New Zealand Society of Diversional Therapists Inc.

Te Kāhūi Kaihaumanu Kanorau o Aotearoa

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2006 NZSDT CONFERENCE
May 5th, 6th, 7th
Vintners Retreat
Blenheim

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PRESIDENT'S REPORT

As I am writing this report I am finding it hard to believe that already the Executive have been in office nearly a year, and what a year. To say that this has been a huge learning curve would be an understatement but we have all gained something from the experience.

The Blenheim Conference Committee have been working extremely hard on your behalf to ensure that the conference is one where you will have the opportunity to learn, network with others and make new friends in very pleasant surroundings. I would like to thank them for their many hours of hard work and I would urge you to register if you haven't already done so.

Proxy voting will be conducted for the first time at Conference, please read the article further in this issue to find out the rules and requirements for casting a proxy vote.

The new Secretary, Bernadette Forbes and the new Registrar, Alaine Percasky are settling into their roles and processing the many queries and registrations they receive daily. My apologies to those of you who have been waiting patiently while the change over took place; I can assure you they are endeavouring to get through the backlog as quickly as possible.

The Treasurer, Marlene Abbott tells me many of you are taking the opportunity to use the different payment options available this year for paying the membership and renewal fees.

The Treasurers role was joined with the Database and Membership roles this year to allow Marlene Abbott to overhaul all the systems and bring them up to date. As you can imagine, this has been a huge undertaking requiring many hours of work, and I would like to thank Marlene (and her family), for allowing her the time to achieve this. Sadly Marlene is resigning from the Executive at Conference due to personal commitments and I, and the rest of the Executive, will miss her expertise and knowledge in the managing of the Society's funds.

An issue that has caused some consternation over many years is the number of hours required to achieve Registration. Who is to say that a Diversional Therapist who has worked 1000 hours in the role is more skilled in that role than someone who has completed 3000 hours? For this reason the Executive will be conducting a discussion group at Conference chaired by Judy Cooper and Alaine Percasky to allow those who have opinions on this matter both fore and against to have their say. Could those attending Conference please find out the wishes of your Support Groups etc., especially if the members are unable to attend Conference and share those thoughts with us, otherwise contact Judy Cooper, Alaine Percasky or myself to make your wishes known. Judy has written more on this matter in her training article.

I would like to issue a big welcome to our new Newsletter editor, Bill Campbell from Christchurch and again thank John Meredith for his many years of faithful service to the Society in this role.

The Executive would like to take the opportunity to wish all those members who are not in the best of health our warm wishes and hopes for a speedy recovery, our thoughts are especially with Jo Bovey and her family.

I receive many queries from around the country and am enjoying the opportunity to make contact with you all, I hope to meet many more of you at Conference. Please remember the Executive is always available to assist you in any way they can.

Kind regards, Sheree McIntyre

TREASURER'S REPORT

Membership renewals have been flooding in, as have New Membership Applications. The move of due date to the 31st January allows for an earlier indication of Fees received to set the Annual Budget. The new payment options have been a great success.

PLEASE NOTE - Direct Credit or Westpac Counter Deposit. It is vital that you state your Membership number or name. Please fax or post your form to me. There are several deposits that I have no idea who they were paid by. If you have not received a Receipt within 2 weeks of payment please contact me.

Membership Status - Full/Associate

There has been some confusion and debate over the Constitutional requirements. The main issues have been the Badge only being available to Full Members, and Volunteers being given Associate status. I indicated to those concerned that I would ask for a discussion on Membership issues to be on the Agenda at the AGM. The current document is below.

Cheers Marlene Abbott

FROM THE EDITORS DESK

Welcome to the March 2006 edition of your newsletter, my first as your editor. I appreciate the opportunity to work with you and hope that I can maintain the high standards of previous editors.

Looking back over previous issues (the first was June 1993); it is interesting to see how it has evolved over the years. One thing that struck me however was the excellence of the material submitted by members. I am sure this trend will continue and I am looking forward to receiving your contributions. Remember, if your item is taken from another source it must be acknowledged in order to avoid claims of plagiarism.

I am also interested in hearing what you want from your newsletter. Do you want it just to be means of disseminating information to members, or as a forum for debating issues that are of interest to members? My feeling is that a newsletter should mainly be the former. However, a certain amount of stimulating debate never goes astray.

Looking forward to receiving your feedback.

Bill Campbell, Editor

QUALIFICATION REVIEW UPDATE (February 2006)

Qualification reviews are never easy...and this enormous review has certainly been a task to remember. Your Diversional Therapy Standards Setting Team has worked extremely hard to ensure the final outcome will be acceptable to you all. There were many "hurdles" we had to over-come. We will be endorsing Unit Standards totally around 87 credits, and there will be compulsory and optional career pathways covering Mental Health, Physical Disabilities and Intellectual Disabilities. The compulsory and optional career pathways will take into account the concerns many of you raised about working with a variety of disabilities in your facilities and in the community.

