Department of Health

health

Strengthening diversity planning and practice

A guide for Victorian Home and Community Care services

State Government Victoria

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Foreword

The Victorian Home and Community Care (HACC) program is committed to respecting the diversity of the Victorian population. The program works to remove perceived or actual barriers to access to necessary care and support for those who require it, so that they can remain living independently in their homes and communities.

In accordance with this commitment, the HACC program has implemented a policy of Diversity planning and practice to improve the accessibility and responsiveness of services to individuals and groups who are eligible for HACC services and are marginalised or disadvantaged. This approach aligns with other initiatives, including the implementation of person-centred assessment and an Active Service Model approach. These initiatives all share a common goal of responding to the specific characteristics and circumstances of the person seeking services.

This practice guide was developed to support the implementation of Diversity planning and practice by HACC services. *Strengthening diversity planning and practice — A guide for Victorian Home and Community Care services* was developed with strong input from the HACC sector, including funded organisations, as well as a range of program areas and peak bodies. These contributed to working groups, attended consultations and forums and contributed to multiple drafts.

The consultants and all those involved in developing the practice guide are congratulated for producing such a practical resource. The guide should make a significant contribution to supporting the HACC program to continue to provide accessible and responsive services to Victorians.

Jane Herington

Director, Aged Care

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1. Introduction

1.1 Purpose of this guide

This guide supports organisations to implement diversity planning and practice across the Home and Community Care (HACC) program, by outlining key concepts, and providing information, resources and tools to plan for and improve service responses to diversity within each organisation's catchment. The guide is intended for HACC-funded organisations and staff responsible for diversity planning and practice.

Section 1 describes diversity planning and practice and the policy context, and outlines key requirements for HACC-funded organisations.

Section 2 explores the concept of diversity, and how to apply a diversity lens to a selection of diverse groups.

Section 3 outlines the process of diversity planning, including planning processes and data sources, and setting measureable goals and objectives. It also gives examples of planning tools and templates to help organisations to:

- identify diversity planning process
- document objectives and actions
- measure and report achievements
- review diversity plans.

1.2 Overview

Diversity planning and practice is an element of an overarching quality improvement strategy that the HACC program in Victoria pursues. Other elements include the implementation of person-centred assessment and the Active Service Model approach, and refocusing services to have a wellness promotion and enabling approach for people who use services. These elements share the common goal of responding to the specific characteristics and circumstances of each person who seeks services.

'Diversity' encompasses the range of special-needs groups who are specified in Victoria's current HACC review agreement with the Commonwealth, which specifically names people from culturally and linguistically diverse backgrounds, Aboriginal and Torres Strait Islander peoples, people with dementia, financially disadvantaged people and people in remote or isolated areas. Diversity also addresses the needs of other groups who may experience barriers to accessing services, such as those who experience or are at risk of homelessness; gay, lesbian, bisexual, transgender or intersex (GLBTI) people; and people living with HIV.

Diversity planning and practice requires population planning to specify the characteristics of the HACC target population in a catchment area, mapping the geographic distribution of groups of people who share these characteristics, and then working out what this means for the way agencies deliver their services (that is, their practice).

All HACC-funded organisations undertake a process of diversity planning. The Victorian Department of Health (the department) and HACC-funded organisations identify gaps and set measurable and achievable objectives to improve the accessibility and responsiveness of services to HACC-eligible individuals and groups who are marginalised or disadvantaged.

Diversity planning and practice responds to the HACC Cultural Planning Strategy (CPS) evaluation report (DHS et al. 2007) , which recommends that the strategy, which aimed to increase access to and better meet the needs of HACC-eligible people from culturally and linguistically diverse backgrounds, graduate to a new strategy that focuses on 'diversity' in a broad sense.

Improved accountability measures support the implementation of diversity planning and practice. The department's regional offices review organisations' diversity plans annually, as part of usual service agreement monitoring, and triennially, through the Community Care Common Standards reviews.

1.3 Background

The HACC program works within the context of Commonwealth and Victorian Government anti-discrimination legislation, same-sex relationship law reforms and the *Charter of Human Rights and Responsibilities Act 2006*. Thus, the program has made a commitment to respect the diversity of the Victorian population and to work to remove perceived or actual barriers to access to necessary care and support for those who require it, so that they can remain living independently in their homes and communities.

The Commonwealth *Home and Community Care Act 1985* requires all HACC-funded organisations to ensure their services are accessible to anyone who is within the HACC target population comprising frail older people, younger people with disabilities and their carers. The HACC program recognises that several special-needs groups may experience particular difficulties in gaining access to HACC services, and that planning and resource allocation should address this. The department has implemented a range of initiatives to improve access to HACC services for these groups, including a more responsive service design and information targeted to particular language groups.

A key initiative implemented to fulfil this aim was the HACC Cultural Planning Strategy (CPS) (DHS et al. 2007). The CPS was established in 1997 to support HACC-funded organisations to better meet the needs of HACC-eligible people from CALD backgrounds. The strategy required organisations to develop and submit an annual HACC Cultural Action Plan to their respective department regions. The CPS was evaluated in 2007, with the final evaluation report published in 2009. Diversity planning and practice is the department's response to the recommendations of this evaluation, which proposes that the CPS graduate to focus on diversity in a broad sense.

1.4 Diversity planning and practice policy framework

Diversity planning and practice is a strategic population planning initiative that supports and encourages HACC service delivery that is responsive to and respectful of the specific characteristics of the person seeking services. It complements a range of HACC quality improvement initiatives, including implementation of the Active Service Model, the Assessment Framework and Service Coordination practice, which seek to improve access to well-coordinated, person-centred service responses.

Diversity planning and practice continues to focus on the five special-needs groups specified in the HACC agreement:

- people from Aboriginal and Torres Strait Islander backgrounds
- people from culturally and linguistically diverse (CALD) backgrounds
- people with dementia
- people living in rural and remote areas
- people experiencing financial disadvantage (including people who experience or are at risk of homelessness).

Diversity planning and practice has a particular focus on these groups and the different characteristics within and across them, including, but not limited to, diversity of age, sexual orientation, gender identity and socio-economic status.

Diversity planning and practice is underpinned by principles that seek to achieve:

- equitable access to HACC services by those eligible, regardless of their diversity or disadvantage
- a respectful and responsive approach to planning services that acknowledges the community's, group's and/or individual's uniqueness and complexity of need
- consideration of diversity as core business, and as central to strategic planning and leadership.

Diversity planning encourages us to recognise the commonality between people as well as the difference within groups, and then to respond to this difference. Diversity planning helps ensure that we adopt a diversity lens when planning how to make services accessible and responsive for HACC-eligible people.

Diversity planning and practice requires skilled staff that can reflect on their practice and assumptions, and implement strategies to change their practice accordingly. It requires tools and resources to enable agencies to respond appropriately to the diversity of their catchment's HACC target population.

1.5 Key requirements

HACC-funded organisations are required to develop a diversity plan for the next HACC triennium (1 July 2012 to 30 June 2015), with implementation of the first triennial diversity plans to commence on 1 July 2012.

All HACC-funded organisations are required to:

- demonstrate an understanding of their catchment's HACC target population
- identify groups or individuals who may not be accessing services equitably
- provide opportunities for HACC-eligible people and other key stakeholders to inform this process
- set priorities in line with those identified in regional diversity plans
- develop an action plan that has achievable and measurable outcomes
- implement the plan
- monitor the plan against outcomes
- review the plan and use what is relevant to develop the next plan.

HACC diversity planning replaces the former cultural action planning approach, and complements (and in some cases expands on) other organisational planning processes. Diversity plans may be developed in partnership with other organisations.

Implementing diversity planning and practice requires population planning to specify the characteristics of the HACC target population in a catchment area, mapping the geographic distribution of groups of people who share these characteristics, and then working out what this means for the way organisations deliver their services (that is, their practice). Diversity planning also provides a basis for organisations to discuss with the department their current service provision, changes to the services they provide and the way these are provided. Such planning also informs the setting of regional and statewide priorities.

Improved accountability measures also support the implementation of diversity planning and practice. The department reviews organisations' diversity planning outcomes annually, as part of its usual service agreement monitoring, and triennially, through the Community Care Common Standards review processes. Organisations provide documentation of their diversity planning and outcomes achieved as part of this process.

Successful diversity planning and practice is not intended to respond to diversity based on numbers, but instead ensures that appropriate organisational policies are in place, and a skilled and adequately resourced workforce is available to respond effectively to the needs of any person who requires a HACC service.

1.6 Diversity planning and practice, the Active Service Model and the Assessment Framework

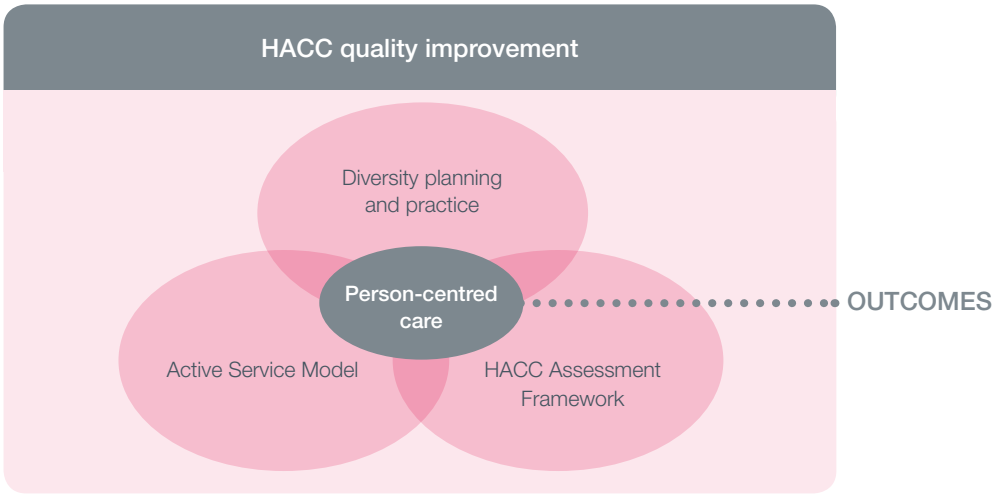
The central and shared aim of implementation of the Active Service Model (ASM), diversity planning and practice and the HACC Assessment Framework is to strengthen the capacity of HACC-funded organisations to deliver services that are responsive and centred on the needs of the person and their family and carers. The ASM focuses on promoting person-centred care, capacity building and restorative care in service delivery. The goal of the ASM is for frail older people, people with disabilities and their carers within the HACC target group to live in the community as independently and autonomously as possible.

