based assessment practice
- acknowledge that the complexity of a person's needs will impact on their level of autonomy
- provide opportunities for the person to practice and enjoy their skills
- encourage people to learn new skills, including problem-solving skills
- ask the person what they think the best way to solve a problem may be to support their emotional wellbeing
- provide opportunities for valued roles, such as volunteering or organising, and thank the person for their contribution
- encourage self-management of health by involving the person in care decisions and activities of daily living
- develop a goal-orientated support plan with the person that reflects their goals, desires and preferences
- design and implement service delivery options that support independence, autonomy and a sense of wellbeing for the person.

Examples for use in everyday practice

- Access equipment to enable the person to do their own personal care.
- Introduce aids and appliances, such as hearing aids and walking frames.
- Ask about the fear of falling (can limit independence) and how to reduce it.
- Consider devices that facilitate calling for help, such as a telephone alarm button or personal alarm, which may restore self-confidence.
- Provide shopping assistance so people can cook their preferred food.
- Assist someone to re-learn cooking rather than rely on delivered meals.
- Provide short-term social support or day centre programs to help people reconnect with other members of their local community or community of interest.
- Provide travel training and support rather than transport.
- Use environmental modifications.
- Involve participants in planning and leading activities.
- Share roles (depending on capacity) usually carried out by staff, such as making cups of tea, setting up craft materials, cooking and serving meals, welcoming new people, taking photos, writing newsletters, sending cards to group members who are unwell.
- Provide programs to help people connect with their community of interest (for example, Aboriginal, CALD, GLBTI communities).

Help sheet 21: Social relationships and connections

Having meaningful relationships with family, friends, peers and the wider community is a key factor in achieving and maintaining quality of life. Social isolation can impact on both physical and mental health. It is not simply the amount of contact that influences health. The perceived *quality* of contacts is most important. Meaningful social connections and having people to do things with and talk about things to, helps people cope with worries and motivates them to get up and about.

Older people who have participated in Well for Life physical activity and nutrition activities often report socialising and connecting with other people as reasons for joining in, and benefits of, group activities. Social interaction not only promotes emotional wellbeing, it can also help in the maintenance of cognitive functioning and physical health. Challenges for an older person to maintain or create social relationships and connections include:

- public transport—frailty or vision impairment may restrict use
- financial restraints—limited money to spend on activities
- attitude—reluctance due to frailty or disability, lack of motivation, fear of falling, an entrenched pattern of isolation
- the effort required to communicate if hearing or speech is impaired
- assumptions made by family members or staff, which can be varied and include concerns about time, resources, health issues, frailty, sexual orientation or gender identity, special needs or knowledge of community resources.

Strategies for supporting social relationships and connections include to:

- provide opportunities for enjoyable social activities
- challenge barriers to social inclusion by supporting engagement with the local community, community of interest, individuals, peers, family members and friends
- acknowledge that for some people, the health benefits of a nutrition activity or physical activity, rather than socialising, may be appealing
- offer emotional support to people at appropriate times
- show respect in communication with older people
- provide direct care staff, volunteers and interested clients and carers with training in active listening skills
- identify a person's preferred method of communication and support staff and group members to adapt their communications
- explore a person's interests, strengths and abilities to encourage involvement in meaningful social relationships and connections
- use the expertise of staff in multicultural organisations to develop strategies and support connections for people from culturally and linguistically diverse backgrounds.

Aboriginal Elders often have a range of community and family responsibilities and may be the main carers for their grandchildren and their relatives' children and grandchildren. Always consider the importance of connection to family, community, the land and place to the spiritual and emotional wellbeing of older Aboriginal people. Fifty years and over is considered 'aged' for Aboriginal people and respect for Elders is highly valued.

Examples for use in everyday practice

- Find a specific common interest between two or more individuals and provide information, resources and activities to support that interest.
- Develop or access community activities that include a mix of age groups.
- Use community facilities such as the library, local clubs or attend community events such as a school fete or street fair.
- Assist a person to attend a community group (for example by asking a family member, friend or volunteer to provide support).
- Assist an Aboriginal person to record their storyline.
- Assist gay, lesbian, bisexual, transgender and intersex (GLBTI) older people to access GLBTI media, including radio.
- Ask an individual if they are interested in doing a project about their favourite topic or hobby; assist them to research and prepare their project and present it to a group.
- Assist people to connect with past friends by writing letters or email.

Help sheet 22: Purposeful activities

The way older people think about quality of life and mental or emotional health is not much different from the way younger people think. Most people need to feel like a useful member of society and connected to their community. Being able to contribute to family and community, whatever this means for an individual, can be important to emotional wellbeing.

Acknowledging roles, skills and interests

Find out about the interests, roles and responsibilities the person had when younger, or they still have. These can include both formal paid roles as well as informal or voluntary roles. These roles may have been in Australia or in other countries. For example:

Council member	Chef	Builder
Home management	Nurse or teacher	Farmer
Home maintenance	Writer, journalist	Local business person
Accountant	Parent/grandparent	Aunt/uncle
Volunteer	Sports coach	Public servant
Shop keeper	Entertainer	Driver
Musician	Passing on cultural traditions	Aboriginal Elder

Listen to the person and consider what they most often reflect about. You may hear statements such as:

- 'When I used to do [x]'
- 'I do miss the excitement and responsibility of [x]'
- 'We used to have so much fun when we [x]'
- 'Times have changed and we don't seem to do [x] as much anymore'
- 'At home in [name of country] we used to [x].'

Comments such as these can prompt a conversation where you can find out more and think about activities that could provide the person with a sense of connection to their current or previous roles and responsibilities. With older people from CALD backgrounds you may need to ensure access to interpreters to facilitate the conversation. With GLBTI people you may need to create a safe, non-judgemental and affirming environment for disclosure of sexual and preferred gender identity, recognising that not everyone doing so will be comfortable being 'out'. Activities linked to previous roles can provide a sense of being productive and contributing to society and community and therefore enhance emotional wellbeing.

Introducing new interests can also provide a sense of achievement, productivity and contribution. Think about new activities that build on the person's strengths and interests.

Case example

A group of Aboriginal women who were part of a HACC Aboriginal planned activity group wanted to pass their cultural traditions to the younger generation of women. They worked with grade six Aboriginal girls at the local primary school to share the traditions and rituals of becoming an Aboriginal woman. This was important in terms of their cultural identity and role as women Elders. The planned activity group coordinator facilitated this process with the school and made sure transport and refreshments were available.

Case example

A mixed group of older men and women in an urban area expressed their interest in wanting to contribute to greening the environment. The planned activity group coordinator found out about the Tree Project, whereby volunteers plant seeds and raise tree seedlings for distribution to rural areas. The emotional wellbeing of group participants was enhanced as they felt they were being productive and making a valued contribution to the environment. See <www.treeproject.asn.au/>

Examples for use in everyday practice

- Gardening, picking produce, selling vegetables or raising seedlings.
- Being involved in local greening groups, LandCare, or the Tree Project to put indigenous plants back into the Victorian landscape.
- Developing a chicken coop, vegetable garden or plant nursery.
- Cooking, using produce, peeling vegetables, cutting fruit, finding recipes or participating in baking favourite cakes for visitors.
- Involvement in local groups, committees, clubs and events such as football, bowls, social services, music festivals, theatre, dining out, churches, schools, book groups and libraries.
- Maintenance opportunities, painting, sanding, being around builders or tradespeople, cleaning tools and participating in a 'Men's Shed'.
- Buying a newspaper or magazine, meeting people for coffee and shopping.
- Inter-generational activities, such as with local schools or child care centres.
- On-line learning, University of the Third Age (U3A) classes, internet café, pen pal program, link with local neighbourhood house or TAFE.
- Folding laundry and sorting clothes.
- Creating items such as rugs or children's toys for a charity or special cause.
- Writing letters or cards for Amnesty International, supporting people in detention or prisons.
- Arranging for a mobile library visit to a planned activity group or regular trips to a library or book club.
- Tai chi group.
- Family tree research using the resources of the local library, historical society or expert volunteer.

Help sheet 23: Physical activity and emotional wellbeing

The Well for Life resource kit *Improving nutrition and physical activity for older people at home* contains extensive information and help sheets about physical activity for older people at home.

Physical activity has many positive benefits for physical and mental health. As we age there is a change in our physical ability. This can include loss of bone density, loss of muscle tone and joint problems. The extent of these changes differs from person to person. Medical evidence suggests that much physical decline is not the inevitable result of ageing but of long term sedentary living. Such physical decline can be halted and even reversed by regularly exercising.

The best reason for being physically active is that it helps to maintain an individual's independence and ability to do the same things through life. It can also be fun, and a way of reducing the stresses and strains of everyday life. Whatever physical activities are chosen, and whether they are by an individual or in a group, indoors or outdoors, there is likely to be a psychological benefit and an increased sense of emotional wellbeing.

Regular physical activity can:

- lift mood
- improve confidence and self-esteem
- help deal with negative feelings
- bring a sense of mental wellbeing
- improve sleep, which can in turn improve emotional wellbeing
- reduce tension levels and feelings of stress or fatigue
- increase energy
- in a group, foster supportive relationships and friendships between participants.

Studies by Morris, ME & Schoo, AM (2004) and Bauman A, et al (2002) have shown that people feel better about themselves once they start some sort of physical activity.

- Changes to body shape through weight loss or improved muscle tone may result in a more positive self-image.
- Learning a new skill or achieving a goal, however minor, boosts self-esteem and motivation.
- Physical activity can be an ideal way to enjoy the company of other people as it gives people a common interest and something to talk about.
- Aerobic activity and resistance activity have been shown to help people who experience moderate or more severe depression, and also seems to have potential for reducing anxiety. Physical activity may even reduce the chances of someone developing such problems.

Physical activities may require the services of a trained physical fitness educator who has the skills to communicate effectively and can recognise an individual's ability to achieve to their optimal level, and adapt the pace during the session as required.

For further information refer to the website

<www.health.vic.gov.au/agedcare/maintaining/wellforlife.htm> for:

- *Well for Life: Improving nutrition and physical activity for older people at home* resource kit including the help sheets
- Well for Life evaluation report
- Well for Life stories.

Help sheet 24: Food and emotional wellbeing

The *Well for Life: Improving nutrition and physical activity for older people at home* resource kit contains extensive information and help sheets about nutrition for older people at home.

There are many explanations for the cause and effect relationship between food and mood.

The following are some examples:

- **Avoid the highs and lows** of mood and energy associated with fluctuating blood sugar levels by choosing foods that are digested slowly. These foods have a low glycaemic index (GI) and include wholegrain rye bread, oats and basmati rice. High GI foods, which are best avoided, include white bread and instant white rice. Brain chemicals (neurotransmitters, such as serotonin, dopamine and acetylcholine) influence the way we think, feel and behave. They can be affected by what is eaten. Low levels of vitamins, minerals and essential fatty acids can affect mental health.
- **Vitamin B6, vitamin C, folic acid (folate) and zinc** are all essential good mood nutrients and support the immune system. They are needed to make the feel-good brain chemical serotonin from the tryptophan protein fragment found in foods such as meat, fish, beans and lentils.
- **Turkey and chicken** contain a good source of mood-enhancing tryptophan, an essential amino acid which is converted into serotonin.
- **Contrary to popular belief, tinned tuna** is not a good source of omega-3 essential fatty acids as the canning process reduces the tuna's fat content.
- **Carbohydrate cravings** may be a subconscious attempt to raise serotonin levels. Serotonin is the neurotransmitter, or brain chemical, responsible for mood, sleep and appetite control.
- **Caffeine** increases mental alertness and concentration and can improve performance. However, too much caffeine (a different amount for each person) has been found to be associated with: anxiety, cravings, depression, emotional instability, insomnia, mood swings and nervousness.
- The romantic associations we have with **chocolate** may be due to the effects on the brain of a naturally occurring substance called phenyl ethylamine (PEA). PEA can enhance endorphin levels, increase libido and act as a natural antidepressant.

It is generally accepted that how we feel can influence what we choose to eat or drink (mood to food). What is less well known is how what we eat can affect our mental functioning (food to mood).

Significant improvement to a wide range of mental health problems can result from making changes to what we eat. There have been reports of improvements in the following: mood swings, anxiety, panic attacks, cravings or food 'addictions', depression, seasonal affective disorder (SAD).

Foods to feel well

- The most vital substance for a healthy mind and body is water.
- Five portions, daily, of fresh fruit and vegetables provide the nutrients needed to nourish mind and body (one portion equals about a handful).
- It is best not to skip breakfast, and to keep regular meal times.
- Eat foods that release energy slowly, such as oats and unrefined wholegrains.
- Eat some protein foods, such as meat, fish, beans, eggs, cheese, nuts or seeds, every day.
- Essential fatty acids, particularly the omega-3 type in oil-rich fish, such as mackerel and sardines, linseeds (flax), hemp seeds and their oils, are vital for the healthy functioning of the brain.
- Other seeds and nuts, such as sunflower seeds, pumpkin seeds, brazil nuts and walnuts, also contain important 'good mood' nutrients.

Food from different cultures and favourite foods

The best way to find out about a person's cultural or religious beliefs and practices related to food is to ask them, or friends or relatives. There may be dietary preferences and restrictions, fasting, styles of serving or special foods for celebrations. Ethnic and multicultural organisation staff with specialist expertise may be able to provide advice on culturally appropriate foods. Further information is available in the Well for Life nutrition help sheets.

Favourite foods can lift spirits and remind people of good times. Assumptions about generational favourites based on a person's age can be wrong! Finger food or food presented in bite size portions can be considered special or bring back memories.

Examples for use in everyday practice

- Bring a favourite recipe and share it
- Develop a booklet or calendar with participants' favourite recipes
- Use photos of food to stimulate discussion
- Choose an international cuisine day for each month
- Share food from different cultures, for example from the Mediterranean or South-East Asia
- Collect seasonal fruits and make preserves
- Prepare food for festivals such as Easter, Christmas and religious days
- Ask people to think about the most memorable meal they have ever had
- Try local restaurants with carers, family members and friends
- Introduce new foods by making own wraps (flat breads) and combination juices (fruit and vegetables)
- Host a morning tea and invite special guests or other group members
- Host a BBQ where group participants prepare their favourite salad
- Borrow recipe books from the local library
- Host a bake-off with a panel of chefs or group members to judge the results
- Visit a chocolate factory; use moulds to make home-made chocolates as gifts
- Recognise that comfort food on occasions is an enjoyable experience.

Additional references

- <www.mind.org.uk/foodandmood>
- Continence Victoria for help sheet 'Fluids and the older person' <www.continencevictoria.org.au>
- Centre for Culture, Ethnicity and Health <www.ceh.org.au>
- Nutrition for older people resources at <www.healthinsite.gov.au/topics/Eating_Well_for_Older_People>

Help sheet 25: Hydration

The most vital substance for a healthy mind and body is water.

Older people have been identified as particularly susceptible to dehydration. Sense of thirst seems to decrease in even healthy older people. Decreased mobility, the effect of the aging process, memory loss and medication can all impact on the body's ability to function adequately, causing fluid and electrolyte imbalances. It is important for people to drink before they feel thirsty.

How dehydration affects older people

Some people have a false concept that if they drink more they will need to use the toilet more often. Failing to drink causes the urine to be more concentrated and the bladder becomes irritated, in turn increasing a feeling of urgency. A person with dementia may forget to drink and therefore needs prompting.

Dehydration makes a person tired, cranky, and stiff-jointed. Being dehydrated can bring on headaches, nausea, aches and cramps and other, more serious physical ailments. Dehydration can make it more difficult for people to be patient with each other. Severe dehydration can cause seizures, coma or even death.