Prior to the review process commencing we were charged with networking with Diversional Therapists nationally to ascertain just what was wanted in a new (reviewed) qualification. Over 300 questionnaires were sent out, and 280 were returned. The Standards Setting Team were well aware of what you all wanted, and what you wanted changed and I can assure you all this was taken into account during the review process.

Each Standards Setting Team member was also charged with networking with up to six Diversional Therapists in their area. Unfortunately we could not cover the whole Country, but there was excellent feedback from the areas concerned.

We were acutely aware of the fact that many of you wanted a higher qualification, a Diploma and we did fight hard for that. We were also aware that you all wanted the qualification to reflect the uniqueness of your role, and most importantly the importance of your role, and I can assure you all we did go into battle many times over this issue!

NZQA are concerned about the duplication of Unit Standards on the framework. Units such as Quality Assurance and Grief are plentiful! We have had to bear this in mind when reviewing our units. The strong message conveyed to your Standards Setting Team was to "keep the qualifications small and achievable" and look at career options for candidates, thus ensuring people are not "stuck" with a large qualification that may not meet their needs. National Certificates had to be kept to a maximum of between 70 and 80 credits, for funding purposes, and achievability.

As this newsletter goes to the printer so the draft unit standards go to NZQA for approval. After they are approved, which will take several weeks, your Standards Setting Team will meet again to begin packaging your qualification. This will be finally announced at conference in May.

Your Standards Setting Team and the NZ Society of Diversional Therapists Inc is happy with the outcome of the review process and we know you will be as well. We look forward to presenting your new reviewed National Certificate in Diversional Therapy to you at Conference 2006 in Blenheim.

We stress strongly the importance of people still signing up, it will be quite some time before the new qualification is registered, and we reinforce very strongly that NO ONE will be disadvantaged, those signing up now to start their training on our current National Certificate will be able to complete it. There will be a lead in time to complete the old one and start the new one, and CSSITO will advise you all of this.

I look forward to discussing this with you all at conference.

Judy Cooper

Chair, Diversional Therapy Standards Setting Team

REGISTRATION REQUIREMENTS

Why is it important that you are registered? All health professionals belong to a registration body, and all health professionals must work within competencies, and be accountable for their practice. It is their insurance against mal-practice.

Diversional Therapists are not covered by the Health Practitioners Act at this point of time, but they are covered by an independent Registration Board and requirements approved within legal boundaries. This is your insurance against mal-practice.

Diversional Therapists are required to work within six Standards of Practice and a Code of Ethics. Your Constitution refer section titled "sanctions" and your Registration Booklet refer 9.3 "complaints" very clearly identify the disciplinary actions that will be taken with Diversional Therapists who may bring their profession into dis-repute. While all members of the Society pledge to work within these Standards. It is vital that Qualified and Registered Diversional Therapists show evidence thru a site assessment and yearly registration renewal, that they are still adhering to their Standards of Practice.

Currently among other requirements are 3000hrs of hands on Diversional Therapy, and two consecutive year's membership of the NZ Society of Diversional Therapists Inc.

We want you to think about and discuss within your support groups and work mates the following questions:

(Referring to the Standards of Practice and Code of Ethics of the NZ Society of Diversional Therapists Inc.)

(1) How would you describe a competent, professional and respected Diversional Therapy practitioner? What would you look for?

(2) Do 3000hours make a competent and respected Diversional Therapy practitioner? If yes, Why? If no what hours would you suggest? Why?

Membership of the Society is important

(1) How many years should a qualified Diversional Therapist have to be a member of the NZ Society of Diversional Therapists Inc. to apply for registration? If you would like to change this, please indicate how many years and why?

11th NEW ZEALAND SOCIETY DIVERSIONAL THERAPIST CONFERENCE MAY 5-7 2006, VINTNERS RETREAT, BLENHEIM

The final details are now in place for the conference in May. The wine and fruit juice is chilling and the raffles are being organised. We have also asked for good weather! A big thank you to everyone who has sent in their registrations already, and if you haven't, then there is still time. For those who have registered please send in your arrival details so we can pick you up. We are endeavouring to make this a conference that you will remember - we want to celebrate that Diversional Therapists/Activity Officers are all a **GREAT BUNCH OF PEOPLE**. Don't forget to get your entries in for the photography competition.

Come along and meet old and new friends, learn skills along the way and just have fun. As requested by the members, we have now allowed time for DT issues and questions, so this will be your chance to have a say, and be listened to.

If you are thinking about putting a bid in for conference next year, to do so in writing to the Secretary. If you are thinking about it and want to know any questions, please contact me. We will see you all in Blenheim in May.... And remember this is one conference that will end in a BANG!

Catherine Donnelly, Conference Convenor

PROXY VOTING

Any member of the NZSDT Inc. who is unable to attend the 2006 Annual Conference in Blenheim, is entitled to vote at the AGM by Proxy vote. Proxy forms are available from the Secretary. A proxy vote is only valid for remits and executive voting already in circulation before the AGM. A proxy vote cannot be used to vote for any remits or nominations that come from the floor during the AGM.