Ultimately, HACC services are delivered in a way that promotes independence and wellness, and is respectful of and responsive to clients' specific characteristics. This means that over time, organisations will adopt an ASM approach as core business, and planning will be incorporated into organisations' quality improvement plans, which will also encompass actions relating to diversity planning and practice and implementation of an ASM approach to service delivery.

Respecting individual's characteristics and circumstances is also central to the way that HACC services approach assessment and care planning activities. The HACC Assessment Framework is the new policy for assessment in the HACC program, and represents a policy shift towards employing HACC assessors with a tertiary qualification to facilitate increased equality in the relationship between HACC assessors (mostly based in local governments) and other assessment agencies, such as community health services, district nursing services and Aged Care Assessment Services (ACASs).

HACC Living at Home Assessments are designed to be respectful of and responsive to diversity. HACC Assessment Services are required to demonstrate a level of cultural awareness and competence when interacting with clients, and should facilitate the development of partnerships with specialist agencies and other services to facilitate care planning that is truly responsive to each person and their family and carers.

Figure 1 HACC quality improvement initiatives



1.7 Diversity planning and practice and the Community Care Common Standards

The implementation of diversity planning and practice by each HACC-funded organisation is reviewed every three years as part of a Community Care Common Standards quality review. Information about this process is documented in the *Victorian HACC Quality Review Resource*. The resource complements the *Community Care Common Standards Guide* by linking Victorian HACC requirements to the quality review tools in the guide. In addition, during the annual service agreement review, the department's regional office staff discuss the diversity plan with each organisation.

2. Understanding diversity

2.1 Diversity in HACC

Diversity planning and practice includes a focus on the needs of the five HACC special-needs groups (as identified in the HACC Act 1985 and review agreement):

- people from Aboriginal and Torres Strait Islander backgrounds
- people from CALD backgrounds
- people with dementia
- people living in rural and remote areas
- people experiencing financial disadvantage (including people who experience or are at risk of homelessness).

Diversity planning and practice considers these groups and the characteristics within and across these groups; including, for example, diversity of age, sexual orientation, gender identity and socio-economic status.

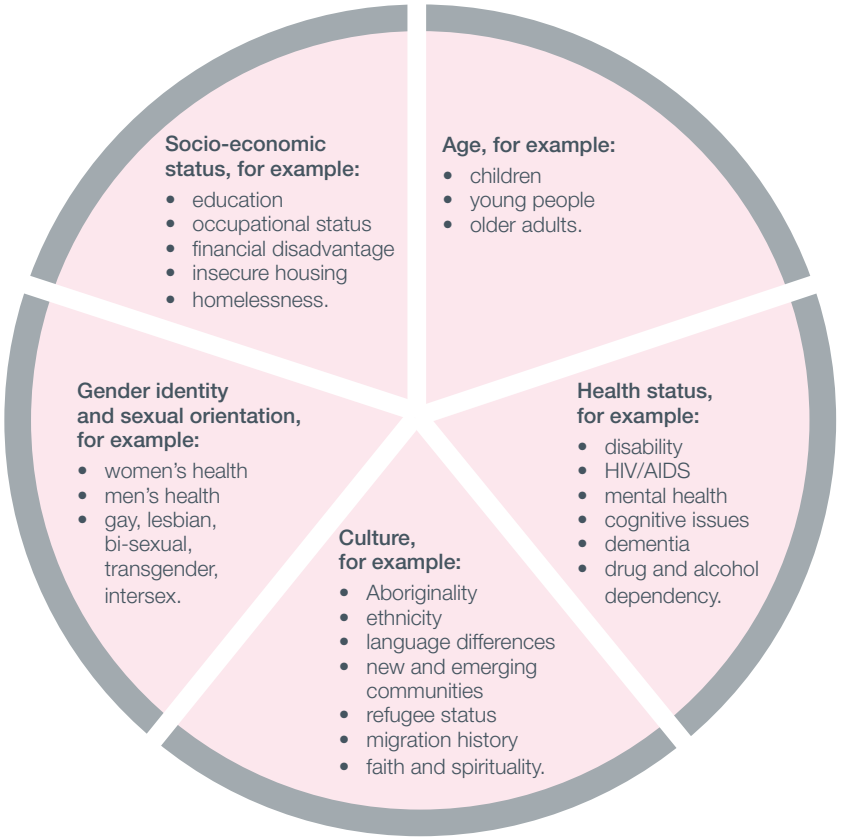
The implementation of diversity planning and practice should improve the capacity of HACC-funded organisations to tailor their services to respond to their local community and provide organisations with the information, tools and actions to recognise and respond to diversity within their respective catchments. Diversity planning and practice should enhance awareness of diversity and assist to identify and understand the diversity of the local community and their needs, establish processes for organisations to work within a partnership approach to respond to diverse needs, develop a workforce that is more diversity responsive and improve accessible and equitable service delivery.

2.1.1 Special-needs groups

Within the HACC target population, some special-needs groups may experience particular difficulties in gaining access to HACC services that are appropriate to their needs. However, the concept of special needs is not a criterion for prioritisation of receipt of HACC services by one individual over another, and organisations are not required to increase their client population or provide extra service hours. Rather, diversity planning and practice is designed to enhance the HACC program's responsiveness to all HACC-eligible people, paying special attention to communities, groups and individuals who experience disadvantage in accessing services due to their diverse circumstances and needs, and thus ensuring that they do not exclude HACC-eligible people from services due to their diverse and complex needs.

> Diversity encompasses the range of special-needs groups, and also addresses the needs of other groups who may experience barriers to accessing services.

Figure 2 Examples of various diversity characteristics



2.2 Applying a diversity lens

Consideration of the diverse social, environmental and economic factors that influence a person's knowledge of and capacity to access a service is central to diversity planning and practice. This involves applying a particular focus or 'diversity lens' when planning to improve equity of access to HACC services by those eligible.

Many diverse characteristics need to be considered when developing an appropriate, person-centred service response; for example, age, sexual orientation, gender identity and socio-economic status.

This section contains information about a selection of diverse groups which your organisation may consider when planning for and responding to your HACC-eligible community. Links to further information and resources about diverse groups can be found in Section 3.4.2 of this guide.

2.2.1 Aboriginal peoples

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.

Introduction

Aboriginal peoples make up approximately 0.6 per cent of the Victorian population, or 38,000 Aboriginal head of population. This number is projected to increase to approximately 47,000 by 2021 (ABS 2009). Most Aboriginal peoples in Victoria live in major cities or inner regional areas (ABS 2007).

The Victorian *Charter of Human Rights and Responsibilities Act 2006* includes special recognition for Aboriginal Victorians:

> Human rights have a special importance for the Aboriginal peoples of Victoria, as descendants of Australia's first people, with their diverse spiritual, social, cultural and economic relationship with their traditional lands and waters (DHS 2010).

Victoria is rich in Aboriginal culture and traditions. Cultural connection is critical to identity, health and wellbeing, and Aboriginal peoples continue to honour and maintain their culture in a variety of ways. Despite this, Aboriginal peoples live within a dominant culture that is very different from their own, and many Aboriginal peoples must balance both cultures in their daily lives.

As First Peoples, Aboriginal peoples have particular cultural needs and rights. While a shared cultural connection is important to Aboriginal peoples, diversity in cultural practices exists, including different languages and religious practices. Aboriginal people also experience differing economic, geographical and social conditions both within and across Aboriginal communities. On 13 February 2008 the then Prime Minister made a national apology to the Stolen Generations. While the strength and pride of Aboriginal peoples is evident, a significant level of disadvantage, hardship, grief and loss still exists in the lives of Aboriginal peoples.

In the context of the above-mentioned circumstances, the Victorian Government is committed to Closing the Gap between Aboriginal and non-Aboriginal peoples with respect to life expectancy, access to early childhood education, educational attainment and employment outcomes (DHS 2008a). This involves working actively towards equal opportunity and improved outcomes for Aboriginal peoples.

The Council of Australian Governments (COAG) has established six targets to improve Indigenous Australians health and wellbeing, under the Closing the Gap initiative:

- life expectancy at birth
- young child mortality
- early childhood education
- reading, writing and numeracy
- Year 12 attainment
- employment.

While these targets are beyond the scope of HACC, the importance of the extended family, shared parenting (including by grandparents) and the broader Aboriginal community means that HACC service responses may have an indirect impact on achieving these aims.

Key issues

Self-determination is a key principle in developing service responses with Aboriginal peoples and communities.

The Australian health and human services system has had a considerable impact on the life and wellbeing of Aboriginal peoples. Many Aboriginal peoples have experienced discrimination and segregation that may negatively affect their perception of non-Aboriginal service providers.

Some Aboriginal peoples may choose to not identify as Aboriginal with generic services until they have developed a trusting relationship with the organisation.

Establishing and maintaining relationships with local Aboriginal Community-Controlled Organisations (ACCOs) is important in the planning and delivery of HACC services to Aboriginal peoples. Aboriginal organisations are fundamentally different to from generic organisations because of their culturally-based value systems, kinship systems and the way they embed cultural practices in their service delivery. ACCOs provide Aboriginal peoples with a voice for their communities as well as delivering a range of programs. However, not all Aboriginal peoples are linked in with their local ACCO.

Strategies to consider

These include:

- participating in key Aboriginal initiatives, such as Closing the Gap and Reconciliation Action Plans
- celebrating and acknowledging Aboriginal peoples and culture by encouraging staff at all levels, including senior management, to attend Aboriginal cultural events, such as those organised by the National Aboriginal Islander Day Observance Committee (NAIDOC) or reconciliation activities, and inviting Traditional Owners to perform welcome to country ceremonies, and acknowledging Traditional Owners at meetings, events and functions
- learning about local Aboriginal culture and history
- providing Aboriginal cross-cultural orientation opportunities and mentoring for staff
- developing culturally relevant information and resources for Aboriginal peoples and placing them in a variety of locations accessed by Aboriginal peoples
- workforce strategies to recruit Aboriginal peoples; for example, actively recruiting an Aboriginal person to the HACC service and providing appropriate orientation and supports
- adjusting service delivery policy and procedures to reflect the integration of Aboriginal values in relation to planning and service delivery; for example, flexible delivery times, support to attend events, inclusion of extended family members
- offering Aboriginal clients a support worker to coordinate services for the person/family.

If your organisation is a HACC Assessment Service, review your assessment and care planning practices. Refer to Section 11.2 of the document *Strengthening assessment and care planning — A guide for HACC assessment services in Victoria*.

Consider how your service delivery approach reflects Aboriginal values, as shown in Figure 3.