Signs of dehydration

	Signs	Action
Mild dehydration	Thirst, dry lips, dry mouth, flushed skin, fatigue, irritability, headache, urine begins to darken in colour, urine output decreases	Increase fluid intake, discuss with supervisor
Moderate dehydration	All of the signs of mild dehydration, plus: skin does not bounce back quickly when pressed, very dry mouth, sunken eyes, output of urine will be limited and colour of urine will be dark yellow, cramps, stiff and/or painful joints, severe irritability, fatigue, severe headache	Call a medical professional
Severe dehydration	All of the signs of mild and moderate dehydration, plus: blue lips, blotchy skin, confusion, lethargy, cold hands and feet, rapid breathing, rapid and weak pulse, low blood pressure, dizziness, fainting, high fever, inability to urinate or cry tears, disinterest in drinking fluid	Call emergency services

Strategies for increasing hydration

- Offer drinks with meals and after exercise.
- Offer a variety of drinks such as juice and water.
- Install a fresh water fountain away from eating tables yet close to activities, with easy access for people in wheelchairs and with walking frames.
- Encourage staff to increase their intake of water, modelling and reminding participants to do likewise.
- Use visual cues to encourage participants to help themselves, for example, leave small jugs of water with slices of lemon on tables.
- Include soups, jellies, custards and ice-cream into meals.
- Give participants information so they can make informed choices.
- Provide reassurance for participants, especially if on an outing, about proximity of toilets and plan for regular toilet stops.
- Invite guest speakers such as a nurse or physiotherapist to discuss pelvic floor exercises and hydration issues.

Help sheet 26: Understanding sensory changes and the impact of the environment

Senses are the primary interface with the environment. Sensory changes occur with ageing. As hearing and vision deteriorate with age it is important to ensure that older people have access to annual tests and updated aids.

Sensory changes can be complicated with the symptoms of dementia. Sensory losses or impairments (aggravated by incorrect or malfunctioning visual and hearing aids) together with cognitive deficits make it difficult for people with dementia to interpret and understand the environment. People with dementia have an increased sensitivity to environmental conditions, stemming from the reduction of the individual's ability to understand the implications of sensory experiences. Gay, lesbian, bisexual, transgender and intersex (GLBTI) older people may lose the capacity to assess when it is safe to disclose their sexual or gender identity.

Temperature

In principle, older adults do not perceive thermal comfort differently from younger adults. Activity and clothing level have an impact on body temperature. On average, older adults have a lower activity level—and thus metabolic rate—than younger persons, which is the main reason they require higher ambient temperature. Further, the ability to regulate body temperature tends to decrease with age.

Smell

Smell interacts closely with taste. A decreased sensitivity to odours may be dangerous—for example, not being able to smell gas, a smouldering cigarette or spoiled food. It can also have social implications. People may be unaware of their own body odour. People may be unaware of the smell of urine should they have incontinence.

Unpleasant smells (urine, strong cleaning products) are known to cause over-stimulation and should be removed as much as possible. Pleasant odours can have positive effects:

- the smell of nice soap or bathwater with fragrance
- cooking smells from an adjacent kitchen improve appetite
- enhanced enjoyment of food and social interaction.

Taste

The number of taste buds decreases beginning at about age 40 to 50 in women and at age 50 to 60 in men. Each remaining taste bud also begins to atrophy (lose mass). The sensitivity to the four taste sensations does not seem to decrease until after age 60, if at all. If taste sensation is lost, usually salty and sweet tastes are lost first, with bitter and sour tastes lasting slightly longer.

Vision

After the age of 50, glare and low levels of light become increasingly problematic. People require more contrast for proper vision and have difficulty perceiving patterns. After the age of 70, fine details become harder to see, and colour and depth perception may be affected.

Older people who experience vision impairment may experience a range of feelings including grief, confusion, anger, fear, loss of control and loss of self-esteem.

Hearing

The sense of hearing begins to be affected by the age of 40 years. High frequency pitches are the first to become less audible, with reduced sensitivity to lower frequency pitches. The ability to understand normal conversation is usually not disturbed at first, but when combined with the presence of background noise understanding may be affected.

Considerations for a positive sensory environment

A positive sensory environment can contribute to a person's sense of emotional wellbeing. Consider these sensory items when choosing venues or environments or planning activities, outings or functions.

Sense	Examples
Temperature	<ul style="list-style-type: none">• Ensure a comfortable temperature by asking people how they feel and making sure they are warm and comfortable.
Smell	<ul style="list-style-type: none">• Minimise offensive odours.• Find out what smells evoke positive memories for people.• Create pleasurable smells, such as through foods or use of fragrances.
Taste	<ul style="list-style-type: none">• Ask people about their favourite tastes and flavours.• Provide additional seasoning for people to add to a meal.
Vision	<ul style="list-style-type: none">• Ensure good lighting.• Avoid surface glare.• Use contrasting colours.
Hearing	<ul style="list-style-type: none">• Eliminate background noise as much as possible as hearing aids magnify background noise.• Remember that for older people the bathroom can cause stress, partly because of sounds and acoustics.• Minimise sounds that may be confusing or irritating, including rushing water, toilet flushing, exhaust fans and outside noises such as traffic or people.• Limit reverberation, for example by using textile floor coverings, provided they are not a falls risk or hinder wheelchair movement.• Limit excessive background noise during meals as it can be distracting to social interaction and communication.

Help sheet 27: Using sensory stimulation

Sensory stimulation is an important aspect of overall emotional wellbeing. It can convey emotional support, affection, and respect. Along with opportunities for sexual expression, it enhances quality of life and wellbeing.

Sensory stimulation plays a major part in activating the potential for communication in people with dementia, as demonstrated through programs such as Sonas aPc.¹ At the same time, it contributes to the reduction of agitation, sleep disturbances and behavioural issues in people with dementia.

General strategies to promote sensory stimulation

Endeavour to create a balanced amount of stimulation—enough to keep the older person from becoming bored but not so much that they become agitated. Too much noise, activity, people and visual stimulation may create overload for some older people and those with dementia. It is important to assess the need for sensory stimulation and observe for over stimulation.

There are many ways of incorporating sensory stimulation and enrichment into group activities and programs to enhance emotional wellbeing. Some considerations include to:

- have a coordinated focus on sensory enrichment and include it as a component in staff training
- be aware and creative in finding sources of sensory enrichment
- offer a range of group activities and outings to cater for individual tastes and interests (games, quizzes, craft groups, gardening, pottery, outings, concerts, exercise programs, cooking, food tasting, singing) to contribute to positive sensory stimulation
- be conscious of the impact of lighting, flowers, décor, and access to gardens and sunshine
- be aware that music has the potential to stimulate in a beneficial way, but also to irritate and pose communication barriers
- reduce competing noise sources and control volume
- facilitate hand and hair treatment and hand, neck, back, shoulder and foot massage.

¹ Sonas aPc – <http://www.sonasapc.ie/approach.html> This program, designed to activate potential for communication in people with dementia, offers gentle stimulation of all the five senses. The DVD has old familiar music, songs and simple instructions for each stage of the program. Activities include gentle exercise, singing, massage, music-making, tasting, smelling and cued speech (completion of proverbs and poems). The visual element is provided by the faces and movement of the diversional therapists and other participants, and bright banners and balloons.

Specific strategies for the five senses

Providing choice and understanding what a person does and does not like should underpin approaches to sensory stimulation.

Sense	Examples
Touch	<ul style="list-style-type: none"> • Manicures, pedicures • Hair care • Hand, head, back, shoulder and foot massage • Different tactile opportunities such as rugs and throws, cushions and clothing • Activities such as gardening or handling food • Animal therapy such as hens on site or visitors with pets • Sunshine in moderate amounts • Clothing, jewellery and makeup • Feeling the sand at the beach.
Sight	<ul style="list-style-type: none"> • Appropriate lighting and views to outside • Bright colours in activity rooms • Restful colours in lounge or dining areas • Food presentation, such as contrasting colours on the plate • Indoor plants and flowers • Non-abstract paintings • Use of magnifying glasses and binoculars.
Taste	<ul style="list-style-type: none"> • Interesting and varied meals • Introduction to new and varied tastes • Finding out people's likes and dislikes and different cultural dishes • Tasting activities (bitter, sour, sweet, salty, spicy) • See Help Sheet 24 on food and emotional wellbeing.
Smell	<ul style="list-style-type: none"> • Flowers—ask people to bring flowers from their garden • Perfumed massage creams and oils • Food smells—coffee, fresh herbs, lemon • Sensory gardens or herb gardens • Have a smelling quiz—but do not include offensive smells • Use aromatherapy oils or incense • Use real Christmas trees or bring in eucalypt branches with aromatic leaves
Hearing	<ul style="list-style-type: none"> • Eliminate background noise as much as possible as hearing aids magnify background noise. • Remember that for older people the bathroom can cause stress, partly because of sounds and acoustics. • Minimise sounds that may be confusing or irritating, including rushing water, toilet flushing, exhaust fans and outside noises such as traffic or people. • Limit reverberation, for example by using textile floor coverings, provided they are not a falls risk or hinder wheelchair movement. • Limit excessive background noise during meals as it can be distracting to social interaction and communication.

Help sheet 28: Sexual expression

Sexual activity and the expression of sexual identity is a basic human right and important for emotional wellbeing. Sexual identity includes concepts of body image, self-esteem, self-perception, sexuality, intimacy and sexual preferences.

Sexual expression can be challenging for a number of reasons. Firstly, it may challenge staff who don't expect older people to be sexual. Consequently, staff may be shocked and uncomfortable when people express themselves sexually. Staff may not have been taught how to respond when sexual expression occurs, or when they find out someone they are caring for is gay, lesbian or bisexual. Secondly, the provision of services in the client's home may mean that staff encountering sexual expression may feel unsure, unprotected or isolated.

Positively acknowledging the way a person expresses their sexuality can enhance emotional wellbeing. For example, a positive response to the disclosure of sexual identity can mean that older gay, lesbian or bisexual people feel understood, valued and safe.

Myths and facts about sexual expression and older people

Myths	Facts
<p>All older people are:</p> <ul style="list-style-type: none">• asexual• physically incapable of sex• uninterested in sex• unattractive• heterosexual• monogamous• do not want to discuss their sexual health• perverted if they think about sex.	<p>All older people may:</p> <ul style="list-style-type: none">• think sex is important• be sexually active—a recent study of sexual health in older adults reported that 53 per cent of people aged 65 to 74 years were sexually active (Stacy Tessler Lindau et al 2007)• have more than one partner• masturbate• have same sex partners• hide evidence at home of being gay, lesbian or bisexual for fear of discrimination and judgement• require opportunities to express their sexuality in an appropriate way• become depressed or lose their will to live if they are unable to express their sexuality.

The following strategies may assist staff to respond to sexual expression and to understand the importance of sexual expression to emotional wellbeing.

Organisational strategies

Give staff permission to talk about what they see, think and feel

Giving staff permission to talk about sexual expression can be a simple and effective way of promoting the emotional wellbeing of older people. It can help staff to understand the importance of sexual expression, reduce their discomfort and enable them to understand how to respond. Staff that are able to talk about sexual expression are more likely to communicate with older people in a positive way. Some strategies to give staff permission to talk about sexual expression include the following:

- Facilitate regular forums for staff to:
 - discuss case studies or experiences in relation to sexual expression
 - raise awareness of the needs of gay, lesbian and bisexual older people and learn about their historical experiences of discrimination
 - understand sexual expression as a person's right.
- Encourage staff to report sexual expression and discuss strategies for responding to sexual expression with case managers or at case meetings.
- Invite staff to discuss what they think about sexual expression in order to:
 - acknowledge values, beliefs and staff discomfort
 - address myths
 - understand the impact of discriminatory responses
 - enable staff to differentiate between their needs and the older person's needs
 - identify inappropriate sexual expression
 - simplify discussion around duty of care
 - enable staff to feel supported.
- Identify staff boundaries and clarify limits of professional responsibility.
- Differentiate between inappropriate sexual expression and staff discomfort with sexual expression.

Ensure staff responses to sexual expression are consistent

- When sexual expression is not discussed staff responses can vary.
- Older people who have cognitive impairment may have difficulty understanding what is required of them if staff responses are not consistent.
- Consistent responses from staff can send a clear message to older people about what is acceptable and what is not.
- Consistency can assist individual team members to feel supported.

Develop a written policy that supports the above and includes, but is not limited to:

- identifying the responsibilities of staff in relation to homophobia and how to protect older people from this form of discrimination
- strategies to support sexual expression and diverse sexual identity
- a description of appropriate and inappropriate sexual activities
- consistent strategies to respond to inappropriate sexual expression
- documentation that protects older peoples' privacy and dignity.

Care planning

- Discuss sexuality with each individual during the assessment process to better understand how they express their sexuality.
- Be aware that an assessment of an older persons needs relating to sexual expression may involve a number of discussions over time.
- Be sympathetic to changes in sexual function or activity that might result from illness, health treatments or partner loss or separation.
- Consider that many diseases like stroke and dementia affect brain function and therefore how an older person expresses their sexuality. This can assist in ensuring that staff responses are effective.
- Identify patterns of sexual expression.
- Acknowledge that families and older people may have different needs and that children may not be comfortable with sexual expression from a parent.
- Document the referral pathway for specialist sexual health assessment.
- Connect older gay, lesbian and bisexual clients to community supports through Gay and Lesbian Health Victoria or Val's Café (for information, advice or education sessions for staff and residents).

Case study 1: clarifying staff–client boundaries

Anna had been visiting John twice a week for the past year. Two months ago John's wife died suddenly. The couple were very close and John talked to Anna about how much he missed his wife. Yesterday when Anna was helping John to shower she noticed that he was aroused. John then asked Anna to have sex with him. Anna was embarrassed and unsure what to do so she changed the subject and pretended that she hadn't heard him. That night Anna told her husband that a client had asked her to have sex. Her husband said that he didn't want her going back to that house. Anna felt confused. She was scared to go back to the house on her own but she didn't want to upset John because he was grieving his wife's death. She rang her manager to ask what she should do. Her manager rang John, acknowledged John's grief, and said a sexual relationship between staff and he was not appropriate. Management advised workers to reinforce the staff-client boundary, and explore counselling or other appropriate support with clients, should the issue arise again. With guidance and support Anna was able to return and care for John.

Case study 2: hiding being gay at home

Paul had a stroke and required assistance from the local council to stay in his own home. The council sent Maria to help him do things he couldn't do any more. Paul decided not to tell Maria that he was gay because he was concerned she would talk about it in their close knit rural town. When Paul was 19 his family found out that he was gay and he was kicked out of home and lost his job. As a consequence Paul hid his sexuality in public. Having the stroke meant that he had people coming into his home that he might not have otherwise have invited. Just before Maria's visits he would 'degay' his house, or remove any information that might indicate that he was gay. Over time Paul developed a special relationship with Maria and her visits became a highlight in his week. However, one day Maria made a comment after hearing Elton John on the radio and said she thought homosexuality was wrong. Paul found himself caught in a dilemma. On the one hand he felt he should be able to be himself in his own home and felt the need to tell Maria her remarks were hurtful. On the other hand he was concerned if he identified himself as gay Maria might not come back.

Help sheet 29: Resilience and coping skills

Across our lifetime, we make changes to adapt to our circumstances and learn how to cope with life changes. Older people are vulnerable to the experience of loss, be it in terms of health, finance, independence or social connection. The maintenance of emotional wellbeing in the face of such losses can be considered a function of resilience.

Resilience and coping in the context of emotional wellbeing

Resilience is the capacity to recover from and adapt to life events. Effective coping skills give people better control over their lives and add to their achievement of emotional wellbeing. The use of appropriate coping mechanisms contributes to resilience and has a protective effect when dealing with ill health or age-related life changes.

People have different ways of coping, which they develop over a lifetime, so older people will have a range of skills in this area. Some will be more resilient than others depending on their background, experience of discrimination and resources.

Coping mechanisms may be internal or external or a combination of both.

Internal factors	External factors
<ul style="list-style-type: none">• Physical health and medications• Thinking patterns and self-talk• beliefs and fears• Stress management techniques• Sense of control and influence over the situation	<ul style="list-style-type: none">• Friends, family and community members to talk to• Practical support• Physical environment and connection to land• Demands from others• Sense of control by others• Cultural differences

In being confronted with a changed situation, an older person may:

- actively try to change an unsatisfactory situation
- change their approach and thinking to adapt to the changed circumstances
- seek help or support
- try to ignore it and hope it will go away.

To help people cope well, there may be ways to support, strengthen or introduce new coping mechanisms.

What can staff do to find out if someone is not coping?

