

Intergenerational Programs Evaluation

Nepean Blue Mountains
Primary Health Network (NBMPHN)

Summary Report
June 2024



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ARTD consultancy team

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We acknowledge that we work on the traditional lands of the Darug, Gundungurra, Wiradjuri peoples. We pay our respects to Aboriginal Elders past and present.

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Abbreviations, acronyms and common terms

AIIP	Australian Institute of Intergenerational Practice
BANC	Blackheath Area Neighbourhood Centre
DoHAC	Australian Government Department of Health and Aged Care
ECEC	Early Childhood Education and Care
GDS	Geriatric Depression Scale - Short Form – a mental health screening tool
GST	Goods and Services Tax
ILU	Independent Living Unit
JOY	Joining Old and Young – a training program offered by Griffith University
KEQ	Key Evaluation Question
KPI	Key Performance Indicator
LGA	Local Government Area
NBMPHN	Nepean Blue Mountains Primary Health Network
PHN	Primary Health Network
PhotoVoice	A qualitative data collection technique which involves asking participants to take photographs to reflect their experiences of a program
RACH	Residential Aged Care Home
SD	Standard Deviation

Snapshot

What we did



Program theory
Developed logic model and KEQs based on document review and scoping interview



Qualitative data
36 interviews and 3 observations during program sessions



Quantitative data
Attendance, structured observations and mental health screening tool administered by providers

What we found

1

Programs were implemented successfully

Six service providers were commissioned to deliver a total of 11 programs, establishing functional partnerships with childcare and aged care providers and recruiting 148 older participants, of whom 2/3 went on to complete a program. Programs were carefully designed to promote interaction between younger and older cohorts and skilfully facilitated to be as inclusive as possible.

2

Older people participated actively and enjoyed the programs

Structured observations by facilitators during the sessions showed that older participants enjoyed the programs and were able to participate actively. The feedback from older participants was overwhelmingly positive. Interactions with children were a source of joy for many participants, and some built strong connections which continued after programs ended.

3

Positive impacts on mood and wellbeing were reported

Older participants reported positive impacts on mood and wellbeing, and this outcome was also observed by facilitators and aged care partners. Depressive symptoms – measured by a screening tool - reduced on average following the programs. Most of those who were depressed at the start no longer had symptoms above the threshold after the programs. Findings suggest that a larger 'dose' of the program may be linked to a greater improvement in mood.

4

Programs fostered social connections among older people

Attending the programs helped older participants to make new friends and broaden their circles of acquaintance. Service providers and aged care partners observed that many participants were now meeting up socially. An unexpected benefit was the ongoing connections that some older participants established with children (and families) they met through the programs.

What we recommend

Training and planning

Ensure there is sufficient time to complete JOY training and co-design the program with stakeholders including older participants.

Recruitment

Build closer connections by having the same children attend each week, limiting the number of older participants, and having at least one child per older participant.

Facilitation and support

Alert and sensitive facilitation, along with support from staff of childcare and aged care partners, can help ensure all participants get the most out of the programs.

Accessibility and inclusion

Where necessary, modify activities or the environment and provide resources such as accessible transport so that older and younger people with disabilities can take part.

Quality improvement

Encourage service providers to reflect, individually and collectively, on what they have learned from delivering the programs. Create avenues for participant feedback and use it to improve programs.

Evaluation

Formal ethics approval is highly desirable, to provide assurance and build the evidence base. Alternative measures of quality of life, physical activation and social connection could be considered.

Executive Summary

During 2023 and 2024, Wentworth Healthcare, provider of the Nepean Blue Mountains Primary Health Network (PHN), commissioned **intergenerational programs** designed to enhance older people's quality of life and enable them to live healthy lives in the community for longer. The programs were delivered by 6 community-based providers in a variety of locations across the region and funded by the Australian Government Department of Health and Aged Care. They were aimed at community-dwelling adults aged 65 years and over, or 55 years and over for those with an Aboriginal or Torres Strait Islander background.

What we did

Wentworth Healthcare commissioned ARTD to conduct this mixed-methods evaluation of the intergenerational programs. We developed a program logic model and key evaluation questions, based on a document review and a scoping interview with a researcher from the Australian Institute for Intergenerational Practice at Griffith University. A further 36 interviews were conducted with stakeholders including 22 older participants, service providers who were commissioned to deliver the programs, and representatives from childcare and aged care partners. Quantitative data collected by service providers as part of their funding agreements was made available to the evaluation team for analysis.

What we found

In summary, **11 of the planned 12 programs were implemented** successfully. Service providers established partnerships with childcare providers, and linked with aged care providers. All provided suitable venues and recruited between 10 and 19 older participants. A total of 148 older people were recruited, with an average age of 80.3 years (ranging from 57 to 99 years). Each program ran for 10 weeks.

Programs were carefully designed to promote **interaction between the younger and older cohorts**, and the environments were set up to be as **inclusive** as possible for those with limited mobility. Older people with cognitive impairment and children with disabilities were also supported to take part. Childcare staff remained on site to assist the children. A variety of **purposeful, educational activities** took place during the sessions, such as singing and music making, crafts, games, gardening and storytelling with participatory elements.