From the NZSDT Constitution:

10.6 Each full Member shall be entitled to vote at any General Meeting, in person or by Proxy.

7.6d The Secretary must issue Voting by Proxy Forms four weeks prior to the AGM.

7.6e The Proxy forms must be returned to the Secretary one week prior to the AGM, where the member elects to have the chairperson vote on their behalf.

7.6f Where another member actions a Proxy Form at the AGM on the behalf of another member, the Secretary will be informed of this fact one week prior to the AGM.

Proxy voting forms are available from:

The Secretary
NZSDT Inc.
14 Dinton Street
Russley, Christchurch
PH 03 342 7890

BRAINSTORM AT CONFERENCE

A brainstorming session is planned at Conference in May. It is really important that you come prepared to discuss the questions above.

If you are not coming to conference we still need to hear from you. You can post your answers to these questions to the Secretary, Bernadette Forbes at 14 Dinton Street Christchurch, prior to 20th April, and your concerns will be discussed at conference.

This is your opportunity to have your say. (Alaine Percasky Registrar, and Judy Cooper Registration Board will Chair this meeting).

2006 NZSDT CONFERENCE PROGRAMME

May 5th, 6th, 7th, Vintners Retreat, Rapaura Road, Blenheim

FRIDAY 5th MAY - 6.00pm

Friday night we get together with a chance to network with old and new friends. Tea included in conference costs.

Wine tastings available at $5.00 pp (own cost) with Mr John Forrest, local winemaker. Entertainment provided.

SATURDAY 6th MAY

Tai Chi in the Vines. Official opening with the Springlands School Kapa Haka Group, your Executive and the Marlborough bunch. Workshops include • Gardening Ideas for the Elderly • Music To Get You Moving (as requested again by you) • Hands-on Lavender Workshop - where you get to take something away and smell nice for the rest of the day • Learn the Art of Bonsai - cost for this is $25.00 pp and you get to take home a small planted Bonsai.

LUNCH

Challenging Behaviour Workshop - followed by the Suzie Brown Maze (this is a little thinking outside the square).

EVENING PROGRAMME

For those wishing to put in Conference Bids for 2007, this is your time to Sell Yourselves!

During dinner there will be presentations for those who have gained their Qualification in addition to those who have gained their Qualified Registration Badge. Those wishing to have their Badge presented at the conference must foward their application for registration to Alaine Percasky by 30th April 2006.

SUNDAY 7th MAY

Workshop with Rev. Judy Parkes.

AGM

LUNCH

Finishing the Conference with a BANG with Lyn Harris-Hogan.

MEMBERSHIP INFORMATION

Full Membership

Full Membership is open to individuals currently employed in the field of Diversional Therapy. This includes Diversional Therapists, Motivation Therapists, Activities or Recreation Officers and Occupational Therapy Aides. Full Membership entitles you to purchase the NZSDT Inc Members Handbook which contains the Code of Ethics, Standards of Practice, Constitution and Membership Policy, the Full Members Badge, and receive a yearly date bar and quarterly Newsletter. This publication provides current information on training and education, a list of support groups, and an opportunity to share ideas and support fellow Members.

The Membership Badge is available for $10.00 and the Handbook $5.00, to be added to the cost of Membership. Full Members only are entitled to wear the Membership Badge, and will be issued with a current yearly bar on renewal (without this your badge is invalid).

Full Membership entitles you to vote at SGMs and the AGM. If fees are paid by a workplace, voting rights will be available to the person who is named on the Membership Application Form.

Associate Membership

Associate Membership is open to Students, Volunteers, Facilities Managers and other interested parties who wish to belong to the Society and are not currently employed as a Diversional Therapist.

Associate Membership entitles you to purchase the NZSDT Inc Members Handbook which contains the Code of Ethics, Standards of Practice, Constitution and Membership Policy, and receive quarterly Newsletters. This publication provides current information on training and education, a list of support groups, and an opportunity to share ideas and support fellow Members.

The Handbook is available for $5.00, to be added to the cost of Membership.

Associate Members are not eligible to vote.

OBITUARY

The Southland Regional Support Group of the NZSDT and Eldercare lost a valued friend and colleague following a road accident recently. Annette Attfield worked at Cargill Home in Invercargill for many years as an Activity Coordinator and had commenced her Diversional Therapy training.

Annette was a great supporter of the Southland Support Group and organised our annual Resthomes picnic for all the facilities in Southland.

Annette was a unique and special person and we are the poorer for her parting. I would like to take this opportunity on behalf of the NZSDT to offer our thoughts and prayers to her family, colleagues, friends and residents in whom she was very proud to be associated with.

Sheree McIntyre, President

Friend Of The Society

Remaining a Friend of the Society is open to past Members who have resigned or retired but would like to maintain their interest and contact with current information and events. Friend of the Society entitles you to receive quarterly Newsletters. Friends of the Society are not eligible to vote.