- Get to know the person. Many of the older generation have experienced the hardship of war, abuse, discrimination, racism, economic depression, immigration or removal from family. The resilience that saw them through these crises may be reduced by their current health and living conditions.
- Identify if the person has just suffered an acute illness or experienced the onset of a disability. This can result in a profound sense of discontinuity giving rise to depression. Knowing the person, their background, their culture and community, previous life roles, and strengths and abilities will help you understand when the person is not managing and help to support the person to develop appropriate solutions. This may mean multiple discussions with the person to build rapport.
- Be aware that the coping strategies older people use to sustain their sense of wellbeing may limit their opportunities to enjoy life to the full. For example, comments such as 'exercise makes me tired' or 'I might fall if I walk in the garden' can be addressed.

Help the person to extend their coping repertoire to promote their emotional wellbeing. Resilience should not be used as a reason not to act when action is appropriate.

How to respond to a situation where an older person appears to be not coping

- Discuss the situation and your concerns with the person.
- Acknowledge what has changed and the person's response.
- Ask the person how they have dealt with difficult times in the past.
- Provide emotional support and encouragement.
- Re-assess the person's support needs.
- Consider whether family, friends or other support people can provide emotional support.
- Develop supportive strategies and positive experiences.
- For Aboriginal people and people from CALD backgrounds always liaise with the appropriate Aboriginal or CALD organisation, with the client's consent.
- Consider referral to a relevant service, support group or specialist.

Examples for use in everyday practice

<p>Changing the environment</p>	<p>A person was no longer able to attend a football game because of physical limitations and instead chose to watch the game on a large screen television at home or with friends. This allowed him to enjoy and discuss the game with friends.</p> <p>A person was no longer able to maintain their garden beds and lawn areas so replaced them with lower maintenance, well-mulched garden beds and synthetic turf. They remained a member of the gardening club and learned about low maintenance drought tolerant plants.</p> <p>Members of a planned activity group invited police to give a presentation on how to improve home safety. This was followed by practical assistance from the home maintenance service to upgrade door and window latches.</p>
<p>Changing the approach or thinking</p>	<p>A person was unable to carry heavy shopping bags and so changed their lifelong weekly shopping routine to do smaller more frequent shopping trips.</p> <p>A person who had lost many life-long friends of their age group purposely joined new activities and groups to make new younger friends.</p> <p>A man becoming increasingly dependent on staff to support him in attending appointments was able to explore ways to access community transport and increase his independence.</p> <p>Members of a planned activity group read and discussed a book about emotional wellbeing. Some people completed the activities in the book about changing thinking patterns.</p>
<p>Learning new skills</p>	<p>A person was anxious about their health. They learned muscle relaxation and deep breathing techniques.</p> <p>A person was getting depressed from focusing on negative thoughts and with the help of a counsellor at their local church, adjusted their thinking patterns to be more positive.</p> <p>A group of older women from a CALD background completed a six-week assertiveness program. It gave them the confidence to say no to unreasonable demands by others and to ask questions of their doctors.</p>

Help sheet 30: Spirituality and wellbeing

Introduction

Spirituality or beliefs may be described as experiencing a deep sense of meaning and purpose in life, together with a sense of belonging. It is about acceptance, integration and wholeness. It applies to everyone, including those who do not believe in God or a 'higher being'. For an individual, their spiritual, religious or personal beliefs may be particularly important in times of emotional stress, physical and mental illness, loss and bereavement. People's beliefs and experiences of spiritual or religious matters can change through the course of their lives and may differ from that of their family of origin.

Religions offer community-based worship, each faith having its own set of beliefs and sacred traditions. It is possible to find advice about spiritual practices and traditions through the resources of a wide range of religious organisations. Secular spiritual activities (separate from religion) are increasingly available and popular. For example, many complementary therapies have a spiritual or holistic element that is not defined by any particular religion. The internet, especially internet bookshops, the local yellow pages, health food shops and bookstores are all good places to look. Spiritual practices span a wide range, from the religious to secular including:

- belonging to a faith tradition, participating in associated community-based activities
- ritual and symbolic practices and other forms of worship
- pilgrimage and retreats
- meditation and prayer
- reading scripture
- sacred music (listening to, singing and playing) including songs, hymns, psalms and devotional chants
- acts of compassion (including work, especially teamwork)
- deep reflection (contemplation)
- yoga, Tai Chi and similar disciplined practices
- engaging with and enjoying nature
- contemplative reading (of literature, poetry, philosophy and so forth)
- appreciation of the arts and engaging in creative activities, including artistic pursuits, cookery, and gardening
- maintaining stable family relationships and friendships (especially those involving high levels of trust and intimacy)
- group or team sports, recreational or other activity involving a special quality of fellowship.

Coping through religion and spirituality

Religious involvement and spirituality can yield positive health outcomes. Religion is a common coping mechanism for older people. Effective coping mechanisms can reduce the psychological morbidity associated with chronic and terminal illness.

Mental health patients have identified the following benefits of good quality spiritual care (Royal College of Psychiatrists):

- improved self-control, self-esteem and confidence
- faster and easier recovery, achieved through both promoting the healthy grieving of loss and maximising personal potential
- improved relationships—with self, others and with God, creation and nature
- a new sense of meaning, resulting in reawakening of hope and peace of mind, enabling people to accept and live with problems not yet resolved.

Spirituality is an important predictor of quality of life. An international study in 18 countries to observe how spirituality, religion and personal beliefs relate to quality of life suggested that it should be more routinely addressed in assessment of quality of life, as it can make a substantial difference in a person's quality of life particularly for those who report very poor health or are at the end of their life (WHO 2005).

Maintaining the spiritual, physical and emotional connection to the land is intrinsic to Aboriginal culture and many Aboriginal peoples' beliefs.

Recognising and supporting the religious and spiritual aspects of a person's life

Staff members need to be aware of whether an older person holds particular beliefs. People are usually receptive to carefully worded inquiries about their spiritual and religious beliefs and practises. A helpful way to begin is simply to ask 'what keeps you going in difficult times?' With older people from CALD backgrounds you may need to ensure access to interpreters to facilitate the conversation. A person's answer to such questions usually indicates their main spiritual concerns and pursuits. There are three aspects to look at:

- 1 What helpful inner personal resources can be encouraged?
- 2 What external supports from the community or faith tradition are available?
- 3 How does this impact on the way services are provided or the way the person's beliefs can be respected within service delivery and group activities?

This discussion should take place in a trusting environment by someone whose interpersonal skills enable them to obtain information using a conversational style rather than via a 'fact finding interrogation'. Value the role, knowledge and understanding about cultural beliefs that staff from multicultural or Aboriginal organisations can offer. Be aware that an Aboriginal person may only feel comfortable meeting with a worker of the same sex (Men's and Women's Business).

Spirituality is a deeply personal matter. However, an individual's spiritual and religious practices can be supported in the home, group or residential setting by the use of everyday strategies.

Examples for use in everyday practice

- Ensure there is space on intake forms for information about a person's spiritual and religious needs.
- Recognise the need for, and ensure regular quiet time and place, such as for prayer, reflection or meditation.
- Organise appropriate cultural, religious or spiritual material to be available.
- Support the person to develop and maintain friendships with others sharing similar spiritual or religious aims and aspirations.
- Provide opportunities for the person to discuss their beliefs and religious practises in a non-judgemental environment.
- Support people to attend religious/cultural services or events.
- Organise outings to temples, cathedrals, mosques, synagogues or sacred sites.
- Provide information and community resources such as pamphlets, books, radio and television programs, and DVDs.
- Provide access to chaplaincy or pastoral care services.
- Celebrate religious festivals matching the religion of group members.
- Celebrate the seasons.
- Be mindful of the choice of music.
- Incorporate simple rituals into programs.

Help sheet 31: Loss and grief

Stressful life events and the loss of a partner, family, community member and friends can adversely affect an older person's emotional wellbeing. Organisations have a duty of care to both staff and clients to have systems in place to accommodate and support the grieving process.

People with dementia and their families and carers are likely to experience feelings of grief from diagnosis and throughout the journey of dementia. Grief is a process that helps us adjust and cope with loss. Everyone has a different, individual experience with dementia and grief. However, there are some common feelings that people may share, including denial, anger, resentment, sadness, loss, and acceptance. It is normal to have conflicting emotions, or emotions that make one feel guilty.

There is significant grief and loss in Aboriginal communities in Victoria from Stolen Generation policies and preventable deaths of infants, children and young adults. Rituals, ceremonies and 'sorry business' are intrinsic to Aboriginal culture.

Gay, lesbian, bisexual, transgender and intersex (GLBTI) older people who may have passed as heterosexual or concealed their same sex relationships from family and society may not feel safe to publically grieve for the death of a partner or homosexual/transgendered friend.

Religious involvement and spirituality is a common coping mechanism for older people. Many older people facing stress, loss or bereavement report that their religious beliefs help them to cope.

What can you do to support an older person who is grieving?

- Acknowledge the person's grief.
- Be aware of an older person's beliefs and practices—see the Spirituality and wellbeing Help sheet 30.
- Talk to the person sensitively and respectfully.
- Ensure staff understand grief processes and have skills in this area.
- Respect the privacy of those who publicly or privately grieve their loss.
- Chaplains and pastoral care workers with experience and knowledge about spiritual issues can be a useful resource.
- Be aware the attendance at funerals and the mourning period is a high priority for all Aboriginal community members.
- Assist the person to relax and do activities they feel comfortable doing.
- Support the person in social or cultural rituals such as memorial services as appropriate.
- Consider referral to specialist services such as counsellors.

Case example

Members of a planned activity group talked about how difficult it was to cope with people in the group dying. They had a psychologist conduct a session with group members, staff, volunteers and carers to learn more about grief and loss and talk openly about it. They decided that each time someone died they would have a ritual. The ritual, which they planned, included sitting in a circle around a candle and photo of the person. Sometimes the carer would come and talk about what the group had meant to the person. Everyone had a chance to say something about the person who had died and a local minister gave some readings and prayers. They completed the ritual by enjoying a shared morning tea. People who wanted to talk more were provided with individual counselling or pastoral care.

Case example

Maureen shares her experience of palliative caring at home for her partner of 19 years, Thelma, who was a lesbian feminist and political activist:

“Thelma was recognised as a lesbian by the services that came into the house when she was sick. The district nurse and palliative care service knew we were lesbians and respected it. I told them straight when they came. I said, ‘We are lesbians and we would like to be recognised as a couple and we ask for your respect and I don’t want any male nurses coming here to wash Thelma or whatever you people do’. They agreed. The only time a male came was the doctor from the palliative care service and he also knew we were lesbians. He took me aside and said, ‘Maureen you’ve got to be strong because unfortunately Thelma hasn’t got very long’. He was caring.”

“They all knew we were lesbians. Thelma’s doctor knew, the lawyer knew, the funeral people knew, everybody knew because we told them all. You’ve got to be honest. If I ever go into an old age home I’ll be bloody telling them, love. What you see is what you get. You go up to the matron or the CEO and say, ‘Well look, I am a lesbian. I don’t want any special treatment; I only want to be respected for my lifestyle and my ideas.’”

Adapted from case study, Matrix Guild Victoria Inc. (2008) *My People; a project exploring the experiences of Gay, Lesbian, Bisexual, Transgender and Intersex seniors in aged-care services*, pp.69–70.

Help sheet 32: Communication and emotional wellbeing

Positive communication

Communication plays an essential role in maintaining a person's autonomy and sense of self, and ultimately affects mental and physical wellbeing. Following the loss of former social partners and social roles, many older people have little opportunity to talk about themselves or past events and achievements. Their status in the family may have changed, with them often becoming progressively isolated.

Consider the following statements that are common reflections of the loneliness felt by those who have lost all the people who knew them when they were young:

'I never wanted to be alone'

'They all went away and left me'

'I still miss the fun and the good times we had together'

'They do not love me'

'I really miss my gay community'.

Patronising communication and negative expectations

Patronising or 'ageing talk' highlights perceived incapacity or powerlessness of older people and can reinforce dependent behaviour, as can 'talking down' or using directive parental language. Patronising speech is an adjusted communication style arising from negative expectations of recipients' communicative capacity.

Patronising communication includes:

- over-simplified vocabulary and grammar
- continuous repetition
- over-familiarity
- disapproval
- non-listening
- inappropriately changing the subject
- altered body language
- inappropriately altered speech pace
- inappropriately altered volume or intonation
- assuming heterosexuality.

Old age 'cues' such as grey hair, wrinkled skin, voice changes, a shuffling gait, walking or hearing aids often activate stereotypes that prompt negative expectations of an older person's competence. These can be self-fulfilling. Older people's self-esteem and confidence in their capacity to communicate often diminishes, as does their performance, if they are made to feel less competent or less worthy of being engaged with on adult terms.

Strategies to enhance positive communication

The foundations of positive communication

- Be aware of the influence of old age cues, and assess each person's needs on an individual basis. Assume competence rather than incompetence as a starting point.
- Be aware and sensitive to older people who have speech difficulties. Inability to speak clearly does not indicate lack of cognitive capacity.
- Avoid speaking over or about older people in their presence. Direct comments and questions directly to them, and include them in any conversation about themselves. Avoid making disparaging comments about other older people.
- There are multiple communication techniques, aids and equipment that can enhance communication. Identify each individual's preferred method of communication. Provide support for staff, volunteers and group members in using the preferred method.
- Minimise background noise such as loud television or radio, vacuum cleaners, leaf blowers and dishwashers.
- Check that hearing aids have batteries and are properly fitted and turned on, and that people with dentures or glasses are wearing them. Ensure people access annual checks for hearing and vision.
- Attract the person's attention, either by speaking or touching if appropriate. Greet the person by name, repeat your own name and speak clearly, keeping your face in view. Avoid speaking from behind the person's back.

Speech

- Avoid using jargon.
- Modify your style of speech only when you have taken time to assess competence, and try to match the demonstrated need. For example, slower speech, shorter sentences, and re-phrasing of groups of words may be necessary for people with hearing difficulties.
- Speak clearly and slowly if the person has a hearing impairment. You may need to raise your voice, but avoid shouting. It is more important to speak clearly and slowly, keep sentences short, and use predictable words as far as possible (avoid modern slang unless you know it will be familiar to the older person).

Listening

- Use active and sensitive listening, encouraging the older person to communicate freely and demonstrate communication skills.
- Provide opportunities for older people to talk about their past lives and achievements and express their views. Strategies could include keeping life books, reminiscence therapy and encouraging residents to discuss photos and life experiences. Genuine interest confirms the value of the storyteller.
- Signal to older people that they are welcome to discuss their sexual orientation, gender identity and relationship status, and that heterosexuality is not presumed. Use open and inclusive questions that are gender neutral and demonstrate acceptance, for example, 'Do you have a partner?'
- Respond positively when gay, lesbian, bisexual, transgender and intersex (GLBTI) older people are open about their sexual orientation, gender identity and intersex condition.

- Address transgender older people using their preferred name, title and gender pronoun on forms and in conversation.
- Use active listening, reflect back what a person has said and check that you have understood correctly.

Culturally appropriate communication

- Be aware that a considerable number of seniors from CALD backgrounds may have specific cultural preferences and limited English language. Ethnic and multicultural organisation staff with specialist expertise may be able to provide cultural competency briefings or workshops, advice on cultural backgrounds and perceptions or practical translation advice and guidelines.
- At all times use language that respects the adult or Elder status of older people.
- For people with a preferred language other than English, you may need to ensure access to interpreters to facilitate the conversation. Use resources that are acceptable to the older person: smiles, touch, gestures, pictures, photos, objects or a dictionary, and consult family members where appropriate. Try to learn a few everyday words in the preferred language of each person, such as hello, goodbye, please and thank you, to demonstrate your interest and willingness to communicate.

Case example

A planned activity group coordinator had observed an older person becoming increasingly isolated following a stroke which left him without the ability to speak. He was encouraged to express himself through drawing and painting. Over time, he also learned how to use an assisted communication device. Other group members became interested in what he drew each week and discussed his art works which made him feel engaged with the group.

Case example

A walking activity was started where people walked in pairs with a volunteer and chatted to one another. The volunteers were provided with training in active listening. The walking group became a favourite activity as it meant each person had the full attention of a volunteer who was a good listener.

