ODYSSEY HOUSE VICTORIA &

MARY OF THE CROSS CENTRE

Supported Playgroup Evaluation

The Springvale and St. Albans Playgroups

March, 2009

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Introduction

The Organisations Involved

Odyssey House Victoria

Odyssey House Victoria has been a leading provider of quality drug treatment services to drug users, their families and children for almost 30 years. Through residential and non-residential programs, a broad range of services are offered to meet the individual and highly complex needs of those with drug and alcohol dependencies and co-occurring mental health issues. Over the last several years, Odyssey has worked closely with the Vietnamese Community through a partnership with the Quang Minh Temple in Braybrook.

Since its inception, Odyssey has been a strong advocate for the needs of children and their substance dependent parents. More recently it conducted the *Nobody's Clients Project* and has delivered specialist child, family and parenting support and brokerage funds through its *Counting the Kids* Programs. As part of this work, Odyssey has assisted several agencies to establish programs for their clients' children and offer better support to their clients' parenting needs. Other Odyssey services include a 90 bed residential Therapeutic Community & Children's Centre, in which parents wishing to overcome drug problems can reside with their children, while developing new parenting and life skills, and while children's social, emotional and developmental needs are addressed.

The Odyssey Institute of Studies, a branch of Odyssey House Victoria, is staffed by a multi-disciplinary team of highly experienced practitioners, trainers and researchers. The mission of the Institute is to respond to service and training gaps through innovative interventions, nationally accredited training for clients and professionals, and the delivery of employment programs, and to inform policy and improve practice.

Mary of the Cross Centre

Since its establishment in 2000, Mary of the Cross Centre (MOCC) provides a number of services to help those whose lives are affected by drug and alcohol use. In particular, the Centre works with and cares for families from culturally and linguistically diverse communities. One of the programs run through MOCC was specifically targeted at Vietnamese mothers who are isolated because of stigma, poverty and chaos. This project, known as 'New Hope', offered these parents the chance to learn about parenting, early childhood development, bonding with their infants and the role of alcohol and other drugs in their lives.

Program Description

The impact of problematic drug and alcohol use can be far reaching, affecting the individual who uses as well as close family members (Advisory Council on the Misuse of Drugs, 2003). Although this is widely acknowledged in the research literature, few service providers in Australia and overseas address the impact of drug and alcohol (AOD) use on families, and in particular families with young children (Department of Human Services, 2000). Local research has demonstrated that children of Vietnamese drug and alcohol users often fall through this gap (MOCC, 2005).

In 2007, two AOD supported playgroups were established for children with drug using parents. Modelled on the successful 'New Hope' playgroup organised by MOCC in 2004 (see MOCC, 2005), these playgroups aimed to increase early parenting education and strengthen parenting capacity, whilst assessing and improving developmental trajectories for children. An AOD supported manual was developed by the MOCC, utilising the cultural expertise of the Vietnamese staff, to assist the playgroup workers in dealing with both drug related and cultural issues. This manual was used by both playgroups and incorporated documents in the Vietnamese language (see Appendix C).

One playgroup was re-established in the southern suburbs (Springvale), operating out of the Sandown Park Kindergarten, and was staffed by a qualified childcare worker and a community development worker. This was funded by local government and private grants. The other playgroup was based in the Western suburbs, (St Albans) and staffed by a qualified primary teacher with intermittent additional support from two social workers based at MOCC. This playgroup was established with the financial support of Odyssey House Victoria. Staff members at both playgroup sites were overseen by the MOCC community development co-ordinator.

Case Studies

Identifying details have been changed to protect the client's privacy

Case study 1

Sam is a three year old boy born in Australia. His mother has an ongoing substance use problem and his father has been diagnosed with a mild intellectual disability. When Sam met the Springvale playgroup support worker on her first home visit, Sam punched and verbally abused her. This aggressive behaviour was mirrored in his initial interactions with the other children at the playgroup- he would throw toys and scream at other children and was unable to share. He also displayed limited hygiene awareness, such as hand-washing and handling food.

Since beginning at the playgroup however, Sam's behaviour has improved markedly. By the end of Term 3, Sam is now able to take turns in play and is considerate of others, offering them food and other toys. He also now regularly attends to hygiene practices and has learnt to ask his parents to help him brush his teeth at night. After receiving information and help from the playgroup worker about processes involved in enrolling a child in kinder, Sam has now been enrolled and at present attends kinder once a week.

Whilst Sam has benefited markedly from the playgroup, so have his parents. At odds with Vietnamese cultural norms, Sam's father attends the group. Feeling as though he is profiting from, and connected to, the playgroup, Sam's father is putting energy back into the group by vacuuming at the end of the sessions and gardening on site. Realising the damage he is causing not only to his own health, but also to the health of his son, Sam's father has cut down on cigarettes with the view to quit smoking.

Similarly Sam's mother has also show improvements. His mother was initially very shy and reserved, withdrawing from playgroup activities when other families where involved. Over time and with the establishment of good rapport with the playgroup staff, Sam's mother began to relax and was more willing and confident to participate in group activities. Whether these gains extend to time outside the playgroup however, is unknown.

Case Study 2

John has just turned five year old and has been attending the St. Albans playgroup regularly with his mother since it begun. When John first attended the playgroup he demonstrated little respect for the needs of others- refusing to wait his turn to receive food or to play with toys. In the last semester of the playgroup however, the support worker noticed substantial changes in his behaviour- he now waits for the group before eating and asks permission to play before taking toys. These are the types of behaviours, the playgroup worker said, that are important for the child to possess before kinder. In addition to his improvement in behaviour, he also demonstrates an increased awareness in hygiene, washing his hands before eating. Aided by information provided by the support worker, John is enrolled for Prep next year.

The playgroup also appears to have had benefits for John's mother, who arrived in Australia fifteen years ago, sponsored as a bride by her current husband. Although she has been in Australia for a number of years, John's mother remains extremely isolated. Her husband is controlling and emotionally abusive, restricting her lifestyle whilst denigrating and demeaning her in front of their son. When she first attended the playgroup, she was visibly depressed, appearing sullen and withdrawn and crying every session. She found it difficult to interact with her son, who mimicked his father's disrespectful attitude and paid little attention to her requests for behavioural changes. The son's conduct in turn, helped fuel her depression and her conception of herself as a bad parent. As she has become more comfortable with the playgroup however, her mood at times has lifted and she has increased confidence in her parenting capacity. She now meets with other parents from the playgroup, outside of group hours, which provides her with the much needed social activity previously absent in her life. In addition, she seems more able to interact and play with her son, and at one of the last playgroup sessions they helped each other in the making of Christmas cards and other Christmas gifts. Although John's mother continues to have periods of low mood and difficulties interacting with her son, the playgroup worker reports that John's mother has found the group beneficial.