Partnerships and relationships

Generic HACC organisations and ACCOs are encouraged to engage and become familiar with one another's services to build trust, undertake planning, and develop and implement appropriate service coordination practices and models of service provision. Consider:

- participating in regular discussions and planning meetings at the local ACCO
- brokering services to Aboriginal peoples to your local ACCO
- if your organisation is a HACC Assessment Service, locating and resourcing an assessment officer to work from the local ACCO for an agreed period of time each week
- holding joint annual information sessions (with a BBQ or luncheon, for example) for the Aboriginal community
- engaging with Aboriginal HACC Access and Support workers in your area (if available) to better understand the needs of clients and improve service coordination practices.

Strengthening HACC in Aboriginal Communities

The Strengthening HACC in Aboriginal Communities strategy seeks to strengthen the capacity of HACC-funded Aboriginal organisations to provide services to Aboriginal peoples and to develop and sustain alliances between Aboriginal and generic organisations funded by the HACC program to improve access to the full range of HACC services for Aboriginal peoples in Victoria.

2.2.2 Aboriginal values to inform planning and service delivery

Principles and values	Examples of how a service reflects and responds to these principles and values
Knowledge and understanding	We believe that understanding the needs, aspirations and priorities of Aboriginal peoples is essential to successful service delivery. We seek advice from Aboriginal organisations and networks, and use demographic data and information from research reports and community consultations to inform our planning. We are aware of the subtle power dynamics between the dominant culture and the Aboriginal culture. We will walk alongside and be led by Aboriginal culture. We understand that the Aboriginal community requires time and trusting relationships to provide input to our service planning.
Partnerships and collaboration with Aboriginal communities and ACCOs	We are committed to improving our service delivery to Aboriginal peoples. Learning and planning with Aboriginal organisations mutually builds the capacity of our service. To do this, we attend community events and meet with the ACCO to listen to their needs and preferences. We seek opportunities to expand our knowledge, understanding and skills. We always seek to promote collaboration with and inclusion of Aboriginal peoples in service planning and development.
Organisational cultural competence	We listen to ACCOs and Aboriginal peoples and accept their traditional and contemporary values, attitudes, aspirations and attitudes. We share stories and use a range of formats to communicate and promote services, in settings that are culturally safe and sensitive to the norms of Aboriginal peoples. We strive to practice cultural competence across all levels of the organisation. We are committed to attending community events, listening to stories and needs, and developing trusting relationships over time. We recognise that Aboriginal peoples often focus on the past and present, rather than on the future, and take this into account in our practice. We provide flexible service delivery and use a person-centred active service model approach. We adjust our assessment and fees policy and practice. We plan for and manage disruptions to service delivery due to cultural events.
Family and extended family are the priority	We believe Aboriginal peoples are key to informing our service planning and delivery. We respect cultural traditions and adapt our service delivery to reflect self-determined and self-directed approaches.

Principles and values	Examples of how a service reflects and responds to these principles and values
Each individual is understood from a person-centred approach	We work to support the community/family/person in their preferred manner, and to support independence and resilience. We seek to expand our knowledge and skills in relation to early identification, holistic assessment, referral, care planning and service coordination with Aboriginal peoples and families. Because Aboriginal peoples have a shorter life expectancy and experience higher rates of disability, we invest effort in integrated and coordinated service delivery, and ensure each person/family has an allocated support worker to promote and facilitate access across services.

Adapted from Salamone 2003 and DHS 2010.

2.2.3 Cultural and linguistic diversity (CALD)

Introduction

Victoria is a proudly multicultural state, where approximately 43 per cent of Victorians were born overseas or are the child of a parent who was born overseas. Victorians come from over 200 different nations, speak over 200 different languages and dialects and follow more than 120 different faiths (VMC 2008).

Cultural and linguistic diversity (CALD) refers to the range of different cultures and language groups represented in the population who identify as having particular cultural or linguistic affiliations by virtue of their place of birth, ancestry or ethnic origin, religion, preferred language or language spoken at home (DH 2009, p. 4).

Approximately 27 per cent of Victorians aged 70 years and over are from a CALD background, and approximately 28 per cent of Victorians aged 70 years and over from a CALD background are users of HACC services. This indicates that people from CALD backgrounds access HACC services at the same rate or higher than people from English-speaking backgrounds — both in terms of number of clients and in hours of service provision. This is a vast improvement on the situation in 2001, where people from CALD backgrounds were substantially under-represented in HACC services (DH 2011b).

Barriers to access for CALD communities continue to be an issue, and anecdotal evidence suggests that particular CALD groups (primarily smaller established and/or emerging migrant groups) continue to experience barriers to accessing HACC services. As Victoria's population continues to grow, the profile (and thus the needs) of the state's cultures, languages, religions and ethnic backgrounds will also change.

Key issues

For people who come from other lands to settle in Australia, the impact of settlement and acculturation is different for each person, depending on their experience and situation.

The determinants of health and wellbeing may relate to those of the person's homeland as well as current factors, such as housing, employment and education, spirituality and social connections. Consequently, the health and wellbeing of many CALD Victorians depends on a complex combination of social, economic, environmental and individual risk factors (NHMRC 2005).

In many cultures the values that underpin concepts of health and wellbeing vary widely. Some CALD communities associate stigma with mental illness, dementia, cognitive issues and/or disability. Despite this, not all people within a particular community or group share the same views on health.

Religion is often closely linked to cultural beliefs, and this may affect a person's health. Religion can have various influences on health behaviours, such as acceptable times to receive a service or attend appointments, diet and eating behaviours, consumption or abstinence of alcohol and opportunities to seek emotional support and guidance (Chatters 2000).

Strategies to consider

These include:

- developing a recruitment strategy to attract, recruit and retain a diverse workforce with skills in working with CALD communities at the board, management, staff and volunteer levels; including an orientation program that familiarises new staff and volunteers with local CALD communities and provides relevant resources, and employing staff who speak other languages or have experience and understanding of other cultures
- cultural awareness training to facilitate change and improved organisational and individual staff cultural competency and awareness
- encouraging staff and board participation in local multicultural events and celebrations, such as cultural diversity week
- allocating time to proactively promote services to CALD community groups, for example, newly arrived migrant or refugee groups.

If your organisation is a HACC Assessment Service, review your assessment and care planning practices. Refer to Section 11.3 of the *Strengthening assessment and care planning — A guide for HACC assessment services in Victoria*.

Partnerships and relationships

HACC services need to engage with Access and Support workers in the area (if available) to better understand the needs of their clients and improve service coordination practices. Ethno-specific and multicultural organisations in Victoria can provide resources and a specialist response to meeting the needs of CALD groups. Consider:

- opportunities for formal and informal collaboration with multicultural or ethno-specific organisations and groups, such as community consultation, staff training activities and the development of CALD information resources
- brokerage arrangements to ethno-specific/multicultural organisations to provide culturally appropriate services to CALD clients

- participating in regular discussions and planning with ethno-specific and multicultural organisations to discuss the specific needs of the catchment's service delivery and access issues for CALD groups
- proactively promoting and providing practical support for participation of CALD community members in planning and decision making groups or as volunteers for community activities and events.

Language services

The Victorian Government's language services policy for departmental services and funded organisations is outlined in *Improving the Use of Translations and Interpreting Services — A Guide to Victorian Government Policy and Procedures*.

Most HACC-funded organisations have access to the department's funded language services credit lines. Contact your regional department contact if you require further information about how to access this service. Consider:

- a targeted CALD communications strategy using culturally sensitive information in appropriate languages
- whether you use interpreters in service access and delivery in line with the Victorian Government's language services policy
- developing an organisational language services policy and procedures for using translating and interpreting services based on the Victorian Government language services policy.

2.2.4 People who experience or are at risk of homelessness

Introduction

In 2006, 20,511 Victorians were recorded as homeless, reflecting a 15 per cent increase in the decade from 1996 (AIHW 2009).

There is no internationally agreed definition of homelessness. Also, there are fundamental difficulties in defining homelessness, and thus, in describing the characteristics of people who might be considered to be homeless (ABS 2011). However, the most widely accepted definition of homelessness, which is used by the Australian Bureau of Statistics census in an attempt to measure homelessness in Australia, is the cultural definition which distinguishes between people experiencing primary, secondary and tertiary homelessness:

> Primary homelessness describes the situation of all people without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, living in improvised dwellings (such as sheds, garages or cabins), and using cars or railway carriages for temporary shelter.
>
> Secondary homelessness describes the situation of people who move frequently from one form of temporary shelter to another. On census night, all people staying in emergency or transitional accommodation provided under the Supported Accommodation Assistance Program (SAAP) are considered part of this category. Secondary homelessness also includes people residing temporarily with other households because they have no accommodation of their own, and people staying in boarding houses on a short-term basis, operationally defined as 12 weeks or less.

> Tertiary homelessness describes the situation of people who live in boarding houses on a medium to long-term basis, operationally defined as 13 weeks or longer. Residents of private boarding houses are homeless because their accommodation does not have the characteristics identified in the minimum community standard (Chamberlain and McKenzie 2008).

Stakeholders have reinforced the importance of the census to both provide prevalence measures of homelessness and track changes over time across the detailed characteristics of homeless people, their dwellings and their geographic locations in order to monitor progress and target services and interventions to reduce homelessness. In response, the Australian Bureau of Statistics is currently developing a broad work program in homelessness measurement. A key element of this work is the consideration of the options both for a definition of homelessness and for ways to operationalise them. In this work the ABS considers:

- the concept of adequacy of the dwelling, and where it could be broadened to include the quality of the structure, need for repair and the security of the occupants
- overcrowding, which is an aspect of dwelling adequacy for its occupants
- the concept of 'home': broadening the concept of housing adequacy to include a place to keep possessions, to relax and undertake recreational activities, a place to withdraw, and a place to build community with family and friends
- a state of houselessness or even rooflessness (ABS 2011).

In Victoria some residents of pension-level Supported Residential Services are vulnerable and at risk of homelessness. Evidence also indicates that greater numbers of ageing Victorians exist who may be particularly disadvantaged in maintaining security of tenure due to long public housing waiting lists and a concomitant shortage of affordable private rental accommodation (ACSA 2005).

The Commonwealth document *The Road Home — A National Approach to Reducing Homelessness* proposes that homelessness is everyone's responsibility, and that it requires sustained long-term effort from all levels of government, business, the not-for-profit sector and the community. It acknowledges that homelessness is not just a housing problem, but has many drivers and causes, including the shortage of affordable housing, long-term unemployment, mental health issues, substance abuse and family and relationship breakdown. It also acknowledges the growth of populations who experience or are at risk of homelessness, such as older people in housing stress, and the over-representation of Aboriginal peoples in the homeless population.

