Somewhere to Call Home

Supported Residential Facilities: *the sector, its clientele and its future*

Mark Doyle

Arthur Hume

Janet McAvaney

Nancy Rogers

Tracey Stephenson

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Research, Analysis and Information

Strategic Planning and Research Branch

Strategic Planning and Population Health Division

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Paul Willey

Jayne Wrigley

Raphael Chapman

Ollie Peters

Carmel O'Connor

Jim Phillips

David Egege

Mark Bagshaw

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1 EXECUTIVE SUMMARY

1.1 The study

- The study was undertaken by the Department of Human Services in order to inform key policy and planning agendas with regards to the housing, care and support needs of vulnerable adults with complex and chronic needs, and in particular the residents of Supported Residential Facilities.

- Supported Residential Facilities are accommodation services licensed under the Supported Residential Facilities Act 1992 to provide accommodation and personal care to their residents. People living in Supported Residential Facilities generally have some form of disability or impairment such that they require assistance in order to function on a day-to-day basis.

- Despite accommodating some of the most vulnerable people in our community, until recently there has been little documentation of who lives in SRFs, their level of disability and care needs. This research is designed to provide clear information about the resident population, and, alongside the financial viability study which is currently underway, will greatly enhance knowledge of the sector and the needs of the people who inhabit it.

1.2 Overview of the sector

- There are currently 65 Supported Residential Facilities licensed by local government and operating throughout the state,[1] including a number of retirement villages that are licensed as Supported Residential Facilities.

- 48 of the 65 facilities cater for individuals whose only source of income is a pension or benefit and who pay the majority of their income to the facility for their on-going care. These facilities are referred to as 'pension-only'.

- In the other facilities residents have the capacity to pay for a higher standard of care; they usually pay a premium to enter the facility; and the facility is generally of a higher amenity. *This study relates only to pension-only facilities.*

- There are about 1300 to 1500 people living in pension-only SRFs.

- Facilities range in size from 4 residents to 64 residents, with an average of 27.

[1] Data current as at September 2002.

- 42 pension-only SRFs operate on a private-for-profit basis. The majority of these receive no government subsidy; eight private-for-profit facilities receive a Board and Care subsidy through mental health services for some or all of their residents. Thus, residents self-fund their own care.

1.3 National Directions

Over the past decade private supported accommodation sectors in Victoria, New South Wales and Queensland have been subject to review. Consistent themes that have emerged in these states are that:

- the private supported accommodation sector is in decline
- the needs of residents have become increasingly complex
- there are issues regarding the viability of the privately provided supported accommodation sector
- there are disparities in the care of vulnerable people living in private supported residential facilities compared to other vulnerable groups
- there is discomfort about the appropriateness of the service model employed by the private supported accommodation services, and
- there is a recognition of the need for formal mechanisms to safeguard and advocate for the interests of residents.

These issues are also relevant for South Australia; however the jurisdictions of New South Wales, Queensland and Victoria are arguably ahead of South Australia in their responses to these issues, which include:

- Changes in regulation, licensing and procedures determining functions of facilities (including in terms of admission and resident assessment)
- Increased funding and support services to residents, including through the designation of residents as a priority group for HACC funding and assertive outreach into facilities by multi-disciplinary primary care teams
- Active and assertive 'watchdog' and resident advocacy structures (such as Community Visitors) to improve resident protection and scrutiny of care
- An increased role of the government and not-for-profit sectors
- Increased separation of the 'accommodation' and 'care' functions
- Funding for sector reforms, including for building upgrades.

1.4 Previous research

The available research into the residents of Supported Accommodation facilities both interstate and in South Australia indicates that residents:

- experience a range of disabilities, with mental illness the most common
- are people on low incomes, predominantly government benefits
- often have complex care requirements, functional impairments and unmet social and health needs
- include a high proportion of aged people, including frail aged
- have minimal community integration, and little access to rehabilitative, skill building or capacity development
- are likely to have a compromised quality of life.

1.5 Findings in relation to residents

SRFs accommodate a range of people with a disability.