Evaluation Logistics

The evaluation commenced after the playgroups had been in operation for nine months, and was conducted over a four month period from October to December 2008. The intention of the evaluation was to contribute to the sector's knowledge about the benefits of AOD playgroups, in addition to providing practical suggestions for how they can be successfully implemented and maintained.

The broad questions posed and addressed by the evaluation were:

- What was the impact of the playgroup on the children?
- What was the impact of the playgroup on the carers?
- Did the playgroup increase carer access to local community resources?

As a time limited project involving a small number of participants, there were restrictions on the choice of evaluation method appropriate for the project. Language barriers and sample size, combined with the need for data methods to be sensitive and unobtrusive, led evaluators to rely largely on qualitative methods.

Data was collected from the adult clients from both playgroups via focus groups, during which clients were asked about their experiences and expectations of the playgroup. Two focus groups were held: one in the middle of the year, halfway through the course of the playgroup, and one at the end of the year, when the playgroup sessions had concluded.

Data from staff was collected through a number of methods. Staff completed an evaluation form at the end of each playgroup session, which covered: attendance rates; demographics of participants; activities of the session that worked well and those that needed improvement; specific issues raised by participants; observation of group dynamics; referrals made; and changes in individual participant's behaviour (see Appendix A for session evaluation form). In addition staff members were individually interviewed in October about their understandings of the benefits and weaknesses of the playgroup (see Appendix B for interview questions).

Key Learnings from the Literature

Experiences during early childhood can have consequences for the rest of the child's life. It is during the early years that children develop their basic social, emotional and intellectual skills which provide the template for future interactions with people and society (Centre for Community and Child Health, (CCCH) 2006). In conjunction with a child's genetic make-up, positive family interactions and social environments are instrumental in helping children shape these adaptive skills (CCCH, 2006). Positive early environments also help a child prepare for school, which influences the likelihood of a constructive and successful schooling experience as well as the likelihood of school completion and job attainment (CCCH, 2008).

Children who grow up in an environment where either one or both parents have substance use problems have fewer positive familial and social experiences in early childhood and are more likely to develop problems in adulthood than other children (Halfon & Hochstein, 2002). For example, they are more likely to have emotional and behavioural problems, higher rates of school failure, more behaviours linked to crime, and are more likely to develop their own substance use and mental health problems when compared with other children (Dawe et al., 2003). At present, it is estimated that 60,000 children in Australia have a parent attending drug treatment (Gruenert et al., 2004), which represents a substantial number of Australian children at risk of developing significant problems in later life. These problems have significant economic and social ramifications, ultimately undermining Australia's productivity and burdening the health care system (Richardson & Prior, 2005).

There is a general consensus among researchers and policy makers that intervening early in the life course has the greatest potential to prevent or significantly ameliorate some of the health and wellbeing problems which have roots in the early years (Shonkoff & Phillips, 2000). Supported playgroups (which employ a paid or voluntary worker as a facilitator) are suggested as an effective early intervention method for children from disadvantaged backgrounds. Play fosters a child's language development, helps children develop motor skills, exposes children to sensory experiences, and teaches children how to relate to others. Playgroups also assist parents, providing families with opportunities to establish friendships, develop social networks, and create pathways to other services. Through play, parents are also able to model and learn positive parenting skills which assist the development of their young children. Playgroups can thus benefit both the child and their families.

Responding to the needs of children with parent drug users however, has been challenging for the AOD sector and child welfare services, as parents with AOD problems often have difficulties accessing mainstream services (Campbell et al., 2000). In addition, an Australian study documented a dearth parent and child appropriate AOD services, and in particular few intervention/prevention services such as playgroups for marginalised families (DHS, 2000).

Given the gap in services noted in the literature, the two playgroups were established with the intention of providing a supportive and non-judgmental environment where children of parent drug users can experience positive periods of play, and where their parents can improve their parenting capacity. The Vietnamese community was targeted particularly because of the lack of resources noted for Vietnamese families with substance use problems (MOCC, 2005).

Results from the Evaluation

Playgroup Profile

As the two playgroups catered to different clients, the characteristics of each group are discussed separately.

The Springvale Playgroup

In total nine families attended the Springvale playgroup, most of whom possessed health care cards and basic English language skills. In seven families either one or both of the primary caregivers were problematic substance users, two families however, did not identify as having drug/alcohol related problems.

Of the families with substance use problems, five families attended over 50% of the sessions. Most of the participating adults were mothers, three of whom identified as problematic drug and alcohol users, with the remaining two identifying as partners of users. At odds with Vietnamese cultural norms, two fathers also attended the sessions. One father was effectively a sole parent with an AOD problem; the other had an intellectual disability and attended with his female partner. Two families ceased attending in the middle of the year because of work and other familial commitments.

The two non-AOD families began attending mid-year, after one of the participating AOD families invited a non-AOD family to attend, who in turn quickly invited another non-AOD family. Discussion was held between staff about this development, but based on the positive and cohesive influence the non-AOD families appeared to have on participants, the non-AOD families were invited to remain. Workers felt the non-AOD families also decreased the stigma felt within the group. Due to funding considerations however, they were asked to pay for their excursion costs which were otherwise subsidised for AOD parents.

Most children attending the playgroup were between the ages of three and four. The size of the playgroup was generally small with an average of 13 adults and children attending each session. The highest number of adults and children attending an individual session was totalled at 17, whilst the smallest number was six. Attendance increased throughout the year (see Figure 1).

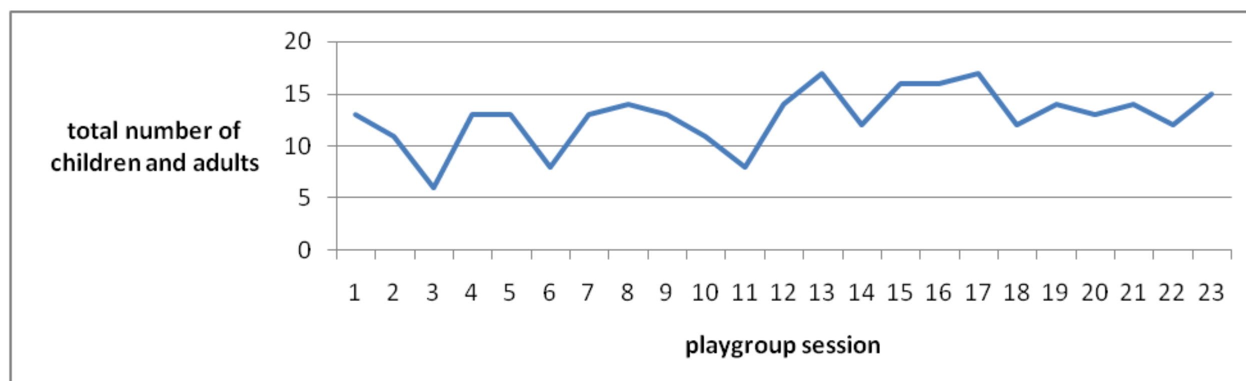

Figure 1. Attendance rates at the Springvale playgroup

The St. Albans Playgroup

In total, eight families engaged in the St. Albans playgroup, with three families attending over fifty percent of sessions. Three families ceased attending, after three, four and ten weeks respectively for practical reasons including familial and work commitments and transport problems. One family attended the playgroup inconsistently and another family joined the program towards the end of the year, and has been to most sessions since joining.