The Road Home promotes a 'no wrong door' approach to supporting people who experience or are at risk of homelessness and encourages all health, human and welfare services to review policies and practices to ensure that they are responsive and inclusive of people who experience or are at risk of homelessness (CGA 2008).

Key issues

The transient nature of some people who experience or are at risk of homelessness means that service capacity to respond differs across localities, and continuity of service may be compromised. Social isolation and a lack of community engagement and participation are common among people who experience or are at risk of homelessness. Services need to be well coordinated, proactive and timely to locate and respond to this client group.

> Services need to be responsive to the specific circumstances of the homeless person, rather than attempt to match the person to an inflexible service model.

Forming trusting relationships with support services and continuity of service are important for many people who experience or are at risk of homelessness who have poor mental health and/or have experienced institutional care or been incarcerated, and thus may be anxious about accessing government services.

Building strong relationships with other services improves client engagement and service responsiveness. Specialist knowledge and skills may be required to respond to the specific needs of people who experience or are at risk of homelessness.

Strategies to consider

This involves exercising awareness of a range of situations and issues that may lead to homelessness when planning, for example:

- waiting lists and client data for pension-level SRSs, boarding houses and public housing in the local area
- trends in the local housing market, such as rental vacancy rates and affordability
- trends in financial disadvantage and requests for financial counselling and material aid from local welfare organisations and financial counsellors
- utilising opportunities to interact with and better understand the needs of residents of SRSs or public and community housing; for example, attending resident meetings in order to break down access barriers and promote understanding of HACC services
- developing models of service provision that are community based, such as community kitchens for meal provision, or using appropriate gathering places close to low-cost housing for social support activities
- planning for models of care that support self-management, empowerment and advocacy, where required
- flexible and assertive case finding and outreach models and partnership approaches to increase HACC service usage by this group.

If your organisation is a HACC Assessment Service, review your assessment and care planning practices. Refer to Section 11.4 of the *Strengthening assessment and care planning — A guide for HACC assessment services in Victoria*.

Partnerships and relationships

Identifying and building links with Low-Cost Accommodation Support programs in your catchment to undertake planning and developing service coordination protocols. These include:

- the Community Connections Program, which uses an assertive outreach model to proactively find, engage, assess and link people into the services they need
- the Housing Support for the Aged Program, which supports people 50 years and over with complex needs and a history of homelessness to maintain long-term public housing and improve their health and wellbeing
- the Older Person's High Rise Support Program, which provides monitoring and support to tenants of eleven older persons high-rise public housing estates in the inner suburbs of Melbourne
- identifying and building links with the Royal District Nursing Service Homeless Persons Program, which provides assertive primary health care in a range of settings and accommodation options
- developing links and conduct joint planning with a range of community health, mental health and welfare providers to identify need and plan for appropriate, multifaceted and coordinated responses for people who experience or are at risk of homelessness
- liaising with housing associations to increase access to social housing opportunities and advise of available HACC services
- co-locating services or out-posting staff with relevant services
- brokering of service to other providers with a particular expertise in working with people who experience or are at risk of homelessness
- joint case assessment and case planning with other key services to develop a shared knowledge of a common client
- conducting joint home visits to share resources and minimise risk
- seeking secondary specialist consultation with relevant services and, where required, resources to encourage sharing of expertise and develop more flexible service delivery.

2.2.5 People with dementia

Introduction

Dementia is the term for a group of conditions resulting in progressive decline in cognitive skills and abilities, of which Alzheimer's disease is the most common. This decline in cognition includes decline in memory, language, perception and personality, and can lead to loss of intellect, rationality, social skills and normal emotional reactions (Alzheimer's Australia 2011).

In 2011 an estimated 69,000 people have dementia in Victoria. Of these, approximately 47,000 live in metropolitan Melbourne (Access Economics 2010). Consistent with changing demographics (including an ageing population) an increase is expected in the prevalence of diseases associated with ageing, such as dementia. By 2020 some 98,000 Victorians are predicted to have dementia, with approximately 67,000 in metropolitan areas and 31,000 in regional and rural areas (Access Economics 2005). Dementia is generally considered a condition experienced by older people, with low rates below the age of 60 years. An estimated 10,000 Australians aged under 65 years have dementia (Alzheimer's Australia 2009).

Dementia has a significant impact on the person with dementia and their family, carers and friends. Challenges of dementia include progressive degeneration of the person's cognitive capacity and ability to undertake usual daily living activities. Health impacts for people with dementia may include depression, anxiety, stress, sleep disruption and poor physical health. Dementia is also a social condition that attracts stigma, social isolation and discrimination.

Key issues

The provision of care and support for people with dementia can be challenging, especially with progressive degeneration in cognition and other abilities. Recognising the important role of carers in providing care and support through supporting care relationships is important. Family carers provide 80 per cent of the value of informal care provided to people with dementia (Access Economics 2003). Caring for a person with dementia can also have a negative impact on the health and wellbeing of the carer.

Anecdotal evidence suggests people with dementia and their carers can live better with dementia when their social connections and recreational interests are maintained. The sustainability of retaining lifestyle relies on various factors, including successful community capacity building.

The social impacts of dementia may be compounded for Aboriginal peoples, those from CALD backgrounds as well as others, such as those who develop the condition at a young age, live alone, are geographically isolated, experience or are at risk of homelessness. Dementia is a significant problem in Aboriginal communities, with some communities experiencing dementia at a rate four times higher than in the general Australian population. Research reveals Aboriginal peoples develop dementia at an earlier age than other Australians (Alzheimer's Australia 2007).

Approximately one in six Victorians with dementia do not speak English at home (Access Economics 2006). This has implications for raising awareness of dementia among people from CALD backgrounds, as well as communicating with people with dementia and their families and carers to offer and provide information and support.

For younger people with dementia and their families, the impact of dementia can be very different, given their stage of life. This can lead to particular crises or situations that may require a response that is slightly different from issues often faced by older people with dementia and their families and carers.

Strategies to consider

These include:

- reviewing how your organisation identifies a person with a cognitive impairment such as dementia, and what specific responses this may entail at intake, assessment, care planning and service delivery stages
- reviewing, and where necessary, implementing a range of learning and development strategies to enhance staff understanding of dementia; for example, recognising the need for other service supports and making appropriate referrals
- considering whether staff members have completed the recognised dementia competency unit as part of their training

- planning to reorient group programs and activities to provide options that support people with dementia and their carers; for example, reviewing PAG sites and adapting facilities to cater for the wellbeing and engagement of people with dementia
- reviewing information and communication processes to cater appropriately for people with memory loss and reduced cognitive processing.

If your organisation is a HACC Assessment Service, review your assessment and care planning practices in the Dementia practice guidelines and the Dementia services guide, available (from January 2012) from the Assessment in the HACC Program website.

Partnerships and relationships

Consider:

- identifying and connecting with dementia diagnostic and support services
- consulting and planning with carer respite services and carers groups to provide access to carer support and information.

2.2.6 Gay, lesbian, bisexual, transgender and intersex people (GLBTI)

Introduction

Sexual orientation includes sexual desires, feelings, practices and identification, and can be directed toward people of the same or different sex.

Gender identity is generally understood as referring to a person's internal and deeply felt sense of being male or female (DHS 2008b). However, transgender people may identify with a gender different from the one they were born with. People who are transgender identify with or express a gender identity different from their biological sex, which may affect their health if services are not appropriate for people who are transgender or if transgendered people are discriminated against.

People who have intersex conditions have sex characteristics of both sexes or indeterminate sexual characteristics.

A 2003 Australian survey found that 2.2 per cent of women and 2.5 per cent of men surveyed identify as non-heterosexual, rising to 15.1 per cent and 8.6 per cent when sexual identity, attraction and experience were taken into account (Smith et al. 2003).

Key issues

While the inclusion of GLBTI people has grown over time, the current generation of older GLBTI people grew up knowing that they could be imprisoned or forced to undergo medical 'cures' if their sexual orientation or gender identity was known. Consequently, many older GLBTI people hide their sexual orientation and gender identity from service providers, believing that it is still not safe to disclose. For example, some older gay and lesbian people 'de-gay' their house before HACC workers arrive, removing photos of social occasions or partners, posters, fridge magnets or anything that might identify them as gay or lesbian.

The experience of discrimination, or the fear of discrimination, can have a detrimental effect on the health and wellbeing of GLBTI people. For example, GLBTI people have poorer mental health and higher rates of drug, alcohol and tobacco use than the general population (Pitts et al. 2006; Hillier et al. 2011).

GLBTI people are more socially isolated than the rest of the community (Gray et al. 2009), are less likely to have adult children who can provide support, and are more likely to live alone (Birch 2009). They are also more likely to avoid or delay seeking care because they fear discrimination from service providers (Leonard 2002), leading to late diagnosis, underuse of screening and lower use of certain health services.

Demographic profiling of GLBTI clients is difficult, because, unlike some diverse groups, no systematic data collection of sexual orientation and gender identity exists. Furthermore, some GLBTI clients may hide their sexual orientation or gender identity, believing they need to do this to be safe from discrimination. Therefore, measuring whether strategies to increase service access and responsiveness to GLBTI people result in an increased proportion of GLBTI clients is difficult.

GLBTI people often scan a service for clues that it is GLBTI inclusive. This might include reviewing information provided by the service, or gauging the responses of staff or fellow clients to GLBTI people profiled in the media. Some GLBTI people wait to build up a relationship with HACC service providers and fellow clients before disclosing their sexual orientation or gender identity. Some gay men not disclose their sexual identity because they fear HACC services assume they are HIV positive and could withdraw services because they fear contagion. Some young GLBTI people with a disability may feel rejected by their GLBTI peers because of their disability and by their disabled peers because of their sexual orientation or gender identity.

Strategies to consider

These include:

- providing a service that is GLBTI inclusive — this can assist GLBTI people to feel safe, regardless of whether they choose to disclose their sexual orientation or gender identity
- conducting training for staff to enhance understanding of the range of issues affecting GLBTI people and how to respond in a positive way to GLBTI consumers
- reviewing your organisation's practice using Gay and Lesbian Health Victoria's GLBTI-inclusive practice standards for Home and Community Care services, available through Gay and Lesbian Health Victoria
- communicating a message of welcome to GLBTI people by including GLBTI information and images in resources for consumers and staff, referring to GLBTI people in information about the services, displaying GLBTI posters and promoting your service to the GLBTI community; for example, through GLBTI media
- checking how consumers would like information about their sexual orientation or gender identity recorded, and informing the consumer how the information is used, how it is stored and who may access it, and seeking consent before sharing this information with another organisation
- ensuring that information about sexual orientation and gender identity is only collected if it is directly related to and reasonably necessary for the services' functions or activities, and is only collected from the individual it relates to
- encouraging intake and assessment staff to include GLBTI information in their service orientation processes: although it can be confronting to ask an older person a direct question about sexual orientation or gender identity, by including an 'other' category in options for gender, and a 'same-sex relationship' category in a marital status question can indicate that such information is welcome
- establishing procedures to identify and manage potential homophobia and transphobia amongst staff and clients.