Examples for use in everyday practice

- Provide staff, volunteers and carers with training in active listening techniques.
- At initial contact or when a person joins a group, find out their preferred method of communication and how they wish to be addressed (preferred name, title/sex pronoun).
- If a person uses an assisted communication device, make sure they carry it with them, and provide information and training to staff and other group members.
- Allow time for listening.
- Reinforce positive examples of good communication practice.
- Acknowledge the emotions people are expressing in their communication and respond to them.
- Provide opportunities for verbal and non-verbal expression, such as visual and expressive arts.

Help sheet 33: Strategies to combat ageism

Ageism

Ageism is about age and prejudice. It can apply to any age, but it most frequently has negative results for vulnerable older people. Stereotyping of older people creates prejudices and misconceptions which frequently result in ageist practice. Ageism impacts on social participation and the involvement of older people in the workplace and in health service delivery.

Ageism in health service delivery and its negative effects on the physical and emotional wellbeing of older people are often unchallenged. People who have negative stereotypes of older people are often unaware of these views. This can impact on care.

Common ageist assumptions	Common incorrect assumptions
<ul style="list-style-type: none">• Older people are all the same• Older people are like children• Physical and mental decline is an inevitable consequence of ageing• Older people do not have the same social needs as other age groups• Older people do not communicate as well as younger people• Older people do not have diverse sexual needs• It is normal for older people to be withdrawn or sedentary	<ul style="list-style-type: none">• A physical disability indicates a cognitive disability• Loss of speech indicates loss of hearing and/or cognition• Older people do not have the same privacy/modesty/confidentiality concerns as others• Inappropriate responses to questions or comments indicate poor cognition or failure to cooperate rather than failure to hear• Conversation with an older person is boring• All older Aboriginal people are Elders• Being kind is the same thing as showing respect• It is acceptable to talk about older people in their presence without including them directly in the conversation.

To combat stereotypes of ageing, **staff training and mentoring** need to reinforce a commitment to *active* and *positive* ageing, and person-centred care, and raise awareness of ageist beliefs, attitudes and practices.

- Do assume physical and cognitive competence to reinforce confidence and self-esteem.
- Do provide care that increases independence to promote personal strengths and abilities.

Strategies to combat ageism in the wider community

Ageist stereotypes can impact adversely on older people's behaviour as well as their self-perceptions. Self-presentation is the monitoring and control of how one is seen by others.

Community strategies to address ageism and promote healthy living can include media campaigns and intergenerational programs.

Organisational level strategies to combat ageism

There are many strategies that organisations can use to combat ageist attitudes and practices.

- Include the topic of ageism in staff orientation, in-services and training.
- Establish a mentor system.
- Invite expert speakers to present models of healthy active ageing from Council on the Ageing (COTA) and the wider community to discuss positive role models.

- Encourage staff to talk about healthy older people they know or have heard of—they are not all exceptions!
- Use role plays to simulate sensory and physical losses of ageing as part of staff training.
- Conduct a ‘challenge your senses’ learning session. Simulate vision and hearing loss and reduced functional ability by wearing distorting glasses to blur vision, stuff cotton balls in ears to reduce hearing and in the nose to dampen smell, wear latex gloves with adhesive bands around the knuckles to impede manual dexterity. Ask participants to read, write, answer the phone, tie shoe laces, pick up coins and so on.
- Establish a resource library to provide staff with access to training videos and DVDs, for example:
 - *The Heart has no Wrinkles* (Health Media, New South Wales Health) about sexuality
 - *Effective communication with people with dementia*, (Alzheimer’s Australia, <www.alzheimers.org.au>).
- Encourage senior staff to model non-ageist practice.
- Monitor language used in care plans.
- Maintain positive expectations in relation to the needs and capabilities of older people.

The built environment and ageism

The built environment refers to the buildings, structures and spaces in which we live, work and play. The built environment impacts on mobility, independence, autonomy and quality of life in old age and can also facilitate or impede a healthy lifestyle. In its submission to the Second World Assembly on Ageing in 2002, the World Health Organization observed that age-friendly built environments can make the:

‘...difference between independence and dependence for all individuals but are of particular importance for those growing older. For example, older people who live in an unsafe environment or areas with multiple physical barriers are less likely to get out and therefore more prone to isolation, depression, reduced fitness and increased mobility problems.’

An age-friendly built environment means having safe footpaths, easy access to transport, toilet facilities, shopping centres, a mix of housing choices, nearby health centres and recreational facilities. These factors can positively affect the ageing experience. Government, industry and community support to change and promote good age-friendly urban design allows seniors to age and remain active, both physically and in their local communities.

Look at ways your organisation can improve the environment for older people: put away unused chairs, provide better storage options, de-clutter the visual environment, and provide outdoor seating.

Case example

A planned activity group went walking in the local area and decided there was a need for a seat to rest along the way. They discussed this amongst themselves and with the support of the staff wrote a joint letter to the Council requesting the seat. The Council responded by installing the seat which has proved to be well used by many older people in the local community as well as the walking group.

Help sheet 34: Involving family members, carers and friends

Involving families, carers and friends in the care of older people can provide multiple benefits. For example, they can help to make the transition into a planned activity group a smooth one for the older person, and may also help themselves adjust to the change.

There are many possible ongoing benefits for the older person from the involvement of family, carers, community and friends, including improved nutrition, promotion of physical activity and improved emotional wellbeing.

Benefits to **older people** include that families, communities, carers and friends:

- provide an understanding about the person that can take many years to develop
- continue important relationships and friendships
- provide visibility and acceptance of cultural, sexual and gender identity
- provide information, interest, variety and increase socialising
- can act as an advocate.

Benefits to **families, carers and friends** of ongoing involvement with the older person include:

- reinforcement and acknowledgment of caring relationships which help people feel valued and needed
- the opportunity for social connection
- spending quality time together
- the ability to share memories, stories, views and opinions
- Aboriginal Elders have a role in teaching the story lines to their communities
- older CALD people reinforce cultural values
- reassurance that the person is receiving appropriate care and support.

Benefits to **staff** of involving family, carers and friends include:

- learning more about the older person's background, interests, aspirations and preferences
- learning of useful strategies for communicating with the person and ways of encouraging them to perform tasks and other activities from families, carers and friends who may have provided care for many months or years gaining information about cultural norms, customs and the person's religion or spirituality
- additional resources and help to organise special activities.

Where a person is very socially isolated, increased efforts to partner with community organisations and volunteer groups to support their emotional wellbeing is important.

Examples for use in everyday practice

- Hold activity planning sessions, inviting staff, clients, carers, family members and volunteers.
- Encourage the families and carers of people from diverse backgrounds to share information on culturally appropriate care.
- Involve carers in activities and special events, for example helping to organise a BBQ or celebrate a religious event.
- Encourage family members to participate or lead activities.
- Provide families, carers and friends the opportunity to make complaints or suggest possible improvements to the program.
- Carry out a satisfaction survey inviting feedback, act on the recommendations and schedule review.

Help sheet 35: Benefits and emotional wellbeing of staff

Most of the suggestions in the help sheets focus on the benefits of promoting exercise, nutrition and emotional wellbeing for older people. These suggestions, however, may be viewed by some staff as 'not another change' or 'yet more work!' Time constraints are often cited as a significant barrier to promoting any change to practice within organisations.

Initially, new programs or practices may be more time consuming. However, in the long term, time can be saved. For example:

- older people who are more mobile, active and happier are generally more interactive, which can promote greater social connection and involvement, and therefore require less staff time
- practice reviews may highlight areas where time could be managed more effectively and outcomes improved for clients.

As well as saving time, promoting nutrition, physical activity and emotional wellbeing can provide benefits to staff. Older people who are mobile and active place fewer physical demands on staff, and happier people generally make the job easier. This may also promote a happier working environment where older people are respected and staff can find more satisfaction in their work.

Job stress and grief

Most workplaces and jobs include some level of stress. This can include psychosocial stressors such as time pressure or physical stressors such as noise. Ongoing exposure to high levels of stress can lead to elevated blood pressure and negative health behaviours, which can lead to long-term health problems. It is important to discuss job-related stress with other team members and management.

Staff members who work with older people are exposed to loss and grief in the workplace.

Managing loss and grief in the aged-care industry (WorkCover, NSW) noted that unresolved grief was a significant stressor for aged care staff. Local HACC training calendars can include training, seminars and professional development for dealing with grief and loss.

It is common for people to have 'down days' and feelings of anxiety, particularly at times of life transitions. However, if these symptoms are out of the ordinary or persist, discuss them with your doctor for advice and assistance.

Strategies for improving staff emotional wellbeing

- Hold regular staff meetings to promote discussion, sharing of information and ideas, reflection on practice and joint decision making on action.
- Place posters with wellbeing messages around the organisation.
- Foster communication between different work groups to understand the range of staff roles, such as role swapping or role-playing.
- Run educational emotional wellbeing programs that use experiential learning approaches.
- Undertake staff satisfaction surveys and encourage feedback and suggestions such as on 'opportunity for improvement' forms.
- Implement procedures for debriefing following a stressful event or death of an older person.
- Recognise the loss of the person who has died, perhaps with a photo of the person, flowers and a candle.
- Mourning rituals or supporting attendance at funerals or memorial services can be a means for staff to show respect for the deceased person, express loss and deal with grief.

- Encourage staff to support a bereaved person by providing opportunities to celebrate the deceased person's life and what they meant to the individual.
- Sometimes stress and grief are compounded by a series of events in a time period, which may be related to both work and personal life. Staff affected may need special consideration.
- Consult professionals and other trained bereavement workers and utilise professional employee counselling services.
- Provide opportunities for staff to attend professional support networks.

Case example

HACC Aboriginal staff had been responsible for organising the funerals for several community members, who they were related to, in a short period of time. They had little time to grieve themselves. A healing circle was held for them.

Case example

A change of management at a community centre at the same time as the death of some long-term clients resulted in staff feeling stressed. A professional development seminar about grief and loss was organised. Following the training, staff held a pampering session which included yoga and massage.

Resources for staff

Discipline or area	Agency and brief description	Contact details
Psychologists	Australian Psychological Association Information on initiatives, academic resources and professional development for psychologists.	www.psychology.org.au
Psychiatrists	<i>Royal Australian and New Zealand College of Psychiatrists (RANZCP)</i> Information about psychiatry in Australia and New Zealand as well as links to more information about mental health.	www.ranzcp.org
Social workers	Australian Association of Social Workers Information on initiatives, resources and professional development opportunities for social workers.	www.aasw.asn.au
Crisis care	SANE Australia If you urgently need help contact the psychiatric team at your nearest hospital.	www.sane.org
Grief services	Australian Centre for Grief and Bereavement Extensive listing of grief counseling services in Victoria.	www.grief.org.au
Depression	Beyondblue The National depression initiative providing information and resources.	www.beyondblue.org.au/
General information	Lifeline A crisis line that is available 24 hours a day, seven days a week.	www.lifeline.org.au

Section 5: Well for life emotional wellbeing – education package

5.1 Aims and objectives

The educational resources contained in this section have been developed to assist staff members to facilitate a meeting or workshop to raise awareness of the emotional wellbeing of older people living at home. It adds to the nutrition and physical education modules included in the *Well for Life: Improving nutrition and physical activity for people at home* resource.

The **aim** is to provide staff with information and education so they can understand, encourage and support positive emotional wellbeing among diverse older people, as an integral part of service delivery.

The guiding principles outlined in Section 2 have been used to provide a context for the education package. They reflect active ageing and positive ageing and are based on a range of approaches including person-centred care, the HACC Active Service Model and health promotion. The guiding principles focus on promoting independence and autonomy, personal responsibility, participation in activities of interest, building relationships with people, respecting them and maintaining their privacy and dignity.

At the end of the program, participants should be able to:

- discuss the benefits of emotional wellbeing for older people
- apply knowledge to individual case examples
- propose strategies to increase emotional wellbeing among older people in their workplace and as part of everyday service delivery
- understand the links between the three health promotion aspects of the Well for Life approach: physical activity, nutrition and emotional wellbeing.

Learning objectives

5.2 How to use the education package

The package is designed to be used by staff members without a formal background in education or training, but with knowledge of working with older people. Older people, their carers and families should be supported and involved in planning and implementing the program.

The educational program is intended to be delivered as a seminar, workshop or meeting. It is divided into **two modules** that can be delivered as a single session or delivered as two sessions:

Module 1: Understanding emotional wellbeing

Module 2: Understanding ageism/action planning

The facilitator may choose to select some components of the package and exclude others depending on the learning needs and interests of the participants.

The **session plan** provides the session facilitator with a clear and logical program to follow and aims to limit the amount of additional preparation required to deliver the session.

A **PowerPoint presentation** for each module is supported by facilitator's notes, including additional references.

Handouts and the **help sheets** are used throughout the session to support the learning objectives.

5.3 Participants

The program is designed for anyone with an interest in the emotional wellbeing of diverse older people as an integral part of service delivery. This includes people with little, through to extensive work experience, or with varying levels of formal education. Participants could include:

- managers and team leaders
- activities coordinators and assistants
- social support workers
- allied health or therapy staff
- community care workers
- any staff member who works in a direct care role
- volunteers
- carers, family members and resident's representatives.

At the beginning of the session, ask participants about their background and understanding of the topic, to tailor the session pitch and examples to the participants' level of experience and interest.

5.4 Preparation

Prior to conducting the session, ensure that:

- there is management support to run the session
- session participants are able to take time off from their regular duties
- there is a follow-up process for management to consider and provide feedback about ideas generated by participants.

Equipment requirements:

- an overhead projector/data projector and screen for the PowerPoint presentation (or sufficient photocopies of the slides as handouts)
- a room large enough to hold the group seated in a circle and with provision for small group work
- tea/coffee facilities and morning or afternoon tea
- butchers paper or whiteboards and marker pens (for each small group).

Module one: Understanding emotional wellbeing

Contents

- Session plan
- Facilitator's notes
- Handouts: *Guiding principles for emotional wellbeing* and *Maintaining an individual's emotional wellbeing*
- PowerPoint presentation slides (or used as handouts)
- Case studies and guide to intervention.

Module one session plan

Time: 1.5 hours

Module 1	Content (What will be taught)	Method (How it will be taught)	Resources
Introduction (10 minutes)	Explain seminar aims, learning objectives, why this is an important topic and why the seminar is being offered.	Use of brief explanatory comments	PowerPoint presentation of aims and objectives
Group discussion (20 minutes)	Facilitated group discussion on: <ul style="list-style-type: none"> • definitions of emotional wellbeing • aspects of emotional wellbeing (and what contributes to it.) 	Group activity. Participants break into small groups to discuss their understanding of their own emotional wellbeing and factors that detract from or enhance it. Participants record key points on butcher's paper and then report back to whole group.	
Presentation (20 minutes)	Overview of current trends and key research findings in relation to emotional wellbeing: <ul style="list-style-type: none"> • definitions of mental health from WHO and VicHealth • benefits • principles • diversity • aspects • inhibitors and enhancers. 	Use the prepared overheads and/or handouts: <ul style="list-style-type: none"> • Session overview/refer to handout of principles • Definitions and principles • Definitions focusing on: Quality of life, social connections • Principles focusing on: older people usually want to maintain their independence, continue participating in activities they have always been interested in, and maintain their privacy and dignity • Understanding diversity – cultural, sexual, gender • Aspects of emotional wellbeing. 	PowerPoint presentation of definitions and aspects with/without handouts of slides. Handout of principles
Case study, role play and feedback (30 minutes)	Discuss and role play case studies demonstrating older people at risk of diminished emotional wellbeing.	Discuss case studies in small groups; volunteers to act out role play in large group, group to suggest interventions and facilitator to record on whiteboard.	Case studies. Facilitator to refer to 'guide to interventions' sheet.
Summary (10 minutes)	Summarise session and introduce next session.	Recap aim, aspects of emotional wellbeing and outcomes of session.	PowerPoint presentation of aims, objectives and/or handout as per first session of this module.

Module one: Presentation and notes

Introduction (10 minutes)

Notes for slides 1–4

- Welcome and introductions
- Describe the aims
- Describe the learning objectives
- Describe the structure and style (interactive, practical) of the session
- Comment on the outcome of an action plan (in Module 2).