All families attending the playgroup were health care card holders, possessed basic English skills and were from refugee backgrounds. None of the adult participants identified as problematic drug users, rather they identified as female partners or parents (i.e., grandparent of child attending group) of problematic drug users.

The average age of a child attending the playgroup was between three and four years of age. Due to the often intense needs of participants, the size of the playgroup was generally small with an average of eight adults and children attending each session. The highest number of adults and children attending an individual session was totalled at 14, whilst the smallest number was four. Attendance in this group remained fairly constant but decreased slightly towards the end of the final term (see Figure 2).

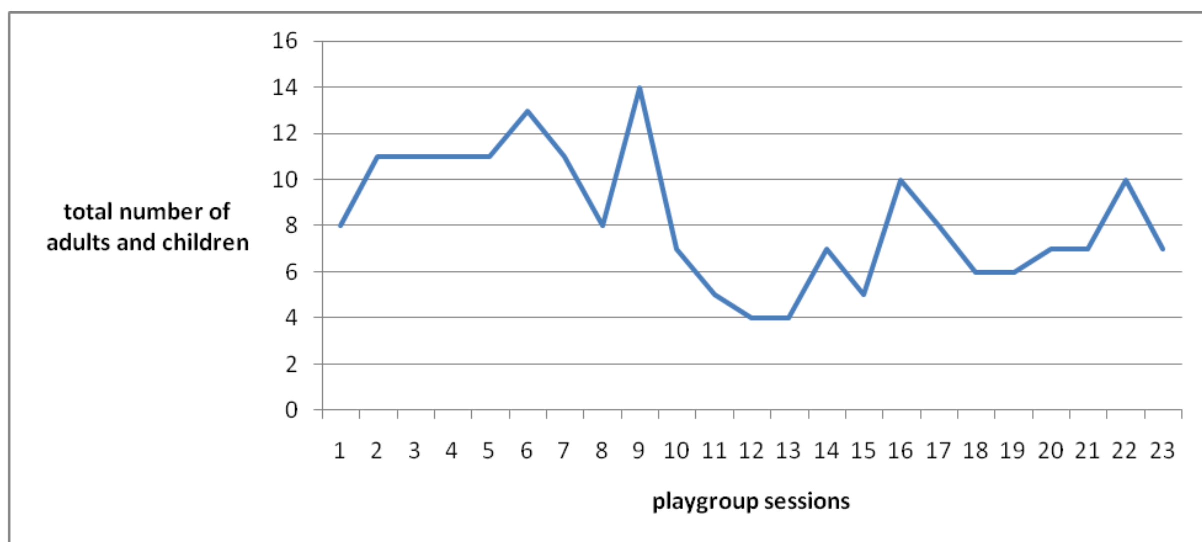

Figure 2. Attendance rates at the St. Albans playgroup

Program Activities

Each playgroup session had a slightly different focus depending upon the needs of the participants. In both the Springvale and St. Albans groups, a variety of indoor and outdoor activities were undertaken throughout the year, depending on the weather and the structure of the session. Frequent play activities included: drawing; play dough; puzzles; reading and story time; time in sandpit; ball sports, kitchen, water and creative craft play. All activities were undertaken with the understanding that play facilitates a child's psychosocial and motor development and improves child/parent bonding. In both groups, facilitators organised excursions so that members of the playgroup increased their contact with their community and dismantled some of their misconceptions about accessibility to public services and spaces. Excursions included going to the local library and to museums. For AOD participants the excursions were paid for by the playgroup.

In each session, time was spent providing caregivers with information about childhood development, good parenting practices and community services. Topics discussed often depended upon the problems voiced by the families. For example, in one session a child had chicken pox and was unable to attend, and this prompted discussion of disease transmission and prevention. The food and drink supplied in the middle of each session provided an opportunity to engender discussions about the importance of nutrition as well as ensuring that once a week the children and parents ate a nutritious meal. In addition to the learning that occurred via discussions about good parenting, learning for both parents and children was also achieved via modelling behaviours demonstrated by the playgroup workers.

In the majority of sessions, playgroup activities ran smoothly and this was facilitated by the creation of a cohesive and safe environment where participants felt at ease and were comfortable discussing their problems. To these ends, at different points throughout the year facilitators in both groups openly discussed the need for the group to be discrete and respectful. In addition, space was provided for members of the group to discuss with both group members and playgroup workers particular issues they were having.

Summary of Key Findings

The following findings are grouped according to the three research questions posed at the beginning of the evaluation. The findings were based on information gathered from individual staff interviews, group session evaluation forms completed by staff at the end of each session (see Appendix A) and on data from focus groups conducted with the adult participants. As the key themes identified were similar for both the Springvale and the St. Albans playgroups, the findings relate to both.

Impact on the Children

1) Increased abilities to interact positively with other children: Playgroup workers reported children in both playgroups improved in terms of their pro-social behaviours, including positive play and respectful interaction. These skills represent the backbone for later social skills development and are also necessary for smoother transitions to mainstream services.

"Children are demonstrating consideration for each other during their playgroup session"

"They have learned the skills of sharing and taking turns, which is important in order to prepare them for future schooling"

St. Albans worker

2) Increased awareness and routine practice of hygiene: This refers particularly to practices around hand-washing after toileting and before eating, brushing teeth, and handling food.

"Nutritional information, healthy eating demonstrated at snack time, cleaning teeth has been understood by children because they have asked their parents to comply with their learnings at home by reminding parents to assist them..."

Springvale worker

"Children are more able to follow the rules of self-help and personal hygiene"

Client from Springvale

3) Reduction in aggressive behaviours towards other children and adults: This incorporates both verbal and physical aggression. Workers report all participating children improved in this area, signalling that they are beginning to develop basic emotional regulation skills necessary for competent social interactions in later life.

"Children who previously snatched things and bit each other are learning to behave in safer more appropriate ways Increased willingness to listen and attend to instructions"

St. Albans worker

4) Development of age appropriate communication: This skill is essential for school readiness and playgroup workers report that all children have improved their communication skills, which include not only a reduction in swearing and an increase in good manners, but also an ability to talk to others competently.

"The children are starting to communicate ....politely. They no longer have to scream to show disagreement and they have been able to say thank you to each other"

St. Albans worker

Impact on Carers

1) Parenting skills improved including:

- Hygiene awareness and practices: This included dental hygiene combined with an emphasis on hand-washing and food handling practices. Workers reported that all families bar one improved in their hygiene practices.

"One family reported sticking a printed wall-chart promoting hand-washing on the wall in their kitchen, to remind family members to wash their hands before mealtimes."