Registration and Qualified Badge

The Registration and Qualified Badge will be presented to those who meet the criteria as outlined in the Qualified Badge Policy and Registration Handbook. The New Zealand Society of Diversional Therapists Inc. shall establish an independent Registration Board to maintain a Register of Qualified Diversional Therapists and issue Registration Certificates and Badges to persons who meet the criteria required by the Society.

Resignation

Any Member wishing to resign shall give NOTICE IN WRITING to the Secretary as per the Constitution. Non-payment of fees does not constitute a resignation. A Member is liable for Membership fees up to the end of the financial year in which notice of resignation is received.

The NZSDT Inc. financial year begins on 1 January each year. Renewal payments due by 31st January.

Please complete all sections of the Membership Form and forward to the Treasurer/Membership.

CHANGES TO REGISTRATION HANDBOOK, EFFECTIVE FROM 10TH JANUARY 2006

4.1 (a) Have been issued with a NZSDT Inc. Qualified Badge and a Registration Certificate.

4.2 On registration, a New Zealand Registered Diversional Therapist shall be issued with a Registration Certificate and a Qualified Badge. The Certificate is valid for one year.

5.2 Applicants will be required to have a personal interview at their own expense before registration can be granted.

5.4 (a) Approve the application unconditionally, and provide a Registration Certificate valid for one year (Full Registration) and a Qualified Badge, or:

(b) Approve the application provisionally, and provide a Registration Certificate and a qualified Badge with the requirement that further information on successful learning and practice be supplied within a specified time for full registration (Professional Registration) or:

The above changes will ensure the Registration Booklet is in line with the NZ Society of Diversional Therapists Inc. Policy on issuing of Badge and Registration Certificate.

THE DIVERSIONAL THERAPIST AND THE "PRIVACY ACT"

The Health Information Privacy Code 1994 is a code of practice issued under the Privacy Act 1993. It was issued to give extra protection to health information because of its sensitive character. The code sets out 12 rules which apply to both private and public agencies.

What is health information?

- Information that identifies a person.
- The health and disability services that a person receives.
- Information that is collected from a person by organisations that are providing the individual with health or disability services.

Examples of health information:

- Medical records, nursing notes, care plans.
- Reports from psychiatrists, specialists, doctors or counsellors.
- Results from medical tests.

Examples of Health Agencies:

- Public and private hospitals.
- Rest homes and retirement villages offering 24hr nursing care.
- Nurses, doctors, psychiatrists, psychologists, counsellors, health care workers, community health providers

Disclosure of Health information:

As a general rule no information about a person should be disclosed without their written consent.

All Rest Homes and Health Agencies should discuss the issue of sharing information at induction or orientation and at least annually at staff training sessions, where individuals can have the opportunity to have their views heard.

Note: Even though there is an agreement, there are some instances where health information can be given out, without the individual's permission. This is when there is serious and immediate threat to their life/ health, or that of another.

If an individual is unable to exercise his/her rights in relation to health information, a representative can act on their behalf.

The code defines a representative as:

- A parent or guardian (for those under 16 yrs).
- The holder of power of attorney for that person (always identify who has power of attorney on entry to your facility or service, especially if the individual has dementia).

An individual's representative can request access to health information. However an agency can refuse if:

- It is not in the clients best interests.
- They believe the client would not want it disclosed to the representative.
- Any of the other reasons set out in the code e.g. prejudice to clients health, unwarranted disclosure about another person's affairs, maintenance of the law.

An individual has the right to access their own health information. They need to request it from the agency concerned. It is recommended that the request be in writing, although it does not have to be. The agency has 20 days in which to respond to a request. The individual has the right to access, not a right to the original files.

A SUMMARY OF PRIVACY INFORMATION PRINCIPLES (BASED ON PRIVACY ACT 1993)

The health information privacy code sets out 12 principles:

1) Personal information should be collected only for the lawful and necessary purposes of the agency.
2) If an agency collects personal information, that agency shall collect that information from the individual concerned, except where an exception applies.
3) If an agency collects personal information it shall do so only with the knowledge and informed consent of the individual, unless an exception applies (i.e. dementia care or someone unable to express or make their own decisions).
4) Personal information shall be collected lawfully and fairly and without unreasonable intrusion into the individual's personal affairs.
5) If an agency has collected personal information it shall ensure that the information is stored in such a manner as to prevent any loss or unauthorized use or access.
6) If an agency has collected personal information it must, upon enquiry from the individual concerned, advise if personal information is held and provide access to the information, unless an exception applies.
7) If an agency holds personal information, the individual concerned is entitled to request correction of that information or have a statement of correction held by the agency.
8) Personal information held by an agency should not be used unless it is accurate, current, and relevant and is not misleading.
9) Personal information should only be kept for as long as is necessary.
10) Personal information collected for one purpose should not be used for another purpose unless an exemption applies.
11) Personal information should not be disclosed to another person, body or agency unless an exception applies.
12) A unique identifier or personal identification number (PIN) should not be used to identify an individual, unless essential to the efficiency of the agency. Two agencies cannot use the same identifier unless disclosure is for one of the purposes for which the unique identifier was assigned.

