Intergenerational Programs Evaluation

Nepean Blue Mountains Primary Health Network (NBMPHN)

Final Report
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artd CONSULTANTS

phn NEPEAN BLUE MOUNTAINS
An Australian Government Initiative

Wentworth Healthcare
Blue Mountains | Hawkesbury | Lithgow | Penrith

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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 within a Residential Aged Care Home
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 rapid 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 also 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, and storytelling with participatory elements.

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).

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.

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

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.

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.

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

In the final chapter of this report, we make recommendations about good practice for future intergenerational programs, most of which 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.

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.

Report

1. Introduction to intergenerational programs

During 2023 and 2024, Wentworth Healthcare, provider of the Nepean Blue Mountains Primary Health Network (NBMPHN), commissioned 11 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 community-based providers in a variety of locations across the region and were funded by a grant from the Australian Government Department of Health and Aged Care. Wentworth Healthcare commissioned ARTD to conduct this evaluation of the intergenerational programs.

The following sections provide background information about the programs, the context in which they were funded, and the evidence base for intergenerational practice.

1.1 The policy context

One of the issues examined by the *Royal Commission into Aged Care Quality and Safety* was the difficulty faced by older Australians in accessing care at the interface between primary care and aged care. In response to recommendations of the Royal Commission, the Australian Government Department of Health and Ageing (DoHAC) provided funding for **early intervention initiatives** designed to delay entry into residential aged care homes (RACH), and reduce avoidable hospitalisations. Initiatives under the early intervention program are aimed at community dwelling older people, defined as those aged 65 years and over, or 55 years and over for people of Aboriginal and Torres Strait Islander heritage.

Funding for early intervention was distributed through Primary Health Networks (PHNs), which are regionally based, non-profit organisations that have knowledge of local population health needs and expertise in commissioning services to meet those needs. PHNs were expected to commission initiatives to promote healthy ageing, slow decline and support the ongoing management of chronic conditions, to improve health outcomes for older people and to help them continue to live in the community for as long as possible. The grants covered PHN staffing costs as well as the cost of commissioning initiatives, and extended over 4 years, beginning in the 2021-22 financial year.

Best practice commissioning approaches were expected from PHNs, including:

- co-design of initiatives with stakeholders, where appropriate
- consideration of initiatives previously implemented and evaluated by PHNs to address similar needs, including expansion of existing healthy ageing programs, where relevant
- monitoring and evaluation to ensure commissioned services are effective and efficient, including the use of standardised assessment tools to measure outcomes.

Funds from DoHAC under the early intervention program were used by Nepean Blue Mountains PHN (NBMPHN) to commission **intergenerational programs** for people aged 65 years and over (or 55 years and over for Aboriginal and Torres Strait Islander people) who live in the community. The goal for NBMPHN was that the intergenerational programs would promote healthy ageing by providing mutual learning opportunities, improving social connectedness, and increasing physical activity levels with the overall outcome of improving their quality of life.

In providing funding for the early intervention initiatives, DoHAC set 2 key performance indicators (KPIs) for NBMPHN:

1. Report on the number of consumers who have participated in the commissioned intervention activities.
2. Report on the number of participants who sustained or improved their quality of life.

1.2 The evidence base

Intergenerational programs bring together younger and older people in planned, purposeful, meaningful activities for mutual benefit. Structured learning activities provide opportunities for older people to share their skills and experiences with young people while participating in games and activities. Intergenerational programs have been piloted in the United States, Europe, and the United Kingdom[1] and Australia[2,3]. A recent meta-analysis of 23 studies demonstrated positive outcomes for older participants, including increased physical health, generativity, and quality of life, and a small but significant reduction in symptoms of depression[4]. Other benefits for older participants include building a sense of purpose, confidence, and dignity, and improving cognition, mobility, and social connectedness[5].

Researchers at Griffith University have developed a model and framework for intergenerational practice, based on a systematic review of existing programs and best practice in early years learning[6]. The university, through the Australian Institute of Intergenerational Practice (AIIP), offers a professional development course with 4 modules delivered online over an 8-week period. This course – Joining Old and Young (JOY) –

[1] Radford K, Gould R, Vecchio N and Fitzgerald A (2018). Unpacking intergenerational programs for policy implications: a systematic review of the literature. *Journal of Intergenerational Relationships, 16,* 302-329.

[2] Fitzgerald A et al. (2022). *The Cromwell Intergenerational Practice Pilot Report.* Southport, Qld: Griffith University.

[3] Australian Institute of Intergenerational Practice (2023). *Report: Intergenerational practice in early childhood education trial.* Canberra: Australian Government Department of Education.

[4] Petersen J (2023). A meta-analytic review of the effects of intergenerational programs for youth and older participants. *Educational Gerontology, 49*, 175-189.

[5] Australian Institute of Intergenerational Practice, 2023.

[6] Cartmel J, Radford K, Dawson C, Fitzgerald A, and Vecchio N (2018). Developing an evidence-based intergenerational pedagogy in Australia. *Journal of Intergenerational Relationships, 16,* 64-85.

introduces the **Australian Intergenerational Practice Framework** and provides evidence-based guidance on developing, implementing, and evaluating an intergenerational program[7].

1.3 The programs

NBMPHN covers the Blue Mountains, Hawkesbury, Lithgow, and Penrith Local Government Areas (LGAs), and supports the primary healthcare needs of more than 360,000 people. Around 16% of the population is aged 65 years and over. The region has a relatively high proportion (6%) of people identifying as Aboriginal and Torres Strait Islander, with the highest concentration in the Lithgow LGA (7.8%). The NBMPHN website notes that 'social and geographical isolation is a major factor excluding people from community participation and is contributing to poorer mental health'.

NBMPHN issued a Request for Proposal for suitable providers to deliver intergenerational programs for older participants by connecting them with children aged 3-5 years. The programs excluded people living in Residential Aged Care Homes (RACH) but included those in independent living units (ILUs).

Up to $80,000 (excluding GST) was available for each program. Programs were expected to consist of 10 weekly sessions, involving a minimum of 10 older participants and with a ratio between 1:1 and 1:2 adults to children enrolled. Providers were encouraged to design programs to meet local needs and resources. A variety of models were eligible, encompassing play-based activities and purposeful learning experiences, and providers were invited to design programs based on a model of their choice (e.g., music, dementia support).

Among the specified deliverables, service provider organisations were expected to:

- complete the JOY online course (with expenses met by NBMPHN)
- create formal partnerships with early childhood services or groups
- partner with independent living units or other community-based groups of older participants
- co-design the program with these partners
- recruit or deploy staff to a group facilitator role and provide resources for that role to run weekly group programs in a suitable, accessible venue
- recruit participants from both age groups and obtain written consent
- participate in regular progress meetings
- collect evaluation data using specified tools
- contribute to monitoring and evaluation and complete a final evaluation report.

[7] https://aiip.net.au/product/joy-online-course/.

2. The evaluation

NBMPHN engaged ARTD to provide evaluation services for the intergenerational programs. Deliverables included:

- analysis of data collected from service providers
- interviews with stakeholders including program facilitators and older participants, to understand their experiences and perceptions about the effectiveness of the program
- preparation of a report showing findings from the evaluation, including quality of life outcomes for older participants, and highlighting any opportunities for improvement to inform future implementation.

2.1 Methods

In this section we provide an overview of evaluation methods. More details are available in Appendix 1. This was a mixed methods evaluation, drawing on qualitative and quantitative data sources (Table 1).

Table 1: Overview of data collection activities

Method	Description	Sample size
Literature scan and document review	Brief review of existing research and evaluation conducted by the AIIP at Griffith University.	n/a
Scoping interview	Interview with one key staff member from the AIIP.	1
Service provider interviews	Individual and group interviews with the 5 service providers delivering these programs.	9
Stakeholder interviews	Individual interviews with staff from 2 ILUs involved in the programs delivered by Mission Australia and Nordoff Music Therapy.	2
Interviews with older participants	Individual and group interviews with older participants. These were delivered face-to-face at the 3 sites we visited and via phone for the other sites.	22
Structured observations	Structured observations of program activities and interactions at 3 sessions across 3 locations: Blackheath (BANC), Richmond (Nordoff Music Therapy) and Kingswood (Mission Australia).	3

Method	Description	Sample size
Program data analysis	Analysis of: • provider data on recruitment and attendance • structured observations of participation using the Leuven scale, conducted by providers • scores before and after involvement in the program from older participants, using the Geriatric Depression Scale – Short Form. • Photovoice data from 3 program sites (Springwood Neighbourhood Centre, Nordoff Music Therapy and Mission Australia)	n/a

We drew on our scan of previous research and the scoping interview with AIIP to develop key evaluation questions (Box 1).

Box 1: Key Evaluation Questions

1. Were the intergenerational programs implemented as intended?
2. What factors facilitated implementation? What were the barriers to implementation?
3. To what extent did older people engage actively in and enjoy the programs?
4. To what extent did the program facilitate social connection and reduce loneliness?
5. To what extent did the program improve the mood and psychological wellbeing of older participants?
6. To what extent did the program improve the activation, mobility and physical wellbeing of older participants?

The key evaluation questions were also informed by a program logic model (Table 2) which represents how intergenerational programs are expected to contribute to improved quality of life for older people (shown as a combination of four indirect outcomes) through a series of intermediate results (shown as a combination of four direct outcomes). Like all models, the program logic is a simplification. It is useful in that it highlights the components of the program that are thought to be critical for generating outcomes of interest to program stakeholders, and shows logical connections between inputs, outputs and outcomes using a type of 'if-then' logic. Each step is considered either necessary or sufficient (or for longer term outcomes they may just contribute) for ensuring outcomes are generated.

Logic models should be treated as living documents that are updated as activities and goals change. We consider this logic model a preliminary representation which should be refined in future evaluations of intergenerational programs, in consultation with stakeholders and informed by the findings of this evaluation and other studies.

Table 2: Program logic for NBMPHN intergenerational programs

Inputs	• Funding from DoHAC to NBMPHN • Commissioning of providers • Program and evaluation guidance from NBMPHN • IGP framework and training course (JOY) developed by AIIP • Infrastructure and resources, such as: venue, transport, catering, requirements for program activities during sessions			
Activities	• Initial facilitator training (completion of JOY online course) • Provider partnerships with aged care and childcare groups • Co-design of program • Recruitment of participants • Delivery of structured 10-week programs at suitable venues • Ongoing reflective practice and planning sessions			
Direct outcomes for older people	Engagement and active participation in the sessions	Improved mood during and following sessions	Making new friendships and social connections	Greater mental and physical activation during sessions
Indirect outcomes for older people*	Greater sense of purpose	Improved psychological wellbeing	Reduced social isolation and loneliness	Improved physical wellbeing, reduced frailty
Impacts	• Healthy ageing with dignity and purpose • Delayed entry into residential aged care homes • Reduction in avoidable hospitalisations			

Note. *Together, these indirect outcomes are conceptualised as 'quality of life', which is the key intended outcome of the intergenerational programs.

2.1.1 A note on outcomes for children

The concept of reciprocal outcomes – benefits for both children and older participants participating in programs – is a core component of IGP. The interview guides we developed for providers and older participants included questions about any observed benefits for children, and findings are reported in Chapter 6. However, the scope of the evaluation precluded a detailed exploration of outcomes for the younger participants or for their parents. This is consistent with the purpose of the early intervention grants program (through which the intergenerational programs are funded), which is aimed at older Australians.

3. Program design and partnership building

This chapter presents program data and interview findings regarding the processes of establishing the intergenerational programs.