Module one: Understanding emotional wellbeing focuses on:

- raising awareness of benefits of emotional wellbeing for all age groups, including older people at home
- applying this knowledge to case examples of individuals
- proposing opportunities to increase emotional wellbeing among older people in their own environments.

**Well for Life including
emotional wellbeing
for older people**

Module 1

1

Slide 1

Aims

- To raise awareness of the importance of emotional wellbeing of older people
- To integrate emotional wellbeing with nutrition and physical activity
- To identify opportunities for improving emotional wellbeing in service delivery practice

Well for Life Emotional Wellbeing: Module 1

2

Slide 2

Learning objectives

At the end of the program participants will be able to:

- Identify and discuss the key elements, enablers and barriers to emotional wellbeing of older people
- Be familiar with the help sheets
- Apply knowledge to settings, services and individual cases to facilitate the emotional wellbeing of older people

Well for Life Emotional Wellbeing: Module 1

3

Slide 3

Session structure

- Introduction, aims and objectives
- Discussion
- Presentation: definitions, principles and elements of emotional wellbeing
- Case study and discussion
- Summary and close

Well for Life Emotional Wellbeing: Module 1

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Slide 4

Activity 1: Group discussion (20 mins)

The purpose of this warm-up exercise is to ask participants to start thinking about emotional wellbeing. Do not provide information about emotional wellbeing at this stage. Definitions of and factors that enhance and detract from emotional wellbeing will be discussed in the following section.

Begin by eliciting staff perceptions of emotional wellbeing by asking the participants to break into small groups or pairs to discuss:

- their understanding of their own emotional wellbeing
- factors that contribute to their own emotional wellbeing.

Encourage all participants to consider these questions, to share their views, and to listen to and respond to other people's ideas.

Record the group's answers on the whiteboard or butcher's paper. Summarise the outcomes by emphasising the range and diversity of factors that both detract from and enhance emotional wellbeing for individuals.

Presentation (20 mins)

Notes for slide 5

Present the current trends and key research findings:

- WHO and VicHealth definitions (as per slides), noting that there is no single definition of emotional wellbeing
- Enhancers and inhibitors to achieving emotional wellbeing giving participants the broader context
- Use of other terms such as 'quality of life', 'thriving' and 'social connections' are often used to describe emotional wellbeing. What is becoming increasingly understood is that the concepts of mental health or ideas held about quality of life held by older people do not differ substantially from those of younger people.
- Most differences in behaviour are the result of physical or mental disease or social disadvantage rather than the ageing process itself.

Other misconceptions include that the elderly choose to 'disengage' socially, that depression is natural, that intellectual decline is a normal feature of ageing and that older people are not distressed by the death of contemporaries or their own disabilities. These attitudes are either in response to disability or are simply not valid assumptions. Dementia has also been confused with the ageing process.

As with the other stages of the life-cycle, the older person's values regarding their mental health should be respected and they should be encouraged to make their own decisions regarding their lifestyle rather than having others decide for them. There will be individual and cultural differences, but the principle remains the same. Efforts to maximise their options through improved physical health, supportive social conditions and opportunities for personal growth and expression will promote improved mental health.

Findings on daily living practice among older people suggest the importance to their physical and mental health of good food habits, regular exercise, seeking knowledge about health, religious activity involvement, good relationships with others and well-planned management of income and expenses.

Notes for slide 6

The WHO (1993) Quality of Life Group defined quality of life as:

'An individual's perception of his/her position in life in the context of the culture and value systems in which he/she lives, and in relation to his/her goals, expectations, standards and concerns. It is a broad-ranging concept, incorporating in a complex way, the person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features of the environment'

(World Health Organization Quality of Life Group, 1993).

Lawton defines quality of life in frail older people as:

'The multidimensional evaluation, by both intra-personal and social-normative criteria, of the person-environment system of an individual in the time past, current and anticipated'

(Lawton, 1991).

When someone is 'thriving' we generally mean they are doing well given their circumstances.

The concept of thriving encompasses several perspectives: thriving as an outcome of growth and development; thriving as a psychological state; and thriving as an expression of physical health state (Bergland & Kirkevold, 2001).

Definitions: mental health

- ... is a state of wellbeing in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. **WHO 2001**
- ... is the embodiment of social, emotional and spiritual wellbeing. Mental health provides individuals with the vitality necessary for active living, to achieve goals and to interact with one another in ways that are respectful and just. **ViHealth 2005**

Well for Life Emotional Wellbeing: Module 1

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Slide 5

Definitions of related terms

- Quality of life
- Thriving
- Social connection

Well for Life Emotional Wellbeing: Module 1

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Slide 6

Notes for slide 7

Present and discuss the key principles for emotional wellbeing (using the handout if desired) to elicit the key points:

- Older people usually want to maintain their independence.
- Older people want to continue participating in activities they have always been interested in, and continue to learn new things.
- Older people want to maintain their privacy and dignity.

Guiding principles

- Promoting emotional wellbeing is aligned with the concepts of *active* and *positive ageing*, including person-centred care, the Active Service Model and health promotion. The guiding principles are to:
 - Support **autonomy** and **independence**
 - Encourage and foster **social connections**
 - Focus on **abilities** and **improving capacity**
 - Promote **personal responsibility**
 - Provide **person-centred services** that are **flexible and responsive**
 - Create **relationships**
 - **Respect** an older person's decision making ability
 - Work in **partnership**
 - Respect **privacy and dignity**

Well for Life Emotional Wellbeing: Module 1

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Slide 7

Notes for slide 8

Present and discuss the diversity of older people. Ensure the group considers all of these factors: age; gender and sexual identity; physical and cognitive ability; emotional, spiritual, religious and cultural background and beliefs; ethnicity; Aboriginality; refugee status; language; and socio-economic circumstances.

The *Victorian Charter of Human Rights and Responsibilities* (2008) states that all Victorians should be treated with equality, fairness and respect.

The Charter encourages us to recognise the commonality between people as well as the difference within groups, and respond to this difference.

Notes for slide 9

Present the Well for Life five key elements to emotional wellbeing.

Using the handout ask participants to expand on each element.

- 1 Resilience and coping
- 2 Being productive and making a contribution
- 3 Social connections
- 4 Basic needs and comfort
- 5 Enjoying sensory enrichment

Understanding diversity

- recognise the commonality between people as well as the difference within groups, and **respond to this difference**
- age; gender and sexual identity; physical and cognitive ability; emotional, spiritual, religious and cultural background and beliefs; ethnicity; Aboriginality; refugee status; language; and socio-economic circumstances.