By Marcia Rickman

From a Community Law handout

EDUCATION - INTELLECTUAL DISABILITY AND DEMENTIA

(Reference: Dementia Educator, Issue No. 2, 2002)

Individuals with an intellectual disability face the same issues as other elders in the community with regard to failing health, retirement, changes in accommodation and dementia. People with an intellectual disability appear to age earlier than the general community and the risk of dementia is higher. This may be due to higher exposure to general risk factors such as reduced educational opportunities, traumatic head injury and nutritional deficiencies. There is also a particular link between Alzheimer's disease and Down syndrome.

Down Syndrome

Down syndrome is the commonest genetic syndrome causing intellectual disability. People with Down syndrome have a higher risk than the general community of developing Alzheimer's disease. People with Down syndrome have three copies (trisomy) of chromosome 21, whereas the general public has two copies of each gene (one from each parent). The gene for the breakdown of Amyloid Precursor Protein (APP) is found on chromosome 21. The by product formed is Beta -Amyloid Protein - the major component of the plaques characteristic of Alzheimer's disease. In Down syndrome amyloid deposition occurs earlier and is more extensive. Plaques have been found in people as young as seventeen years. By thirty years of age it can be expected that all people with Down syndrome who have trisomy 21, will experience the extensive deposition of amyloid and therefore the potential to develop the symptoms of Alzheimer's disease. As with the general population however, the presence of plaque does not seem to lead inevitably to the development of obvious symptoms of Alzheimer's disease.

Service providers report people with Down syndrome who reach their seventies without symptoms of memory loss, or changes in activity indicative of Alzheimer's disease. There is no doubt however, that a significant number of people with Down syndrome who live to an older age will develop the symptoms of Alzheimer's disease and therefore require specialized care.

Assessment and Diagnosis

The recognition of dementing symptoms and the subsequent provisional diagnosis of Alzheimer's disease (or another illness causing dementia) is complicated by:

- Pre existing communication difficulties
- The presence of other illnesses
- Reduced cognitive functioning and
- The possibility of co-existing psychiatric disorders

Access to specialist services is limited. It is rare to find health professionals experienced in assessment and diagnosis of both intellectual disability and dementia.

Diagnostic criteria for diagnosing a dementing illness in the presence of a learning disability:

- Signs and symptoms present greater than 6 months
- Not a direct consequence of other psychiatric or physical disorders
- Represents a change from the person's premorbid state
- Not due to a delirium
- Deterioration in personal skills
- Impaired memory
- Impairment of other cognitive skills - judgment and thinking
- Reduced emotional control, gradual change in social behaviour
- Neurological symptoms supportive of diagnosis
- Seizures
- Frontal release signs

Health professionals rely on the observations of paid carers and\or family members to judge change in function over time. People with an intellectual disability may be reluctant to participate in diagnostic testing including blood tests and CT scans. Further, regular psychological screening tests may not be appropriate in a person who is already cognitively impaired.

Carers need to be concerned when they observe new symptoms that worsen over time. These include:

- Onset of seizures
- Personality changes and general behaviour disturbance
- Increased anxiety and resistance to completing tasks
- Depressive features (more common)
- Psychotic features (less common)

Change in memory may be one of the earliest symptoms noticed by carers. For instance the person:

- Doesn't remember names of familiar people
- Doesn't remember what has just been said
- Repeatedly asks who is coming on the next shift
- Doesn't remember routines
- Doesn't remember where things have been put or kept

The carer may also have noticed reduced motor skills, for example:

- Unable to do up buttons, zips, shoe laces
- Difficulty putting on tops and trousers (change in style of clothes i.e. to elasticized waists)
- Decline in table manners and ability to manipulate utensils
- Rolls rather than folds clothes
- Doesn't wash or dry self properly (less pride in appearance)
- Gait deterioration

The carer may also notice spatial disorientation for example:

- Getting lost along well known streets
- Not being able to find own room or toilet
- Decline in complexity of art work

Knowing the person's abilities is essential if change is to be recognized. Baseline observations of a person's abilities to conduct activities of daily living are required. It is recommended that a comprehensive assessment is carried out in early adulthood (before the effects of accumulation of plaque are experienced). People with Down syndrome experience more rapid changes in the progression of Alzheimer's disease than the general population. They will require more frequent reviews and assessment of needs.

Carers play an important role in providing evidence for the differential diagnosis of other potential causes of dementia that need to be eliminated before a provisional diagnosis of an irreversible dementing illness can be made. We have to look closely for symptoms, as we cannot rely on the person to complain.