3.1 Outcomes of the tender process

Six providers were commissioned to deliver 11 programs across the 4 LGAs in the NBMPHN region (Table 3). Five programs took place in Term 4, 2023, and the remaining 6 took place in Term 1, 2024, concluding in mid-April. They included 5 specialised programs: 2 in Penrith LGA for people with disability (50% of children attending must have a disability); and 3 programs facilitated by registered music therapists, one in Penrith LGA and 2 in Hawkesbury LGA.

Table 3. Intergenerational programs commissioned by NBMPHN

Provider	No. programs	Delivery timing	Specialised
Nordoff Robbins Music Therapy	3	Term 4 2023 x2 Term 1 2024	Music focused
Nepean Area Disabilities Organisation	2	Term 4 2023 Term 1 2024	Disability focused
Blackheath Area Neighbourhood Centre	1	Term 1 2024	
Marathon Health	1	Term 1 2024	
Springwood Neighbourhood Centre	2	Term 4 2023 Term 1 2024	
Mission Australia	2	Term 4 2023 Term 1 2024	

3.1.1 Selection of providers

Most providers, except for one, had not previously delivered an intergenerational program. Some providers had run aged care programs for older participants, such as music programs for participants with dementia. Some worked in the broader space of community wellbeing and delivered programs that indirectly involved many older participants, such as social housing or health. Other providers had more experience in delivering programs for young people in the early childhood space. Regardless of previous experience, all service providers were enthusiastic about bringing the cohorts together as they appreciated the value that younger and older people could offer each other.

3.2 Preparation for the programs

A sixth specialist program, focused on engaging Indigenous people, was commissioned to be delivered in 2024 in the Lithgow LGA. However, the provider withdrew before delivering the program as they felt there was insufficient lead time for relationship building and co-design.

Although other providers were able to get everything organised in the required timeframe, most would have appreciated more time to prepare, to promote programs and to collaborate with early childhood partners and older participants to understand what they would like to see in the programs.

3.2.1 JOY training

One of the requirements for the funding was that staff of the funded organisations had to complete the JOY (Joining Old and Young) online training. The structure of this two-part training course is outlined in Box 2. Overview of JOY trainingThe course encourages trainees to use consistent language and have a clear understanding of intergenerational programs. This is considered necessary for fostering a culture of creating meaningful, reciprocal intergenerational relationships. The course also gives trainees the knowledge and tools to establish programs.

Box 2. Overview of JOY training

JOY 1 – Introduction to Intergenerational Practice

- Module 1: Introduction to intergenerational practice program
- Module 2: Developing an intergenerational practice program
- Module 3: Implementing an intergenerational practice program
- Module 4: Evaluating an intergenerational program with tools to start your evaluation and building the evidence base.

JOY 2 – The Art of Facilitation

- Module 2.1a/b: Foundations of Facilitation
- Module 2.2: Young Children and Communities
- Module 2.3: The Art of Facilitation for Teenagers
- Module 2.4: Navigating Grief and Loss in Intergenerational Programmes
- Module 2.5: Online Intergenerational Connections

There were mixed reviews about the extent to which the training supported service providers in developing and preparing their programs. Some had completed similar training courses in the past and said the JOY training reiterated what they had previously learned. Others said the training provided a basic structure to work with when developing their own programs.

Service providers appreciated that the training was evidence-based and included resources such as links to comparable programs and studies, which were useful for upskilling staff and providing a deeper understanding of intergenerational programs. This assisted staff when promoting the program to early childhood partners and older participants. However, one service provider said the training was 'very scholarly' and did not provide practical guidance about how to connect young people and older participants. They would have appreciated more advice about how to implement the theory in practice and facilitate connection.

In addition, service providers liked the training's interactive nature and opportunities to collaborate and share ideas with other participants. One provider suggested incorporating a session at the halfway and at the end point of the 10-week program for service providers to discuss successes and challenges they've experienced in delivering the program.

While some participants found the website easy to navigate, others said accessing the resources via links and picking up the training from where they left off was 'clunky', and participants needed to be attuned to online learning.

3.3 Partnerships between service providers and early childhood education and care (ECEC) centres

3.3.1 What service providers were looking for

Each program generally had around 10-15 children attend each session, predominantly targeting those aged 3-5 years old. At each program, a couple of staff from the ECEC centre supervised the children during the sessions.

Two providers had existing connections and established relationships with ECEC centres through other intergenerational or community programs they had coordinated. They approached these ECEC centres to be part of the program, which made it easier for these service providers to organise this part of the planning stage. Those who did not have established connections were ideally looking for ECEC centres located in the local area and close to where the program was being held.

Programs were either run at the service provider premises, at the ILU premises or at ECEC premises, or a combination. For those programs that were not run at the ECEC centre, it was important they had their own access to transport to travel safely to the location of the program.

Service providers felt that children who were willing to engage with older participants would be best suited to the intergenerational program. Children needed to be open to going to a new location and meeting new people. ECEC centres tended to keep the same group of children attending the sessions each week so that the children could settle into the program and connections could be formed with the older participants. However, one ECEC centre had different children attending each week, and one participant said they did not like this as there was not time to establish relationships with the children.

At some programs, children with disability attended and they sometimes required assistance from the ECEC centre staff to enable them to be involved in activities. In doing so, some providers promoted a more flexible approach.

> *The children [with a disability] had the option to go and play and then come back when they're focused. We kept things more open and relaxed. (Service provider)*

3.3.2 How the program was promoted

Service providers promoted the program to ECEC centres by networking with those in the local area and having discussions to gauge their interest. Some ECEC centres sent letters to parents explaining the program and inviting them to allow their children to take part. One service provider said the ECEC centre they engaged was initially hesitant and concerned about the risks involved and logistics of needing to obtain parental consent. The service provider overcame this challenge by organising all the materials themselves in advance to ensure the process was as streamlined for the ECEC centre as possible.

3.3.3 Advantages for ECEC centres

All service providers told us that the ECEC centres recognised the importance of children engaging with older people, and said this program was a great opportunity to do this, particularly for those children who had no or limited contact with their grandparents. ECEC centres saw the program as a useful opportunity to aid the children's social developmental skills, for example, having one-on-one engagement with older people could help with socialisation in the community. Some ECEC centres were keen to be involved as they had seen the program 'Old People's Home for 4 Year Olds' on television and were impressed with the positive outcomes for both children and adults.

3.4 Recruitment of older people

3.4.1 Target population

The intergenerational programs were targeted at community-dwelling older people, defined as those aged 65 years and over, or 55 years and over for people of Aboriginal and Torres Strait Islander heritage. This included those in ILUs located on Residential Aged Care Homes (RACHs) sites.

Service providers generally said the program works for everyone, in different ways. One provider gave more detailed feedback, saying the program suits older people who are easy-going, open to new experiences and challenges, enjoy socialising and spending time with children, and are perhaps feeling a little isolated and want to get out of the house and meet new people.

While some service providers did not purposely target older people who were socially isolated, when promoting the program, one ILU actively tried to recruit residents who had cognitive impairments or were more isolated or looking for something to do.

> *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)*

Another ILU was careful to select people who would be positive role models for the children, were proficient in English, could express themselves to interact with the children and had obtained family consent to go on an outing from the centre. The ILU staff member said it was ideal if the older participants were available to commit for the full 10-week program, as continuity was important to building relationships. This same interviewee said the program was suitable for people with dementia, as it provided a distraction, and they indicated that ILU staff were available to support participation of people with dementia.

3.4.2 Avenues for promotion

Service providers targeted a mix of older people both from the community and those living in ILUs. They tended to promote the program through:

- print media, including advertisements in the local paper and flyers, which were distributed to ILUs, neighbourhood centres, churches, social housing and bulletin boards
- online, via social media and the service providers' websites and mailing lists
- information and expressions of interest sessions with staff and older participants at ILU and with older members of the community, and regularly checking in with ILU to gauge interest from older participants

- contacting people who service providers knew from the community that may benefit from the program (e.g. those who live on their own)
- word of mouth from participants who completed the program previously (for those service providers that were running the program for a second time).

People living in ILUs often heard about the program through staff members at these centres, while those living in the community tended to hear about it through flyers and advertisements through the local community or via a service provider mailing list. Residents in ILUs were integral in influencing or encouraging other residents to join the program.

> *There's a lot of grief with older people. We got our psychologist that we work with to give a presentation to older participants in the retirement home about the importance of looking after your emotional wellbeing. They helped promote the program and showed the benefit of intergenerational programs like this. Quite a lot of people attended, about 80. I had an EOI form for them to fill out if they were interested. (Service provider)*

> *Because they're in Independent Living, it wasn't always staff promoting the program, it was the people. You had to get the people on board and then they would bring other people around. (Service provider)*

Older participants said the program information generally included a brief outline of what an intergenerational program was, who it was aimed towards, and that it was a 10-week program; the information generally didn't provide detail about what activities the sessions would involve. However, once they were recruited into the program, some service providers provided them with a program outline so that they were aware of what would be involved.

3.5 Challenges with recruitment

Service providers encountered a few challenges when recruiting older participants to the program. Participants needed to reside within the Nepean Blue Mountains area, meaning those who lived outside the area weren't eligible to participate. However, sometimes service providers sought (and received) permission from the PHN to include people who lived in areas on the fringe of the region.

Most service providers received expressions of interest from more older participants than could be included in the program. Service providers told us that older participants who were not chosen to engage in the program (because capacity had been reached) were understanding and expressed interest in being involved in any future iterations of the program.

Limiting recruitment to community-dwelling older adults was a challenge for one service provider because there were not many ILUs in the local area. This service provider said other people from RACHs expressed interest but were not eligible as they were not from ILUs (but rather from general aged care wings or dementia wings for example).

3.6 Older participants' reasons for joining

Most participants we spoke with did not have any specific expectations of the program but joined with an open and curious mind. The majority did not know other people attending the program, although those who lived in retirement villages had often *'seen each other around and said hello, but did not completely know each other'* [participant]. Many participants we spoke with had seen the ABC television program, *Old people's home for 4 year olds*, and enjoyed it, and this sparked their interest.

Most participants we spoke with had grandchildren who either didn't live nearby or were grown up (or both), and some did not have any grandchildren. Many missed connecting with children, describing children as *'joyful and bring out your own inner child'* [participant]. A small number of participants had worked as teachers or in the early childhood sector earlier in life and enjoyed the connection with children. A few participants also recognised the value they could provide to the children, teaching them about life and passing on skills.

> *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 have an amputated leg and wear a prosthetic leg. Children need to see these things, as they are a part of life and are nothing to be ashamed about. (Participant)*

3.7 Design and co-design processes

Service providers used a variety of inputs to inform the program's design, including:

- the JOY training course and the AIIP resources

- the structure of existing or previous intergenerational or community-based programs they had run
- the intended outcomes outlined in the funding agreements
- input from older participants and ECEC partners
- input from specialist staff involved in the program (e.g., speech therapists, psychologists)
- staff members' own personal experiences engaging with children and older participants.

There did not appear to be any participatory co-design processes undertaken by the providers; no such processes were described by providers during the interviews or documented in program materials.

Often, service providers used a generic program framework from the JOY training course as a starting point. Alternatively, they based the program on the intended outcomes from the funding agreement and tailored this to meet the needs of the program location and participants. Some service providers held introductory sessions for participants before the program began, where they described in more detail the proposed activities; or they included questions in the initial EOIs to older participants and ECEC centre centres, asking people what activities they would be interested in to understand more about them and their hobbies. These enquiries provided the nuanced information needed to tailor activities and maintain participant engagement throughout the program.