Lots of older people in our program really liked gardening. Children liked painting [the plant pots]. Watering [the plant] and seeing it grow was exciting for them. At the ECEC centre they have a gardening veggie patch, so this was an activity they were already familiar with.
(Service provider)

Quite a lot of the residents don't go out of their units [much] ... and they don't go to many activities. So, we tried to get those residents in [the program]. A couple of them were like, "Oh, I don't know" ... And they actually said to me afterwards, "I'm so glad you suggested that I do that because it was great". (ILU provider)

There was a woman with an artificial leg and the children enjoyed putting stickers on her leg, they were so interested in her leg. (Service provider)

Factors such as **accessible transport** and available staffing (at independent living units) were important to allow older people to attend. Some missed sessions due to illness, surgery, or other commitments. Only four decided to opt out of the programs because they did not wish to continue.

Observations during the sessions (by facilitators and evaluators) showed that **older people enjoyed the programs and participated actively**. Two thirds of the older people recruited went on to complete the programs (i.e., attended at least seven sessions).

I don't see my grandchildren much and I need to have some interaction with the youngies and bring a bit of youthfulness back in my life – they're [the children] so innocent, they're amazing. (Participant)

I enjoy the creativity. I find small children are very joyful, creative and I like to facilitate this. When I worked, I facilitated the growth of other people, and I feel this is doing that with these children. (Participant)

I thought this is exactly what I needed, to have a connection again with little ones. I knew it was going to be fun. I looked forward to it week to week. (Participant)

The feedback from older participants was overwhelmingly positive, with many saying that the programs were fun and gave them something to look forward to each week. They appreciated being able to help the children with tasks and to share skills, which made them feel needed. **Interactions with the children were a source of joy** for many, and some built strong connections with individual children which continued after programs finished.

I enjoyed the program more as the weeks went on. You are interacting more with the little people, they are no longer 'a mob of children', they tell you their names, their dog's name and sister's name, week by week it becomes a bigger relationship. (Participant)

My favourite moment was when the children entered the room, I overheard one of the children whisper to their friend - 'that's my one', while pointing at me. This made me feel most special. (Participant - reported by facilitator)

A lot of the children would go in, walk into the room, instantly go to their adult and hang with that person the whole time. And that's why the parents were like, "I need your number because she does not stop talking about you" - that's sort of what I wanted... I wanted the experience to be good not only for the children, but for adults as well, just sort of give them a little bit more purpose. (ILU staff member)

Positive impacts on mood and wellbeing were observed by program facilitators and reported by older participants.

It adds an 'oomph' to your day, which carries through the day and week. (Participant)

This program expands [one's] world in absolutely delightful ways. (Participant)

As an older adult, you feel different when the young people are around – feel more alive, more excited. (Participant)

Depressive symptoms were measured using a mental health screening tool, the Geriatric Depression Scale – Short Form (GDS). At the start of the programs, 19 individuals had scores indicating depression; for 13 of these people, their scores fell below the threshold for depression following the program. Across all participants, **depressive symptoms reduced on average following the programs**. Post-program GDS scores, and change in GDS scores, were associated with attendance and participation, suggesting that a larger 'dose' of the program may be linked with greater improvement in mental health and wellbeing.

For a small number of older people, the programs appeared to have positive impacts on physical health and mobility, based on participant self-reports and facilitator observations.

I had a walker when I started the program... I could barely walk, with children you need to walk and I became a lot more mobile as a result. (Participant)

The intergenerational programs **fostered social connections among older people**. Participants across all six providers reported that they had made new friends and broadened their circles of acquaintance. Service providers and aged care partners observed that many participants were now meeting up socially outside of the sessions.

I most enjoyed about the program the fact that I made a new friend, another lady, we swapped addresses and we're going to go out, this is really good – I wasn't thinking that this might happen. (Participant)

They got to know one another; it worked well. I can sense some connections happening now with some of the seniors. (Service provider)

Based on the evidence of direct outcomes collected for this evaluation, we conclude that the intergenerational programs have achieved high levels of participation along with likely positive impacts on the indirect, quality of life outcomes.

What we recommend

Many of the following recommendations are based on existing good practice that we have observed or has been otherwise documented during the evaluation. Some are based on stakeholder suggestions for improvements. We also suggest ways to enhance future evaluations of these programs, to build the evidence base for intergenerational practice. Full recommendations can be found in the main report.

In summary, the main recommendations are as follows:

- **Training and planning:** Ensure there is sufficient time between commissioning and implementation to complete JOY training and co-design the program with stakeholders including older participants.
- **Recruitment:** Build closer connections by having the same children attend each week, limiting the number of older participants, and having equal or greater numbers of children so that all older participants can have one-to-one interaction if they wish.
- **Facilitation and support:** Alert and sensitive facilitation, along with support from childcare and aged care staff, helps ensure all participants can participate actively and get the most out of the programs.
- **Accessibility and inclusion:** Where necessary, modify activities or the environment and provide resources such as accessible transport so that older and younger people with disabilities (including sensory impairments such as deafness, poor vision, or sensitivities) can take part.
- **Quality improvement:** Encourage service providers to reflect on what they have learned through delivering the programs. Consider building networks such as a community of practice between service providers so they can share learnings. Create avenues for participants to provide feedback and ensure it is acted upon or explain why this is not possible.
- **Evaluation:** Studies involving vulnerable groups such as older people, children, and people with disabilities benefit from formal ethical oversight. Allow sufficient time for application to a suitable Human Research Ethics Committee before future evaluations commence. Consider replacing the current mental health screening tool with one that can be compared with population estimates, or with an appropriate quality of life measure. It may be worthwhile to include additional measures of physical activation and social connection in future evaluations.



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