Older people with an intellectual disability may experience depression. They may face grief when faced with the death of parents, difficulty adjusting to changes such as moving out of a group home or retiring from work.

Symptoms of depression include:

- Lowered mood - irritability, tearfulness, not smiling or laughing
- Loss of interest - refusal to participate or do usual activities
- Sleep, appetite and weight changes
- Increase of baseline behaviours or onset of new behaviours
- Self injury, verbal and physical aggression, property destruction, repetitive behaviours
- Diminished interaction - speech and communication
- Restlessness or apathy

People with Down syndrome have a higher risk for medical conditions that can result in acute confusion. These include hypothyroidism, altered cardiac function, hearing and visual disturbances (e.g. cataracts), susceptibility to infection and drug toxicity.

Symptoms of hypothyroidism are:

- Lethargy
- Functional decline
- Confusion
- Constipation
- Complaints of feeling cold
- Depression

Issues arising for the service system

Many issues arise including:

- What access do the elderly intellectual disabled have to mainstream aged care services such as daycare?
- Is it appropriate for a person with Down syndrome in their forties to be accommodated with frail older people - where aged care workers have little training or experience in working with people with intellectual disabilities?

If the person with a disability has dementia and is living in a group home, this will impact on other residents in the house who may still be working. Community residential unit design may be inappropriate. Will the facility undergo costly and disturbing renovations to be able to meet the need when abilities are lost? Staffing levels will need to be adjusted to meet the increasing needs of the person with dementia. Some homes are not staffed during the day. There may be restrictions on the activities of other residents if a staff member is required to remain at home and care for a dementing resident.

Philosophy and a program of service may also need review. Does the provision of care (as opposed to the fostering of independent, living and growth in skills) meet the mission statement and aims of the organization? Are staff equipped to cope with a change from "training and support" to "care" in order to meet the changing needs dementia gives rise to in those effected?

These are amongst the most pressing issues that are arising to confront funding bodies, managers and service providers as both the ageing and intellectual disability fields meet on a larger scale - for the first time.

Implications for workers supporting family carers

Family carers of people with an intellectual disability are often also ageing. They are likely to be elderly women on limited incomes who are facing their own susceptibility to the fragilities of old age - including dementia. In the absence of parents it may be a sister who assumes responsibility, juggling work and family commitments. There are also implications for increased risk Alzheimer's disease in non Down syndrome family members.

Family members may have the expectation that community disability services will provide support to their client for their whole life. The carer may have developed skills in caring for someone with an intellectual disability, but may also require additional information, support and assistance pertinent to the diagnosis of the dementing illness. This will include:

- Accurate diagnosis as early as possible, (ensuring other conditions, which may cause confusion, are excluded.
- Information about the course of the dementing illness, including susceptibility to seizures, behaviour changes.
- Knowledge about change in communication techniques and how to respond to behavioural change. This includes changes in how they approach care of their relative who is experiencing the symptoms of a dementing illness. For instance, the carer may need to learn how to enter their relative's changed reality - rather than continuing to insist on age appropriate activities. Learning that the presence of a toy car or doll for some in an uncertain world may constitute a major breakthrough for a family member.
- Support and access to counselling and mutual support to help including access to funding.

Conclusion

People with an intellectual disability and their carers have the same basic needs as other members of the general community who are affected by dementia. Potentially, the intellectually disabled person has the additional challenges of a complex medical condition and fewer skills to draw upon.

Workers and carers may be faced with a paucity of information and skills within known organisations and from the people they rely on for assistance. It may be a daunting time for dementia care workers. But it is also an exciting opportunity for workers in the aged care and disability fields to work together and learn from each other. Through so doing much can be achieved for the person with dementia at the local service level.

Further reading

Cairns, D. and Kerr, D. (1994). Realities: A Training Guide for People with Down's Syndrome and Alzheimer's Disease. DSDC Stirling University, Scotland.

Janicki, M. and Dalton, A. (Eds) (1999). Dementia, Aging and Intellectual Disabilities. Taylor and Francis, USA.

Kerr, D. (1997). Down's Syndrome and Dementia. Venture Press, Birmingham, UK.

Koenig, B. (1995). Aged and Dementia care Issues for People with an Intellectual Disability (3 volumes). Minda Inc, Brighton, South Australia.

CHRISTCHURCH DIVERSIONAL THERAPY SUPPORT GROUP

Report on 2005 Meetings

In March, Sue Gunn presented a hands-on workshop getting everyone to make an Easter poster. We followed Sue's instructions and created a colourful masterpiece - a fun exercise!

In June, Laurie Te Nahu, Cultural Development Manager with CSSITO presented *'Understanding the Articles of Tiriti O Waitangi - How to relate the Four Article to the Workplace'*. This was a very interesting presentation and well received.

Anne Millar, a counsellor with Presbyterian Support spoke on *'Spiritual Wellbeing in Residential Care'*. A big thank you to Anne for coming out on a cold July night to give a thought provoking talk with great interaction and time for discussion. Anne also gave us some resource ideas.