> *We spoke with the ECEC centre to understand what [the children] are familiar with. We asked, "Do you know the hokey pokey? If this is too old a song/dance, can you give us a Wiggles song, for example, that the children are familiar with?" (Service provider)*

Some providers also sought participants' input after each session, inviting them to say what activities they did and did not enjoy, through feedback forms or by drawing a picture. Older participants from one of the programs said they were invited to contribute ideas for the program and brought extra books and toys for the activities.

> *In the first week, a person said they felt nervous, wanted more knowledge of what was going to happen – so now, at the door at the beginning of each session a senior welcomes the children, this dispelled nerves for the person. (Service provider)*

Some service providers structured the program around core components (e.g., literacy or movement) and then included activities that matched those components. When choosing activities, service providers considered those that both older participants and children could enjoy, would bring these groups together and foster interaction (e.g., "I'll draw you, and you draw me"), and where children and older people could both teach and learn from each other.

> *For us it was about the framework. We want to make sure we have a music component, literacy component, movement component. Also, what are the milestones we want to achieve? And then we'll research activities that fit into those models. (Service provider)*

Many service providers also had 'themed' weeks that coincided with major events (e.g., Easter, Valentine's Day) and tweaked the activities to relate to this. One example we observed was asking participants to colour in pictures of the Easter bunny and making Easter baskets with chocolate eggs for the children to take home with them.

Most older participants said that generally they did not have any input into the activities in the sessions, and they were okay with this, often saying that they felt the facilitator knew what was best. They had confidence in the service providers to organise the program and choose activities based on what older people were interested in and able to do. One participant said having this structure was useful, as participants knew what to expect. Nevertheless, participants felt staff would be open and receptive to their suggestions or feedback if they had any.

Where several activities were available to participants simultaneously (e.g., numerous tables with different activities on each), the older participants said they did have input and autonomy over which activities they chose to engage with.

4. Program delivery

This chapter presents qualitative findings on the delivery of the intergenerational programs.

4.1 General observations

At many of the program sites, most of the older participants were female. Some couples participated in the program together. Although the program targeted people over 65 years of age, one person who was younger enrolled in the program with permission from the PHN as they had early onset dementia and attended the sessions with their carer.

Most older participants had to miss a couple of sessions due to health and life appointments (refer to Section 6.1 for further information on attendance). Some factors that encouraged attendance included accessible transport or running the program at the ILU.

Sessions typically ran for 1.5 hours (range 1-2 hours). Many programs had a morning tea break during the session, although this looked different across service providers. For example, one service provider incorporated it into the activities for their Easter-themed session, with participants decorating Easter biscuits, while another provided refreshments for the older participants every week, whereas children brought their own morning tea to sessions.

Of the three programs we observed, Provider 6's program was the most punctual, starting right on the scheduled time. This may have been helped by the fact that all the participants lived at the location where the program was held. This program also had the shortest sessions, running for one hour with no breaks. The service provider told ARTD that punctuality was important to the older participants, as it demonstrated respect for their time and other activities they had scheduled. One hour seemed an appropriate length, given this program involved several activities that required high engagement and physical exertion.

One participant noted there seemed to be a big difference in maturity between three-year-olds and five-year-olds, and it was sometimes a challenge to get them all to do the same activity. This observation was confirmed by one of the program partners, an ECEC centre staff member, who said it may be better to be more targeted in the age group for the younger participants. This interviewee felt that four-year-olds were probably the best choice for participation as they were 'at a good age where they can get the most out of it'.

4.2 The environments in which programs took place

All locations that ARTD visited were comfortable spaces, with a pleasant temperature, appropriate light, not too loud with all people in the space, and had enough room and chairs for people to sit down for the activities if needed. All participants could choose where they

wanted to sit. The different layouts across the sites were both **inviting and accessible** for participants. Some examples included:

- for whole group activities, setting up chairs for the older participants in a circle with space for the children to sit in the middle on the floor
- having activities set up at different heights (i.e., tables at different heights, on the floor) to cater for different abilities
- setting up soft toys in positions that give participants ideas for play
- having interactive playmats with a question written on each one (e.g., 'How are you feeling today?') and a variety of faces and words describing different emotions
- maintaining a similar layout at each session to ensure familiarity, but slightly adapting to maintain engagement with a variety of activities.

We adapt as we go along. For example, I moved a table that was at the side of the room to the centre as no-one went to it when it was at the side. (Service provider)

4.3 Common elements and key ingredients

While the sessions looked different at each site, there were some common elements across the content and delivery of all the programs. There was often a **mix of activities**, each involving varying levels of physical exertion or energy. Some common activities across sites included craft, story-time, singing and dancing, and physical activities/exercise such as yoga or balloon tennis. This variety helped keep participants engaged throughout the sessions and catered to people's various interests and preferences. One site provided written observations and commented that breaking the group into two smaller groups, with one doing games and the other going to the library, and then swapping the groups over, worked well as it was easier to manage a smaller group when doing games. Most programs involved some outdoor activities, including gardening and Easter egg hunts.

We observed that story-time remained engaging for participants when there was an **interactive** element (e.g., encouraging participants to make the sounds of different farm animals to match those mentioned in the story). Similarly, interactive crafts and singing were the most common activities mentioned by service providers and participants. Crafts allowed quiet time for children and older participants to interact one-on-one and build connections; while singing and dancing could engage the whole group, encouraged older participants to be 'silly' and promoted physical activity and movement. These different activities catered to the various interests and abilities of participants.

All providers focused on activities that required interaction between the older participants and children, although this looked different across programs. For example:

- older participants and children drawing pictures of each other

- older participants shaking maracas as the 'conductors' and the children following their actions
- older participants and the children passing eggs to each other using cups
- older participants reading stories to the children
- older participants and the children making friendship bracelets together.

> *You often found that a child would grab your hand and pull you to whatever they wanted to do. (Participant)*

The facilitator's role involved setting up the activities, as well as **encouraging connections** and interactions between the older and younger participants. The extent to which facilitators did the latter appeared to differ across the programs that we observed. Facilitators also constantly **checked in** with older and younger participants as to how they were feeling and if they had energy for certain activities. This was particularly important for programs that had activities which involved more physical activity, there were no breaks during the session, or if all participants engaged in the same activities (rather than participants choosing an activity amongst several that were running simultaneously).

Staff from the **partner organisations** played important roles in facilitating the programs. ECEC centre staff attending the sessions often helped to manage children's behaviour and sometimes participated in activities, encouraging children to participate. Staff from the aged care centres supported the older participants, particularly those who were less mobile.

4.4 Distinctive features of individual programs

Some differences across the sites included the **structure of the sessions**, with some providers offering one activity at a time, while others created a 'free play' environment that allowed participants to choose and move between various activities. Older people we spoke to at the sites overall enjoyed whichever type of activities they participated in. All participants had the ability to be involved as much as they wanted, whether this was a 'free play' environment or a structured one.

Some programs offered **one-off activities**, such as:

- a session run by a psychologist about understanding and managing emotions
- an Indigenous day, including a talk from an Indigenous elder and colouring pictures of native Australian animals
- a magic show with a magician.

One provider ran a distinct program compared with the other sites, with music-based activities. As this program consisted predominantly of group activities involving everyone, it

was important that everyone stayed engaged so they did not cause disruption to the whole group. Therefore, the facilitator constantly encouraged people to participate.

The programs run by one provider had a unique structure, with half the sessions being held at the ECEC centre and the other half at the Neighbourhood Hub. This flexibility was an effective risk management strategy if rain was predicted, as the session could be moved so that the children did not need to walk to the neighbourhood centre.

4.5 Logistical issues and challenges

Service providers, ILU staff and program participants spoke of several logistical challenges in delivering the program. For example, due to **COVID**, older people who were invited to take part in one program were initially hesitant to travel and interact with younger children for fear of getting sick. The service provider also had to recruit another ILU, as participants from the initial ILU had to withdraw from the program due to a COVID outbreak.

One ILU did not have accessible vehicles to **transport** older participants to the program. This meant that only those who were relatively mobile or had alternative transport options could participate in the program. Another service provider had to ensure they had enough staff and vehicles to pick up older participants from the community who could not make their own way to the venue.

> *The bus provided [by the service provider] was not accessible from a disability perspective, so the people needed to be able to get on and off the bus with some assistance. We had several people who were interested but we could not physically get them to the program. (ILU staff member)*

Staffing shortages within one ILU also posed a challenge, meaning only one staff member could accompany residents to the program. This also has the potential to pose a health and safety risk. One service provider found it difficult to design and run **a 10-week program**, given the other programs they run usually go for 20 weeks, allowing more time for people to *'get comfortable'* and *'show their true colours'*.

Another service provider said they felt it was odd that a **Working with Children Check** was not required for the older participants. Prior to commissioning the programs, the need for Working with Children Checks for participants was investigated by PHN staff and, based on the information provided on the Service NSW website, was not deemed essential. It was required for program staff, however, and has subsequently been introduced as a requirement for older participants in later programs.

4.6 Changes made to the programs

Some service providers made changes to activities both from their first and second program, or during a 10-week program, to boost engagement with activities. For example, a service provider dropped an activity that involved participants choosing some music they enjoyed and drawing or communicating how it made them feel. The service provider felt this did not work well as there were too many instructions involved for the one activity: *'they had to listen to something, then think about it, then draw to communicate their feelings'.* Some service providers also re-arranged the layout of activities to encourage engagement, such as moving a box of toys off a table and onto the floor so that children could reach into the boxes.

Other providers made modifications to activities for people with limited mobility, to ensure they could meaningfully participate in activities. Service providers provided chairs for participants who preferred to sit rather than stand during more physically demanding activities. They added elements to an activity to ensure those participants sitting remained engaged, for example encouraging dancing in chairs during the music sessions. Some swapped out physically demanding activities, such as parachute play, for activities that all people could get involved in, such as singing. Others recognised the need to modify the activity so all could participate, such as doing 'chair yoga' instead of standing yoga. One service provider noted that they assisted those with walkers to move around to another activity if they wished to do so [service provider journal reflection].

At one program there were deliberate efforts to re-shape the patterns of interaction, which had formed spontaneously early in the program, to encourage introverted, shy or quiet individuals to participate more actively.

> *At first all the outgoing children went to the outgoing adults and the quieter children went to the quieter adults, and there was not much interaction happening [with the quiet pairs] because they both didn't know what to do next. (ILU staff member).*

One service provider said they had planned at the beginning of the program for the older participants to take photos during the session, but stopped this after some older participants said it made them feel like they *had* to take photos and they could not just enjoy the session.

5. Experiences of the programs

This chapter presents findings from the interviews and observations regarding older adults' *experiences* of the programs. It should be read in conjunction with Chapter 7, which also draws on qualitative data but focuses on *outcomes* for older adults.

5.1 The first session

Some participants were able to recall the first session they attended and what they did in the session, which commonly included introductions and a few activities. One participant said they used a rhyme to introduce themselves to the other participants. Some participants recalled that the children were shy at first and hesitant to interact with the older participants.

Almost all participants very much enjoyed the first session, particularly watching the children play and interact with each other and with the older participants. Many said they felt happy and joyful after the session and looked forward to coming back the following week. Common feedback included '*pleased with the session*', '*feeling enthusiastic*', '*made me feel this was very worthwhile coming along*'.

> *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)*

In contrast, one or two participants we spoke with felt the first couple of sessions were boring, as people were shy to interact, and some people were a little nervous.