- Most residents are male (about 63%)
- Mental illness[2] is the predominant primary disability (54%), followed by age-related disability (23%), intellectual disability (11%) and brain injury (9%).
- The age profile is skewed heavily towards older groups (40% are aged over 65 years and 26% over 75 years).
- About half have a Guardianship Board order (predominantly an administrative order).
- Residents generally have long histories of institutional or supported care: most have lived in their current SRF for over 2 years; and usually moved to the facility from another similar facility. There is a significant group of older people who have been long term residents, have pre-existing disabilities and have aged in place.
- Residents vary in the type of support they require and the complexity of their needs. Assessments indicate that most require at least two hours of support per day, and over a quarter require more than four hours.
- Those residents with lower support needs usually require supervision of medication, preparation of meals and assistance with household chores.

[2] See explanation of the use of the term 'mental illness' in Chapter 2.4.

- Just over half the residents require higher levels of support than this. Frail or physically disabled people require support with personal care, mobility and transport; others have active mental health needs and require behavioural and social support.

- A further group has high and complex needs that require support across a range of life domains including physical health, personal care, behaviour and social issues. These residents also have active mental health issues and are more likely than other residents to display anti-social or self-harming behaviours and to require support at night.

Five clusters of residents are proposed, with estimated resident populations of each group as follows:

1. The minimal care needs group (20.4%)

2. The minimal care needs and stable mental health issues group (26.8%)

3. The frail and disabled group (19.9%)

4. The active mental health issues group (17.2%)

5. The high and complex needs group (15.8%).

In terms of their contact with the service system:

- Most residents have regular contact with a General Practitioner

- Almost half (46%) do not have regular contact with another kind of worker/service

- Of those who do have such contact, this is most commonly a mental health worker (38%), and to a lesser extent, a disability case worker or support worker (both 8%). However, the regularity of this contact varies.

- Younger residents are more likely than older residents to have a worker and be in contact with a service.

- Over half of residents do not have a key worker.

- Having contact with a service/worker does not necessarily correlate with a resident's assessed level of need.

- DHS data suggests that about one third of SRF residents are active clients of mental health or disability services.

- In the many cases where residents do not have an active support worker, family member or guardian, the SRFs are likely to step into that role.

- Owner/manager satisfaction with the involvement of key workers seems to hinge on clarity of role definition, regularity of contact and worker responsiveness and reliability.

Given the level of vulnerability, disability and dependency and what is known from other research about the health and wellbeing profile of people in supported accommodation, this data suggests unmet needs and, for many residents, the absence of external mechanisms to provide support, services, advocacy, planning and protection.

Key messages from the data in relation to residents are discussed in the report namely:

- The diversity and vulnerability of the resident population
- The need for support in the tasks of daily living, including a portion with high and complex needs and requiring intensive support
- The distinctive age profile, with a high proportion of aged residents;
- The ambiguous position of SRFs, who are described as 'partly in and partly out' of the service system.
- The unmet support needs of residents, particularly in the areas of primary health care and social and recreational activities.

1.6 Findings in relation to facilities

- Typically SRFs operate in older buildings that were formerly large private residential homes or former residential/institutional facilities.
- The predominance of shared bedrooms is one of the consequences of the use of this older style of building - less than half of residents have sole use of their bedroom.
- Facilities have quite diverse resident profiles, along dimensions including gender, age, disability type, length of stay, mental competancy and levels and type of need. At the same time, most facilities cater for a mix of residents of both genders and of varying ages and disabilities.
- Facilities commonly provide services including laundry; monitoring of medication; organising appointments; taking residents to appointments; and organising recreational activities. To a lesser extent, facilities also manage or help some residents with their finances (42% of residents); assist with bathing and personal hygiene (32%); and assist with dressing and grooming (27%).

- Private SRFs are generally family businesses, sometimes assisted by (often) part-time employees. Employment of staff is kept to a minimum by the use of family members.

- No specific qualifications are required to own or operate a facility unless nursing care is provided, in which case registered nursing qualifications are required. Staffing levels, qualifications and professional backgrounds of managers vary considerably.

- Most facilities are concerned about their financial viability, indicating rising costs and a falling profit margin, with income largely fixed.

- Proprietors reported that the level of resident need has increased over recent years, especially with more aged (including those who are ageing in place) and also younger residents with complex needs. The three major issues which proprietors saw as key to improving the current situation were:

    1. Financial assistance/subsidies

    2. Better access to opportunities and programs for residents, and

    3. Improved primary care and health services.

- According to local government authorised officers, most SRFs are of an appropriate standard and complying with the requirements of the Act. However, there are exceptions, including failure to provide a 'home-like' environment, failure to provide for aspects of personal dignity and safety, and poor physical standard. Authorised officers propose better access to activities and life-skills programs for residents; assistance with continence issues; financial assistance to facilities and training for staff as strategies to improve care.