September saw Helen Heany from Canterbury Arthritis Society get us moving with some exercises when she delivered an excellent overview of Arthritis and its various forms. Helen also gave us an extremely large set of exercise pages to copy and they were keenly accepted.

November was a busy month with two meetings to end a busy year. Chair exercises with Jill from the YMCA was well attended and we quickly got in the exercise mode by having the meeting at the YMCA.

Sue kindly finished off the meetings for the year as she had started - this time the hands-on was making snowmen and angels.

For anyone wanting to know about attending the meetings, please contact Jeanine Campbell or Janice Paterson - numbers as on the support group information page. A special thank you to Gwennyth for her help.

Jeanine and Janice

CRAFT CORNER

Potpourri

Many people remember gathering and drying flower petals to give their homes and especially their wardrobes a sweet aroma long before air fresheners were available. More recently potpourri has been a popular gift item.

Persons with dementia may enjoy creating potpourri to keep for themselves and to give to others.

Basic requirements are:

- Flower petals and herbs
- Scented oil to refresh the potpourri
- Containers for packaging gifts (plastic or paper bags or small baskets)

Have some potpourri already made to show the group. Pluck the petals of flowers or the leaves of herbs (fresh or those that are ready to be discarded). Spread the petals and herbs out on newspaper to dry. When the petals and herbs are dry add a few drops of scented oil (optional) and mix thoroughly.

Package the potpourri in appropriate containers. As a variation fill small sachet bags with potpourri as special gifts for family and friends.

Painting with Marbles

Marbles have been found in ancient ruins and they are still popular today as game pieces, decorative accents and collector's items. Here is another way to make marbles useful.

Persons with dementia will have lots of fun working with their old friend the marble, to create beautiful abstract art.

Basic requirements are:

- A box large enough for a piece of A4 paper to lay down flat inside. Cut the sides of the box down to about 75mm high
- Masking tape
- White A4 paper
- Tempera paint
- A few marbles
- A few plastic spoons
- Small containers for paint

Tape the paper onto the bottom of the box. Place paint in the small containers, a different colour for each container. Place one marble in each container of paint.

Using the plastic spoon, move the marble from the container to the box. Roll the box around causing the painted marble to colour the page. Take the first marble out of the box and put in another marble of a different colour. Repeat the routine with as many colours as desired.

THE SECRETS AND SUCCESSES OF MEN'S GROUPS

Excerpt from an article by Alexa Andrew, Diversional Therapy Lecturer, Otago Polytechnic.

Men are marginalized in residential care facilities in a number of ways. They are of course outnumbered by women due to the fact that women live longer than men. Also the vast majority of staff are female, including diversional therapists. The gender of the activities programme planner and the fact that many leisure are more female orientated further marginalize men.

The types of activities that are practical to replicate in the residential care facility are similar to those activities from other "home" settings for example food preparation and arts and crafts. The generation of men that are currently in care have often developed leisure interests which are more outdoor orientated for example fishing and sport. Many men who were totally involved with their work neglected to develop any interests at all. Therefore many men are difficult to cater for within activity programmes.

It is important therefore to give careful consideration to the leisure and social needs of men. One of the ways in which this is achieved in many aged care facilities is a men's group. As women we know the importance of having female friends, men also have this need as is evidenced in New Zealand society of men gathering in pubs or to watch sports.

The men's groups I have been involved in have clearly been designed to meet these two need; firstly to be in hands on leisure activities and secondly to associate with other men.

HANDS ON ACTIVITIES IDEAS

Look around your homes for a place to run a men's group. It is frustrating when doing messy activities with paint, potting mix and wood to always be aware of cleanliness. There may be a garage area or storage area you could use and this is amore authentic environment.

Woodwork

- Silhouettes, e.g. dogs and cats
- Repairing toys for playcentres
- Varnishing
- Painting trays, wooden puzzles
- Key hangers
- Restoring and decorating picture frames
- Furniture restoration e.g. coffee tables, wooden chairs

Gardening

- Seed sowing
- Vegetables
- Herbs
- Flowers

- Potting clumps
- Strawberries in pots

Outings

- Picnic lunch
- Trip to pub or RSA
- Lunch at the casino
- Races, TAB
- Carisbrook (or other stadia) - try and get the use of a corporate box
- Early settlers museum
- Fishing
- Library

Sports

- Darts
- Bowls
- Pool or snooker
- Table tennis
- Petanque
- Croquet
- Golf

IDEAS FOR SOCIAL GROUPS

Speakers

- Botanic gardens
- Mitre 10 or other hardware store to demonstrate new tools
- Shipping, Navy
- Oversea trips
- Local celebrities
- Retired mayor
- Radio personalities
- Railways

Social Activities

- Happy hour
- Videos - tramcars, travel, vintage cars, trains
- Wine and beer tasting
- Readings: Poetry, Barry Crump, Ancestors, Blokes and Sheds
- Reminiscence: Work, war, the depression, sports, courting, holidays etc.
- Miming occupations
- Sports quiz
- Sweepstakes

Think about men's roles when planning activities: worker, breadwinner, minder of family finances, handyman, gardener and car driver.