At three program sites, program staff documented participants' experiences of the program, using photos and/or feedback from older and younger participants and facilitator reflections. At two sites, facilitators gathered comments from older participants describing how much they enjoyed the first session. These included: '*love to watch children and learn from them*', '*what a wonderful day!*', '*It made my day!*'

5.2 Participation

Although older participants participated in activities in different ways, and to a varied extent across the weeks of the program, most participants in the sessions we observed actively participated in activities. A service provider said that level of interaction can be influenced by many factors, including '*energy levels, physical wellness, mental health*', as well as interest in the specific activity. While a small number of older participants, when given a choice, often focused on the same activity each week, others moved between activities. No specific abilities or experience were needed to participate in activities, with older participants and children often helping each other or teaching each other an activity if they didn't know how to do it;

and those with physical limitations able to participate in a modified capacity (e.g., older participants dancing and singing in their chairs). At the sessions we observed, participants who were unable to stand to participate in some activities nevertheless actively joined in, smiling and enjoying watching the children.

> *We encouraged everyone to join in but were respectful of the fact that people could choose how much they wanted to participate at a level that made them feel comfortable. One lady, with noise sensory issues, felt quite comfortable about stepping out of the classroom if it was getting too noisy. (Service provider)*

> *We have had one participant who was content to just sit back and watch the children playing. He joined in with singing and craft but was a quieter man who just said it was nice to come along and see everyone. (Service provider)*

However, there were some activities where participants who were less mobile did not directly participate in an activity, such as an outdoor Easter egg hunt, although some were offered support to participate. Those not participating seemed to enjoy watching the children hunt for eggs, but they were not able to fully participate in the experience, for example, not being paired with a child who could share their eggs with them.

Nevertheless, children were very curious and honest and sometimes people's differences were a springboard for older participants and children to connect (e.g., pushing a woman in a wheelchair around while other older participants guided the children).

> *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)*

We observed story time at two sessions, and this activity captured and held the interest of most if not all program participants. Both older and younger participants appeared more engaged when there was an added element of interaction (e.g., making noises for each of the animals mentioned in the story, or patting puppet animals). This also gave opportunities for older participants to interact with the children. Written feedback from three programs also had examples of children being engaged and enthralled when being read to, *'(Older participant) read a book about dinosaurs with 4 boys listening intently.'*

One service provider we observed had deliberately structured some group activities so that each older person had a chance to lead an activity. While this fostered engagement from all older participants, some children appeared to lose engagement as time passed on.

5.2.1 Level of interaction between older and younger participants

At the three sessions that we observed, we saw many examples of older people and children interacting. We also received written feedback from three programs (including one which we did not observe) that described instances of children and older participants enjoying each other's company, for example a child proudly showing an older participant some colouring in they had done.

Many service providers fostered purposeful interactions between the older participants and children, for example:

- having children hand out materials to the older participants for the next activity
- singing a goodbye song, after which the children gave a hi-5 to each older adult
- encouraging children to play at one of the tables where there was only an older participant (or vice versa).

We also observed and heard about many situations where incidental interactions occurred between older participants and children. For example, we observed lots of one-on-one interaction between older people and children during free play activities, as they would work together on tasks (e.g., making playdough together, craft, playing with soft toys). Photos taken by program staff at three sites illustrate how older participants and children participated in activities together, e.g., potting up succulents, chatting together while painting and drawing. In the written feedback we received from three programs there were numerous comments about older participants and children sharing stories about their lives, such as a four-year-old telling an older participant about their baby brother.

Service providers recalled some instances where they or an older participant thought the participant would struggle to connect as the adult was quiet or unused to interacting with small children, yet the person ended up forming bonds with the children and enjoying the experience. For example, one facilitator mentioned an older participant who was nervous about starting the program, who commented at the end of week 2, *'I had a really good time'*.

Some older participants and children formed close bonds over time, and the children would immediately approach the older participant when arriving or for an activity. It appeared that some older participants and children found it easier to form connections (for example, an older woman who used to be a teacher interacted well with two autistic children; some of the young boys connected with the older males in the group). Sometimes there were no obvious reasons for the friendship occurring, the older participant and the child just 'gelled'. In written feedback we received from one site, an ECEC centre teacher commented that one child kept asking when he would see a particular older participant again.

Based on our observations, highly structured group activities seemed to limit opportunities for one-on-one interaction between older participants and children. While some children did approach specific older participants and chat with them in between activities, it did not seem that as many children had a 'favourite' older person they would remain with during the session, compared with less structured activities.

ECEC centre staff told us they felt their role was to support the children who needed it, but they tried not to get too involved as they wanted the children to interact with the older participants. We heard from service providers and older participants that both children and older participants become more confident in approaching one another over time, which was confirmed through our observations at sessions towards the end of the program (e.g., children asking older participants for help with tasks and older participants going up to children who were playing by themselves).

5.2.2 Popular and less popular activities

When asked what they enjoyed most, older participants nominated a variety of activities:

- drawing, painting and craft
- songs and music
- gardening
- treasure hunts and Easter egg hunts
- parachute activity
- beach ball tennis

Some of the one-off events were popular, including the magic show, the Indigenous day, and when one of the facilitators brought in a companion dog.

> *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)*

Some participants enjoyed playing with the children outside, while others preferred indoor activities. Some participants said they enjoyed activities that involved direct interaction with the children (e.g., pushing them on a swing) or where they had to work together (e.g., older people helping younger children to write their names or work on a collage).

Many participants said they did not have an activity they liked the most, but just enjoyed being with the children, watching them during the activities and spending time with them. One participant said they appreciated the support provided by the ECEC centre staff in helping them to interact with children.

Some participants said there were no activities they did not enjoy or would prefer not to do. However, some activities that older participants said they enjoyed the least were:

- Yoga – two participants in the same program thought it was boring and did not allow for much interaction between the older participants and the children. The service provider also recognised this and said they would not run it again.

- Activities that involved sitting down on the floor – for example, sitting on the racetrack mat and playing with cars - as the participant had physical limitations
- Show and tell – one older participant did not enjoy talking in front of people.
- Painting – the older participant did not feel they were good at this activity.

5.2.3 Missing sessions

Older participants and service providers had mixed opinions about whether missing sessions led to less engagement with the programs overall. While some believed older people could derive benefits from the sessions they attended – even if they did not complete the program – the general sentiment from stakeholders was that the benefits increased with greater attendance and participation, as it gave older people an opportunity to build stronger connections with the children and other older participants. These observations were confirmed by the quantitative data (see Section 6.3.2).

5.3 Changes in experiences over time

Most participants said they enjoyed the program more as time went on. They became more familiar with the children and other older participants and were able to build deeper connections as they became more comfortable with each other. Many said they very much looked forward to the sessions each week, and for some it was the highlight of their week. A few older participants said their experiences did not change over time; they enjoyed the sessions from the beginning of the program and continued to do so.

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)

Little children get to know you and throw their arms around you. The children were more outgoing towards us. (Participant)

The program got better as it got going as us oldies got to know each other… all the oldies got involved – and I could see our shyness in doing events at the beginning of the program had changed by the end of the program. (Participant)

6. Outcomes for older people – program data

This chapter draws on data provided to NBMPHN by the providers of the intergenerational programs, and reports on the key quantitative outcomes for older people: attendance, participation and quality of life, measured by change in depression scores.

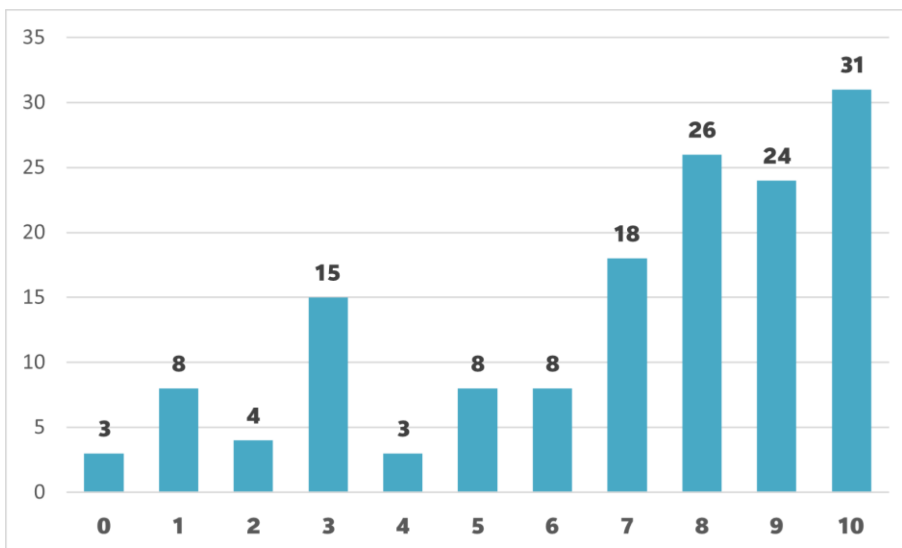
6.1 Attendance

A total of 148 older people were recruited by the 6 providers: 71 in Term 4, 2023, and 77 in Term 1, 2024. Of these, 117 (79.1%) were female. All but 3 participants provided their age. The average age of those recruited to the programs was 80.3 years (range 57-99, SD 8.3).

All providers succeeded in recruiting at least 10 older people for each program, as required by their funding agreements. Across the 11 programs, the number of older people recruited ranged from 10 to 19 (Table 4).

Those recruited to intergenerational programs attended 6.9 sessions on average (range 0-10, SD 2.9). Three recruits did not attend any of the sessions and 107 (72.3%) attended at least half of the program (i.e., 6 or more sessions; Figure 1).

Figure 1: Attendance by older participants



'Completion' was defined as attendance for at least 7 of the 10 sessions. According to this definition, 99 older people (66.9% of those recruited) completed an intergenerational program. Completion rates varied among providers and groups (Table 4**Error! Reference source not found.**).

Table 4: Program completion by service provider and group

Service provider*	Year	No. recruited	Completed n (%)
Provider 6	2023	10	10 (100.0)
Provider 1	2023	13	12 (92.3)
Provider 1	2024	12	10 (83.3)
Provider 6	2024	16	13 (81.3)
Provider 4	2024	12	9 (75.0)
Provider 6	2023	19	14 (73.3)
Provider 2	2024	16	10 (62.5)
Provider 5	2023	16	8 (50.0)
Provider 4	2023	13	6 (46.2)
Provider 3	2024	11	4 (36.4)
Provider 5	2024	10	3 (30.0)
		148	**99 (66.9)**

Note. *Service providers are ordered from highest to lowest completion rate.

Reasons for non-completion were noted for 28 participants across all the programs (Table 5). Seven missed some sessions due to other commitments, such as appointments or travelling. Four opted out after one or 2 sessions, and a further 2 felt they were unable to continue due to disabilities: one was in a wheelchair, the other had poor hearing. For some people, multiple reasons for non-completion were given.

Table 5: Reasons given for non-completion of intergenerational programs

Reason	Number of participants*
COVID**	13

Reason	Number of participants*
Lack of transport/staffing	7
Other commitments	7
Other illness or surgery	6
Decided not to continue	4
Disability	2
Started late	1
Moved away	1

Note. *Total is greater than 28 because some people had multiple reasons for non-completion. **Not all of these participants had COVID but all were prevented from attending by COVID precautions.

COVID and other illnesses or surgeries were other common reasons for participants to miss sessions. A COVID outbreak had a major impact on Provider 5's first program, preventing 5 older people from attending the first 3 sessions. Seven older people attended the first 3 sessions of Provider 5's second program but were absent for the remainder of the sessions. Some (not all) had contracted COVID, and although the program was not the source of the infection, the ILU manager preferred all residents to withdraw from the program due to perceived risk of COVID. Consequently, only 3 of the 10 recruits completed this program.