Springvale worker

- Health awareness and practices: By informing participants of basic nutritional information and by providing nutritional snacks every playgroup session, carers became more aware of the need for good diet for themselves and their children and workers report changes in dietary habits outside of the playgroup session. In addition, participants became more aware of the impact of their drug use on their children

"Some families indicated they never purchased fresh fruit or vegetables, in the early days of the playgroups' operations. Some families have incorporated regular fresh fruit purchases into their lifestyles throughout the year and have expressed their positive reactions to the different diet."

Springvale worker

- Disciplinary practices: Carers were encouraged to learn appropriate disciplinary practices via psycho-education and by modelling the playgroup workers behaviours. This lead to observable changes in parent/carer disciplinary practices during both playgroups. The disciplinary practices of a parent can have a profound effect on a child's later development.

"Parents in our group have begun to set boundaries for their children using assertiveness skills and consistency in daily routines."

"Parents have increasingly adopted strategies such as speaking respectfully to their children, instead of only shouting and force, to help their children to learn to accept NO."

St. Albans Worker

- Basic awareness of developmental needs of their children: During each session the playgroup workers provided information about basic needs of the children, e.g., season appropriate clothing, amount of sleep needed, need for consistent bed times. Becoming more aware of children's developmental needs, carers incorporate this new information into their parenting practices, which will help facilitate the healthy development of their children.

"Previously they were allowing their children to stay up until they fell asleep in front of the television, or kept the children up with them because the adult was lonely....as the parents have become more aware of the children's developmental needs [they] have begun implementing regular bedtimes for their children."

St. Albans worker

2) Improved communication with children: Carers were encouraged to positively communicate and play more with their children. In both playgroups workers noted and increase in positive carer/child communication. Parental engagement is a significant predictor on the long term development of a child.

"One mother expressed surprise at the idea of addressing her child in a "respectful" tone. On reflection she later indicated that she had not seen "respect" demonstrated to children anywhere before. She said that she liked the idea and would attempt to use that method of communication with her child in future."

St. Albans worker

3) Increased socialising: Carers have formed social networks at the playgroup, reducing their isolation. These networks have been strengthened by carers organising social events outside of playgroup hours. This not only helps decrease stigma but also provides social support and a forum for discussion.

"The parents have opportunities to interact with others and make friends"

Client from Springvale

4) Increased feeling of community participation: Participating carers report a strong sense of belonging to the playgroup, fostering a sense of community, which has been otherwise lacking for many carers.

"I am very happy I joined this group and therefore don't want to miss out on any sessions"

Client from Springvale

5) Decreased stigma around AOD use: Participants feel less pigeonholed as 'parents with AOD issues' and more like *"normal parents."* This normalisation may help increase parenting confidence and capacity and may also promote increased access to local community parenting resources.

Promoting Interactions with Community

1) Information about local resources: Carers were provided with information about various local community resources in their own language, including: maternal and child health care; mental health services and English and computer classes and various local festivals. The provision of this information may lead to increased access of local resources

"As the participating families are isolated by language barriers, as well as financial hardship, being made aware of these activities within the wider community and encouraged to participate is one way the playgroup establishes links between the participants and the social and cultural networks in the residential area."

St. Albans worker

2) Increased referrals: Referrals have been made for carers to access other services. In the St. Albans playgroup three families were assisted to access Sunshine Hospital's specialist service for assessing developmental delay in children. Additional referrals were made to social workers and counsellors.

   In the Springvale playgroup, referrals were made to counsellors and social workers.

"Trust levels between parents and staff are good for future referral purposes"

Springvale Worker

3) Increased kinder and school enrolments: Carers were assisted with the paperwork necessary for kinder/school enrolments, which may increase the uptake of this mainstream service.

4) Assistance with paperwork: Carers were assisted with additional necessary paperwork including applying for housing. As one participant commented, the facilitators were

"…very kind persons, helped fill in forms, encourage us to gain our own knowledge"

Client from Springvale

Practical Considerations

Success Factors for the Program

Playgroup Victoria's supported playgroups manual details a number of practical considerations that facilitate the development of a viable playgroup. The considerations relevant to the success of the programs are detailed below. If not otherwise specified each factor applies to both groups.

- Playgroup environment: Efforts were made to ensure the playgroups were sensitive to parental drug and alcohol use and that the playgroup environment was supportive and non-judgemental. Families thus felt comfortable in the group which in turn facilitated their participation and learning.

"I feel very relax mentally and the children are very happy coming to the group"

Client from St. Albans

"Parents are very comfortable being in the group. They said this is a place where they can come and share their personal issues without concern that their discussed problems will be known by others outside the group."

St. Albans worker

- Engagement: Clients who had been engaged in an earlier supported playgroup were visited by staff and encouraged to attend. Through word of mouth and via referrals from other agencies, other clients then expressed interest. To encourage attendance and to provide additional contact with the workers, in the first term families were called to remind them of the playgroup time. If a family failed to attend one week, workers phoned to maintain engagement and to determine whether additional referrals were needed.

"*It was great to hear some of the group members say that they missed the group when they were unable to come."*

St. Albans worker

- Cultural considerations: Workers of both support groups were of Vietnamese origin and addressed cultural issues sensitively. This helped overcome language barriers which may have otherwise hindered participants from accessing mainstream services.

"I never can imagine any of these parents/carers would be able to bring themselves to participate in any of the other playgroups that are available in mainstream community. It is not that they don't want too but the main obstacle is their language."

St. Albans worker

- Flexibility: Although there was a structure to each of the playgroup sessions, this was adapted according to the needs the presented by the clients on the day.

- Group size: Group sizes were kept relatively small. This ensured that: each caregiver and child could receive adequate attention; problems could be identified more readily; and a familiar and safe group environment could be fostered.

"The size of the group plays an important part in providing participants with the opportunity to open up and contribute."

Springvale worker

- Staffing: The Springvale playgroup employed two staff workers, one with qualifications in childcare and another possessed community development and managerial skills. For the Springvale group, this combination addressed the needs of the children as well as the needs of the carer. The staffing arrangements were different in the St. Albans playgroup which only employed one staff member (*this is discussed further in the recommendations section).*

- Variations in activities: A variety of activities not only helped engender and maintain client interest in the group, but also ensured clients were exposed to a range of new parenting skills and information. In a clients words this helped them "*understand more about their life and parenting skills*"

Recommendations

Although both staff and clients found the playgroups rewarding, a number of suggestions were made by staff through interviews and by participants via focus groups to further develop the program. Again, recommendations pertain to both groups unless otherwise stated.

- Location: It is important for future playgroups to be located centrally and close to public transport. Although not a problem for the Springvale playgroup, the St. Albans playgroup was hard to access via public transport. This limited the accessibility of the program for people who did not live close to the centre and/or who did not own cars. This may help explain the smaller size of the group compared to the Springvale playgroup.

- Outings and activities: Parents said they wanted more excursions.