Partnerships and relationships

Consider:

- developing links with local GLBTI social support and information services
- contacting Gay and Lesbian Health Victoria for information and resources to support planning nd organisational awareness and responsiveness to GLBTI people.

2.2.7 People in rural and remote areas

Introduction

The health status of people is not homogeneous across Victoria. Significant differences exist between the health status of people living in metropolitan Melbourne and those living in rural and regional Victoria. Overall, rural and regional Victorians are more likely to suffer from adverse health conditions, and likely to die earlier than those living in metropolitan areas.

The Victorian burden of disease studies show that the burden of mortality is greater for rural Victorians than for those living in metropolitan areas, and that rural Victorians have a lower health status than those in metropolitan areas. Rural males and females have higher rates of disease burden than city males and females, due to cardiovascular disease, cancer, neurological and sensory disorders, chronic respiratory diseases (males only) and musculoskeletal diseases and injury (DHS 2005).

Proportionally, regional Victoria has an older population than does Melbourne. In 2006 the proportion of regional Victorians aged over 60 was 21.3 per cent, compared with 17.3 per cent of the population of metropolitan Melbourne. The rate of increase of seniors in rural and regional areas is projected to be twice that of metropolitan areas. By 2021 the number of people aged 80 years and over in rural Victoria is expected to increase from nearly 62,000 to 101,000 (DPCD 2008).

The increases in the proportion of older people may be attributed to the emigration of young people from urban areas and the ‘ageing in place’ of older age groups. Retirees and semi-retirees seeking a sea change also migrate to regional areas, and put pressure on most coastal areas and some inland regions to meet the needs of an ageing population. In some instances this leads to situations where demands for service delivery are greater than the available skilled working-age population to service those demands (DTF 2004).

Key issues

Geographic isolation, population dispersion, transport, viability and sustainability of service provision, and the capacity for partnerships with specialist services all affect the ability to provide effective service responses to people living in rural and remote areas (Allan 2007).

People living in smaller communities and outlying areas who may already experience disadvantage in accessing services may have pronounced needs due to their distance from service providers. Services are generally located in regional centres and townships, and often have limited capacity to deliver services to outlying areas. People living in small towns or outlying areas may wait longer to receive services and have less service choice than people living in regional centres or metropolitan areas. While modern communication technologies can overcome some of the challenges associated with reaching geographically isolated people, some people do not have access to these technologies or may not be comfortable using them (Brownlee 2005).

Emigration of younger people from rural and remote areas has a direct impact on the capacity of families and communities to support ageing relatives and friends, as well as on the recruitment and retention of an appropriately skilled workforce to meet their care and support needs (Gregory 2008).

Rural and remote communities may be affected by reduced economies of scale to develop and sustain appropriate service infrastructure to meet the needs of smaller numbers of people spanning larger geographic areas than in metropolitan Melbourne and larger regional town centres.

Environmental and climatic events (such as drought, fire and flood) are often more common and far more devastating in rural areas. The floods and bushfires that have affected Victorians over recent years have had devastating effects on community service infrastructure and availability of extra resources required to meet the growing demand for and costs of delivering services in these areas.

Strategies to consider

These include:

- matching casual or part-time staff to clients who live close to their homes
- investigating technological solutions to increase reach and efficiency of service provision
- putting policies and procedures in place and adequately training staff members to respond to small and emerging diverse population groups and individuals
- outposting services to ensure local access, pending viability and feasibility
- providing information about HACC services to people across the whole catchment, not just those in local towns
- implementing volunteer and workforce recruitment and development programs that engage residents in small rural centres
- participating in events held in small townships to expand the reach of HACC service information.

Partnerships and relationships

Consider:

- developing relationships with other service providers working in or visiting isolated rural areas such as rural health services, bush nursing services, neighbourhood houses and community groups that can extend the capacity and reach of local HACC services
- developing relationships with statewide organisations and organisations that respond to diverse groups
- collaborating with multiple organisations to consult with the community about service access issues
- partnering with other organisations to provide traineeships for people in rural areas in HACC and related careers
- linking with community organisations which could assist with supporting people in isolated areas such as sporting clubs, churches or associations.

3. Planning for your community

Diversity planning focuses on understanding the needs of all people who are eligible for and require a HACC service, and taking action to improve access to service responses that meet those needs.

3.1 Planning processes and options

The characteristics and needs of each catchment population may change as existing diverse groups diminish or grow, age or become more experienced service users. Therefore, diversity planning is a dynamic process, and diversity plans are living documents in which the knowledge about the diversity of your local population is updated regularly to inform priorities.

Diversity planning requires skilled staff that can reflect on their practice in providing accessible and responsive services to diverse and disadvantaged people. It requires tools and resources to enable organisations to implement interventions and change their practice to respond appropriately to their local population.

Most organisations already have, and are familiar with, a range of planning processes. For many organisations, establishing new plans and diversity planning processes is not necessary, and diversity planning and practice can be integrated into existing, relevant planning processes. Where planning already occurs, existing planning processes and plans may be extended to include HACC diversity planning requirements. In such cases this guide may be used as an information resource to ensure diversity considerations are fully reflected in these processes and that specific outcomes are identified for HACC clients. Alternatively, if an organisation does not already have appropriate planning processes, consider developing a local area HACC diversity plan with other organisations, or develop a single-organisation HACC diversity plan. The information contained in this guide should assist you and your organisation to achieve this.

Three distinct options are available for organisations to consider:

Option 1: Include HACC diversity planning within existing organisational planning processes and plans. Ensure HACC diversity considerations are effectively considered and priorities, objectives and actions and documented. Ensure outcomes are specified for HACC clients.

Option 2: Participate in a local area planning process to develop an integrated HACC diversity plan with other local organisations. Develop shared goals and priorities. Ensure specific objectives, actions and performance measures are noted for each organisation.

Option 3: Develop a stand-alone HACC diversity plan for your organisation. Specify priorities, goals, objectives, actions and performance measures.

3.2 Planning considerations

3.2.1 Local governments

Local governments have specific planning responsibilities under the *Planning and Environment Act 1987* and the *Public Health and Wellbeing Act 2008*. Local governments are familiar with managing planning processes under the policy objectives of all levels of government, as well as the integration of built and natural environment considerations and community health and wellbeing.

In relation to older population groups, local governments have positive ageing or later years strategies that focus specifically on the needs of their current and projected older population. These strategies explore opportunities for making urban environments more accessible and supportive and for keeping older people healthier, physically active and socially engaged.

In relation to younger people with a disability, councils have disability action plans that focus on accessibility and community inclusion. These plans also link to other local government plans and strategies in areas such as recreation, transport, housing, footpath and bike path management, street lighting, community safety and so on, thus highlighting the needs of older people and people with a disability across a range of local government functions.

Many local governments use their positive ageing, municipal public health and wellbeing, and disability action plans to engage with other health and welfare service providers, including Primary Care Partnerships, and create links with other related plans and initiatives for providing necessary health promotion and support services in their local areas.

3.2.2 Health services

The National Safety and Quality Health Service Standards require health services to provide culturally appropriate services and consider the rights of consumers. Victorian public hospitals, including small rural health services and public dental services in community health services report under this accreditation scheme, with an 18-month transition phase that commenced on 1 July 2011. Health services across Victoria are also required to respond to a range of policy and program requirements which encompass diversity considerations in community participation plans and strategies, culturally responsive health care delivery, and in the provision of disability, mental health and public sector residential aged care service provision.

The Cultural Responsiveness Framework was specifically developed for health services to respond to cultural and linguistic diversity. The principles underpinning the Cultural responsiveness framework are congruent with those underpinning *Diversity planning and practice*. Thus, the Cultural Responsiveness Framework can be adapted and applied to the HACC program to streamline planning for diverse groups, and vice versa.

Health services may build strategies to address equitable and responsive HACC service provision and respond to other diversity considerations (as described in this guide) under their cultural responsiveness plans. This is particularly relevant for small rural health services.

3.2.3 Community health services

Community health services in Victoria may be part of an integrated health service, or may be an independent community health centre registered with the department. Typically, community health services receive HACC funding for the provision of allied health and associated services to the HACC target group. Rural areas may have HACC rural allied health teams located at the health service in major regional centres. Community health services have a long history of engagement with a range of community groups that experience disadvantage, and acknowledge that all communities are diverse or heterogeneous.

At present, no similar planning requirements exist for community health services that align to HACC diversity planning. Despite this, responding to diversity is core business for community health services, and is considered best practice. The task of community health is to:

- understand the diversity of its catchment community
- offer programs and services that are respectfully responsive to this diversity
- work with other providers in that catchment to ensure that the diverse range of community members have appropriate access to the health and human services they require.

Community health services should plan and design for diversity for its own organisation — through strategic and operational plans, and with other services in the catchment through partnerships and protocols. Community health services may consider including strategies to address equitable and responsive HACC service provision to diverse groups within these planning processes.

3.2.4 Small organisations

In Victoria over 470 organisations provide HACC services. Many of these receive relatively small amounts of funding; for example, small community groups, small not-for profit organisations, ethno-specific or multicultural organisations and Aboriginal Community-Controlled Organisations.

The capacity to undertake diversity planning and the comprehensiveness of the subsequent plan is influenced by each organisation's capacity in relation to the size of the organisation and the amount of HACC funding which the organisation receives. Organisations should be realistic about what they can achieve with available resources. Each organisation determines its diversity planning processes and ensures the scale of planning is appropriate to both its organisational capacity and the size of its HACC target population.

A small organisation receiving HACC resources for a PAG may choose to develop a plan in conjunction with other PAGs in the area. This may involve reviewing the participant profile of the relevant groups and identifying gaps in provision of social support to groups identified as having low participation rates.

If a small ethno-specific or multicultural organisation provides services to a specific cultural group, the organisation may focus on the diversity within this group; for instance, people who reside in geographically isolated areas, or people with dementia, or people with insecure living arrangements. Smaller HACC organisations may develop partnerships with other organisations to expand their capacity to plan and respond to specific diverse groups.