6.2 Participation

Active participation is considered an important precursor to achieving the expected quality of life outcomes of intergenerational programs (see program logic, Table 2). The extent to which older participants engaged with the programs was measured through a structured observation instrument, the **Leuven Scale**, which allows measurement of engagement in educational activities. The assessment is completed by educators or other experts who are observing the group learning sessions. Although usually used to measure children's involvement, in the context of these programs the scale was used to assess older participants.

At the end of each session, facilitators or assistants completed the instrument for each older person present, rating their wellbeing and involvement on 5-point scales from 5 *Extremely high* to 1 *Extremely low*. These scores provided an indicator of the 'dose' of the program they received. The **wellbeing** score indicated how much they enjoyed the sessions, and the **involvement** score indicated their engagement during the sessions).

Mean scores were calculated if participants had attended (and had ratings for) at least 4 sessions (Table 6**Error! Reference source not found.**). Scores were available for 121

participants[8]. Wellbeing ratings ranged from 3.30 to 4.86 (mean 4.11, SD 0.53). According to the Leuven Scale scoring instructions, a score of 4 *High* for wellbeing indicates that participants were, on average, demonstrating obvious signs of satisfaction, cheerfulness, self-confidence and openness (albeit at less intensity than 5 *Extremely high*) and no signs of stress or tension.

Involvement ratings were slightly higher overall, ranging from 3.75 to 4.76 (mean 4.35, SD 0.36). The Leuven Scale scoring instructions suggest that a score of 4 *High* demonstrates continuous activity and involvement with some intense moments of energy or creativity; participants are reasonably persistent and not easily distracted.

The fact that the ranges for both scores do not fall below 3 *Moderate* for either wellbeing or involvement indicates that facilitators largely succeeded in engaging participants. Most of the older people were able to concentrate on the activities and none expressed sadness, discomfort or unease in their facial expressions or body language.

Table 6: Leuven scores for older people who attended at least 4 sessions

Service provider*	Group year, location	Participants n	Wellbeing mean (SD)		Involvement mean (SD)	
Provider 6	2023, location 1	10	4.54	(0.39)	4.58	(0.43)
Provider 1	2023	13	4.62	(0.35)	4.73	(0.24)
Provider 1	2024	12	4.63	(0.45)	4.74	(0.31)
Provider 6	2024, location 2	13	4.86	(0.22)	4.76	(0.26)
Provider 4	2024	12	3.81	(0.53)	4.19	(0.41)
Provider 6	2023, location 2	17	4.45	(0.26)	4.62	(0.25)
Provider 2	2024	12	3.65	(0.58)	4.09	(0.69)
Provider 5	2023	13	3.30	(0.51)	3.75	(0.28)
Provider 4	2023	9	3.67	(0.32)	4.03	(0.40)
Provider 3	2024	7	4.12	(0.43)	4.44	(0.40)
Provider 5	2024	3	3.57	(0.33)	3.99	(0.56)
		121	**4.11**	**(0.53)**	**4.35**	**(0.36)**

[8] The criterion for calculating participation scores (at least 4 sessions) was set lower than that for program completion (at least 7 sessions) to maximise the use of available data for analysis.

Note. *Service providers are ordered consistently with Table 4 (highest to lowest completion rate) for easier comparison.

6.3 Quality of life

Older participants were asked to complete the Geriatric Depression Scale - Short Form (GDS) during or after the first and last sessions, to provide an indication of their quality of life at baseline and any change during the programs. The tool was presented to participants as the 'Intergenerational Questionnaire'. Data were collected and compiled by service providers as part of their reporting to NBMPHN at the conclusion of each program.

The GDS is a mental health screening tool which asks respondents to answer 'yes' or 'no' to a series of 15 statements. Example statements (with scoring guidelines indicated in brackets) include *'Are you in good spirits most of the time?'* (yes=0, no=1) and *'Do you feel that your situation is hopeless?'* (yes=1, no=0). Total scores range from zero to 15, with a score of 5 or more suggesting that the person may be depressed.

Of the 148 older people recruited to the programs, 144 (97.3%) completed the pre-program questionnaire and 117 (79.1%) also completed the post-program questionnaire.

6.3.1 Prevalence of depressive symptoms

A total of 22 individuals had scores of 5 or more - indicating depression - at one or both measurement time points. The maximum score was 12. The prevalence of depressive symptoms at the pre-program measure was 19/144 individual respondents (13.2%).

It is difficult to comment on how this compares with the wider Australian population as there are relatively few studies reporting specifically on the prevalence of depression in community-dwelling older participants and estimates vary widely. For example, a national survey[9] of 22,251 community-dwelling people aged 60 years and older, who were contacted via their General Practitioners and asked to complete the Patient Health Questionnaire, found a prevalence rate of 8.2%. The 2017-2018 National Health Survey, conducted by the Australian Bureau of Statistics, used the Kessler-10 Psychological Distress Scale and found a prevalence rate of 19% for moderate distress among older Australians (65 years and over).[10]

The prevalence of depressive symptoms among participants of the intergenerational programs falls between these estimates. Although our study cannot be compared with these

[9] Pirkis J, et al. (2009). The community prevalence of depression in older participants. *Journal of Affective Disorders, 115*, 54-61.

[10] Australian Institute of Health and Welfare (2023). *Older Australians: web report*. Downloaded from https://www.aihw.gov.au/reports/older-people/older-australians/contents/health/health-disability-status#Mental%20health

previous studies directly, due to differences in the definition of 'older Australians' and in the instruments used, our findings do not appear to be outside the expected range.

6.3.2 Change in depressive symptoms

Pre- and post-program GDS scores are shown in Table 7 by service provider and program. For every program there was a positive difference between the pre-score and post-score means, showing that depressive symptoms were reduced slightly across the intergenerational programs (that is, post-scores were consistently lower than pre-scores).

A paired samples t test showed that, averaged across all participants, there was a statistically significant reduction in depressive symptoms after older people participated in an intergenerational program, $t(116) = 4.53$, $p<.001$.

Table 7: Scores on Geriatric Depression Scale before and after participation

Service provider*	Year	Pre-score n, mean (SD)			Post-score n, mean (SD)			Mean difference
Provider 6	2023	10	1.50	(1.65)	10	0.70	(0.95)	0.80
Provider 1	2023	12	2.17	(1.27)	12	1.42	(0.90)	0.75
Provider 1	2024	12	2.17	(1.95)	12	1.83	(1.64)	0.33
Provider 6	2024	16	1.75	(2.67)	13	0.46	(0.66)	0.69
Provider 4	2024	12	2.67	(1.72)	12	2.08	(1.56)	0.58
Provider 6	2023	19	2.37	(1.77)	17	2.24	(1.79)	0.12
Provider 2	2024	14	2.71	(2.61)	10	1.40	(0.70)	0.60
Provider 5	2023	16	2.19	(1.94)	13	1.69	(1.32)	0.77
Provider 4	2023	13	3.54	(3.28)	8	2.00	(1.77)	2.25**
Provider 3	2024	10	2.80	(1.55)	3	1.33	(1.15)	1.00
Provider 5	2024	10	1.70	(1.70)	7	1.14	(1.35)	0.57
		144	**2.32**	**(2.01)**	**117**	**1.48**	**(1.25)**	**0.77**

Note. *Service providers are ordered consistently with Table 4 (highest to lowest completion rate) for easier comparison. ** Mean difference is large because 4 participants had very high initial scores, including one whose score was 12. Three of the 4 had considerable reductions in depressive symptoms on the second measurement occasion; the fourth did not complete the program.

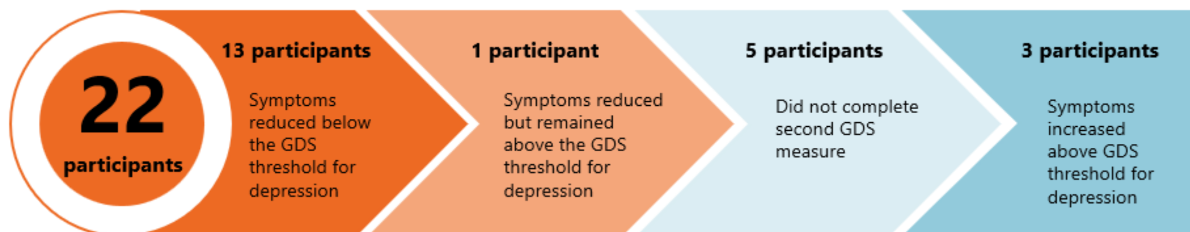
Clinically significant change

Another way to consider outcomes is to look at whether individuals with GDS scores over the threshold for depression before the program were below the threshold afterwards. This could be considered a clinically significant change, as they were no longer depressed after the 'treatment' (i.e., the intergenerational program). Figure 2 outlines the 15-point GDS scale.

Figure 2: GDS scale

Figure 3**Error! Reference source not found.** presents findings for the sub-group of 22 participants who scored 5 or more on the GDS (5 being the **threshold** score, indicating depression) at either or both measurement points. Of the 22, 19 participants had pre-scores over the threshold and 3 had scores which increased from below the threshold on the pre-score to over the threshold on the post-score.

Figure 3: Outcomes for 22 participants with GDS scores indicating depression



The majority (13/19) of participants who had pre-scores over the threshold had post-scores below the threshold and could be considered no longer depressed.

Five of the 19 individuals who had pre-scores indicating depression did not complete a second measure because they did not complete the program. This attrition rate (5/19, 26.3%) is slightly higher than the overall rate (27/144, 19.0%), suggesting that those with depression might be more likely to drop out of the programs. There is insufficient data to test this statistically, but it would be worth investigating in future studies.

Relationship with attendance and participation

More frequent attendance was associated with lower post-program depression scores. Greater participation (observer-rated involvement) was associated with reduction in depression scores. These significant relationships suggest that participants who received a larger 'dose' of intergenerational programs tended to achieve better outcomes.

Bivariate (Pearson) correlations among attendance, participation and depression scores are shown in **Error! Reference source not found.**. There was a significant correlation between p ost-program GDS score and number of weeks attended, which shows that depressive symptoms decreased with more frequent attendance at sessions.

Leuven scores for wellbeing and involvement were negatively correlated with change in GDS score. This means that those who demonstrated greater levels of participation – as observed by the facilitators during sessions – were more likely to have reduced depression scores at the end of the programs.

Table 8: Correlations among attendance, participation and depression scores

	No. weeks attended	Pre-program GDS	Post-program GDS	Change in GDS	Mean wellbeing	Mean involvement
No. weeks attended	1					
Pre-program GDS	-0.19* (N=144)	1				
Post-program GDS	-0.23* (N=117)	0.58*** (N=117)	1			
Change in GDS	0.05 (N-117)	0.71*** (N=117)	-0.16 (N=117)	1		
Mean wellbeing	0.36*** (N=121)	0.31** (N=120)	-0.17 (N=117)	-0.25* (N=117)	1	
Mean involvement	0.35*** (N=121)	-0.34*** (N=120)	-0.10 (N=117)	-0.32*** (N=117)	0.88*** (N=121)	1

Note. * p<.05, ** p<.01, ***p<.001

7. Outcomes for older people – qualitative data

This chapter presents qualitative data on the benefits for older people involved in the programs, based on self-reports from participants and observations of other stakeholders.

7.1 Perceived benefits for older people

All service providers said their programs had positive impacts on the quality of life of older participants, particularly in developing new friendships, enriching social interactions, and in bringing joy into their lives.