- An additional women's support group: A support worker suggested that an additional women's only support group may be of benefit so that during the playgroup mothers spend the majority of the time with their children rather than discussing their problems with other mothers.

"Most of the mothers are finding this is their time to talk to other mothers, therefore the quality time spent between parent and child is limited"

St. Albans worker

- Male attendance: Play groups workers suggested that increasing male attendance may be of benefit to the playgroup.

"Having other males in the group would make it more balance for the children to see and have some kind of contacts with other males in a safe environment."

Springvale worker

- Increased nutritional information: Both workers and clients highlighted this as an area for improvement. Suggestions for how this could be introduced included excursions to local shops and supermarkets to show families healthy foods to purchase and in session cooking demonstrations.

"Most participants do not have the knowledge and skills to prepare simple yet healthy meals for their family."

St. Albans worker

- Increased information about community resources: Both clients and workers desired more information about local community programs such as English lessons or computer lessons. For example, one client stated that they would like "*guest speakers"* from different community service groups.

- More structured sessions: Although flexibility was a factor which contributed to the success of the program, workers also commented that the client group may benefit from more structured session with an agenda set at the beginning of each session.

- Staff: *(This recommendation pertains specifically to the St. Albans group*). Staffed by one worker, the St. Albans playgroup had a high client to staff ratio. An additional worker would reduce this ratio, and increase time the worker spends with each client. As a client said, there needs to be *“more funding for facilitator to help out group”*

Summary and Future Directions

Both staff and clients found the playgroups to be a rewarding experience, and in the focus groups conducted in the latter half of the year participants expressed disappointment that the playgroup for 2008 was drawing to a close.

The key benefits of both playgroups noted by workers and by adult participants include:

- increase in children’s age appropriate behaviours and communication skills;
- increase in parenting skills and capacity; and
- greater community engagement by the families.

These gains are in line with the aims of the playgroup set out by the organisers of the group.

Having received a grant from the Lord Mayor’s fund, the Springvale AOD playgroup will run again in 2009, staffed by one of the previous workers.

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Appendix A

Group session evaluation form

Session date: **Session number:** **Session staff (initials):**

Group members present:

Participants absent (include whether facilitators informed prior to the group):

1. What activities were undertaken in this session?
2. What information was provided to group members?
3. What were the main issue raised and by whom?
4. What worked well and why?
5. Is there anything you would not do again?
6. What could you change about the group to improve it for the next session?
7. What is the level of trust/cohesion in the group (high/medium/low)?
8. What is the participation level (high/medium/low)?
9. Were any changes in individual participant's behaviour/contribution observed, e.g., increased participation in group discussions, disclosure, learning?
10. How well did the facilitators work together (very, somewhat, not very, not)?
11. Were any referrals made for family or group members? If yes, please list and note purpose of referral?
12. Is any individual or group follow-up required before the next session? If yes, describe the issue to be addressed and the staff member/s responsible
13. Are there any incidents to report? If yes, please describe.

Appendix B

Individual Interview Questions for Staff

1) How has the children's play improved?

2) How has the children's co-operation improved?

3) How has the children's communication improved?

4) How has the children's respect towards others improved?

5) Have the playgroups helped parents link in with other services?

6) Have the playgroups improved parent's knowledge about the health and hygiene of their kids?

7) Have the playgroups helped the parents connect with other parents? With the community?

8) Have the health behaviours of parents changed?

9) Have the parents increased in parenting confidence?

10) How have you engaged the parents to attend?

11) How have you maintained attendance?

Appendix C

Families Are Welcome

AOD Supported Playgroup

Manual

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Thanks to Playgroup Victoria for its guidance contained in the Supported Playgroup Manual 2007

The Manual

This Manual defines a supported playgroup and sets out policies and guidelines addressing the following issues:

- Best Practice
- Health and Safety procedures

Definition of a Supported Playgroup

Supported playgroups are those that are initiated and facilitated by a paid coordinator and are available to families who might not normally attend a playgroup.

They target culturally and linguistically diverse (CALD) families, indigenous families, families with mental health and/or disability issues (either the parent or the child), teenage and young parent families and families who are socially isolated and/or disadvantaged.

Best Practice

Playgroup Victoria identifies that best practice playgroups:

- Build friendships and social supports
- Help children learn and develop through play
- Take responsibility and work together
- Provide a safe and supportive environment
- Exchange ideas and share parenting information (2001)

Families are Welcome AOD Supported Playgroup goals

- Promote positive family interactions in a safe and non-judgemental environment
- Assist isolated and vulnerable families to better address the needs of their children

- Increase early parenting education
- Increase participants' awareness of the effects of AOD use on children
- Increase parental access to local community resources and supports
- Assess participants' needs and provision of appropriate responses within the project scope

Playgroup Model

Participant Numbers

The ceiling for families attending the playgroup and/or excursions is seven. This is in order to allow for the maximum benefits to be derived for the participants, many of whom may lack confidence in joining a group where large numbers are a regular occurrence.

Keeping the group capped at seven also allows the facilitator to address highly marginalised clients' needs at a manageable level.

School aged children

As the child participants of the target group for the Families are Welcome AOD Supported Playgroup Program are children aged 0 - 5 years, it is not appropriate that school-aged children attend playgroup sessions or organised excursions and therefore children older than 5 years are not usually admitted, however sometimes there may be an 'emergency' situation requiring the facilitator's discretion.

Waiting List

In the event that referrals produce greater numbers of eligible families than there are vacancies, the facilitator can confer with the Community Development Coordinator with a view to assessing what means could be provided to assist these families in some other way.

A register of eligible families who wish to attend the playgroup can be kept at the back of the attendance book.

Grievance Policies for Playgroup Participants and Staff

Grievance Policy for Playgroup Participants

It is important for playgroup participants to have a clear understanding of how to make a formal complaint, who to make it to and how it will be handled.

Simple strategies work best if they encourage families to share their concerns together with suggested solutions.

A process for working through grievances arising from either a child or adult that is causing annoyance or harm to other members may be:

- In the first instance, all complaints are made to the facilitator
- The facilitator talks to the offending party who is asked to modify their behaviour and is offered the support of the group
- If the situation is not resolved, the Community Development Coordinator is asked to intervene
- If there is still no change the family will be asked to withdraw until they agree to modify their behaviour, in compliance with the playgroup's stated values

In the event that a client's behaviour constitutes a threat to the playgroup or its participants, the facilitator has the discretion to direct the participant/s to vacate the playgroup immediately.

The facilitator will report this incident to the Community Development Coordinator at the end of the session, when all other participants have left the venue.

Grievance Policy for Playgroup Staff

It is accepted that from time to time, individual employees may have grievances with other staff or with management. Any such grievances need to be resolved in the interests of good relationships and a healthy workplace environment. It is anticipated that the following procedures are only enacted when the usual strategies of discussion and negotiation have been exhausted.