Key messages with regards to the facilities discussed in the report are:

- The mix of residents within facilities, which is likely to create difficulties in fairly large congregate living environments

- The built form of facilities (old properties, not purpose built) which does not support quality care

- Concerns about the future viability of the sector

- The multiple roles which the SRF assumes in the lives of residents (carer, case manager, advocate, family member, friends, guardian), given the absence of external supports, services, family members and guardians. This brings inherent role conflicts, as well as risks for the resident and

increased demands for the proprietor. It also does not accord with disability standards.

1.7 Conclusions

A vulnerable group

- People living in Supported Residential Facilities are a highly vulnerable and disadvantaged group who are not receiving care which meets current policy and standards. On the whole, residents have impaired cognitive ability, little power to choose where or how they live, few supports, receive few services and have a greatly reduced ability to protect themselves from exploitation or harm. Lack of income and minimal family support adds to the general impoverishment of their circumstances and lifestyle.

- Despite having few resources and significant disabilities, residents do not receive a coordinated and targeted service response, and there are minimal mechanisms to plan for and protect the interests of residents.

- Particular note is made of residents who have lived long-term in SRFs (or their precursors) who may be quite institutionalised, have minimal capacity for independent living, and are ageing in place, largely in isolation from the community and with little attention, aside from the SRF, to their needs, and no planning for their future.

Up to standard?

- The research indicates that the model of supported accommodation fails to meet a range of disability standards, principles and expectations in relation to privacy, dignity, consumer choice and decision-making, community participation, independence, rehabilitation, skill development, housing quality and health care.

- The model that appears to have evolved by default, where private facilities meet the 'whole of life' needs of the people living in their facility, on a 'for profit' basis, in an semi-institutionalised environment, with few professional supports and with care entirely self-funded, is inherently flawed.

- Variable standards, practices and quality of facilities are apparent across the sector.

- Currently in South Australia there appears to be a situation of 'unequal care', where some people with disabilities receive government funded support, to accredited standards and in line with disability policy; whereas others self-fund their care. The evidence suggests that the

resources a person on a government benefit has available to them cannot purchase other than a 'fairly basic' level of care.

Implications

The approximately 1,500 residents of SRFs have largely been a 'hidden' group to the South Australian community, living in facilities which many do not know exist. They have also arguably been hidden in relation to service policy, planning and delivery, and thus have failed to benefit from reforms and advances in supported accommodation, disability and mental health. This study indicates fundamental issues which should be considered in relation to Supported Residential Facilities in South Australia including:

- ***Policy***: The lack of integration of the SRF sector into a broader policy framework gives rise to inconsistencies and a lack of focus. This is exacerbated by the disconnection of regulatory responsibilities (the role of Local Government) from the broader state and federal government-led policy in the disability, ageing, housing and mental health areas.

- ***Funding:*** SRF residents are currently outside the range of funding to disability and aged care services, and their self-funding of their own care is an anomaly.

- ***Regulation*****:** Questions are raised about the adequacy of the current regulatory regime.

- ***Service provision***: There are significant areas of unmet need in relation to disability support, primary health care and recreational/community integration needs of residents, suggesting that a targeted response that provides assessment, case management and the provision of a range of appropriate services, could be considered. Access to specific services available to others in the community (such as HACC, CSI and aged care support) also needs to be addressed.

- ***Safeguarding interests of residents****:* There is an absence of mechanisms to protect the interests of residents, whether that be key workers or an independent consumer advocacy and protection role (such as Official Visitors) which now exist in other jurisdictions. The particular issues for residents with impaired competency and no active guardian also require consideration**.**

- ***Development of alternative models****:* The findings call into question the model of supported accommodation that is provided by the Supported Residential Facilities sector, and suggest that alternative models should be considered. The development of alternatives needs to recognise the need for a continuum of options, from independent living to fully supported residential accommodation, acknowledging the diversity of needs and preferences.

- ***The needs of long term residents***: The development of alternative models will largely benefit the 'potential' rather than existing clients of SRFs (ie people moving into housing with support, rather than those already in accommodation) especially where existing residents are largely hidden from the service system and unlikely to be considered for placement. Consideration needs to be given to the long-term population of SRFs who are ageing in place, often without a key worker, involved family member or external supports, and without access to the range of aged care and other services which exist in the community. The care and support needs of this population must increase over time.