3.3 Collecting information about your community

Gathering information on the diversity of your catchment is the key to effective planning. A range of data and information sources are available about your local community or catchment which may be useful to inform diversity planning. A selection of these are listed in Section 3.4 of this guide.

While the collection and analysis of demographic and quantitative data is encouraged, many aspects of diversity are difficult to measure. Therefore, other qualitative sources of information should also be considered.

Sometimes evidence-based data may not be available, and an action of a diversity plan may collect consumer feedback; for example, where a service provider is fairly certain that people from a particular diverse group do not use their services, but the reasons are unknown. Action would then focus on developing and implementing consultation strategies to gather information about service access barriers to inform subsequent strategies and responses to this particular group.

> Community and consumer engagement and consultation is important to developing a profile of your local community or catchment and understanding diversity and access issues and needs.

Key steps in using data and information collected to identify barriers to access and diversity needs and issues are presented below (adapted from DHS 2001). Decide on the process, responsibilities and timelines. Consider:

- Who will lead the planning process?
- Who will be involved?
- How will this process link to other mapping, research or planning undertaken by the organisation or group of organisations?
- What time and resources will be allocated to the process?
- Define the purpose and planning questions
- Select data items and indicators of interest; for example, age, postcode, income, social connectedness, rent stress, service use, community safety, burden of disease and physical activity
- Access data sources.
- Collect new data and information if required, for example through consultation or surveys.
- Compile, synthesise, analyse and interpret data.
- Summarise the data findings and use the information to inform diversity priorities for action.

3.3.1 Analysis

Analysis of data and information collected provides evidence for the development of priorities for action. Because information and evidence can be interpreted differently by people looking at it from different perspectives, it is useful to summarise, present and discuss the information with key stakeholders. This allows the interpretation and understanding of nuances to inform and confirm priorities for action.

Analysis may include mapping your current client profile against available demographic data about your catchment to gauge under- or over-representation of access to your service by particular diverse groups. Investigating the service use and health trends of your catchment can assist in the evaluation of the effectiveness of current service delivery, structure improvements where necessary and guide future planning.

3.4 Resources

A range of data and information is available about your local community or catchment that may be useful to inform diversity planning. However, data from different sources may not be directly comparable, due to differences in definitions or catchment areas. Thus, care is needed in comparing data from various sources and drawing conclusions from this analysis and comparison. Consider:

- What evidence, rationale and logic is required to underpin your decisions about diversity planning and practice priorities for action?
- Do you want to work with other organisations in the local area to undertake data collection and analysis?
- What data sources do you already have access to?
- Is the data and information is specific enough to inform your planning? What other data and information might you require? How can you best access it?
- Do you need to build on the data and information you have collected to improve your understanding of your community through engaging and consulting with other stakeholders. Who are they?
- Are there other service providers, peak bodies or consumer groups who can support you to analyse and interpret the data and information you have collected?
- Can local service providers confirm your understanding of your local community or catchment and priorities for action?
- Does the information you collect about your local community align to the profile and issues of the region?

For information about establishing and developing partnerships with specialist and/or small community-based organisations and groups, access the Ethnic Communities' Council of Victoria report *Practising Positive Partnerships in the Ethnic and Multicultural Community*.

For information about consultation tools and strategies, including engaging with hard-to-reach groups, access the Victorian Local Governance Association's Consultation and Engagement web-based resource.

3.4.1 HACC client data

A set of reports on your organisation's HACC client profile is already available on the department's Funded Agency Channel. If you don't currently have access to this, find out who in your organisation is responsible for HACC MDS reporting and has access to the website. You can also register by visiting the Funded Agency Channel website.

Data on your HACC clients

These HACC reports on the Funded Agency Channel are updated quarterly using the data your organisation transmits to the department via the HACC Minimum Data Set. They can be printed or downloaded as Microsoft Excel files for your own further analysis. Relevant reports include:

- client age group
- type of accommodation
- existence of a carer

- relationship of carer to care recipient
- client's country of birth
- client's preferred language
- client's living arrangements
- Indigenous status
- pension type
- number of clients and hours received by service type.

The reports are specific to the clients of your organisation.

You should also have access to a suite of reports on the Funded Agency Channel describing all HACC clients in any local government area (as well as region- and Victoria-wide):

- age group by sex
- average hours of service
- carer availability
- client type (Indigenous status)
- country of birth
- language spoken
- living arrangements (lives alone, with family, with others)
- pension status
- client numbers by service type
- hours by service type.

These reports can be downloaded into Microsoft Excel for further analysis. This information is a good starting point for compiling your own analysis of existing and potential HACC clients, mapped against the demographics of your catchment area or local community profile

3.4.2 Population data and diversity information

The department's Funded Agency Channel provides links to a range of useful government, research sites and community profiles. See 'Data on your HACC clients' in Section 3.4.1 for more information on how to access this resource.

Key sources for demographic, health and wellbeing data include:

- Australian Bureau of Statistics
- Australian Institute of Health and Welfare.

Key sources of population data at the local government sub-regional and local government area levels are:

- local government planning units
- Primary Care Partnerships.

HACC assessment alliances and other relevant local service provider networks may also provide local area population data and information about trends and client service preferences to inform planning. You could also consider the information presented in Section 3.4.3 and Section 3.4.4 for access to service usage and demographic data and information about health and wellbeing issues and diverse groups.

3.4.3 Population data

Item	Source	Access
Counting the homeless	Australian Institute of Health and Welfare	http://www.aihw.gov.au/publication-detail/?id=6442468264
4714.0 — National Aboriginal and Torres Strait Islander Social Survey, 2008 (demographic, social, environmental and economic indicators)	Australian Bureau of Statistics	http://abs.gov.au/AUSSTATS/abs@.nsf/mf/4714.0/
Projections of dementia prevalence and incidence in Victoria 2010–2050: Department of Health Regions and Statistical Local Areas (dementia prevalence and incidence at an LGA level)	Access Economics	http://www.alzheimers.org.au/common/files/VIC/Dementia_Statistics_Victoria_DoH_regions.pdf
Settlement Reporting Facility (migrant settlement)	Australian Government Department of Immigration and Citizenship	http://www.immi.gov.au/living-in-australia/delivering-assistance/settlement-reporting-facility/
SEIFA: Socio Economic Indexes for Areas	Australian Bureau of Statistics	http://www.abs.gov.au/websitedbs/D3310114.nsf/home/Seifa_entry_page
Selected Government Pensions and Allowances 2005-2009 (age pension, carer payment, disability support pension)	Australian Bureau of Statistics	http://www.abs.gov.au/ausstats/abs@nrp.nsf/webpages/Selected+Government+Pensions+and+Allowances+2005-2009#Find
Use of HACC Services by People Born in Non-English Speaking Countries	Victorian Department of Health	http://www.health.vic.gov.au/hacc/publications/cald_hacc_services.htm
Government-funded specialist homelessness services: SAAP National Data Collection annual report 2009–10: Australia	Australian Institute of Health and Welfare	http://www.aihw.gov.au/publication-detail/?id=10737419170

3.4.4 Information about diverse groups and responsive practice

Item	Source	Access
Diversity News	Department of Health	subscribe via email: diversity@health.vic.gov.au
consumers reforming health (consumer perspectives in the Australian health system)	Health Issues Centre	www.healthissuescentre.org.au/
Cultural Competency in Health: A guide for policy, partnerships and participation	National Health and Medical Research Council	http://www.nhmrc.gov.au/guidelines/publications/hp19-hp26
Cultural responsiveness framework (guidelines for Victorian health services)	Department of Human Services	http://www.health.vic.gov.au/cald/cultural-responsiveness-framework
Aboriginal Cultural Competence Framework	Victorian Aboriginal Child Care Organisation, Department of Human Services	http://www.cyf.vic.gov.au/__data/assets/pdf_file/0008/312668/framework_cultural_support_2008.pdf
Housing & Accommodation (public housing, social housing, disability supported accommodation services and other accommodation-related support for Victorians most in need)	Department of Human Services	http://www.housing.vic.gov.au/home
Supported Residential Services	Department of Health	http://www.health.vic.gov.au/srs/index.htm
Low Cost Accommodation Support Programs	Victorian Department of Health	http://www.health.vic.gov.au/agedcare/services/lowcost/index.htm
Models of Care for Elderly People with Complex Care Needs Arising from Alcohol related dementia and brain injury	Wintringham	http://www.wintringham.org.au/files/Wntr.MoC.1.7.pdf
Working with People with Hoarding Behaviours	Southern Metropolitan Region HACC Training, Inner South Community Health Service and Vision Australia	http://www.visionaustralia.org/info.aspx?page=2382
Change and Disadvantage in Regional Victoria Reports	Department of Planning and Community Development	http://www.dpcd.vic.gov.au/home/publications-and-research/urban-and-regional-research/Regional-Victoria/chnage-and-disadvantge-in-regional-victoria
Alzheimer's Australia Research & Publications (Victoria's peak body dedicated to supporting people with dementia, their families and carers)	Alzheimer's Australia Vic	http://www.alzheimers.org.au/research-and-publications.aspx

Item	Source	Access
DementiaNet (dementia information service)	DementiaNet	http://www.dementianet.com.au/
HammondCare (dementia, palliative care, older person's mental health and aged care)	HammondCare	http://www.hammond.com.au/
Aboriginal health e-bulletin	Department of Health	http://www.health.vic.gov.au/aboriginalhealth/publications/bulletin.htm
Multicultural Resources Directory	Victorian Multicultural Commission	http://www.multicultural.vic.gov.au/
Ethnic Communities' Council of Victoria Inc. (peak advocacy body for culturally diverse communities in Victoria, including access to the Multicultural Aged Care Services Directory)	Ethnic Communities' Council of Victoria	http://www.eccv.org.au/
Centre for Culture Ethnicity and Health (specialist information, training and support on cultural diversity and wellbeing)	Centre for Culture Ethnicity and Health	http://www.ceh.org.au/
ADEC (advocacy and support for people with disabilities from a CALD background)	Action on Disability Within Ethnic Communities	http://www.adec.org.au/
Support for refugees and asylum seekers	Victorian Foundation for Survivors of Torture	www.survivorsvic.org.au/
Australian Institute of Interpreters and Translators (AUSIT) (interpreting and translation)	Australian Institute of Interpreters and Translators	http://www.ausit.org/eng/
GLHV website and clearinghouse (health resources for Gay, Lesbian, Bisexual, Transgender and Intersex Victorians)	Gay and Lesbian Health Victoria	http://www.glhv.org.au/
Well Proud – A guide to GLBTI inclusive practice for health and human services	Victorian Department of Health	http://www.health.vic.gov.au/glbtimac/downloads/wellproud.pdf
Private Lives — A Report on the health and wellbeing of GLBTI Australians	Australian Research Centre in Sex, Health & Society, La Trobe University	http://www.glhv.org.au/files/private_lives_report_1_0.pdf
The ALSO Foundation (advocacy for Victoria's diverse gay, lesbian, bisexual, transgender, intersex and queer communities)	The ALSO Foundation	http://www.also.org.au/