This policy and these procedures apply to employees of Centacare attached to the Mary of the Cross Centre.

Procedures
Any employee has the right to be heard through all levels of the line of management by following these steps. This process shall be initiated within the first seven days from the time the matter is first raised with the staff member's immediate superior. *See the Grievance Procedure policy.*

Disciplinary Procedure
Prior to any disciplinary action being commenced or warning being given, the Manager and the Director, Community Services, should be consulted. The matter will then be dealt with according to individual agreements and the discretion of the Manager acting in consultation with the Director Community Services of Centacare, and in accordance with Centacare's Conditions of Employment.

(See Centacare EBA displayed in front office of Mary of the Cross Centre)

HEALTH & SAFETY PROCEDURES

All playgroups are engaged in developing and writing their own safety policy. The facilitator assists the participants a policy which establishes playgroup values and rules.

Rules

At the first session, the facilitator encourages the group to formulate their own rules and agreements on the playgroup's values. These values then determine policies about how the group is to be conducted. Rules could cover site-specific issues such as:

- Toys and equipment
- Toileting of children
- Fences, gates and doors
- Playground and fixed equipment
- Car parking and transporting of children
- Kitchen issues
- Other issues specific to the venue

These rules need to be identified, as far as possible, by the facilitator prior to commencement of the playgroup, however, some issues will not be evident until after the group has begun to meet regularly. They can then be drawn up, using the participants as scribes, (if they are comfortable doing so), on butcher paper and reviewed regularly.

Values

Values are not site-specific and address issues that could include respectful behaviour, confidentiality, creating and maintaining a safe environment for all participants etc.

These agreed rules and values are written up clearly on butcher's paper and displayed prominently every session. It is important to keep these lists on display in consideration of new participants joining throughout the course of the year. Be sure to make new playgroup members aware of the purpose of the lists, which should be renewed, by the participants, each term.

Playgroup Safety Policy

Listed below are policies for the following issues. These issues need to be discussed and agreements reached by the group about its expectations of members.

Policies are not negotiable as they are safety-related and playgroup facilitators have a duty of care to ensure that they are activated at every playgroup session, including excursions.

As early as possible in the group's life, the facilitator asks the participants to focus on the important issue of safety and assists them to define who is responsible for safety regarding:

1. Supervision of children
2. Infectious diseases
3. Allergies
4. Sun Protection
5. Smoking and other drug use
6. Emergency evacuation procedures in cases of fire or trauma.

1. Supervision of Children

Each parent/carer attending a playgroup must be responsible for the welfare and safety of the child/ren they bring to the playgroup at all times.

There is also a collective responsibility to ensure every child is safe.

2. Infectious Diseases

For the health and well-being of all the playgroup members and to reduce the spread of contagious diseases, it is important that participants agree to **not** attend playgroup if they or their child/ren are, or are becoming ill.

It is left to the discretion of the playgroup facilitator to decide whether participants who present showing signs of illness may be admitted. (See p.9 for signs & symptoms of illnesses)

See 'Guidelines' at www.health.vic.gov.au/ideas, for a guide for playgroups.

3. Allergies

It is important that all playgroup participants are sensitive to any food or other allergies that children or adults may have. The playgroup facilitator may need to adjust practices to help families with these matters.

Parents/carers are required to sign a document stating the health status of their children, in relation to known allergies, at the commencement of their participation in the playgroup. (*See Heading 'Other Tasks', p.)*

If the child has allergies, the parent/carer is to provide a medical management plan signed by the child's doctor and ensure that parents/guardians provide a complete EpiPen® kit while the child is present at the service and know how to use it. A parent/carer needing to learn this important procedure may need support from the playgroup program staff.

4. Sun Protection - The role of playgroups in preventing skin cancer

Ultra-violet (UV) radiation has a causal link to skin cancer and so it is important that children and their carers are not exposed to the sun without protection while attending the playgroup.

To reduce the risk of sunburn, it is important that playgroup participants use shady outdoor areas whenever possible.

Role models

Children often copy those around them and learn by imitation. Playgroup facilitators need to demonstrate sun protection behaviours so that the carers and their children are more likely to do the same.

Encourage the use of sun-hats, protective clothing and sunscreen: (a small number of suitable hats can be stored for new attendees, but parent/carers are advised to bring their own). Apply sunscreen before taking part in outdoor activities.

When the UV level reaches 3 and above, use 'The Outside 5' *(Handout 2: This is included in the attachments in English and Vietnamese)*

5. **Smoking and other drug use**

Adult participants may be currently undergoing pharmacotherapy treatment and therefore using prescribed medication. They may also be current AOD users. As our service delivery is premised on the 'harm minimisation/reduction' principle this need not necessarily preclude them from attending a playgroup session. However, they may only attend if well enough to participate in the group's activities and care for their children.

Participants are not to bring alcohol or illicit drugs to playgroup/excursions and are not to participate in any illegal activities during the course of the playgroup session.

Passive smoking (the inhalation of environmental tobacco smoke) increases

risks to health (*Cancer Council Australia*, *2004).*

The Mary of the Cross Centre and the Cyrene Centre have a duty of care under occupational health and safety legislation to provide a safe and healthy environment for all persons who utilise the service.

The smoking of any substance in any areas it utilises is not permitted and parents, family members or relatives of children enrolled at the service are not to smoke on the premises.

The Mary of the Cross Centre and the Cyrene Centre have adopted a Smoke Free Environment Policy to protect all persons from the effects of environmental tobacco smoke.

The 'environment' refers to: The playgroup premises' building and outdoor areas, including car parks.

6. **Emergency Evacuation in case of fire or trauma**

'Standard Fire Orders for Playgroups'

1. Upon discovery of a fire:

1. Assist anyone in immediate danger, only if safe to do so.
2. Group facilitators/assistants to check all areas including toilets, storerooms, kitchen etc., close doors after check. Ensure all children are accounted for, only if safe to do so retrieve attendance book.
3. Raise the alarm – ring fire brigade on 000 (alert other building users).
4. Evacuate to designated assembly area.
5. Remain in assembly area and ensure all are accounted for using attendance book. Do not return to the building until an ‘all clear’ for return has been given.

It is also important that the playgroup facilitator seeks out and has an understanding of the ‘General Fire Orders’ of the building where the group meets and use in conjunction with ‘Standard Fire Orders for Playgroups’

2. State where the following are kept and who is responsible for them:

- Emergency numbers for fire
- Enrolment forms with personal contact details, in case of injury to an adult
- First aid kit
- Attendance book
- Accident, incident and injury book

3. Define how members can raise and report safety concerns and how these concerns will be handled.

A safety policy is a living document. Regularly revise and update it to ensure your practices are consistent with this policy. *Playgroup Manual, 3rd Edition*

See also Centacare policies:

First Aid & Medical Emergencies, Occupational Health & Safety, Infection Control, Critical Incident Policy

Other Tasks

As each family joins the playgroup, the parent/carer needs to fill in and sign a copy of the Clients’ Rights & Responsibilities form, *(Handout 1: This is included in the attachments in English and Vietnamese)* which is then copied and returned to them at the following session.