SECTION 1 OVERVIEW

2 INTRODUCTION

2.1 Why a focus on Supported Residential Facilities?

This study has been undertaken by the Department of Human Services in order to inform key policy and planning agendas with regards to the housing, care and support needs of vulnerable adults with complex and chronic needs, and in particular the residents of Supported Residential Facilities in South Australia.

Supported Residential Facilities are (predominantly) privately operated facilities providing accommodation to people who require personal care and support. People living in Supported Residential Facilities can be assumed to have some form of disability or impairment, whether that be physical, intellectual or psychiatric. Supported Residential Facilities thus sit as private providers within the arena of accommodation and support services to people with disabilities and services for vulnerable adults.

There are, however, tensions around the role of SRFs. Whilst their operation has been monitored and regulated under the Supported Residential Facilities Act 1992, to a certain extent it is still unclear what role these facilities play, and should continue to play, in the broader provision of accommodation and care to people with disabilities.

Supported Residential Facilities are quite different to other forms of similar accommodation. Unlike boarding houses and rooming houses, they offer a more extensive range of services that includes personal care and are more involved in meeting the 'whole-of-life needs' of residents.

Vulnerable adults in Supported Residential Facilities fund their own accommodation and care. While SRFs accommodate many frail elderly people, they are not Commonwealth-funded aged care services; nor are they funded as disability services under the Commonwealth State Disability Agreement.

The Supported Residential Facilities industry has increasingly made it clear to government that their sector is under pressure, and considers its future as dire without some form of intervention or support.

The government has made a commitment to reviewing the Supported Residential Facilities Act, 1992. It is anticipated that this review will examine the adequacy of the current regulatory arrangements for the operation of facilities, and for safeguarding and facilitating the rights of residents to safe, decent, and life-enhancing care.[3]

[3]At the time of writing the Review and its Terms of Reference had not yet been announced.

In this context, this research study is designed to provide clear information about those people living in Supported Residential Facilities, their needs and current care. Despite accommodating some of the most vulnerable people in our community, until recently there has been little documentation of who lives in these facilities, their level of disability and care needs.

In 2001 the SRF Association[4] conducted a snapshot of Supported Residential Facilities and their residents. This was the first South Australian study to document both the industry and its clientele.

Further to this, a financial analysis study[5] is underway to examine the cost drivers for SRFs, including the development of a unit costing methodology for an SRF providing a preferred level of service and amenity of care. These studies, alongside the current research, will greatly enhance knowledge of the sector and the needs of the people who inhabit it.

2.2 The research study

This study of Supported Residential Facilities forms one half of a larger study which also examines boarding houses (see the companion report: *'It's No Palace' Boarding Houses: the sector, its clientele and its future*).

Boarding houses and Supported Residential Facilities provide quite distinct forms of accommodation to different target groups. Nevertheless there are areas of commonality: both forms of accommodation involve tenure arrangements and rights generally regarded as less secure than other mainstream housing options; tenants are required to live in a communal arrangement, and cannot choose who they live with. Such accommodation does not meet what some commentators have defined as a minimum community standard of reasonable accommodation ie. that a person should have their own living area, bedroom, kitchen and bathroom.[6]

The broad aims of the overall research project were to*:*

- map and profile the existing stock of boarding houses and Supported Residential Facilities in metropolitan Adelaide
- profile the residents of these facilities and
- assess the future viability of the sector and the appropriateness of existing facilities to the housing and support needs of the residents.

[4] The SRF Association represents the interests of owners and operators of Supported Residential Facilities.
[5] The *Financial Analysis Study of Supported Residential Facilities* has been commissioned by DHS.
[6] Chamberlain C & Johnson G (2001) *The debate about homelessness*, **Australian Journal of Social Issues** Vol 36 No. 1.

Key research questions were:

> *What is the current picture in relation to boarding houses and SRFs across the metropolitan area? (where are these facilities, who is in them, what tenancy arrangements exist, what do the facilities provide, and what is the quality of the establishments?)*
>
> *How appropriate is the accommodation and care provided to the needs and wishes of the residents?*
>
> *What is the likely future of this sector, and consequently of its residents?*
>
> *How should government respond to this sector and its clientele?*
>
> *Are boarding houses and SRFs appropriate accommodation options, and if so, for which groups?*

For Supported Residential Facilities, additional questions were:

> *What are the dependency levels of people in SRFs?*
>
> *Are people able to have their care needs met through SRFs?*
>
> *What personal care is provided?*

The methodology for the Supported Residential Facilities research is described more fully in Chapter 6. Briefly, the primary data collection comprised:

- gathering information from SRF owners/managers about their facilities and residents, and
- third party assessments of 437 residents.