Item	Source	Access
Matrix Guild Victoria Publications (GLBTI inclusive aged care)	Matrix Guild Victoria	http://www.matrixguildvic.org.au/publications.htm
Ageing, Cognition and Dementia in Australian Aboriginal and Torres Strait Islander People: A Life Cycle Approach (review of literature on dementia in the Aboriginal and Torres Strait Islander population)	Neuroscience Research Australia	http://www.neura.edu.au/content/ageing-cognition-and-dementia-australian-aboriginal-and-torres-strait-islander-people-life-c
Strengthening aged care assessments for Aboriginal consumers — A guide for Aged Care Assessment Services in Victoria	Victorian Department of Health	http://www.health.vic.gov.au/agedcare/downloads/pdf/strengthening_acas.pdf
Val's Café Audit (a tool to measure GLBTI (gay, lesbian, bisexual, transgender & intersex) inclusive practice in aged care services)	Gay and Lesbian Health Victoria and The ALSO Foundation	http://www.glhv.org.au/files/Val'sCafeNationalAgedCareAudit-blue.pdf
Gay and Lesbian Health Victoria (GLBTI inclusive practice standards for home and community care services — a diversity planning resource)	Gay and Lesbian Health Victoria	Available by contacting Gay and Lesbian Health Victoria: http://www.glhv.org.au/contact

3.5 Setting priorities

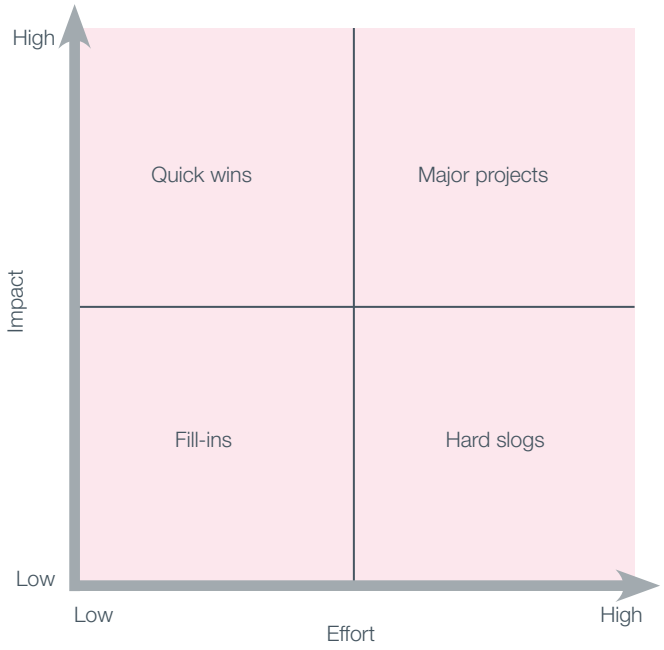
Each Department of Health regional office prepares a regional diversity plan that reflects ministerial and statewide health and HACC priorities, and takes account of region-wide issues. Each organisation prioritises HACC diversity planning strategies to reflect aspects of the regional plan as relevant to their local catchment.

Numerous methods exist to establish priorities. Key considerations are:

- the most important need, based on evidence (data analysis and consultation)
- the area in which most impact can be achieved for the effort invested.

A simple impact-versus-effort matrix can be used by plotting options so that you can see which actions deliver the greatest returns on your efforts.

Figure 3 Impact versus effort matrix



Once priorities are established, more specific objectives can be framed.

3.6 Developing measurable goals and objectives

Priorities may be short, medium or long term. This is influenced by the complexity and the scale of the tasks involved:

- short term (one year)
- medium term (two to three years)
- longer team (three to five years).

Many HACC-funded organisations are already familiar with the use of specific, measurable, achievable, realistic and time-oriented (SMART) objectives to enhance planning.

Where possible, focus on quantitative measures that indicate not only performance inputs (for example, training provided for 20 people), but also the impacts and changes achieved. Adapt or use existing measures if possible (for example, number of clients or client satisfaction). Be confident that the measures you use will give you the information you need in order to assess the success of actions undertaken to implement your diversity plan.

3.6.1 Example of a medium-term SMART objective

S	Specific	To increase acceptance of HACC services by the Aboriginal community through the location of an assessment officer at the ACCO who will provide holistic assessment and care planning that facilitate the uptake of required HACC services and supports.
M	Measurable	The assessment officer attends the ACCO PAG each fortnight for a two-year period.
A	Achievable	Working in partnership with the ACCO and using an informal, person-centred, self-determination approach to establishing a relationship with the Aboriginal community to provide opportunistic information about HACC services and facilitate access to living at home assessments.
R	Realistic/resources	Using existing resources: PAG and assessment officer.
T	Time orientated	By 31 December 2013.
	Resulting objective: To increase access to HACC services to the Aboriginal community through the location of an assessment officer at the ACCO PAG each fortnight, so that by 31 December 2013 all participants have access to holistic assessment in a culturally appropriate, self-determined manner.	

Tips for effective planning

- Be creative, be inspired and explore your organisation's strengths. Look at the strengths of your organisation's HACC service delivery, your sphere of influence and explore new possibilities.
- To identify priorities, use a combination of statistical data as well as information and advice from key stakeholders about trends and needs.
- Be inclusive and responsive, collaborate with other HACC-funded organisations and related health and community services, consumers and other key stakeholder groups.
- Use evidence-based strategies where possible.
- Be realistic in your actions, targets and timeframes. Diversity planning is about evidence and quality of outcomes, not quantity. Be realistic, keep it simple, set priorities and make sure objectives are measureable.
- Use the plan, do, study, act (PDSA) process.

3.7 Examples of planning tools and templates

This section contains a selection of optional planning tools and templates to guide your diversity planning approaches. They can be used to:

- assess your diversity planning process
- document objectives and actions
- measure and report achievements
- review diversity plans.

Alternatively, your organisation may have existing tools and processes which you can use.

3.7.1 Diversity planning steps

Step	Outcomes
1. Agree on the process and who should be involved	
Who needs to be involved in the planning process? Consider the CEO, board members, community advisory groups, representatives of diverse groups or organisations. Who should be responsible for developing, approving and implementing the plan? What resources are available for developing and implementing the plan? Is it better to develop a joint plan with other organisations or a plan for your own organisation only? When does the plan need to be completed? Identification of resources available Development of timeline	Selection of person responsible and participants in planning
2. Gather information	
Who do you provide services to? What diverse needs do they have? What sources of data can you use, and what do they indicate? Do some people miss out on your service because of their transiency, gender, religion, distance, dementia, culture or language? Do some people stop using the service? If so, why? Have any complaints about discrimination, lack of understanding or respect been made? Is there another organisation, group or person that can provide useful data or information?	Profile of service users Service gaps Complaints data Other feedback
3. Understand needs	
Talk to people who represent those missing out on services. Find out what they need or why they do not access the service. Do they need better information? Are they worried about discrimination or privacy? Is there something about the location of the service, the timing or the way it is provided that does not suit them? Are there diversity issues or behaviours that your staff find difficult to understand or manage when working with clients?	Identification of access barriers Suggestions for practice change Workforce training plan
4. Meet with other service providers	
Are there local organisations that could work with your service to provide more suitable options? Consider religious organisations, ACCOs, housing services, neighbourhood houses, migrant resource centres, volunteer programs, leisure centres, men's sheds and so forth.	Identify partnership opportunities
5. Decide what can be done	
From the information you have gathered, decide on the most important things to address. Plan realistic, achievable objectives and actions that improve your service provision to the groups you chose to target. Decide on short-, medium- and longer-term actions.	Action plan
6. Plan the measures	
Decide how you will measure the change. Set up a system to record the information. Appoint staff who have the responsibility to record and report measures. Commence implementation.	Agreed measures and reporting timetable

3.7.2 SMART objectives blank template

S	Specific	
M	Measurable	
A	Achievable	
R	Realistic/resources	
T	Time oriented	
Resulting objective:		

3.7.3 Diversity action plan template

What are the organisation's diversity priorities for the next 12 months?	Strategies for achieving diversity priorities	Who is responsible for this action?	What partnerships/ collaborations would be useful?	When should it be completed?	What indicates that we have successfully achieved this?
Nominate 3–6 priorities for the next 12 months	Strategy	Who	What	When	Measure
1					
2					
3					
4					
5					
6					

Adapted from the HACC ASM action plan (DH 2010).

3.7.4 Diversity planning checklist

	Relevant stakeholders (such as board members and HACC staff) have been provided with information about the planning process
	Resources have been allocated to develop the plan
	Timelines have been established for the development of the plan
	Responsibility for developing and writing the plan has been allocated
	Partner organisations have been engaged to develop a joint plan or participate in the process
	Department of Health regional diversity planning priorities have been considered
	Service usage data has been analysed
	Regional and local population data has been analysed
	Relevant stakeholders have been consulted
	Complaints data and other sources of community and consumer feedback have been collated
	Specific priority population groups have been consulted
	Information about service access and barriers related to HACC services has been compiled
	Service gaps have been identified
	Internal ‘diversity lens’ audits have been conducted
	Strategies or changes to improve quality or equity of service delivery to identified priority groups have been listed
	Strategies selected are based on available resources and evidence to support effectiveness
	Partner organisations are engaged to support strategies in plan
	Methods or systems to collect data have been identified and established in order to indicate the effectiveness of strategies
	Responsibilities for implementation have been established
	Staff have been appointed and assigned responsibility to record and report on outcomes and associated measures
	Diversity plan has been documented
	Timeline for review has been established

3.7.5 Monitoring template — example strategies and achievements

Strategy/action	Target	Actual progress	Lessons learned	Self-rating			
Examples				Exceeded	Achieved	On track	Not achieved
90% of staff to undertake cultural education/ awareness training over the next three years	30% of staff by end year 1	30% of staff trained in year 1					
Invite ethno-specific services to attend staff meetings							
Work with Gay and Lesbian Health Victoria to plan and conduct a voluntary, confidential survey with clients to assess suitability of service to GLBTI clients							
Capacity building in relation to working with older homeless women							
Contact Rainbow Carers at Carers Victoria to access up-to-date information and training regarding lesbian and gay carers							

Appendix 1
Diversity planning process

Include HACC diversity planning within existing organisational planning processes and plans

One local government area has a large and culturally diverse aged population, with 20,000 (17 per cent) of its people aged 65 years or over. The council prepared an overarching Later Years Strategy to provide a framework to address the needs of its older citizens and to improve social conditions.