Well for Life Emotional Wellbeing: Module 1

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Slide 8

Five elements

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graph TD; A((Emotional wellbeing)) --- B((Resilience and coping)); A --- C((Being productive and making a contribution)); A --- D((Social connections)); A --- E((Basic needs and comfort)); A --- F((Enjoying sensory enrichment));
```

Well for Life Emotional Wellbeing: Module 1

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Slide 9

Notes for slide 10

Present and discuss the factors that contribute to emotional wellbeing.

- Physical activity: exercise has many benefits for physical and mental health.
- Nutrition, including hydration: it is generally accepted that how we feel can influence what we choose to eat or drink. What is less well known is how what we eat can affect our mental functioning and wellbeing. Ethnic and multicultural organisations' staff with specialist expertise may be able to provide advice on culturally appropriate foods.
- Purposeful activities: being able to contribute to community, whatever 'community' is for an individual, can be important to emotional wellbeing.
- Assessing and modifying sensory changes: changes to the senses occur with age. Modifying the environment, assessing and treating sensory change are important to promote emotional wellbeing.
- Respect, dignity and privacy.
- Social connections: most people need to feel like a useful member of society and connected to their community. Being able to contribute to family and community, whatever this means for an individual, can be important to emotional wellbeing. The expertise of GLBTI staff or staff in Aboriginal and multicultural organisations can be used to support connections for people from diverse backgrounds.
- Spirituality: for an individual, their spiritual, religious or personal beliefs may be particularly important in times of emotional stress, physical and mental illness, loss and bereavement.
- Resilience and coping skills: older people are vulnerable to the experience of loss, be it in terms of health, identity, finances, independence or social connections. The maintenance of emotional wellbeing in the face of such losses can be considered a function of resilience. The use of appropriate coping mechanisms or skills contributes to resilience and has a protective effect.
- Sexuality: sexual and sensual expression enhances wellbeing. It can be viewed as a broad concept that encompasses not only sexual behaviour but also body image, self-esteem, physical intimacy (cuddling, touch), romance, social relationships, same-sex attraction and behaviour.
- Gender identity: it is a person's own sense of identification of male or female. Gender identity is independent of a person's sexual identity. Wearing clothing that expresses preferred gender enhances emotional wellbeing.
- Communication: empathic and respectful communication involves interest in and recognition of the value of the older person.
- Grief and bereavement: stressful life events and losses can adversely affect a person's emotional wellbeing. Older people face the loss of partners, family and friends, as well as familiar environments.

Contributing factors

- Physical activity
- Nutrition (including hydration)
- Purposeful activities
- Sensory changes
- Respect, dignity and privacy
- Social connections
- Spirituality
- Resilience and coping skills
- Sexuality, sexual and gender identity
- Communication
- Grief and bereavement

Well for Life Emotional Wellbeing: Module 1

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Slide 10

Notes for slide 11 – 22

The following slides provide additional information about these.
Refer to the help sheets or use them as handouts or for discussion.

Physical activity

Regular exercise can:

- Lift mood
- Help deal with negative feelings
- Bring a sense of mental wellbeing
- Improve sleep
- Reduce tension levels
- Reduce feelings of stress or fatigue
- Increase energy
- Improve confidence and self esteem

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Slide 11

Nutrition and hydration

- Water vital for healthy mind and body
- Eat at least 5 portions of fresh fruit and vegetables every day
- Eat breakfast and have regular meal times
- Eat foods that release energy slowly, such as oats and unrefined wholegrains
- Eat some protein foods, such as meat, fish, beans, eggs, cheese, nuts or seeds, every day
- Eat oil-rich fish (eg. mackerel and sardines) and linseeds. They contain oils that are vital for a healthy functioning brain
- Eat sunflower seeds, pumpkin seeds, brazil nuts and walnuts which contain important 'good mood' nutrients

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Slide 12

Purposeful activities

- ...the concepts of mental health or ideas held about quality of life held by older people do not differ substantially from those of younger people
- Continue roles and contributions to family, friends, community and society
- Have a meaningful role in daily affairs

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Slide 13

Sensory changes

- Senses are the primary interface with the environment
- Sensory changes occur with ageing
- Ensure regular assessing and prescribing for vision and hearing

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Slide 14

Respect, dignity, privacy

- Dignity is about having a sense of control in your life (autonomy)
- To find out what dignity means for an individual – ask them!
- Privacy and confidentiality are important to maintaining a person's dignity
- We demonstrate respect when people have choices and are enabled to participate in decisions that affect them

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Slide 15

Social connection

- Being connected to 'community', within and external to the family
- Changes to social networks can affect physical and emotional well being
- Social interaction promotes emotional health and can help maintain good cognition
- Social support need not be wholly face-to-face (e.g. telephone, email, Skype, Facebook)
- Even in a caring environment, older people may still be at risk of social isolation

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Slide 16

Spirituality

- Spirituality is an important predictor of quality of life
- Spiritual needs should be assessed as people enter aged care facilities or community care programs
- Research suggests that people are receptive to carefully worded inquiries about their spiritual and religious beliefs

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Slide 17

Resilience and coping

- The ability to cope with life events and stresses associated with changes in circumstances.
- Effective coping skills gives people better control over their lives and adds to their sense of emotional wellbeing.

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Slide 18

Sexuality & sexual identity

- Sexual expression and sensual experiences enhance quality of life and wellbeing
- There are many, diverse ways people express their sexuality
- Sexuality and sexual identity is a normal part of older people's health
- Sexuality can be viewed as a broad concept that encompasses not only sexual behavior but also body image, self esteem, physical intimacy, romance and social relationships

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Slide 19

Gender identity

- Gender identity is a person's own sense of identification of male or female.
- Gender identity is independent of a person's sexual identity.
- Gay, lesbian, bisexual, transgender and intersex people may hide their sexual /gender identity for fear of discrimination
- A positive response to the disclosure of sexual/gender identity can mean an older person feels understood, valued and safe

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Slide 20

Communication

- Demonstrate empathic and respectful communication
- Use language that respects the adult and Elder status of older people
- Assess each person's needs on an individualised basis
- Assume competence rather than incompetence as a starting point
- Listen to and affirm a person's history, ideas and feelings, even where the person may not be able to express these clearly

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Slide 21

Grief and bereavement

- Stressful life events and losses can adversely affect a person's emotional wellbeing
- Older people face the loss of partners, family and friends
- Loss of familiar surroundings, abilities and senses may lead to grief
- Those working aged care are exposed to death of those around them, making them vulnerable to bereavement of varying degrees of severity

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Slide 22

Case studies, role play and feedback (30 mins)

A practical exercise should be included to provide experiential learning opportunities for the session participants.

Case studies have been prepared to be initially discussed in small groups and then 'role played' by two volunteer participants. Ask for two volunteers, one to 'play' the older person and the other to play the staff member. The case studies can be provided as handouts.

This activity provides an opportunity for participants to analyse the issues associated with emotional wellbeing for older people and to suggest interventions. This is a simple exercise and props will not be required.

At the start of the case study discussions and for the role play participants will be provided with a guide to intervention to consider (attached). At the conclusion of the role play, ask the group: 'what are the specific difficulties these older people experience and what strategies may improve their circumstances?' List suggestions from the group on the whiteboard.

Summary (10 mins)

Slide 23

Summarise the main points from Module one and explain what will be covered in Module two. Briefly explain how participants can start thinking about the interventions in their everyday work.

Summary

- Emotional wellbeing varies from person to person
- A range of factors contribute to emotional wellbeing
- Provide a range of opportunities to promote emotional well being
- Identify and minimise risk factors to emotional wellbeing
- Promote attitudes and behaviours to enhance emotional wellbeing

Well for Life Emotional Wellbeing: Module 1

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Slide 23

Other useful resources

Determinants of mental health

www.health.vic.gov.au/healthpromotion/downloads/mhr_determinants.pdf>

Approaches to promotion of mental health

<www.health.vic.gov.au/healthpromotion/downloads/mhr_appb.pdf>

Module one: Handouts

Handout 1: Guiding principles for emotional wellbeing

The guiding principles are based on a range of approaches that uphold *active* and *positive ageing* including person-centred care, the HACCC Active Service Model and health promotion.

- 1 Support **autonomy** and **independence** by 'doing with' rather than 'doing for' and actively involve clients in setting goals and making decisions about their care.
- 2 Encourage and foster social connections within and external to the service.
- 3 Focus on **abilities** and **improving capacity**, rather than disabilities.
- 4 Promote **personal responsibility** for activities of daily living and engagement in activities of personal interest.
- 5 Provide **person-centred services** that are **flexible and responsive** to changes in an older person's health and wellbeing, and based on their goals.
- 6 Create **relationships** with the older person to explore their interests and strengths and to develop their goals.
- 7 **Respect** an older person's decision-making ability and incorporate their wants in decisions about care they receive and types of services provided.
- 8 Work in **partnership** with other local services and agencies, and with the person's carers and family, but recognise that in some cases a person may not want these parties consulted if making decisions about their future.
- 9 Respect **privacy and dignity** in relation to consulting friends, families, neighbours, relatives and service providers when making decisions about a person's future.

Module one

Handout 2: Maintaining an individual's emotional wellbeing

Well for Life identifies five elements crucial to an individual's emotional wellbeing:

1 Resilience and coping: being able to cope with life events and stresses associated with changes in circumstances. Effective coping skills gives people better control over their lives and adds to their achievement of emotional wellbeing.

An awareness of when the person is not managing, and what is important to them, will assist in developing, with the person, practical solutions. Positive communication is required.

2 Being productive and making a contribution: staying active and happy and enjoying what life has to offer. Maintaining self-esteem, and having a meaningful role in daily affairs. We can challenge ageism. Get to know the person, their interests and respect their role in life, past and present. Show respect and incorporate their wishes in their care. Encourage independence and autonomy and participation in purposeful activities.

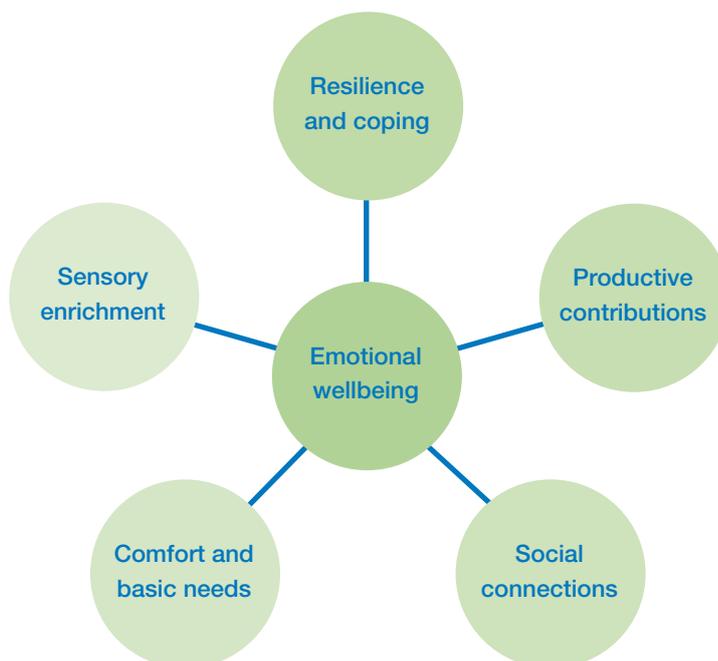
3 Social connections: having meaningful relationships with family, friends, peers, and the wider community, staff/workers. Receiving and giving affection.

We can provide opportunities for individuals to be involved in positive social activities, challenge barriers to social inclusion by supporting networks and engagement between the local community and individuals, and also between peers, families and friends. We can offer emotional support to individuals at appropriate times.

4 Basic needs and comfort: fulfilment of basic physical needs and the absence of health problems. Having a sense of privacy, security and safety and being comfortable in your environment. Resources for this include nutritious enjoyable meals, good healthcare, appropriate lighting, temperature control, nice ambience and having sufficient funds. We can safeguard privacy; provide pain relief; equipment and appliances; and social welfare.

5 Enjoying sensory enrichment: having one's senses stimulated. Having a pleasant amount of activity and arousal to convey emotional support, affection and respect.

Resources for this include group activities catering for individual tastes and interests. Ensuring noise, décor, lighting and access to sunshine are appropriate and do not irritate. Offer hand and hair treatments, spas and massages. Be aware and inventive in finding sources of enrichment for individuals whose emotional wellbeing is at risk.



Module one: Case studies

The following case studies are intended to be used as part of group discussion and role plays. Use the case study role play discussion points to consider how the person's emotional wellbeing could be improved or supported.

Case study 1

John: loss and grief, social connection

John came to the planned activity group for the first time after a referral from the community health occupational therapist. John recently had a fall while going to collect the mail from his mailbox. He tripped on the steps as he was coming back inside the house and broke his leg.

John is 89 years of age and lives alone. He recently lost his wife of 60 years. She had suffered a stroke ten years earlier and he cared for her during that time. John has three sons who all live interstate. He is a retired school principal and was actively involved with the local primary school and volunteered with the local meals on wheels service until his wife had the stroke. During the last ten years he has been housebound and socially isolated.

As a result of the fall, John has been unable to become involved with local activities, as he is unable to leave the house without assistance. He is also mourning the loss of his wife and feeling lonely and isolated. He agreed to 'give the group a go' as he does not want to remain at home but has lost contact with many of his friends due to circumstances of the last ten years.

John is very interested in board games and noticed that these are not available at the group. He spoke to other group members about their interest and they have also expressed the same desire. As he was leaving the group after his first visit staff asked him if he enjoyed the session and he provided information about his interests.

Case study 2

Gladys: spirituality, social connection

Gladys is 92 years of age and lives alone. She has two daughters who are both within close distance and visit her every second night. They are all busy during the day looking after their grandchildren. During the weekends her daughters are usually not available to visit as they have other commitments.

Gladys has been attending the planned activity group for the last four years on a weekly basis. At the group she discussed her other regular outing that she enjoyed, which involved attending a church service every Sunday. Until recently, Gladys was taken to church every Sunday by a neighbour. Her neighbour has now shifted to another suburb and Gladys is not able to attend church.

Planned activity group staff notice that Gladys is withdrawn and concerned. They speak to her about her family, living environment but are unable to identify her concerns.

Case study 3

Harry: cognitive stimulation and social connection

Harry moved in with his son. He has a number of health problems including reduced mobility (walks with a frame) and emphysema. His only other relative, a niece, lives interstate. A woman neighbour, who is a friend of his son, assists with laundry and practical shopping needs. He has a male friend who occasionally takes him out for coffee: 'I enjoy talking to him. He doesn't make me feel old'.

Harry is cognitively alert but hearing impaired. He is shy, modest, undemanding and grateful for every attention paid to him, but deafness and shyness stop him from initiating or sustaining interaction with others. Because he has few teeth he does not articulate clearly. His emphysema adds to his speech difficulties. He doesn't like wearing hearing aids. He dislikes going out to functions or events, afraid of not hearing and perhaps giving offence. He spends most of his time in his room where he falls asleep in the chair and is dissatisfied with himself for sleeping so much.

Harry is very interested in current events and values his right to vote. He is glad he has his sight and can read the newspaper, but feels he has nobody to discuss the news with. People who meet him do not realise he has full cognitive capacity or that he is very lonely. He does not complain to his son. He says he is very good to him, and that he is lucky, but then says sadly 'I did not expect to end my days like this'.

Case study 4

Mira: communication and affirmation

Mira is 70 years of age. She has right hemiplegia with a high degree of physical dependency as a result of two left hemisphere strokes. She has limited mobility and requires assistance with some personal care tasks. She receives a range of in-home supports funded through a disability support package.

Mira was born in Central Europe, and has lived and worked in Australia for 30 years and has an excellent knowledge of English. She has a photograph of herself in nursing uniform with a television celebrity at her side, reminding her that she was an active, useful, valued member of the community. She was also renowned for her cooking skills and prefers stronger flavours. When an old friend visits they eat cheese pastries together.

Despite her language competence the strokes have left her with difficulty in finding words in English. She tends to use her native language unless reminded and encouraged by a conversation partner. Mira's comprehension of English is very good, though this is not generally recognised. Her communication problems are sometimes blamed on poor cognition or poor hearing.

Mira is not linked with any multicultural organisations. She attends some group social activities and spends many hours in solitude or in silence and has gradually become increasingly isolated and depressed.

Case study role play discussion points

Element of emotional wellbeing	Questions	Comments and suggestions
Resilience and coping	How does the person look? (for example happy, sad, tired, hesitant, anxious, withdrawn)	
	Does the person communicate willingly with others?	
	Is the person undertaking physical activity?	
	Has the person suffered a recent grief or bereavement?	
Social connections	Does the person have social connections? (for example family, friends, peers, connections in the wider community, multicultural organisations or a good relationship with staff)	
	Are there adequate opportunities to interact with family members and friends?	
	Are there any communication barriers, which you can identify? (for example language, hearing impairment or speech difficulties)	
	Are there other people with similar interests that could form the basis of a new friendship?	
	Does the person access a range of community facilities and events?	
Productive contributions	What roles has the person held in the past and how can these be respected and reflected?	
	Is there anything in the person's background, life history or case notes which might help to improve their emotional wellbeing?	
	Are there ways of knowing what the person would like to be able to do; what activities does the person like or dislike?	
	Is the person involved in planning and organising activities in some way or sharing roles?	
Comfort and basic needs	Is communication respectful and positive (non-ageist)?	
	Are there aspects to the physical environment that need to be considered to better suit the person?	
	Are the person's nutritional needs and food preferences being met?	
	Is hydration adequate?	
	Are aids correctly prescribed and fitted? (for example teeth, hearing aids or glasses)	
Sensory enrichment	Have sensory environment matters been considered?	
	Are there opportunities to engage in sensory activities that the person enjoys?	
General	Is the person's sexual identity and sexuality acknowledged and supported?	
	Are the person's spiritual or religious beliefs acknowledged and supported?	
Other comments?		

Module two: Understanding ageism and action planning

Contents

- Session plan
- Facilitator's notes
- Handout: *Checklist of true/false statements about older people*
- PowerPoint presentation (or handouts)
- Case studies and action plan template
- Handout: *Evaluation/feedback form*

Module two session plan

Time: 2 hours

Module 2	Content (What will be taught)	Method (How it will be taught)	Resources
Introduction (10 minutes)	Explain seminar aims and learning objectives.	Recap seminar aims and learning objectives and what will be covered in this module	PowerPoint presentation of aims and objectives
Presentation and activity (20 minutes)	Awareness raising about ageism; the impact on emotional wellbeing of ageist attitudes and practices	Awareness raising activity PowerPoint presentation	Post-it notes Presentation on ageism
Discussion (20 minutes)	Positive communication maintaining emotional wellbeing	Large group discussion (whiteboard) about strategies to enhance positive communication and overcoming barriers	Facilitator notes on positive communication
Break (10 minutes)			
Case study and action planning activity (40 minutes)	Review of aspects of emotional wellbeing Discuss practical issues concerned with participants' own service and develop action plan	Small groups consider case studies based on the emotional wellbeing aspects. Handouts of case studies as provided or participants use own case studies. Each participant to record the discussion points on the handout, paper or whiteboard. Development of action plan.	Case studies Action plan template
Report back, summary and conclusion (15 minutes)	Present strategies discussed in small group sessions relating to case studies (real or provided) Facilitator to summarise session	Member of each group to present a summary of their strategies. Facilitator to draw together main themes and record on whiteboard. [Prepare as minutes/ seminar notes for each participant]. Conclude the seminar by revisiting the learning objectives. Learning objectives	Learning objectives