REGIONAL SUPPORT GROUPS

Please when you contact us, can you give us a contact phone number. If you do not want it published that is fine.

For further information on Support Groups, contact: Raywin Frith, 12 Duncan Street, Wanganui East, Ph: (06) 343 7964, Fax: (06) 343 7973, Email: rayedkc@inspire.net.nz OR Catherine Donnelly, 3 Boyce Street, Blenheim, Ph (03) 577 7808

FAR NORTH Jan Gough, PO Box 456, Kerikeri, Bay of Islands

AUCKLAND Mary Gracie, Jervois Hospital, 302 Jervois Road, Herne Bay

PAEROA/THAMES/COROMANDEL Kathy Bell, Te Aroha Community Hospital, Te Aroha, Ph: (07) 884 8883 hm
Elaine Arbuckle, Kenwyn Home, Te Aroha, Ph: (07) 884 9370 hm

WAIKATO Annette Whittle, 1130/2 Bank Street, Te Awamutu, Ph: (07) 870 4041 evenings and weekends, Email: busterannette@xtra.co.nz

BAY OF PLENTY Tamar Courtney, Thorndon Park Rest Home, PO Box 550, Opotiki, Ph: (07) 315 7867

TAURANGA Marilyn Liddington, C/- Aspen Aged Care, PO Box 915, Tauranga, Ph: (07) 578 0979, Fax: (07) 578 0978
Barbara Bishop, C/- Carter House, 69 Moehau Street, Te Puke, Ph: (07) 573 5317, Fax: (07) 573 6034

ROTORUA Christine Mitchell, C/- Cantabria Home & Hospital, 369 Old Taupo Road, Rotorua.

TAUPO Leigh Sullivan, 432 Whangamata Road, RD 1, Taupo 2730

HAWKES BAY DT SUPPORT GROUP Jenny Taylor / Niki Keelan, C/- Atawhai Elderly Care, Gloucester Street, Napier, Ph: (06) 844 2109

PALMERSTON NORTH Kay Pearce. Olive Tree Rest Home. Ph: (06) 350 3016 wk.

WANGANUI Rosemary Forman, Summerset Rest Home/Hopsital, 40 Burton Avenue, Wanganui East (Secretary)

WAIRARAPA Joan Davies, 20 Hessey Street, Masterton, Ph/Fax: (06) 378 6692

HOROWHENUA Kathy Marshall, Reevedon Elderly Care, 37 Salisbury Street, PO Box 142, Levin, Ph: (06) 368 7900, Fax: (06) 368 0899, Email: reevedon.presbytsupt@xtra.co.nz

WELLINGTON Jane Jackson, Ph: (04) 970 8535

NELSON Barbie Reay, Wakefield Village Rest Home, Ph: (03) 541 8792

BLENHEIM/PICTON Lorraine Davis, C/- Marlborough Community College, 65 Scott St, PO Box 471, Blenheim

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Janice Paterson, 7 Algidus Street, Christchurch, Ph: (03) 343 1124 evngs & wkends, Fax: (03) 343 5413

NORTH CANTERBURY Dianne Nicols, 62 Courgage Road, Amberley, Ph: (03) 314 9066

SOUTH CANTERBURY DT SUPPORT GROUP Denese Keenan, 19 June Street, Timaru

OTAGO DT & ACTIVITIES SUPPORT GROUP Pam Gilchrist, 5 Keithmore Road, Balclutha

SOUTHLAND SUPPORT GROUP Josie Ladbrook, 21 Milford Street, Invercargill, Ph: (03) 216 7810

NOTICEBOARD

Membership Fees:

Have you paid your 2006 membership fee? There are still a considerable number of members who have not renewed. You can now pay your fees by Direct Credit or over the counter at any Westpac branch. See Treasurers Report on page 1 for procedure

Library:

Are you aware that the Society has a number of books that are available for loan to members? A full list of books available and the procedure for borrowing can be viewed on the Society's website www.diversionaltherapy.org.nz. If you do not have access to the web the list of books and procedure can be obtained from Sheree McIntyre, Cussock Creek, RD 1, Winton, phone (03) 221 7060.

Change of Address:

Do we have your latest address? It is imperative that you notify the Society when you change address as we have a number of newsletters returned as address unknown.

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WHY IS MAY 15th 2006 A SPECIAL DAY?

Because it's the deadline for **YOUR** contributions to the next newsletter! What things have you done? What would you like to share? Send it to me! Bill Campbell, Editor.

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DISCLAIMER:

All views expressed are those of the writers and not necessarily those of the NZSDT

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Articles, letters to the Editor are welcomed. The Editor reserves the right to edit any material submitted for publication.

DEADLINE:

Date for next newsletter contributions 15th May 2006