In addition, the study drew information from:

- A survey of local government conducted by the Supported Residential Facilities Unit of the Department of Human Services
- Round Table focus groups with service providers
- Examination of ABS Census and survey data
- Analysis of service provider client data systems, specifically Royal District Nursing Service, Community Mental Health Services, and Disability Services.

2.3 Structure of report

The report is divided into four sections. Section One provides an overview of facilities in South Australia and places SRFs and their residents in a context of the history of this form of care, the current industry and contemporary directions within Australia in relation to supported accommodation for adults with disabilities.

Sections Two and Three contain the findings of the research project. Section Two profiles residents in relation to demographic factors, level of assessed need and contact with the service system. Section Three provides information about the nature and operation of facilities, business arrangements, quality of facilities, and trends and views according to SRF operators.

Section Four provides conclusions and discusses the implications of the findings.

2.4 Terminology

The term 'mental illness' has been used throughout this report when, in most instances, 'psychiatric disability arising from mental illness' is the more accurate term. Psychiatric disability refers to the consequences of mental illness ie the functional impairments and social disadvantages arising from mental illness, whereas mental illness refers to the disorder itself as it has been diagnosed.

However the term 'mental illness' has been used in the data collection processes of the study as the most widely understood term, and hence the reporting and analysis of the data maintains this terminology. It should be assumed that the reporting of mental illness as a form of disability in this report acknowledges the presence of disabilities associated with mental illness.

3 SUPPORTED RESIDENTIAL FACILITIES IN SOUTH AUSTRALIA – AN OVERVIEW

3.1 A quick history

The facilities currently referred to as Supported Residential Facilities today have, in the past, been variously called hostels; mental health hostels; rest homes; and boarding houses. Prior to the introduction of the Supported Residential Facilities in 1992, these facilities operated under a variety of arrangements.

- *Private rest homes* were privately owned premises licensed by local health boards under the South Australian Health Act 1935 and providing care to people who were 'aged, infirm, helpless or partially helpless.'[7]

- *Mental health hostels* were privately owned facilities providing supported accommodation to people with a psychiatric disability. These were licensed under the Mental Health Act 1935. Licensing was undertaken by mental health authorities within the South Australian Health Commission, which also provided social work support and a subsidy to residents. [8]

- *Aged care hostels* (also licensed under the South Australian Health Act) were operated by charitable organisations to provide support to the aged and some younger disabled people. Aged care hostels were eligible to receive Commonwealth funding under the Aged and Disabled Persons Homes Act 1954.[9]

The common feature of these facilities was the provision of supported accommodation; that is, they provided support or personal care services to residents with a functional or social disability. However, some boarding houses (privately owned premises traditionally providing accommodation and board) also provided personal care services.[10] Boarding houses were not included in any of the above licensing regimes.

The *Review of Psychiatrically and Intellectually Disabled Residents in Boarding Houses,* conducted in 1988 by the Human Services Committee of Cabinet, found that boarding houses were accommodating many people with psychiatric and intellectual disabilities following the de-institutionalisation of in-patient facilities. The review was very concerned that such people were being housed in minimal conditions without adequate treatment or care, and recommended that new legislation be introduced to bring boarding houses accommodating people with disabilities and mental health issues under

[7] Human Services Committee of Cabinet, **Psychiatrically and Intellectually Disabled Residents in Boarding Houses**, 1988
[8] ibid.
[9] ibid.
[10] Hefferan, P, **Review of Boarding and Lodging Accommodation in Metropolitan Adelaide**, 1988.

licensing provisions. At the same time, rest homes, mental health hostels and aged care hostels were also to be brought under the new legislation, with the proviso that, where facilities were covered under another Act (eg Commonwealth legislation) they could be exempted.

The recommendation for a new regulatory arrangement was brought into effect with the introduction of the Supported Residential Facilities Act in 1994. Some facilities were unable to meet the new standards, and either closed down or changed function.