Evaluation/feedback (5 minutes)	Ensure participants have an opportunity to provide feedback	Distribute the evaluation/feedback form to each participant.	Evaluation/feedback form

Module two: Presentation and notes

Introduction (10 minutes)

Notes for slides 24–27

- Welcome and introductions
- Describe the aims
- Describe the learning objectives

By the end of this program participants will be able to:

- recognise the benefits of emotional wellbeing and identify aspects of good emotional wellbeing, as discussed in Module 1
- identify barriers and enablers to emotional wellbeing in older people
- apply this knowledge to individual cases
- identify target areas in own agency for enhanced resident emotional wellbeing
- identify staff with skills to champion intervention strategies
- develop an action plan.

**Well for Life including
emotional wellbeing
for older people**

Module 2

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Slide 24

Aims

- To raise awareness of the importance of emotional wellbeing of older people
- To integrate emotional wellbeing with nutrition and physical activity
- To identify opportunities for improving emotional wellbeing in service delivery practice

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Slide 25

Learning objectives

At the end of the program participants will be able to:

- Identify and discuss the key elements, enablers and barriers to emotional wellbeing of older people
- Be familiar with the concept of ageism
- Apply knowledge to settings, services and individual cases to facilitate the emotional wellbeing of older people

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Slide 26

Session structure

- Introduction, aims and objectives
- Ageism
- Discussion
- Case study
- Action plan
- Summary
- Evaluation

27

Slide 27

Workshop exercise and presentation (20 minutes)

The purpose is for participants to consider and challenge their own understanding and attitudes about older people.

Ask the group to brainstorm a range of statements about older people, including their own beliefs or the values they have heard others express, both positive and negative. Ask participants to write them on post-it notes. Collect the post-it notes, read them out and discuss them, using the facilitator's notes below. Ask the group to rephrase any negative or ageist statement into positive statements.

Checklists that focus on attitudes to ageing include:

- *Fraboni Scale of Ageism*
Fraboni, M., Saltstone, R., & Hughes, S. (1990) The Fraboni scale of ageism (FSA): An attempt at a more precise measure of ageism. *Canadian Journal on Aging*, 9, 56–66.
- *Reactions to Ageing Questionnaire (RAQ)*
Gething, L., Fethney, J., Persson, L., Goff, M., Churchward, M., Matthews, S., Halvarsson, M., & Johannsson, I. (2004). Validation of the Reactions to Ageing Questionnaire. Assessing similarities across several countries. *Journal of Gerontological Nursing*, 30(9), 47–54.

Examples of negative comments

- Older people have different social needs from other age groups.
- Older people aren't interested in talking to younger people.
- Older people do not have sexual needs.
- Older people would rather sit quietly and not have to move about.
- An older person with a physical disability is very likely to have a cognitive disability as well.
- Inappropriate responses to questions or comments indicate poor cognition.
- It is better to discuss older people with their relatives if you think they might not understand.
- Older people don't worry as much about privacy.
- The best way to show respect is by being kind.
- It is easier to do it for them.

Present the following PowerPoint slides about ageist attitudes and perceptions of older people.

Notes for slide 28

- Most people working in aged care, as in the rest of the community, are not consciously or deliberately ageist, but may hold ageist beliefs which they do not recognise as such.
- Sorting out myth from fact is an important part of overcoming ageist stereotypes which can influence practice and have a negative impact on the emotional health and wellbeing of care recipients.
- The facilitator's role is not to suggest that participants are ageist, but begin by asking them what they think ageism is.
- 'Ageism is about age and prejudice' (Bytheway, Ward, Holland, & Peace, 2007). It can apply to any age, but it most frequently has negative results for vulnerable older people.

- Stereotyping of older people creates prejudices and misconceptions, which frequently result in ageist practice such as social and economic discrimination, and the exclusion of older people from participation in service development, research and policymaking. Institutional and personal ageism has an impact on social participation and the involvement of older people in the workplace and in health service delivery. Ageist attitudes and practices are obstacles to healthy ageing, yet ageism is often not recognised or acknowledged as such even by older people themselves (Bytheway et al., 2007; O'Shea, 2005).
- Make comparisons with other types of stereotyping.
- Ask if participants have been the target of stereotyping themselves (for example ethnicity, religion, where they live, the car they drive).
- Equal opportunity legislation forbids discrimination on grounds of race, gender, age and disability. Does this mean there is no discrimination?

Notes for slide 29

- Are these true or false? Ask participants to explain their answers.
- Response to myths 1 and 2: Individuals of all ages have different social needs from other individuals. Older people are not likely to have changed social needs just because they are older. If they enjoyed social interaction in their youth they are likely to enjoy it as they age. Their health and sensory function may affect the kind of interaction they can enjoy. People who are isolated by the loss of family and friends are likely to have even greater need for social interaction.
- Response to myth 3. They have all been young and many remember what it was like for them. Some may not understand the different economic and social conditions which affect young people in the 21st Century, but that doesn't mean that they don't know what it is like to be young.
- Response to myth 4. There is plenty of evidence to disprove this generalisation. Just like any other generation, older people have diverse sexual identities and practices.

What is ageism?

- Holding negative attitudes or beliefs about older people i.e. stereotyping, making judgements based on prejudice
- Acting on these stereotypes to treat older people differently from other age groups

Well for Life Emotional Wellbeing Module 2

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Slide 28

Ageism in practice

- Failure to respect and to show respect for older people
- Under-estimation of the value and capacities of older people, leading to social and financial discrimination
- Stereotyping contributes to risk of misdiagnosis or poor care decisions
- Failure to develop the strengths and preserve function in older people

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Slide 29

Notes for slide 30

- Discuss. Encourage participants to think about these statements. Why are they often repeated?
- Is there evidence that all older people are sick? Is there evidence that many are not? Is there evidence that being old is the same as needing care? Are all older people unhappy?
- What are the social influences which support the belief that old age is 'a miserable decline'?
- Advertisements, birthday cards, comedy routines, media (film, radio, TV), literature (Shakespeare presented old age as a return to childhood).
- What role, if any, does a focus on keeping fit and preserving youth play in stereotyping older people? Considerations: keeping fit may be depicted as the preserve of the young, especially by the fitness industry. Additionally, family and health professionals may take the attitude that 'now that you are old you should take it easy', and can shape self-perceptions.
- Many people are afraid of being unattractive, and being attractive is often equated with being young.
- People are blamed for 'letting themselves go', and may be held personally responsible for poor health.
- Fear of ageing and fear of dying contribute to avoidance of the company of older people.

Notes for slide 31

- Evidence of lack of respect in the media and in language used about old people for example 'Silly old goat', 'stupid old bag'. Not taking the older client's point of view seriously, not listening and talking over the client to family members.
- Results of under-estimation. Ask participants for examples. Suggestions: older people are sometimes obliged to leave the workforce while they still feel able to contribute. For example, insurance policies and banks' lending practices can be discriminatory.
- Misdiagnosis. Health practitioners not listening to the client's concerns, or treating age itself as an illness can lead to misdiagnosis or failure to treat curable conditions. 'It's just old age'. 'What else do you expect at your age?'
- Assumption of incapacity. Support staff not encouraging clients to maintain function, or to be active socially in ways which would build on their strengths and heighten self-esteem.

Myths or facts?

1. Older people do not have the same social needs as 'us'
2. Older people just want to be left alone
3. Older people do not remember what it is like to be young
4. Older people are not interested in sex

Well for Life Emotional Wellbeing Module 2

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Slide 30

Health myths or facts?

1. Older people are all sick
2. People need care because they are old
3. Old age is a state of miserable decline
4. 'It's all downhill after 50'
5. 'I'd rather be a beautiful corpse'

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Slide 31

Notes for slide 32

- Loneliness exacerbated by lack of opportunities for conversation or other social interaction.
- Negative expectations of older person's cognitive and communicative performance can lead to worse performance and loss of confidence—if expected to fail, will fail.
- If spoken to in a childish way, an older person can feel loss of worth as well as sense of powerlessness.

Notes for slide 33

- 'Old people are like children' is a common myth. There is no foundation for believing that old people are like children. Loss of function and independence mean that some older people are in need of care and protection, but even when there is severe cognitive impairment and the older person has no impulse control, the psychological condition of an older person is not like that of a child (Hockey, J and James, A. 1993).
- 'All older people are frail and sick'. A little over two-thirds of people over 90 are in need of care assistance. The average age for entry into residential aged care is 82, and less than one third of people in this age group are in need of care assistance. According to the 2006 Census, 'The rates of need for assistance increased sharply around age 70–74 years, where 10% required some assistance. By age 80–84 years the rate was 29%, and among people aged 90 years and over, around 68% were in need of assistance' (ABS 2008). Discuss this question. Does being kind mean 'doing for' or 'doing with'. Does it involve a partnership or is it one-sided? Does it always recognise the needs and wishes of the older person? Person-centred practice places the older person at the centre and focuses on self-determination and empowerment (Dow, Haralambous, Bremner and Fearn 2006) What might this mean in practice? How can staff support the older person and build on their strengths, rather than be tempted to do 'everything for them'? What practical goals might an older person have and how can you help them achieve them?

Effects on emotional wellbeing

- Increased loneliness and isolation
- Risk of functional decline: physical, cognitive and communicative
- Loss of confidence
- Loss of self-esteem
- Increased sense of powerlessness

Well for Life Emotional Wellbeing Module 2

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Slide 32

Challenging stereotypes

- Common myth that 'old people are like children' has no foundation
- Perception that 'old people are frail and sick' is not backed by statistics: less than one third of people aged 80-84 years need care assistance
- Person-centred care means 'doing with' rather than 'doing for'

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Slide 33

Interactive discussion (20 minutes)

Facilitator to speak briefly about the importance of positive communication and experiences of the older person (see following paragraphs). This will be followed by an interactive group discussion about strategies to enhance positive communication and overcome barriers.

Communication plays an essential role in supporting an older person's autonomy and sense of self, and ultimately affects mental and physical wellbeing. Empathic and respectful communication involves recognition of the other person, and ideally that recognition involves the whole person.

It also indicates, beyond the message of recognition and acceptance, willingness to engage with the history, the ideas and the feelings of a partner, even one who is unable to express these clearly. The demonstration of interest conveys a positive valuation of the person as a worthwhile conversation partner, and confirms that the story is worth telling and worth hearing.

Following the loss of former social partners and social roles, many older people have little opportunity to talk about themselves or past events and achievements. They often become progressively isolated, whether living in the community or in residential care.

Pay particular attention to people who might be lonely, withdrawn or depressed because of:

- loss of spouse, family, friends and previous social groups
- loss of cognitive or communicative function through illness or the ageing process for example dementia; speech impairments caused by Parkinson's disease or stroke; hearing or vision impairment
- loss of home, pets, privacy, and so forth.

Having people to do things with and talk about things with as an equal is important for physical and emotional wellbeing. This helps people cope with any worries, have their social needs met, and motivates them to get up and about.

Older people are all individuals and have uniquely diverse needs. People who have a full social life and are satisfied with their existing circle of friends may have little need of outside intervention. People who have never been very sociable may continue to need less social interaction than those who are more outgoing. Nonetheless, it is important to get to know each older person and find out their interests.

Communication enables older people to engage with others and take part in social interactions, and decisions relating to their care and environment. It reinforces the sense of self-worth of the older person.

Opportunities to communicate provide a means of remembering and talking about past experiences and achievements as well as current interests and activities. Positive communication confirms the adult status of the older person, and can help to build the confidence that supports independence.

Patronising communication includes simplified vocabulary and grammar, repetition, over-familiarity, disapproval, non-listening, and changing the subject.

Discuss strategies to enhance positive communication and overcoming barriers. Begin by initiating a brainstorm for about 10 minutes. The session is intended to run as a large group brainstorm. However, the facilitator may choose to ask participants to break into small groups to discuss and/or role play ways to promote good communication with older people.

Ask the group to list strategies to enhance positive communication and overcome barriers. Generate ideas and list all suggestions for the group to see on whiteboard or butchers paper. It might be helpful to provide categories/headings to structure the brainstorm (see points below).

Strategies for enhancing positive communication:

- Be careful not to judge by appearances. Assume competence not incompetence even if the person has a shaky voice or a hearing aid. This is not evidence that a person cannot communicate well.
- Assume that the person **can** communicate. Encourage the person to communicate freely.
- Be aware that a considerable number of older people from CALD backgrounds have cultural preferences and limited English language competence which can impact on their emotional wellbeing. Ethnic and multicultural organisation staff with specialist expertise may be able to provide cultural competency briefings or workshops, advice on cultural backgrounds and perceptions or practical translation advice and guidelines.
- Encourage participation in decisions about their care.
- Listen attentively, giving feedback (nods, sounds of interest), encouraging the older person to communicate freely.
- Always speak respectfully. The tone of your voice, facial expressions and body language should all communicate this respect. Use the person's preferred name, title and gender pronoun.
- Remember that older people are adults, and speak to them in adult language.
- Avoid talking over or about older people in their presence.
- Modify your style of speech (slower, louder, simpler sentences and instructions) only when you have taken time to assess the older person's competence.
- Be aware that speech difficulties do not indicate loss of cognitive capacity. Health and disability can affect brain function, lung capacity and throat muscles (for example stroke, cerebral palsy, Parkinson's disease).
- Provide opportunities for older people to talk about their past lives and achievements and to express their views.
- Maximise the opportunities provided by one-to-one care tasks to talk and listen to residents.

Overcoming barriers to communication:

- Try to minimise environmental noise (for example TV and radios, vacuum cleaners, dishwashers).
- Check that hearing aids have batteries and are properly fitted and turned on, and that people with dentures or glasses are wearing them.
- Ensure annual checks for hearing and vision.
- Attract the person's attention, either by speaking or touching if appropriate.
- Greet the person by name, repeat your own name and speak clearly, keeping your face in view. Avoid speaking from behind the person's back.
- Speak clearly and slowly if the person is hearing impaired. You may need to raise your voice, but avoid shouting.
- For the speech-impaired, allow time, and always check what you have understood. Do not say yes if you do not understand.
- Check what you think you understand by repeating it as a question.
- Use whatever resources are helpful and acceptable to the older person: smiles, touch, gestures, pictures, photos, objects or a dictionary. Use interpreters and consult family members where appropriate.
- Try to learn a few everyday words in the preferred language of the person, such as hello and goodbye, please and thank you.

Case studies and action planning (40 minutes)

The purpose of the activity is to provide experiential learning opportunities for the session participants. The activity should result in the development of an action plan.

In small groups or pairs consider case studies based on aspects of emotional wellbeing. Participants can use their own case studies if they choose but these should be based on one of the following aspects:

- Physical activity
- Nutrition, including 'mood food'
- Purposeful activities
- Assessing and modifying sensory changes
- Communication
- Sexuality
- Grief and bereavement.

Information from practitioners and recent research highlights links between nutrition, physical activity and emotional wellbeing. For example, in 2005, the American Dietetic Association reported on the pleasurable experience of food and that eating contributes to the person's quality of life and nutritional status. Some services have reported highly popular walking programs and innovations in nutrition such as a trolley of mocktails made of various fruit.

Provide participants with an action plan template (below) to guide them in this task. Participants will be guided to develop action plans and consider:

- practical issues concerned with participants' own service and environment
- addressing enablers and barriers.

Each participant should record the outcomes of their group's discussion on the action plan template.

Invite a member of each small group to present a summary of their action plan.

The facilitator will integrate the main themes and record them on a whiteboard. (These can be used to prepare as minutes/seminar notes.)

Summary and conclusion (15 minutes)

Summarise the main points from Module 2. Explain how participants can start implementing the learnings in their everyday practice.

Ask each person to identify at least one thing they intend to change or implement in their work practice as a result of the session.

Evaluation and feedback (5 minutes)

Invite participants to provide feedback. Distribute the *Evaluation/feedback form* to each participant and thank group members for participating.

Module two: Case studies

Case study 1

Maggie: privacy, dignity, respect

Maggie attended the Darleydale Gardens Planned Activity Group regularly and participated willingly in a range of activities. Suddenly she began to withdraw socially contributing little or nothing to conversation. Staff were concerned about the change in Maggie's behaviour. When questioned, she simply asked to change her days of attendance. Staff were initially unwilling, but gentle one-to-one discussion with Maggie revealed that a new participant in the group was an ex-neighbour who had known Maggie's family situation well. Maggie considered this person a gossip and was afraid that her privacy might not be respected.

Case study 2

Evelyn: communication

Evelyn lives alone and apart from an occasional trip to the shops or to church, the highlights of her life were the twice-weekly visits from her two daughters. She felt a need to extend her activities and joined a local community centre group in the hope of meeting new people and experiencing new things.

Evelyn had been attending the group regularly for over a month and had always been considered a 'grouch' by her fellow attendees. She seemed to scowl, which deterred other members from approaching her to make conversation. Evelyn did not seem to enjoy any activities available, in particular board games and film sessions.

It seemed to everyone that Evelyn was wasting her time attending a group that she was not enjoying. Finally, another group member approached Evelyn and asked her gently why she always wore a scowl and was she not enjoying the group? 'Oh', replied Evelyn, 'I'm sorry; it's just that I don't see too well and I screw up my face to concentrate on things. I didn't know it made me look unhappy. No wonder I haven't been able to get to know people very quickly!' They laughed together and explained her visual impairment. Other group members take the time to explain what is happening around them and staff sourced large print board games. Evelyn enjoys her time at the group and has made many new friends. She also has plenty of interesting things to tell her daughters and grandchildren when they visit.

Case study 3

Bernard: autonomy, independence

Bernard's partner John had died recently. Together they had done everything and gone everywhere. He was 71 years of age and his physical activity was limited by severe arthritis. He had moved in with his daughter and her family, so that they could keep an 'eye on him' but he didn't want his movements monitored and he had not 'come out' with his daughter about being gay. He had been used to his independence all his life and now it seemed that it was being taken away from him. He was uncomfortable at home with his daughter and frustrated by his perceived dependence. A friend, in an attempt to lift Bernard's mood, suggested he join a local community centre group.