This important document also contains the health status of their children and would indicate whether their child has any allergies, as well as being the document that indicates the carer's emergency contact person.

Facilitators spend some time after each session making note of the issues arising and how the participants seemed during the playgroup, by completing the Session Evaluation Form.

Any issue arising can be noted in the weekly data collection sheets and these will then be addressed as part of the regular communication structure in place between playgroup staff and the Community Development Coordinator.

Attendance Records

Facilitators are to record in an exercise book the attendance details of all participants on a regular basis at the outset of each session. This book is to be secured in a lockable cupboard at all times when not in use, to preserve the confidentiality of participants.

Accident/Incident Records

A complete First Aid kit is provided on each playgroup site, for use by carers, if needed. Parents/carers will attend to any (minor) injuries sustained by children while attending the playgroup/excursion. Any major injuries need to be attended by a qualified health professional, either through ringing 000, or by transporting the family to a local GP.

After taking whatever safety response necessary, facilitators are to record on the appropriate Incident Form, the details of any accident or incident occurring during a playgroup session or excursion. This needs to be reported immediately to the Community Development Coordinator, for discussion and reported more formally in a Critical Incident Report.

Data Collection for Research Evaluation

Facilitators are to record information about how the group is functioning, after each session, using the materials provided by the evaluating body. A brief monthly meeting with the supervisor can develop a 'snapshot' of the group's progress, identifying arising issues and problem-solving that may be required.

Focus groups may be held at the end of each term, or half-yearly, to explore the needs and satisfaction rates of the participants.

Further Information………….

Signs and Symptoms of Illnesses

Symptoms indicating an illness may include:

- behaviour that is unusual for the individual child, such as child who is normally active and who suddenly becomes lethargic or drowsy;

- high temperature or fever;
- loose bowels;
- faeces which is grey, pale or contains blood;
- vomiting;
- discharge from the eye or ear;
- skin that displays rashes, blisters, spots, crusty or weeping sores;
- loss of appetite;
- dark urine;
- headaches;
- stiff neck or other muscular and joint pain;
- continuous scratching of scalp or skin;
- difficulty in swallowing or complaining of a sore throat;
- persistent, prolonged or severe coughing; or difficulty in breathing.

(*Staying Healthy in Child Care*, *2005, p. 18*)

Sun Protection

Family information

It is helpful if families understand the playgroup's sun protection policy and are aware of how they can assist by ensuring their child is wearing appropriate clothing, hats, sunscreen, and possibly sunglasses, and being good role models themselves.

SunSmart can provide materials (posters, brochures and information sheets) for this purpose. Their website also has useful information. See attached Vietnamese language version for photocopying and distribution to each playgroup participant.

(www.sunsmart.com.au)

Additionally, playgroups have the potential to help prevent skin cancer in future generations and they play an important role in protecting children's skin. This is because:

• Children attend playgroup at times when ultraviolet (UV) radiation levels are high: in Victoria, this is between 11am – 3pm from September to April

• Most damage due to sun exposure occurs during the early years

• Playgroups can play a significant role in teaching about sun protection and developing sun protection habits that can last a lifetime

Although our senses can easily detect sunlight and infrared radiation (heat), they cannot detect the level of ultraviolet (UV) radiation from the sun. UV radiation can't be seen or felt and can be damaging to our skin on cool, cloudy days as well as hot, sunny ones.

While UV radiation comes directly from the sun, it can also be scattered and reflected by surfaces such as buildings, concrete, sand, snow and water. It can also pass through light cloud.

The UV Index is a rating system which indicates the amount of UV radiation from the sun that reaches the earth's surface. The SunSmart UV Alert, issued by the Bureau of Meteorology, shows the UV radiation index levels for that day. It is reported in most daily newspapers and some television and radio weather forecasts. Whenever UV radiation index levels reach 3 (moderate) and above sun protection is required. At that level UV radiation is intense enough to damage our skin and contribute to the risk of skin cancer.

In Victoria from September to April, UV radiation index levels are 3 and above for most of the day. Particular care should be taken between 10 am and 2 pm (11 am and 3 pm daylight saving time) when UV levels reach their peak.

From May to August, UV radiation index levels in Victoria are usually low (below 3). †Therefore sun protection measures are not necessary during these months unless you are in alpine regions, or near highly reflective surfaces like snow or water.

The effect of UV radiation – skin cancer

Too much exposure to UV radiation can cause sunburn, skin damage and skin cancer. Sun exposure in the first 15 years of life contributes significantly to the lifetime risk of skin cancer. Australia has the highest rate of skin cancer in the world. One in two people living in Australia will develop skin cancer during their lifetime, however most skin cancer can be prevented.

UV radiation and vitamin D

Some UV radiation exposure is important for vitamin D production. Vitamin D is necessary for bone, joint, muscle and neurological function. To get enough vitamin D from September to April, you only need 10 minutes of sun exposure to the face, arms and hands before 10 am or after 3 pm, on most days of the week.

To get enough vitamin D from May to August, when UV radiation levels are low, you need to expose your face, arms and hands to the sun for two to three hours per week.

THE 'OUTSIDE 5'

Use these 5 important sun protection measures to be SunSmart

To protect against skin damage and skin cancer, when the UV index level is 3 and above (in Victoria from September to April, UV index levels are 3 and above for most of the day), use a combination of these 5 sun protection measures whenever you are outside.

Particular care should be taken between 10 am and 2 pm (11 am and 3 pm daylight saving time) when UV levels reach their peak.

1. Shade

Try to use shade whenever possible. Even while in the shade, UV radiation can reflect from surfaces such as water, sand and concrete so it is important that children continue to wear a hat, appropriate clothing and sunscreen.

2. Sun protective clothing

As well as hats, SunSmart recommends loose fitting, close weave clothing that covers as much skin as possible during outside activities. Tops with elbow length sleeves, and if possible, collars and knee length or longer style shorts and skirts are best.

Garments especially designed for sun protection will carry a UPF (ultraviolet protection factor) level on their tags: the higher the number, the greater the protection from UV radiation. Fabric rated above UPF 30 provides very good protection.

3. Hats

To protect the neck, ears, temples, face and nose, encourage children to wear a broad brimmed, legionnaire or bucket hat.

• Broad brimmed hats should have a brim of at least 7.5 cm (6 cm for very young children)

• a legionnaire hat should have the front peak and the long, back flap meet at the sides to protect the side of the face, neck and ears

• bucket hats should have a deep crown and a brim of at least 5 cm for young children

Baseball caps and visors offer little protection to the cheeks, ears and neck and are therefore not recommended.