7.1.1 Social lives and new friendships

Service providers, particularly from three of the sites, said the program provided opportunities for participants to develop new friendships. This was especially the situation with programs that involved participants from the same ILU, who may have known each other casually but now had the opportunity to develop deeper friendships. Staff at one of the ILUs, who attended the sessions, said they were 'enthralled' by seeing previously quiet residents 'come out of their shell' and actively participate in the program.

During interviews, we heard stories of people who now regularly meet for coffee outside the program sessions. One of the service providers put on a breakfast for the older participants halfway through the program, with the aim of fostering friendships. A facilitator from a program site where many of the older participants are from the community, talked about participants sharing photos of their family with each other.

They've been able to communicate and hang out a bit more and sort of meet new people since doing this program; they mingle a little bit better. (ILU staff member)

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

Friendships have also developed between older people and children. For example, one facilitator mentioned that several children called out hello and goodbye using the older participants' names.

An older person and a young person developed a friendship – when they see each other they run to each other. (ILU staff member)

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)

7.1.2 Broader community connections

Service providers weren't aware whether program participants had joined other community groups or activities since being involved in the program. Providers based in Neighbourhood Centres did mention that participants now had a broader knowledge of what they do and the services they offer.

7.1.3 Mental and physical health

Service providers at three sites provided feedback on the positive benefits to participants' mental health from being involved in the program. They described participants feeling more relaxed after attending the sessions, and with improved mood. One service provider said a participant described the program as having *'saved my life and gave me life'*.

Sense of lightness – energetically they just change. (Service Provider)

They want to participate in whatever is happening because it makes the child happy, and they love it that children are engaged with them. (Service Provider)

For some of the residents who may have been feeling lonely or even suffering some depression, the program provided a sense of purpose and brought smiles to their faces. (Service Provider - written feedback)

There was also a perceived increase in some participants' physical health, with one service provider saying that some older participants who used walkers or sticks, had increased physicality as the program continued as a result of actively interacting with the children.

7.1.4 Creativity and play

Service providers didn't give much feedback on whether the program provided opportunities for older participants to develop creative and art skills; their feedback focused more on the opportunities provided for older participants to do creative arts together with the children or to learn from each other how to do specific art or craft activities. For example, children teaching older people how to make paper planes, older people teaching children to make cards, helping them with cutting and glueing, or demonstrating how to use Lego. Older people appreciated the opportunity to help and mentor the children and to share skills, which made them feel needed.

> *Some seniors are very creative and help the children with creating something; and other seniors don't know how to play – it's lovely to see them take it in and learn how to be a child. (Service provider)*

> *During balloon tennis, an older woman was heard to say to a child, 'this is called a serve'. (Service provider)*

7.2 Self-reported benefits for older people

We interviewed some of the older participants, asking them what changes, if any, the program has made to their life and to them. We also received feedback from three sites where the program facilitator had taken photos at the sessions, collected drawings and comments from participants, and written their own reflections on the sessions.

7.2.1 Social lives and new friendships

For some participants, the highlight of the program was getting to know the children as the program progressed and establishing connections with them. Some participants said the program made them almost *'feel like a child again'*.

> *Getting to know children as the weeks pass. Getting to know their names and learn more about them. Children look at you and smile. They know you, they come up to you. (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)*

Many of the participants we spoke with said the program had enhanced their social lives, as they had connected with other participants whom they didn't know previously and enjoyed talking with them during the program, with some meeting up outside of the program.

At all six sites, at least some participants we spoke with said they had made new friends through the program. This included establishing deeper friendships with people from their retirement village whom they previously only knew casually; making casual connections, that may lead to a more formal friendship later; and meeting up with new friends (e.g., for coffee) outside of the sessions.

> *This program is a jumping off point for other connections. (Participant)*

> *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)*

> *You could see stronger bonds happening between older people, they would tell you their names and what they've been doing – they weren't superficial chats, they were intimate and friendly chats. (Participant)*

In addition to reporting their own positive outcomes, older participants observed that friendships developed between other older participants and children, and between other older participants, as the program progressed.

7.2.2 Broader community connections

There were mixed views from participants as to whether they felt differently about their community because of the program. A small number said there was no change, either because they were already involved in lots of community activities, or they didn't live in the area. Others said that they now knew more about what was available in their community.

A few participants said they now felt more a part of their community as they had got to know other community members. For example, one participant told program staff that they felt a sense of *'purpose and connection to my community in a way I haven't felt for years'*.

7.2.3 Changes in physical health

Many participants said they were already physically active, so the program didn't contribute to increasing their physical health. A small number though said the program did positively impact on their physical health and flexibility, particularly as some of the program activities required them to bend down and move around more often than they normally would.

> *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)*

> *Energising & fun! (Participant - comment collected by program staff)*

> *I love it here. I love the people. It keeps me healthy. (Participant - comment collected by program staff)*

7.2.4 Changes in mental health

Participants told us that attending the program had improved their mental health, mainly by giving them something fun and enjoyable to look forward to each week. Common feedback included that the program *'brightens up my week'*, *'weekly dose of joy'*, *'come home on a high after each session'*. At some sites, where older participants were invited to draw or write how they felt after each session, many participants drew a smiley face.

> *The sense of doing something I like; it cheers you up. I have chronic health conditions and they can make me feel depressed – this [IG program] has cheered me up. (Participant)*

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

> *After the session finished, I felt brighter and happier, and this lasted the whole day. (Participant)*

I just thoroughly enjoyed the program… [during the sessions] you feel enlightened, don't worry about paying your rent, etcetera. (Participant)

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)

A small number of participants said the program had affected how they thought and felt about themselves. All these impacts were positive. One older person said the program had empowered them, because they could use skills that they were good at; another said they were learning to be patient as this is what is required when interacting with children; another was encouraged to leave the comfort of their home to go out and do other things.

7.2.5 Creativity and play

We asked participants whether the program had made a difference to the amount of time they spent doing things they valued and enjoyed. Participants tended to interpret this question as, 'Did you enjoy attending the program?', and most said they did; only two did not feel the program had increased the time they spent doing enjoyable activities. Older participants perceived that other older people also enjoyed the program, with some saying that you could see this by the way they interacted with the children, looked happy, and continued to attend the program.

At the end of the program, we laughed more - we 'let our guards down' and we did it together, there was no judgment. (Participant)

Being around little children makes me happy … brings me joy. I don't have any family close by. This is something to look forward to. All the children in my life are older now … Helps bring out the kid in yourself. (Participant)

[It is fun to] revert to childhood and not be embarrassed to act like a kid. (Participant)

Across the program sites, many participants provided examples of teaching children new skills or supporting them to learn. This included helping children with specific skills, such as colouring in, threading beads, building sandcastles, and reading them stories; and teaching them general skills such as quicker ways to do things. Participants also taught children about 'life', for example, explaining what 'bald' meant, teaching children left and right hand, and showing children a prosthetic limb and explaining why the participant had one.

At one site, older participants were invited to draw pictures to show what they did and how they felt at the sessions. One participant drew a picture of them and a child playing a form of tennis, both with big smiles on their face. And a facilitator provided examples of older participants teaching children how to count, and how to colour in within the lines.

One participant though talked about learning to play animal bingo for the first time, which they enjoyed; and another enjoyed threading beads, which they had not done for decades – they appreciated that doing this was good for their manual dexterity, 'good to polish those manual dexterity skills as need to do this as you get older'. Most, however, said they had not learned or renewed art, craft or games skills through the programs.

7.2.6 Would participants recommend the program to others?

All participants we interviewed said they would recommend the program to others and some had already recommended it to people they knew. However, one participant said that they recognised that committing to 10 weeks may be difficult, as people have ongoing commitments or travel plans.

8. Unintended consequences

The focus of this evaluation was on outcomes for older people; however, other consequences were also evident. This chapter reports on perceived benefits for children, observed by service providers and older participants, and self-reported reported benefits for the staff of service provider organisations. Unintended outcomes for older people are also reported here.

8.1 Perceived benefits for children

Service providers saw the program as positively affecting the children and described a variety of benefits. Commonly, they said that the program was beneficial for children who either did not have grandparents or who had infrequent contact with their grandparents, as the children learned to engage with older people. One provider summed up the benefits of contact with an older generation for the children, who:

> *… see fragility, learn empathy, also see that [older people] have so much to give. Learning patience, learning different styles of music, like different things they've never heard of.*
> *(Service provider)*

Program staff captured photographs of older participants showing children elements of their life, such as an older participant giving a child a 'ride' in their walker, an older participant showing children a photograph of them taken when they were younger. These illustrated how children became confident and comfortable to learn about other people's lives.

Providers talked about situations where children who took part in the programs had approached older participants in the community and introduced them to their parents. A couple of providers talked about seeing shy children 'come out of their shell' over time and participate in more activities. Another benefit was the opportunity for children to experience being an expert, by teaching older people how to do things, resulting in increased confidence.

Older participants also said they thought children got a lot out of the programs. They observed children having fun, with some having increased confidence to be involved in activities and being less reserved and shy as the program progressed. They also noted that children became confident to mix with different people as time went on, for example being confident to approach older participants rather than waiting for older people to approach them. Children also got the opportunity to demonstrate their talents and skills. Some participants noticed with amazement that some children, who were normally quite active, sat still and focused during story time.

Some children formed attachments with individual older participants, with these relationships enduring over the life of the program. The older participants felt that children gained an

understanding of 'old' people, for example, that they could help with doing things; and they learned what things were like for older participants when they were younger.

What children primarily got out of the program was relationships. And some understanding of old people. (Participant)

They learnt we aren't scary, and we don't have those 'old' smells. (Participant)

One site collected feedback from children about what they liked about the program. Some of their comments are provided below:

My friend tells the best stories and plays lot of music with the music stuff. (Child participant)

I like my new friends, they look like my Grandma who I don't see much. (Child participant)

Did you know the older people know the Old MacDonald song as well? (Child participant)

8.2 Self-reported benefits for service providers

For service providers, being involved in the program was beneficial for them as an organisation, but also for their staff. One provider described staff feeling happy at seeing the interactions between the older people and children:

We didn't realise how much joy it would bring to people not directly involved. Their stories bring light to all of us when they share with us, for example, photos from the sessions. (Service provider)

Another reported that the facilitator had enjoyed seeing the participants' progress as the program went on. In addition, programs provided opportunities for organisations to connect with other services, along with *'local preschools, guest facilitators and the NBMPHN'*, lifting the service provider's profile in the local community.

8.3 Unintended outcomes for older people

Some service providers recognised that delivering a program and then ceasing it with no further ongoing supports could leave participants upset. This insight was confirmed when we interviewed older participants, many of whom said they were sad when the programs ended.

However, at some sites, the service providers arranged for older participants to continue to visit the ECEC centre after the program finished if they wished, to foster ongoing relationships between young and older people.

We'll keep communication going with one of the preschools so the seniors can still have connections; we couldn't not continue this. (Service provider)

We commonly heard from older participants that, after the program finished, they were offered the opportunity to continue interacting with the children they met in the program.

For example, at the end of the 2023 school year, one ECEC centre invited the older participants to the preschool graduation. At the event, some parents approached the older adults to ask whether they would mind if their children kept in contact. Another provider invited participants to join a playgroup at a local school. Further, some parents have contacted an ILU directly to get in contact with the older person their child interacted with in the program.

It appears though that community connections have been fostered between some of the children and their families and some of the older residents since the program ended. These ongoing connections are a positive unintended outcome of the programs.