Case study 4

Anna: spirituality

Anna attended a planned activity group on a regular basis and enjoyed the activities. She was the only Greek speaking person in the group. Whilst the food was not entirely to her taste, Anna enjoyed the company and did not raise any issues about it. As Anna lived alone, the lunch meal at the group was her main meal of the day on the days that she attended. Her Greek Orthodox faith was very important to her and as Lent approached, Anna became anxious about what she would be able to eat at the group. Staff realised that there was something wrong when Anna did not attend for some weeks.

Case study 5

Andrea: sexuality

Andrea had mild cognitive impairment and had been attending a community centre group for several years. Over the last few months she attended with her husband, until he died unexpectedly. For several weeks, Andrea was withdrawn, but she gradually became more sociable and willing to participate in group activities. She had several friends in the group and seemed to have developed a special friendship with Martin who had been a friend of her husband.

Andrea always insisted on sitting next to Martin. She began to touch him at every opportunity. The other group members were embarrassed and the staff unsure how to respond.

Case study 6

John: grief, bereavement and end of life issues

John was a very organised kind of person. He liked things to be orderly, 'done and dusted' as he put it. It was seven years since his wife had died, and lately he had become preoccupied with his own demise. He thought his wife's funeral had not been well thought out. She had been a published author in her time and he wished that some of her pieces had been read out at the proceedings. She had died suddenly so he had not had any time to arrange things like this.

He wanted to talk over possibilities for his own funeral with his family, but they were reluctant to discuss this rather 'morbid' obsession of their father's. He wanted to discuss these matters at his club, his various groups and with his mates. Nobody would engage in any kind of serious discussion with John. He mentioned this at the planned activity group and said he wanted an opportunity to deal with these matters.

Case study 7

Mr Poulton: communication, autonomy and independence

It was time for a regular review of Mr Poulton's coordinated care plan. His case manager asked him who he would like to attend the meeting and subsequently his two sons and GP were invited. His sons were anxious to discuss what they perceived as signs of their father's depression. Mr Poulton, aged 89 years, had Parkinson's disease, cardiac problems and signs of dementia. His speech was halting and hesitant. 'What do you miss most?' he was asked. 'The loss of speech' he replied, with some emotion. His older son explained that, until he was 85, Mr Poulton had been a regular participant in an elite play-reading group, skilled in performing Shakespeare's characters. Through the discussion it became evident that his preference was for more time to be spent on verbal communication than trying to improve his mobility: 'I don't mind if I can't walk, but I do mind if I can't have a chat'.

Adapted from Department of Health and Ageing (2006). *Guidelines for a Palliative Approach in Residential Aged Care*. Canberra: Commonwealth of Australia. p.154

Case study 8

Bill: grief, bereavement and end of life issues

Bill had cared for his wife at home for three years until her dementia made her increasingly dependent and debilitated. As a result of Bill's decision to have his wife admitted to residential care, he felt guilty that he could not give her sufficient attention. Bill spent many hours of every day assisting with his wife's care and also helping out with the service's leisure activities and would assist any of the other residents whenever he could. When his wife died, the aged care team wondered how Bill would cope, as he had no close family. His wife, and the aged care facility, had become his whole life. 'When he was asked, Bill indicated that he had no need for formal bereavement counselling. 'No, I don't want to talk to anyone, particularly a stranger.' After the funeral, the service manager asked Bill what he was going to do with his time and he answered that he really didn't know.

Module two: Handouts

Action plan template

Identify case study _____

Discuss the five elements crucial to maintaining an individual's emotional wellbeing:

- 1 Resilience and coping
- 2 Productive contributions
- 3 Social connections
- 4 Comfort and basic needs
- 5 Sensory enrichment

Refer to the help sheets as needed.

Prepare a basic plan for improving the older person's emotional wellbeing

Element of emotional wellbeing	Summary description of issue or area of support	Actions to be taken and by whom	Review date
<i>Example:</i> Productive contribution	<i>Example:</i> Identifying individual participant's interests and ways of contributing	<i>Example:</i> 1 Manager to discuss with PAG staff using Help Sheet number 22 as a resource. 2 PAG staff to discuss previous/current roles, interests and experiences with each participant and plan ways in which the person may wish to contribute. 3 PAG staff to document outcomes of plan.	<i>Example:</i> Review each person's plan in three months

Well for Life: Understanding emotional wellbeing and ageism

Evaluation/feedback form

1 Was the program relevant to your work? *(Tick one only)*

- Highly relevant
- Relevant
- Limited relevance
- No relevance

2 How much do you think you learnt about promoting emotional wellbeing for the older person?
(Tick one box only)

- Learnt a great deal
- Learnt some new information
- Not much was new
- Learnt nothing new

3 Have you (or will you) use any of the information from the program in your work? Please describe.

4 How could the program be improved?

5 Would you recommend this in-service program as a useful resource to other services?

- Recommend highly
- Recommend
- Not recommend

6 Do you believe that your service needs to change its practice to promote older people's emotional wellbeing? If yes, in what ways?

7 Please describe any difficulties or barriers to making these changes.

8 Any other comments?

Thank you for your time and participation in the program.

Section 6: Resource and contact list

Ageing well

Source: [The Jean Hailes Foundation for Women's Health](#)

Description: Tips and information on ageing well for women.

Advantages: Information on a wide range of topics on one website including sexuality, nutrition, physical activity, emotional health, menopause and ageing well.

Contact for further information:

www.ageingwell.org.au

Source: [COTA Victoria](#)

Description: Council on the Ageing is an independent consumer organisation run by and for senior Australians

Advantages:

- COTA protects and promotes the well-being of all seniors
- Provides details of innovative activities that demonstrate new ways to defy negative stereotypes and age well
- Information on issues of importance to seniors

Contact for further information:

www.cotavic.org.au

Source: [Department of Health](#)

Description: The Department of Health is a state government organisation committed to achieving the best health and wellbeing for all Victorians.

The role of the Aged Care Branch is to plan, fund and monitor services for older people, people with a disability and the carers of both target groups.

Aged Care in Victoria – Victorian Government Health Information

Provides information relating to aged care programs, policies and services for both professionals and the public.

Contact for further information:

www.health.vic.gov.au/agedcare

Alzheimer's disease and dementia

Source: Alzheimer's Australia

Description: Alzheimer's Australia is the national peak body representing the interests of people with dementia and their families and carers. They manage a range of national programs including support, counselling, training and education for both people with dementia and their carers as well as professionals working in the area of dementia. Website includes numerous information and fact sheets.

Advantages:

- Publications and resources
- Help sheets and update sheets
- Memory Lane cafe information
- Elder rights
- Spirituality
- Grief, bereavement and loss
- CALD information
- Information for carers

Contact for further information:

www.alzheimers.org.au

National Dementia Helpline: 1800 100 500

Carer/staff support

Source: DVD – Away From Her

Description: A man coping with the institutionalisation of his wife, who has Alzheimer's disease, is devastated when she transfers her affections to a fellow patient.

Advantages: This is a film for carers and staff to obtain an insight into the lives of people with dementia and their carers.

Contact for further information: Your local video store

Source: DVD – The Notebook

Description: *The Notebook* is an epic love story centred on an older man who reads a notebook diary about their shared youth to an invalid woman whom he regularly visits.

Advantages: This is a film for carers and staff to obtain an insight into enduring friendship and ways of renewing memories of youth and sustaining sense of self in a frail older person.

Contact for further information: Your local video store

Source: DVD – The Savages

Description: A sister and brother face the realities of familial responsibility as they begin to care for their ailing father, despite the fact that he has been estranged from them for many years.

Advantages: This is a film for carers and staff to obtain an insight into the life of a person with dementia and the challenges for families in accepting unexpected responsibility and for care staff trying to provide supportive residential care.

Contact for further information: Your local video store

Carer/staff support

Source: Stoyles & Flanagan (2002) *In their homes: caring for people as individuals.*

Description: A simple and informative handbook for home care workers that explains the role of the worker and the expected outcomes of their position. It was written to help all paid home care workers and registered nurses who provide personal care, care around the home, nursing care or a combination of activities to people in their own homes.

Advantages:

- A comprehensive work covering many topics relevant to home care workers, including advice on respecting older people as individuals.
- This handbook adds to the more formal training and information on safety and general work requirements provided by employers.

Contact for further information:

Aged and Community Services Australia

Level 1, 36 Albert Road

South Melbourne Vic 3205

Phone: (03) 9868 3460

Fax (03) 9686 3453

Email: agedcare@vicnet.net.au

Website: www.agedcare.org.au

Source: Stoyles & Flanagan (2000) *In their shoes: caring for residents as individuals.*

Description: A guide for all staff and students working in residential aged care. It is designed to help staff understand residents and treat them as individuals who have a lifetime of experience and history behind them.

Advantages:

- A comprehensively referenced handbook covering many topics for people working in an aged care facility, with a primary focus is on respect for the individual person.
- By recognising each resident as an individual and understanding their background staff can improve their standard of care, quality of work and job satisfaction.

Contact for further information:

Aged and Community Services Australia

Level 1, 36 Albert Road

South Melbourne Vic 3205

Phone: (03) 9868 3460

Fax (03) 9686 3453

Email: agedcare@vicnet.net.au

Website: www.agedcare.org.au

Crisis situations

Source: Lifeline

Description: A website and crisis line that is available 24 hours a day, seven days a week

Advantages:

- Lifeline's 13 11 14 service is staffed by trained volunteer telephone counsellors 24-hours a day, any day of the week from anywhere in Australia. These volunteers operate from Lifeline Centres in every State and Territory around Australia.
- The Lifeline Information Service is a nationwide service providing mental health and self-help resources. These resources are accessible by a national number 1300 13 11 14 Monday to Friday from 9 am to 5 pm or online.
- Lifeline has a variety of self-help tool kits available.
- The Lifeline National Service Finder lists details of around 20,000 services and service providers around the country

Contact for further information:

Telephone 13 11 14

infoservice@lifeline.org.au

www.lifeline.org.au

Community supports

Source: Yellow Pages/ Local Community Council Guide

Description: Information regarding a variety of community organisations. Places to obtain information include:

- Local Council
- Senior Citizens
- Probus
- Rotary
- Community Newspapers
- Neighbourhood Houses
- Local Churches

Advantages:

- Suggested community groups – walking groups, gardening groups, craft groups, specialist groups
- Provides a wide range of activities

Contact for further information:

www.yellowpages.com.au

Continence

Continence Victoria help sheet 'Fluids and the older person'

<http://www.continencevictoria.org.au>

Cultural and linguistic diversity

Source: Ethnic Communities' Council of Victoria (ECCV)

Description: Ethnic Communities Council of Victoria Multicultural Aged Care Services Directory 2009.

Order form available from ECCV website <http://www.eccv.org.au>

For languages services and cultural competency advice, guidelines and resources – Centre for Cultural Diversity in Ageing <http://www.culturaldiversity.com.au>

For cultural competency guidelines Centre for Ethnicity and Health website <http://www.ceh.org.au>

Dementia

Source: Australian Government Department of Health and Ageing

Description: This Australian Government website describes services and resources in the area of dementia.

Advantages: Provides information booklets on a broad range of topics related to dementia, such as living with dementia, family and friends, planning for the future, quality of life, and useful contacts and resources.

Contact for further information:

www.health.gov.au

Switchboard: (02) 6289 1555

Freecall: 1800 020 103

After hours: (02) 6122 2747

Postal address:

Central Office

GPO Box 9848

Canberra ACT 2601

Source: Victorian Department of Health

Dementia friendly environments

Contact for further information:

www.health.vic.gov.au/dementia

Depression information and support

Source: Beyondblue

Description: Beyondblue is the national depression initiative. This website also includes information and resources on anxiety, bipolar, perinatal depression and other related syndromes.

Advantages:

- Provides the older person and their carers with information and effective treatment.
- Finds the location and contact details of a doctor or other mental health professional.
- Provides training and support for professionals to enable them to provide a better service to the older person.

Contact for further information:

www.beyondblue.org.au

Info Line Ph: 1300 22 4636

Grief information and support

Source: Australian Centre for Grief and Bereavement

Description: Website with extensive lists of grief counselling services in Victoria

Advantages:

- Counselling service
- Grief and loss resource site
- Regular Newsletter
- Has a toll free bereavement information and referral service

Contact for further information:

Telephone (03) 9265 2111

Email: support@grief.org.au

GLBTI (Gay, Lesbian, Bisexual, Transgender and Intersex)

Ministerial Advisory Committee on GLBTI health and wellbeing, *Well Proud: a guide to gay, lesbian, bisexual, transgender and intersex inclusive practice for health and human services* (2009)

Assists the Department of Health, the Department of Human Services and funded agencies provide quality care to their GLBTI clients. It includes additional recommendations for specific health care settings, including aged care settings. www.health.vic.gov.au/glbtimeac

Gay and Lesbian Health Victoria, *Well Proud: An Audit of inclusive practice for aged care services, 2010* (in development – due June 2010)

Tool adapted from *Well Proud* to assess how inclusive aged care services are of GLBTI clients.

Barrett, C: *My People; a project exploring the experiences of Gay, Lesbian, Bisexual, Transgender and Intersex seniors in aged-care services* (2008)

This report is the result of a study conducted by the Matrix Guild and Vintage Men exploring the experiences of older non-heterosexual people as recipients of services and support for older people. www.matrixguildvic.org.au/MyPeopleReport2008.pdf

Positive Ageing: Older Gay Men and Lesbians. Policy Suggestions for Local Government (2008)

Council on the Ageing (COTA), the Municipal Association of Victoria (MAV) the ALSO Foundation and Gay and Lesbian Health Victoria have jointly produced guidelines to assist councils in engaging with people from the older GLBTI community. www.glhv.org.au/files/glbti_positive_ageing.doc

Gay and Lesbian Health Victoria. The role of the Unit is to 'to enhance and promote the health and well being of GLBTI people in Victoria. They do this through training health care providers and health organisations about GLBTI health needs and appropriate service delivery, developing health resources for GLBTI communities, in conjunction with mainstream services and establishing a research and information clearinghouse as a resource for health care providers, researchers and individuals to use in researching their own health issues. www.glhv.org.au

Birch, H, Dementia, *Lesbians and Gay Men*, Alzheimer's Australia 2009

A research paper commissioned by Alzheimer's Australia to promote an informed discussion about the issues affecting lesbians or gay men with dementia or caring for someone with dementia. www.glhv.org.au/files/DementiaLesbiansGayMen.pdf

GLBTI

Val's Café www.also.org.au/communities/seniors/vals_cafe

A support network for service providers caring and promoting the rights for older GLBTI people facilitated by Gay and Lesbian Health Victoria and the {also} Foundation. Meets four times a year.

Telephone: (03) 92855296

Email c.barrett@latrobe.edu.au

Matrix Guild Victoria www.matrixguildvic.org.au/

Support and advocacy group committed to the support of appropriate care and accommodation choices and for older lesbians. They do this through the provision of information on care and support services, whilst at the same time promoting and liaising with government agencies and service providers to develop more appropriate lesbian friendly services.

Vintage Men www.vintagemen.org/

Social and Support for Gay and Bisexual men and their friends.

The Seahorse Club of Victoria www.seahorsevic.com

Support and social group for the transgender community.

Health Promotion

www.health.vic.gov.au/healthpromotion

Integrated health promotion resource kit

www.health.vic.gov.au/healthpromotion/evidence_res/integrated.htm

Medical services and community health services

Source: [Yellow Pages or your Council Community Guide](#)

Description: Lists the various medical services and community health services to be found in your area.

Advantages: A wide range of medical and community health locations in your area.

Contact for further information:

www.yellowpages.com.au

Mental health helpline and support

Source: [SANE Australia](#)

Description: Crisis care website.

Advantages:

- Guidebooks, factsheets, videos and other resources on mental illness and related topics
- A national freecall telephone and online service offering information and referral
- SANE News quarterly magazine on mental health issues.

Contact for further information:

www.sane.org

If you urgently need help, contact the Psychiatric Team at your nearest hospital.

Call SANE Helpline 1800 18 SANE (7263) or use Helpline Online

Social workers

Source: [Australian Association of Social Workers](#)

Description: Often you can contact an agency directly and ask to speak to a social worker or you can contact your nearest community health centre or local government office and ask for information. The Community Help and Welfare Services pages at the front of the telephone directory also list settings where social workers may be located.

Advantages: Direction for where to find a social worker.

Contact for further information:

www.aasw.asn.au

Psychologists

Source: [Australian Psychological Association](#)

Description: Website contains information on initiatives, academic resources, brochures, tool-kits, articles and so forth.

Advantages:

- 'Find a psychologist'
- About psychologists & psychiatrists
- Psychologist specialist areas including depression, lifestyle effects on health, traumatic events and so on.
- Numerous help sheets

Contact for further information

www.psychology.org.au

Psychiatrists

Source: [Royal Australian and New Zealand College of Psychiatrists \(RANZCP\)](#)

Description: Website containing information regarding psychiatry in Australia and New Zealand as well as links to more information about mental health

Advantages:

- How to contact a psychiatrist
- Information about psychiatry

Contact for further information:

The Royal Australian and New Zealand College of Psychiatrists

309 La Trobe Street

Melbourne Victoria 3000

Australia

Tel: +61 3 9640 0646

Toll free: 1800 337 448 (for Australian residents)

Toll free: 0800 443 827 (for New Zealand residents)

Fax: +61 3 9642 5652

Email: ranzcp@ranzcp.org

Allied health associations and professional organisations

Alzheimers Australia—Victoria

Locked Bag 3001, 98 – 104 Riversdale Road, Hawthorn Vic 3122

Phone: (03) 9815 7800 Fax: (03) 9815 7801

Email: alz@alzvic.asn.au Website www.alzheimers.org.au

Australian Centre for Grief and Bereavement

McCulloch House, Monash Medical Centre

246 Clayton Road, Clayton Vic 3168

Phone: (03) 9265 2100; 1800 642 066 (Freecall Australia wide) Fax: (03) 9265 2150

Email: info@grief.org.au Website: www.grief.org.au

Australian Physiotherapy Association—Vic Branch

6/651 Victoria Street, Abbotsford 3067

Ph: (03) 9429 1799 Fax: (03) 9429 1844

Australasian Podiatry Association—Vic Branch

Suite 26, 456 St Kilda Road, Melbourne 3004

Ph: (03) 9866 5906 Fax: (03) 9866 2094

Carers Victoria

5th floor, 130 Little Collins Street, Melbourne 3000

Ph: (03) 9650 9966 Fax: (03) 9650 8066

Careline: 1800 242 636 Internet: www.carersvic.org.au

Beyondblue

40 Burwood Road, Hawthorn Vic 3122

Postal address: PO Box 6100, Hawthorn West Vic 3122

Phone: (03) 9810 6100 1300 22 4636 (Info Line) Fax: (03) 9810 6111

Email: bb@beyondblue.org.au Website www.beyondblue.org.au

Council on the Ageing (COTA) Victoria

Level 4, Block Arcade, 98 Elizabeth Street, Melbourne VIC 3000

Phone: (03) 9654 4443 Fax: (03) 9654 4456

Email: cotavic@cotavic.org.au Website: www.cotavic.org.au

Dietitians Association of Australia (DAA) National Office:

1/8 Phipps Close, Deakin ACT 2600

Ph/Fax: (02) 6282 9798 / 1300 658 196

Victorian Office:

Ph: (03) 9642 4877

Accredited Practising Dietitian

Hotline: 1800 812 942 Email: vic@daa.asn.au

Allied health associations and professional organisations

Lifeline

PO Box 173, Deakin West ACT 2600

Phone: (02) 6215 9400 (office hours) / 13 11 14 (24 hours a day) Fax: (02) 6215 9401

Email: infoservice@lifeline.org.au Website: www.lifeline.org.au.

OT Australia—Australian Association of Occupational Therapists

OT Australia National

6 Spring Street, Fitzroy, Victoria 3065

Ph: (03) 9416 1021 Fax: (03) 9416 1421

OT Australia—Vic

PO Box 1286, Nth Fitzroy 3068

Ph: (03) 9481 6866 Fax: (03) 9481 6844

Speech Pathology Australia

2nd floor, 11–19 Bank Place, Melbourne 3000

Ph: (03) 9642 4899 Fax: (03) 9642 4922

The Jean Hailes Foundation for Women's Health

173 Carinish Road

PO Box 1108, Clayton South, Victoria 3169

Jean Hailes Medical Centre

Phone: 03 9562 7555 Fax: 03 562 7477

Email: clinic@jeanhailes.org.au Website: www.ageingwell.org.au

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