4. Sunglasses

Eyes, like skin, can be damaged by exposure to UV radiation. SunSmart suggests, where practical, wearing close fitting, wrap around sunglasses that cover as much of the eye area as possible. The sunglasses should meet Australian Standard 1067 (Sunglasses: Category 2, 3 or 4) and preferably be marked EPF (eye protection factor) 10. There are products available that have been specifically designed for babies and toddlers and have soft elastic to keep them in place. You can also get swimming goggles with EPF 10.

Please remember that the colour or darkness of the lenses doesn't indicate the level of sun protection and you will need to check the label. It is also good to find sunglasses that are polarised as these reduce the glare.

If your playgroup prefers not to introduce the wearing of sunglasses, or a child is reluctant to wear them, you can still protect the eyes by avoiding peak UV times, wearing a hat and staying in the shade.

5. Sunscreen

It is good to teach children to apply SPF 30+ broad spectrum, water resistant sunscreen 20 minutes before going outside and to reapply it every two hours. Sunscreen screens out UV radiation but does not completely block it out so some UV radiation still reaches our skin. Sunscreen should never be the only method of sun protection nor should it be used to stay out in the sun longer. Always check the expiry date.

Whenever UV radiation index levels are 3 and above, skin damage can occur. The SunSmart UV Alert is issued by the Bureau of Meteorology when the UV Index is forecast to reach 3 and above. It is reported in most daily newspapers and some television and radio weather forecasts across Australia.

In Victoria, from September to April, UV radiation index levels are 3 and above for most of the day. Particular care should be taken between 10 am and 2 pm (11 am and 3 pm daylight saving time) when UV levels reach their peak. If possible, try to take children outdoors earlier in the morning or later in the afternoon.

GROUP MEMBERS’ RIGHTS

(‘group members’ refers to parents/family members and workers)

Group members have the right to:

1. be treated with dignity and respect
2. take part in group activities regardless of gender, religious belief or sexual preference
3. participate safely in activities
4. express opinions and contribute to decisions about the group
5. express satisfaction or register complaints about group activities
6. access information about themselves and/or their children
7. have their confidentiality respected within legal/ethical limitations
8. know how and when information about the groups will be used

GROUP MEMBERS’ RESPONSIBILITIES

Group members have a responsibility to:

1. treat all group members (parents, children and staff) with dignity and respect regardless of race, gender, religious belief or sexual preference
2. not act in an intimidating or violent manner
3. attend only when well enough to participate in the group’s activities and care for their children
4. not bring alcohol or illicit drugs to group/activities
5. provide staff with any information required to meet their own, their children’s or group members needs and/or safety
6. respect the confidentiality of others
7. ensure the safety of their own children during combined parent/child activities
8. respect the property and equipment belonging to the venue

Membership and attendance depends on agreeing to the rights and responsibilities listed above.

Participation statement:

I have read and understood the group members’ rights and responsibilities and I agree to abide by them.

Group Member’s Name:

Signature: **Date:**

Witness’ Name:

Signature: **Date:**

(see Vietnamese version next page)

QUYỀN LỢI THÀNH VIÊN CỦA NHÓM

(Thành viên của nhóm gồm phụ huynh, thân nhân và nhân viên)

Thành viên trong nhóm có quyền:

1. được đối xử công bằng và tôn trọng
2. tham gia vào sinh hoạt nhóm bất kể tuổi tác, tôn giáo và giới tính
3. tham gia sinh hoạt một cách an toàn
4. cho ý kiến và góp phần trong quyết định của nhóm
5. biểu lộ ý hài lòng cũng như được khiếu nại về sinh hoạt nhóm
6. có được thông tin về mình và con cái của mình
7. được tôn trọng quyền riêng tư trong phạm vi luật pháp và đạo đức
8. biết thông tin về nhóm sẽ được sử dụng ra sao, ở đâu

TRÁCH NHIỆM CỦA THÀNH VIÊN TRONG NHÓM

Thành viên trong nhóm có trách nhiệm:

1. đối xử với tất cả thành viên (phụ huynh, trẻ em, và nhân viên) công bằng và tôn trọng bất kể chủng tộc, tuổi tác, tôn giáo và giới tính
2. không có hành vi chế giễu và bạo lực
3. chỉ tham gia nhóm khi đủ khỏe để sinh hoạt và để chăm sóc con em mình
4. không đem theo rượu và ma tuý trong nhóm/ sinh hoạt
5. cho nhân viên biết đầy đủ bất cứ thông tin nào cần thiết cho nhu cầu, cho sự an toàn của chính mình, của con mình và thành viên khác trong nhóm
6. tôn trọng riêng tư của người khác
7. bảo đảm an toàn cho con em mình trong sinh hoạt nhóm
8. tôn trọng tài sản và vật dụng tại nơi sinh hoạt nhóm

Để làm thành viên nhóm và tham dự nhóm tuỳ thuộc vào việc tuân thủ những quyền lợi vá trách nhiệm kể trên.

Lời xác nhận tham gia:

Tôi đã đọc và hiểu quyền hạn và trách nhiệm của thành viên nhóm, và tôi đồng ý tuân theo.

Tên thành viên:

Ký tên: **Ngày**

Nhân chứng:

Ký tên: **Ngày**

Family Name (parent/carer who brings child/ren to playgroup…………………………

First name………………………..

Address………………………………………………………………………………………

Phone number……………………………….Mobile………………………………………

Language/s spoken at home…………………………………………………………..

Name of child attending playgroup	Date of Birth	Known allergies	Medical conditions

Emergency Contact

Relationship to participant		
Surname	Family doctor's name	Contact phone number
First name	Address	
Phone number	Mobile	

Starting date………………..

Handout 3

Families are Welcome Playgroup Program

Parent/Carer Focus Group Questions

1. Was the group like you expected it to be?
2. How has coming to group helped you and your child/ren?
3. How has being part of the group brought about any change in yourself or your family?
4. How confident did you feel in the facilitators?
5. Did you get what you needed from the group?
6. What else did you need?
7. What have you liked about attending the playgroup/what worked well?
8. What have you not liked/what could have worked better?
9. How could the playgroup be improved?
10. Do you have any other comments about the playgroup?

(see Vietnamese version next page)

Chương trình Families are Welcome

Câu hỏi dành cho nhóm đối tượng Phụ huynh/ người chăm sóc

1. Nhóm có như những gì bạn mong đợi không?

2. Đến sinh hoạt trong nhóm giúp cho bạn và con ra sao?

3. Là thành viên trong nhóm có đem đến thay đổi gì cho bản than bạn và gia đình hay không?

4. Bạn có tự tin về người điều hành nhóm không?

5. Bạn có đạt được điều bạn mong muốn trong nhóm không?

6. Bạn cần thêm điều gì nữa?

7. Bạn thích điều gì trong sinh hoạt của nhóm?

8. Bạn không thích điều gì về nhóm/ điều gì cần cải thiện để được tốt hơn?

9. Làm sao để nhóm được cải thiện thêm?

10. Bạn có ý kiến đóng góp thêm về nhóm hay không?