9. Suggestions for improvement

Service providers and participants offered suggestions for improvement, outlined below.

Provide more information

One participant would have appreciated receiving more detailed information about the program before it commenced, including the types of activities to expect. This would have allowed them to 'mentally prepare' before they started and be more aware of the aims of the program. A few sites did communicate with participants before the session each week outlining what to expect.

Extend the programs

There were mixed views among participants as to whether the program should extend from 10 weeks to 20 weeks. Some participants said 10 weeks was a suitable amount of time as they had to block out time in their calendars to ensure they were free for the whole program. While participants we interviewed were interested to do the program again, some were reluctant to reserve 20 weeks for the program up front. One participant suggested doing 2 x 20-week programs during the year split into 10-week blocks, alternating between 2 cohorts.

Participants who wanted the program to run for longer were interested to see the increased benefits experienced by older people resulting from developing connections with young people and other older participants over a longer period.

A small number of participants felt the sessions could be longer, but appreciated the current length was appropriate for the age and attention span of the children involved.

Keep things consistent

Older participants said it was important to have the same children attend each week, as this allows participants to build deep connections and relationships.

Encourage reflection for quality improvement

Some participants and service providers said it could be useful to have some purposeful reflection at the end of the program with children and adults, to understand what they enjoyed and gauge interest in returning for another program. We note that some providers do ask participants to provide feedback after each session if they would like to. One participant suggested it could be beneficial for service providers to debrief at the end of the program and share learnings amongst each other.

10. Discussion

In this final chapter, we summarise findings against the KEQs (Table 9) and discuss the key outcomes of participation and quality of life. Based on the evidence presented in this report, we then make some recommendations about how NBMPHN might foster good practice and continuing improvement in its intergenerational programs in future, and how future evaluations might be improved.

10.1 Key evaluation questions

Evaluation results presented in chapters 3-7 are summarised below.

Table 9: Summary of findings against Key Evaluation Questions

	KEQ	Findings
1	Were the intergenerational programs implemented as intended?	• All six service providers succeeded in establishing functional partnerships with ECEC centres • All 11 programs recruited at least 10 community-dwelling older people, either through ILUs or directly • A total of 148 older people were recruited across all the programs, with an average age of 80.3 years (range 57-99) • Almost four in five older recruits (79.1%) were female • 99 (66.8%) of the older people completed a program (i.e., attended at least seven sessions) • Program designs were based on a range of useful inputs: the JOY course, AIIP resources, providers' experiences, consultations with stakeholders, expert advice. Inputs did not appear to include participatory co-design processes. • Five specialist programs were delivered: three music programs and two which included people with disabilities • A sixth specialist program for Indigenous participants did not go ahead as planned • Commissioned programs were delivered in late 2023 and early 2024 in a variety of locations across the region • All service providers collected the data required by their funding agreements: attendance, Leuven ratings for each older participant at each session, and completion of the GDS by older participants before and after the programs

	KEQ	Findings
2	What factors facilitated implementation? What were the barriers to implementation?	• The three sessions observed by the evaluation team took place in comfortable, inviting and accessible environments that were set up thoughtfully for both cohorts • Programs typically incorporated a mix of purposeful activities that required high levels of interaction between the cohorts, such as crafts, singing and music making, games, and storytelling with participatory elements • Very structured whole-group activities appeared to inhibit one-to-one interaction by limiting opportunities for spontaneous contact between the cohorts • The timing of sessions (1-2) hours appeared appropriate, with shorter sessions for programs requiring intense concentration or physical exertion and longer sessions for more relaxed activities • Some stakeholders suggested that narrowing the age range for children to four-year-olds might be helpful, so that activities can be designed to suit their abilities • Having the same children attend each week helped establish deeper relationships between them and older participants • Factors that encouraged attendance by the older participants included accessible transport or running the program at the ILU • Barriers to attendance included COVID outbreaks, other illnesses and surgeries, other commitments, and logistical issues such as lack of transport or staffing • Strong efforts were made to ensure that those with physical mobility problems or dementia were supported to take part as much as possible; however, two people dropped out of programs because of disability (wheelchair use, poor hearing)
3	To what extent did older people engage actively in and enjoy the programs?	• Observer-rated wellbeing and involvement during sessions (i.e., Leuven scores) were high on average, indicating that most of the older people were able to participate fully, concentrate and enjoy themselves • Many older participants said they very much looked forward to the sessions each week, and for some it was the highlight of their week

	KEQ	Findings
		• Older people appreciated the opportunity to help and mentor the children and to share skills, which made them feel needed • Some older participants and children formed close bonds over time, and the child would immediately approach the older participant when arriving or for an activity, which was a source of happiness to the older participant • It appeared that some found it easier than others to form connections with children, but even reserved or cognitively impaired older people could participate in the programs to the extent they wished, with evident enjoyment
4	To what extent did the program facilitate social connection and reduce loneliness?	• Intergenerational programs provided opportunities to build social connections among older people • Across all six program providers, participants said they had made new friends • They established deeper friendships with people from their retirement villages whom they previously only knew casually, or expanded their circles of acquaintance, which they hoped might deepen to friendship later • Service providers observed that many older participants were meeting up for coffee and chats outside of sessions • A few participants said they now felt more a part of their community as they had got to know other community members
5	To what extent did the program improve the mood and psychological wellbeing of older participants?	• The prevalence of depressive symptoms (i.e., GDS scores greater than or equal to 5) at the pre-program measure was 19/144 individual respondents (13.2%) • Following the program, 13 of these individuals had their symptoms reduced below the threshold for depression • Across all participants, on average, depressive symptoms were significantly reduced following the programs • There are indications that those who received a larger ‘dose’ of the program (i.e., attended more sessions, had higher Leuven ratings for wellbeing and involvement) experienced a larger reduction in depressive symptoms • Program facilitators observed positive impacts of the programs on the mood and wellbeing of older participants

	KEQ	Findings
		• Older participants reported that the programs improved their mood and wellbeing, mainly by giving them something fun and enjoyable to look forward to each week
6	To what extent did the program improve the activation, mobility and physical wellbeing of older participants?	• Many participants said they were already physically active, so the program did not contribute to increasing their physical health • A small number said the program helped improve flexibility and mobility, as some of the program activities required them to bend down and move around more often than they normally would • Positive impacts on participants' mobility were also noticed by some service providers

10.2 Participation and quality of life

The intergenerational programs are one of several initiatives commissioned by NBMPHN using funding available through the aged care early intervention initiatives. The goal for NBMPHN was that the intergenerational programs would promote healthy ageing through:

- improving social connectedness
- providing mutual learning opportunities
- increasing physical activity levels.

Findings for the KEQs (above) indicate the first two goals have been met. The third goal appears to have been partially met, but more evidence is needed.

In addition, NBMPHN will report back to DoHAC on two KPIs: the number of participants overall, and the number who sustained or improved their quality of life.

Quality of life was defined for the purposes of this evaluation as a combination of greater meaning in life, psychological and physical wellbeing with reduced social isolation following the programs. In the logic model (Table 2), these constructs were considered *indirect outcomes* because they relied on the participants' levels of **engagement**, improved **mood**, physical **activation** and **social connection** during the sessions. As these are more directly observable and more closely connected with program activities, we refer to these as *direct outcomes*. Program logic indicates that where the direct outcomes are evident, the indirect outcomes are likely to follow. This is particularly useful when it is not possible to measure

indirect (longer-term) outcomes, such as improvement in chronic disease management, as in the current study.

10.2.1 Conclusions

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.

Observations during the sessions (by facilitators and evaluators) showed that **older people engaged in the programs and participated actively**. Two thirds (99) of the 148 older people recruited went on to complete the programs (i.e., attended at least seven sessions).

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

These qualitative findings were consistent with the results from the quantitative analyses. At the start of the programs, 19 individuals had GDS 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.

There is less evidence available for **physical activation**. 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.

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.

10.3 Recommendations

In this section we make recommendations about good practice for future intergenerational programs, most of which are based on existing good practice that we have observed and 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.

10.3.1 Good practice for intergenerational programs

Training and planning

- Provide training for service providers ahead of time so all staff complete the training before the intergenerational program commences.
- Ensure there is sufficient time between obtaining the funding to commencing the program. This will allow service providers to establish the necessary partnerships with ILUs or ECECs, promote the program and plan the sessions[11].
- More lead time would enable service providers to co-design the program with ECECs and older people, and this tailoring should foster greater engagement. Co-design can take more time than expert design but often has longer term benefits.
- Sufficient time for co-design is a particularly important consideration when developing future intergenerational programs for First Nations people. Guidance is available on co-designing health programs, including specific advice for working together with First Nations communities.[12]

Delivering the program

- Keep things consistent by having the same children attend each week, to allow older participants and children to build connections week-to-week.
- It is important to have a limit on the number of participants to ensure that people can engage in the group setting and get to know others on a more personal level.
- Programs should have at least a 1:1 ratio of children to older participants, preferably more children than older adults. This is because often children like to play with each other in pairs or groups, and it is important that no older participants are excluded.
- Enough ECEC staff and ILU staff should be present during sessions to supervise children, assist older participants where needed, and manage any potential risks.
- Ensure participants with disability are catered for so they can meaningfully participate and engage with the program, whether this be modifying activities or providing necessary resources such as accessible transport.
- Sessions should be held in a comfortable space that is set up in a way to encourage engagement with different activities (for example, showing pictures on a large screen so all participants can see clearly, or ensuring participants have enough space for the planned physical exercises or games).

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[11] We note that some providers had up to 4 months to prepare; nevertheless, most said they would have preferred additional time.

[12] For example, the NSW Agency for Clinical Innovation has developed a co-design toolkit which incorporates the 8 Aboriginal Ways of Learning, https://aci.health.nsw.gov.au/projects/co-design

- Include a variety of activities to cater for all interests and abilities, involving varying levels of physical exertion or energy. This variety should help keep older participants engaged throughout the sessions by accommodating individual preferences.
- Ensure all participants – young and old – have opportunities to interact with each other. Active, alert and sensitive facilitation can greatly enhance one-to-one interaction between older participants and children, to complement incidental interactions.
- If possible, service providers should organise and facilitate opportunities for older people to meet up once or twice after the program ends, to build on the friendships that develop throughout the program as people see these connections as a benefit of the program. This should encourage older participants to take things into their own hands to continue these benefits after the program ends.

Reflection for quality improvement

- Provide opportunities for service providers to reflect and share ideas on what has worked well for them while planning and delivering the program.
- Create avenues for participants to provide feedback during and after programs to understand what they enjoyed and gauge interest in returning for another program. Ensure any suggestions from participants during the program are acted upon, either by implementing changes or communicating why certain things cannot be modified.

10.3.2 Recommendations for future evaluations

- As the programs were under way when the current study began, it was not feasible to obtain ethics approval. Program data (attendance, age, sex, Leuven scale observations, GDS scores) were collected by service providers as part of their funding requirements and provided to the evaluation team for analysis.
- Nevertheless, regardless of formal approval, all studies with vulnerable participants (such as older people and children) must be conducted with attention to ethical principles around avoiding risk of harm and ensuring informed consent. We took great care and are confident that this study was conducted in an ethical manner.
- In future evaluations, timely submission of an application to a suitable Human Research Ethics Committee would provide the assurance of ethical oversight. Importantly, it would allow for the publication of results in peer-reviewed journals to build the evidence base for intergenerational practice.
- Rather than a mental health screening tool, use of a health-related quality of life measure may provide more relevant data and be more sensitive to change over the course of the intergenerational programs.
- Given that the intergenerational programs aim to keep people healthy and living in the community for longer, it would be valuable in future evaluations to include an objective measure (e.g., grip strength) or expert rating of physical activation and mobility impacts.