The Supported Residential Facilities Act established a licensing and monitoring regime whereby each local government authority is responsible for the regulation of facilities in its area. The Act also established conditions related to tenancy arrangements; required service plans for resident care to be developed, and specified a range of standards and conditions relating to personal care, physical facilities, safety, and staffing. The Act provided mechanisms for licenses to be revoked and penalties applied for breaches. It also provided for the establishment of a Ministerial Advisory Committee to advise on issues relating to the sector and the administration of the Act.

3.2 Legislation

The Supported Residential Facilities Act defines a Supported Residential Facility as

> 'a premises at which, for monetary or other consideration (but whether or not for profit), residential accommodation is provided or offered together with personal care services (other than for members of the immediate family of the proprietor of the facility).'

The key distinguishing feature from other similar forms of accommodation is the provision of *personal care*, which can mean any of the following:

- Nursing care
- Assistance or supervision in bathing, showering or personal hygiene; toileting or continence management; dressing; or consuming food
- Direct physical assistance to a person with mobility problems
- Management of medication
- Substantial rehabilitative or developmental assistance, or
- Management of personal finances.

An important function of the Act is to set out principles under which the management and administration of facilities must occur, mandating residents' rights to :

- high quality care, including choice of medical practitioner
- reasonable levels of nutrition, comfort and shelter in a home-like environment
- a safe physical environment
- dignity, respect, and a reasonable degree of privacy
- independence and freedom of choice
- management of their own affairs as much as possible, and
- choice about the provision of accommodation or personal care services.

The Act distinguishes Supported Residential Facilities from other similar types of accommodation. Commonwealth-funded residential aged care facilities are exempted from the Act. Boarding houses and rooming houses (ie where 'residential-only' services are provided) are also not covered, except for a provision that requires the manager of a 'residential-only' service to seek assistance for any resident who may be in need of care (S42).

3.3 Overview of the sector

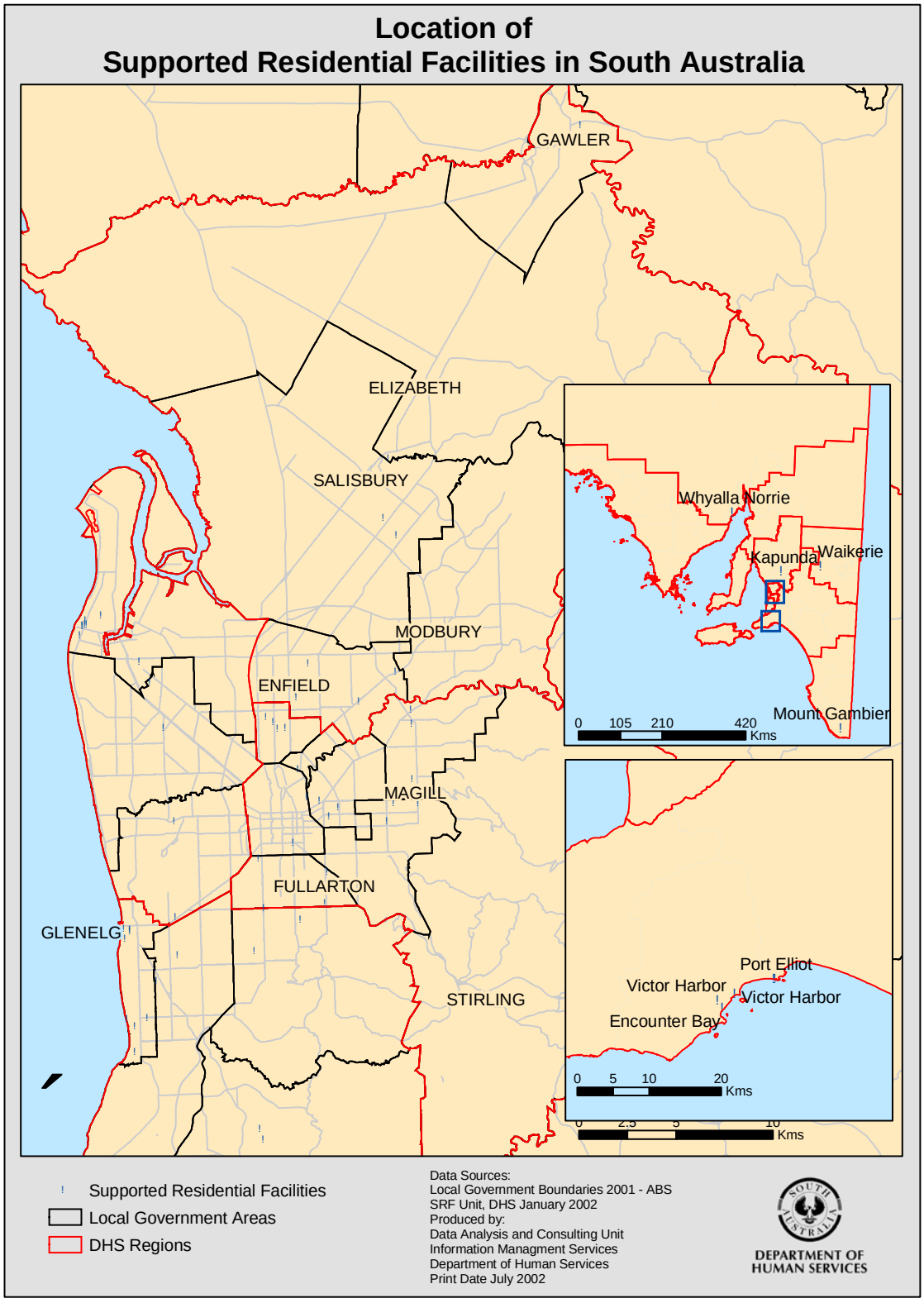
At the time of writing[11] there were 65 Supported Residential Facilities in South Australia. The sector includes a number of retirement villages that are licensed as Supported Residential Facilities. Figure 3.1 shows the location of all facilities in the state. The names and addresses of facilities are listed in Appendix 1.