The Later Years Strategy was developed using a broad range of information sources. These included a review of Commonwealth and state policy directions in aged care and healthy ageing, socio-economic data and projections from ABS census data, a review of the council's residential aged care strategy and a literature review about the attitudes of older people. In addition to these information sources, consultation was held with various cultural groups and networks, such as the inter-faith committee, neighbourhood houses coordinators' group, and the Aged and Disability Service Providers Network. The strategy included multiple objectives, one of which was to engage with primary care and community health services in an integrated approach to health promotion for older people, with a focus on self-management and prevention.

With the introduction of HACC diversity planning, the council decided to use their existing planning process and update their broad, overarching Later Years Strategy to incorporate HACC-specific diversity actions. To do so, further analysis was undertaken of HACC MDS data and additional focus groups were held with diverse groups that had not previously been considered in any detail (including people with early onset dementia and people identifying as GBLTI). Additional actions and performance measures were added to the existing plan.

Because the Later Years Strategy focused on older people, the council also updated their Disability Action Plan to better incorporate HACC diversity consideration for younger people with a disability, using a similar process. Further analysis was undertaken of HACC MDS data and additional focus groups were held with diverse groups that had not previously been considered in detail (including young people with a disability who were homeless or in insecure housing, young people with a disability who identified as GBLTI, young people with a disability). Specific actions and performance measures were added to the existing plan.

Participate in a local area planning process to develop an integrated HACC diversity plan with other local organisations

Three HACC-funded organisations in a catchment area met to discuss their service delivery to people living both permanently and temporarily in their catchment. At the meeting they divided up the data-gathering tasks (such as looking at the ABS data, providing their own MDS reports and reviewing the relevant literature). They also met with a representative of the local Migrant Resource Centre, key leaders of local cultural groups and the project leader of the Dementia Action Planning Group.

From the information gathered they agreed to base their plan on improving access to PAGs for CALD people with dementia. They documented a simple, shared action plan that outlined roles, responsibilities and actions for each agency, and agreed to review progress quarterly through telephone meetings.

Develop a stand-alone HACC diversity plan for your organisation

A HACC-funded ACCO ran PAGs twice a week at their local gathering place. They looked at their HACC MDS data for the previous twelve-month period, which showed that 90 per cent of participants were female. Although there were registered HACC male clients, they did not attend the groups.

The organisation engaged a respected male elder from the ACCO board to contact the men to discuss their past experiences of the groups, why they no longer attended and the types of activities that would interest them. The men consistently indicated their preference for a meeting place separate from the women.

The organisation developed a diversity plan with a priority to focus on establishing a separate, PAG for HACC-eligible males. The plan listed several actions in partnership with the local council, the local TAFE and the men's shed program. These included allocating a space one day per week, training male volunteers to assist with the program, allocating staff with the appropriate skills and seeking funding for program implementation. Timelines, responsibilities and measures were listed in the plan for each stage.

Appendix 2
Strategies addressing diversity priorities

Focus: Aboriginal peoples

Case study 1

A generic HACC organisation collated population and Aboriginal service usage data. Analysis of the data showed minimal HACC service usage by Aboriginal peoples.

The organisation met onsite with the local ACCO to discuss this issue and generally share information. The ACCO advised that the local Aboriginal population tended to prefer service provision through the ACCO, even though it did not offer as many HACC activity types as the generic organisation.

The generic organisation and the ACCO agreed that generic HACC allied health staff would attend the ACCO PAG to build rapport with community members. The ACCO did not have an Aboriginal Liaison Officer, or the capacity to support clients to access to generic services, so agreement was reached that the generic organisation would provide funding to the ACCO for an Aboriginal support person for the clients.

Through these arrangements, trust slowly developed between the Aboriginal community and generic organisation staff, leading to an increase in the number of Aboriginal people using HACC services provided by the generic organisation and the different types of HACC activities accessed.

Focus: people with dementia

Case study 1

Data projections from Alzheimer's Australia Victoria indicate that the number of people with dementia would increase in the local community over the next ten years.

A HACC allied health service provider in a rural area used 'fail to attend' data and follow-up telephone calls to identify that a number of clients were not accessing services because they forgot about appointments. A diversity plan was established with an objective of providing information and education to the local community about supporting people with dementia. Actions included:

- providing contact information for community members (such as hairdressers, retailers and cafés) if they had any concerns about customers with dementia
- conducting dementia awareness training at the neighbourhood house
- recruiting volunteers to support people with dementia to attend appointments
- developing a protocol for telephone reminders on the day of the appointment.

Outcome measures included:

- the number of people engaged in dementia awareness training
- the number of people with dementia attending and not attending appointments
- the number of calls from retailers about concerns.

Case study

A group of five HACC PAG managers met to plan for the increasing number of people with dementia in their catchment. A review of referral trends indicated that the referral rate for people with dementia had been steadily increasing over the previous three years. The managers were experiencing challenges in supporting people with dementia in current groups due to different support needs, different behaviours relating to dementia and concerns for safety and independence of movement.

To support participation, wellbeing and independence of their clients with dementia, the managers agreed on the following strategies:

- conduct a specific program for clients with dementia focusing on health and wellbeing one day per week in two locations
- engage participants in activities of their choice to support retention of their recreational interests
- recruit and train volunteers to provide individual support for people with dementia
- commence an ethno-specific dementia group
- install safe and secure doors in PAG facilities
- plan and organise dementia training for staff and volunteers.

The combined actions resulted in increased access and participation in PAGs for people with dementia, which led to increased engagement and enjoyment in activities of their choice, improved physical and mental health outcomes and the establishment of a carers group with a social worker to provide ongoing support, social connection and information.

Focus: geographic isolation

Case study 1

A HACC-funded Living Longer, Living Stronger program was being successfully implemented in a regional town centre. However, an analysis of referrals from general practitioners, hospitals and self-referrals indicated a trend of an increasing number of HACC-eligible people living in outlying areas who could not attend due to transport barriers.

To improve access for those living in outlying areas, plans were developed for the program to be delivered in three small rural towns. Actions included:

- identifying appropriate facilities in each town
- applying for funding to cover staffing, equipment and venue hire costs
- collaborating with other organisations to provide a minibus for participant transfer
- informing referral sources
- promoting the new locations via local media in each of the small towns
- training two volunteers in each town to assist with program delivery.

Outcomes measures included an increase in number of people attending from small towns and outlying areas and positive participant feedback gathered through participant surveys.

Focus: CALD

Case study 1

A rural community health service funded for HACC PAGs and delivered meals undertook an analysis of local demographic data, ABS data, staff feedback and consultation with the local Ethnic Communities' Council. The review identified an increasing number of frail older Italian people who were socially isolated during the day because they lived with or near family members who worked during the day.

Staff discussed the issue with a local Italian community group and together developed a plan to better respond to the target group. They agreed to establish a social program, one day per week, where Italian food was served and Italian media and music was used to stimulate discussion between participants. A minimum of one Italian-speaking volunteer or staff member would be recruited and trained to support the group, and an Italian brochure to promote the program would be developed and disseminated through the Italian community group and the community health service.

Outcome measures included the number of participants in the program and the results of a client satisfaction survey conducted by telephone and using an Italian interpreter.

Focus: inclusion of GLBTI people

Case study 1

An inner city local government has a diverse population that includes a large GLBTI community. As part of consultation and research for its Older Persons Strategy, council staff conducted a street survey amongst its residents to determine service gaps and the needs of older people living within the municipality. Survey feedback indicated that the council should further develop its HACC services to make them more accessible and responsive to older GLBTI people.

Council's aged services staff consulted with Gay and Lesbian Health Victoria and developed an action plan to respond to the identified needs. The action plan, supported by council's senior management team, included:

- enrolment and participation in workshops conducted by Gay and Lesbian Health Victoria on how to create a GLBTI-inclusive service
- a consultation strategy that included inviting GLBTI people who accessed HACC services to participate in a consumer focus group, and consulting the GLBTI community to inform service planning
- a statement of commitment to GLBTI people
- a training program to upskill staff to work effectively with GLBTI clients
- reviewing assessment processes, tools and care plans
- implementing reviewed documentation with the assessment team
- a communications strategy that included the promotion of GLBTI-inclusive practices in the GLBTI media and local papers.

Outcomes were to be measured through a variety of mechanisms including a self-evaluation audit in preparation for a Rainbow Tick' (an external assessment of GLBTI-inclusive practice) and then undertaking the Rainbow Tick processes.

Focus: younger people

Case study 1

A HACC-funded allied health service examined data from local mainstream and specialist schools, health services and GP divisions. The analysis revealed a significant number of school-aged children with disabilities who were not accessing allied health services. The data was compared with the results of a mapping exercise to identify which allied health services were available in the catchment. Focus groups were held with parents and allied health services to provide additional qualitative information and enhance the understanding of the access issues.

The issues identified led to the design and implementation of a strategy to focus on improving access for school-aged children with disabilities to the full range of allied health services, including HACC-funded allied health activities.

Outcome measures included an increase in the number of children provided with each allied health service type.

Focus: residents of low-cost accommodation

Case study 1

A HACC Access and Support worker met with a local community housing provider to identify access and equity issues for residents of local rooming houses. Of the 300 residents of 19 rooming houses, 80 per cent were identified as HACC-eligible, but only 10 per cent were accessing HACC services.

Data collected over a twelve-month period indicated that 7.5 per cent of residents were evicted each year due room clutter and unclean or unhygienic conditions, resulting in high levels of health risk and the need for hospital admission or residential care.

A range of stakeholders were consulted to identify the reasons why this group did not engage with HACC services. Service accessibility issues included residents' reluctance to pay fees, low motivation to have clean rooms, anxiety, mistrust of service providers and hoarding behaviour. Many residents of the rooming houses experienced poor mental health, acquired brain injury, substance abuse or other forms of cognitive impairment, and lacked the finances and motivation to sustain their living space.

A partnership between the local community health service, local council and community housing provider was developed with the aim of supporting HACC-eligible rooming house residents who were at risk of eviction.

A pilot project was implemented in which rooming house staff facilitated referral and access to HACC domestic support, and council domestic support staff worked with residents to assist them in regular room cleaning using an Active Service Model approach. Timelines, responsibilities and evaluation measures were established for the pilot project.

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