- Social network analysis is potentially a useful tool for measuring social connections among older participants in future evaluations. For example, all participants could be asked to rate the strength of social connections with all other participants before and after the program to allow analysis of change in networks associated with the program.

Appendices

Appendix 1. Detailed methods

A1.1 Literature scan

We conducted a brief review of existing research and evaluation conducted by the Australian Institute for Intergenerational Practice (AIIP) at Griffith University. Our scan focused on understanding what outcomes might be expected from these types of programs, how they have been measured in previous studies, and the proposed mechanisms by which these outcomes are achieved. The intention was to provide a solid foundation for evaluation design by basing it on program theory and existing knowledge about intergenerational programs.

Key reports included:

- Intergenerational Practice in Early Childhood Education Trial (Griffith University, 2023)
- The Cromwell Intergenerational Practice Pilot Report (Cromwell, 2020).

A1.2 Scoping interview

We conducted a scoping interview with one key staff member from the AIIP on 11 March 2024, to gain a better understanding of:

- principles of intergenerational practice and expected outcomes
- content and delivery of the JOY training undertaken by the service providers for NBMPHN's intergenerational programs
- expert views on balancing fidelity to the principles and training content with adaptation to local needs, to achieve expected outcomes.

A1.3 Evaluation plan

We delivered a project plan that outlined our approach, methods, and delivery timeframes.

The key evaluation questions are listed in Table A 1, along with the indicators and data sources, which together comprised the evaluation framework.

Table A 1. Key evaluation questions, indicators and data sources

Questions	Indicators	Data sources
1. Were the intergenerational programs implemented as intended?	Partnerships between providers and childcare/ aged care groups	Documents, interviews with providers
	Completion of facilitator training (JOY course)	Documents, interviews with providers

Questions	Indicators	Data sources
	Co-design of curriculum-based content that (a) incorporated core components of IGP, and (b) addressed local needs	Documents, interviews with providers, interviews with older participants
	Recruitment of target group of community-dwelling, socially isolated people aged over 65 years	Program data, interviews with providers
	Program governance (oversight, consent processes, regular reflective practice and planning sessions, progress meetings)	Documents, interviews with providers
	Collection of evaluation data using specified tools	Program data, interviews with providers
	Delivery of the 10 weekly sessions in a suitable venue	Program data, interviews with providers
2. What factors facilitated implementation? What were the barriers to implementation?		Interviews with providers, documents, observations by evaluation team
3. To what extent did older people engage actively in and enjoy the programs?	Attendance	Program data
	Engagement	Leuven scale ratings by facilitators, observations by evaluation team, interviews with older participants, PhotoVoice data
4. To what extent did the program facilitate social connection and reduce loneliness?	Observed interactions during sessions	Interviews with providers, observations by evaluation team, PhotoVoice data
	Self-reported sense of social connection and reduced social isolation	Interviews with older participants

Questions	Indicators	Data sources
5. To what extent did the program improve the mood and psychological wellbeing of older participants?	Reduced symptoms of depression	Geriatric Depression Scale before-after scores
	Observed change in mood	Leuven scale ratings by facilitators, PhotoVoice data
	Self-reported change in psychological wellbeing	Interviews with older participants
6. To what extent did the program improve the activation, mobility and physical wellbeing of older participants?	Movement and physical activation during sessions (considering the physical limitations/ capacity of individual participants)	Leuven scale ratings by facilitators, observations by evaluation team, PhotoVoice data
	Self-reported change in physical wellbeing	Interviews with older participants

A1.4 Document review

We reviewed program documents and available data collected by service providers for the evaluation to understand program delivery. We received the following documents from NBMPHN.

- Request for Proposal (RFP) to deliver intergenerational programs in NBMPHN area
- Annual work plans from all providers
- Program descriptions for some providers
- Geriatric Depression Scale (GDS) and scoring instructions
- Leuven Scale and scoring instructions
- Attendance data and outcomes scores for participants in Term 4 2023 programs
- PhotoVoice data for 3 providers (Springwood Neighbourhood Centre, Nordoff Music Therapy and Mission Australia).

In addition, we briefly reviewed the evidence base for the program to establish expectations around what the program is expected to achieve, how, and for whom. Among the relevant reports and articles for inclusion in the document review were the following.

- Developing an Evidenced Based Intergenerational Pedagogy in Australia (Cartmel, J. et al, 2018)
- Some Lessons Learned about the Design and Functioning of ICZs (Kaplan, M. et al, 2020)
- A meta-analytic review of the effects of intergenerational programs for youth and older participants (Petersen, J., 2023)

- Unpacking intergenerational (IG) programs for policy implications: A systematic review of the literature (Radford, K. et al, 2018)
- ‘All in a day's play’ – An intergenerational playgroup in a residential aged care facility (Williams, S. et al, 2012).

A1.5 Service provider interviews

During March and early April, we collected evaluation data via **interviews with service providers**. One or 2 key staff members from each of the 6 organisations commissioned to deliver the program were recruited for these interviews. We sought assistance from NBMPHN with recruitment; by sending an email to introduce the evaluation team, explain our purpose and what we were asking service providers to do, and encourage them to take part.

Interviews were conducted online by Kerry Hart, Kate Williams, and Natalie Martino using Microsoft Teams or Zoom to record and automatically transcribe the discussions, with the participants’ consent. Targeted questions addressed:

- previous qualifications and experience, what the JOY training added, and the extent to which they felt prepared for delivering the program
- experiences of delivering the program, including recruiting and supporting the older and younger participants
- perceptions of how well the program worked, including any changes made to arrangements and activities to adapt to local needs, or suggested changes to improve for potential future opportunities, and observed benefits for participants and staff members.

We interviewed staff members from BANC, Nordoff Music Therapy and Mission Australia before we conducted observations (see below), so that we were fully informed before attending the sessions.

We also interviewed 1 staff member from 2 ILUs involved in the programs deliver by Mission Australia and Nordoff Music Therapy. These were conducted online after we completed our observations.

A1.6 Structured observations

Two evaluation team members – Kerry Hart and Natalie Martino – undertook **structured observations of program activities and interactions** at 3 sessions, across 3 different programs and service providers. We worked with the client to ensure the selected sites were geographically spread across the PHN and provided a broad overview of the programs offered, and to find a time that was convenient for the service provider (

Table A 2).

Table A 2. Observations at 3 sites

Program location	Provider	Type of program	Date of observation
Blackheath	BANC	General	22 March
Richmond	Nordoff Music Therapy	Music	25 March
Kingswood	Mission Australia	General	28 March

The observations were intended to corroborate the data collected by service providers (using the Leuven scale) and, most importantly, to provide an opportunity to conduct face-to-face interviews with participants after the sessions.

A1.7 Interviews with older participants

In a previous evaluation conducted by the AIIP[13], low participation rates led to a lack of valid outcomes data from the perspectives of older participants. This risk led us to suggest that informal, short qualitative interviews was the best way to collect this information.

We conducted interviews with older participants in late March and early April 2024.

We conducted individual and group interviews with 13 participants face-to-face immediately after the sessions we observed. We relied on assistance from the service providers to recruit suitable participants and gauge their interest in participating prior to the session. Participants also completed a consent form prior to engaging in the interview.

In addition, we interviewed 9 older participants from some of the other programs (past and current) by phone, allowing us to capture data on a range of experiences. Recruitment and gaining participant consent was arranged via the service providers.

To reduce the risk of creating any distress for participants we took care to avoid personal issues and instead focussed the conversation on the following topics:

- expectations and initial impressions of the program
- experiences of the program over time
- self-reported outcomes of the program
- perceptions and observations of outcomes for the child participants (and any observations about other older participants)
- overall assessment, including whether they would recommend the program to others.

[13] Australian Institute of Intergenerational Practice (2023). *Report: Intergenerational practice in early childhood education trial.* Canberra: Australian Government Department of Education.

A1.8 Qualitative program data

A8.1.1 Thematic analysis of interviews and observation data

Detailed notes were taken during the interviews and, where possible, online interviews were also recorded so that we could check for accuracy and identify quotes. Files – including the notes from the observations we conducted at three sites - were imported into NVivo for storage and management. Evaluation team members collaboratively developed a coding framework based on the key evaluation questions. Thematic analysis involved the use of a modified Framework methodology[14], starting with deductive coding around the questions and proceeding to inductive coding to draw out and explore any additional issues and ideas that we found in the dataset. Continuous discussions throughout the analysis process ensured that ideas could be compared and conclusions verified among the team members.

A8.1.2 PhotoVoice data

PhotoVoice methods involve asking people to describe their views or feelings by taking photographs. Traditionally, after taking their photographs, participants get together and talk about what their photographs mean to them and identify themes.

Three program sites (Springwood Neighbourhood Centre, Nordoff Music Therapy and Mission Australia) collected data using a modified form of PhotoVoice, where program staff took photographs of program participants engaged in activities, and at some sites participants commented on what the photographs depicted or meant to them through post-its or quotes that were captured by program staff.

At some sites, program staff also wrote short diary notes after program sessions, that described participant interactions and involvement in activities.

Our analysis of the PhotoVoice data involved reading the comments and feedback and adding quotes and comments from the data to relevant sections of our qualitative analysis to further illustrate and enrich our findings. We also described some of the activities and interactions in the photos to add to that which we gathered through our interviews and observations.

A1.9 Quantitative program data

Contracts for the providers commissioned by NBMPHN included 2 KPIs around commencement and completion of the programs, and the collection of required pre- and post-intervention measures and participation data, which comprised the following.

- Number of adult and child enrolments
- Attendance of each adult at each session

[14] Gale NK, Health G, Cameron E, Sahid S and Redwood S (2013) Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC Medical Research Methodology, 13,* 117

- Attendance of each child at each session
- Completion by adult participants of a pre- and post-measure, the Geriatric Depression Scale – Short Form (renamed 'Intergenerational Questionnaire') during or after the first and last sessions of the program
- Use of the Leuven Scale by the facilitator or an assistant each week to assess older participant involvement in the sessions
- Use of Photovoice by older and younger participants to document their activities and record their experiences and feelings about the program.

The **Leuven scale** is an observational tool that allows measurement of involvement and engagement in educational activities. Engagement is rated on a 5-point scale from extremely low to very high. The assessment is completed by educators or other experts who are observing the group learning sessions. Although usually used to measure children's involvement, in the context of these programs the scale will primarily be used to assess older participants. Assessments will be completed for each older person at each session they attend, providing an indicator of the 'dose' of the program they received and whether their engagement levels changed over time as the program progressed.

The **Geriatric Depression Scale – Short Form** is a self-report, 15-item screening tool for symptoms of depression, which has acceptable validity (sensitivity and specificity) for assessing risk of depression in adults over 65 years of age with normal cognitive function[15]. Scores over 5 indicate risk of depression. To ensure that participants have had a sufficient 'dose' of the intervention to make a difference to scores, NBMPHN has indicated that only participants who have attended at least 7 sessions should be included in analyses. Based on preliminary analyses, we will provide advice on the best approach to including or excluding participant scores in the analysis based on attendance records.

A9.1.1 Data analysis

Separate spreadsheets for each program were provided to the evaluation team. These were compiled into one dataset and analysed in Excel and SPSS.

[15] Park SH and Kwak MJ (2021) Performance of the Geriatric Depression Scale-15 with older participants aged over 65 years: an updated review 2000-2019. *Clinical Gerontologist, 44,* 83-96

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