3.3.1 Pension-only' facilities

Of the 65 facilities, most cater for individuals whose only source of income is a pension or benefit and who pay the majority of their income to the facility for their care. These facilities are known as pension-only facilities (48 of the 65 at time of writing). In the other facilities residents have the capacity to pay for a higher standard of care; they usually pay a premium to enter the facility; and the facility is generally of a higher amenity. *This research project relates only to pension-only facilities.*

[11] September 2002.

Figure 3.1 Locations of All Supported Residential Facilities, South Australia



There are about 1300 to 1500 people living in pension-only Supported Residential Facilities.[12] The smallest of these facilities is licensed for four persons and the largest for 64. Typically a facility will accommodate an average of 27 people with a range of disabilities.[13] Two facilities are attached to nursing homes.

The majority (42) of pension-only Supported Residential Facilities are operated by private providers on a for profit basis. The six Not For Profit facilities comprise: Palm Lodge (a transitional mental health unit run by Eastern Mental Health Services); Tregenza House (part of Tregenza Aged Care Services funded from the Lyell McEwin Hospital); and Russell House, Glenelg House, Amaroo Lodge, and Warrawee Lodge, all run by community organisations.

Most facilities are located in the metropolitan area, with clusters in the Semaphore/Pt Adelaide area and Brighton/Glenelg, and the Unley, Prospect and inner eastern suburbs to a lesser extent. There are seven facilities in country areas including four on the South Coast. The distribution of facilities by Council area and regions is shown in Table 3.1. Figure 3.2 shows distribution of beds by suburb.

3.4 Policy context

The Supported Residential Facilities Act 1992 is framed in the context of contemporary public policy in the area of disability, ageing and mental health. There are also a number of key policy 'drivers' which guide policy and practice. These include:

The Commonwealth State Disability Agreement (CSDA)

The Commonwealth Disability Services Act 1986

The South Australian Disability Services Act 1993. This sets out principles and objectives for disability services which form the framework for service provision.

The National Standards for Disability Services. These are consistent with the Commonwealth Disability Services Act 1986 and the South Australian Disability Services Act 1993. They set out eight standards for all services funded by state governments.

[12] This figure is derived from information provided by local government indicating that the 48 pension-only facilities are licensed to accommodate a maximum of 1,496 persons; however their usual number of residents is calculated to be 1,290 (Survey of Local Government Oct 2001)

[13] Mean derived from the number of usual residents, from Survey of Local Government, Oct 2001

The *National Standards for Mental Health Services* were agreed to in 1996 under the National Mental Health Strategy. They promote the rights of consumers, their involvement in service planning and delivery, and set out criteria for the delivery of care to consumers.

Current priorities for the Department of Human Services in the areas of mental health and disability are articulated under the *Disabilities Services Planning and Funding Framework 2000-2003;* the *Mental Health Implementation Plan 2000-2005* and *Action Plan for Reform of Mental Health Services.*

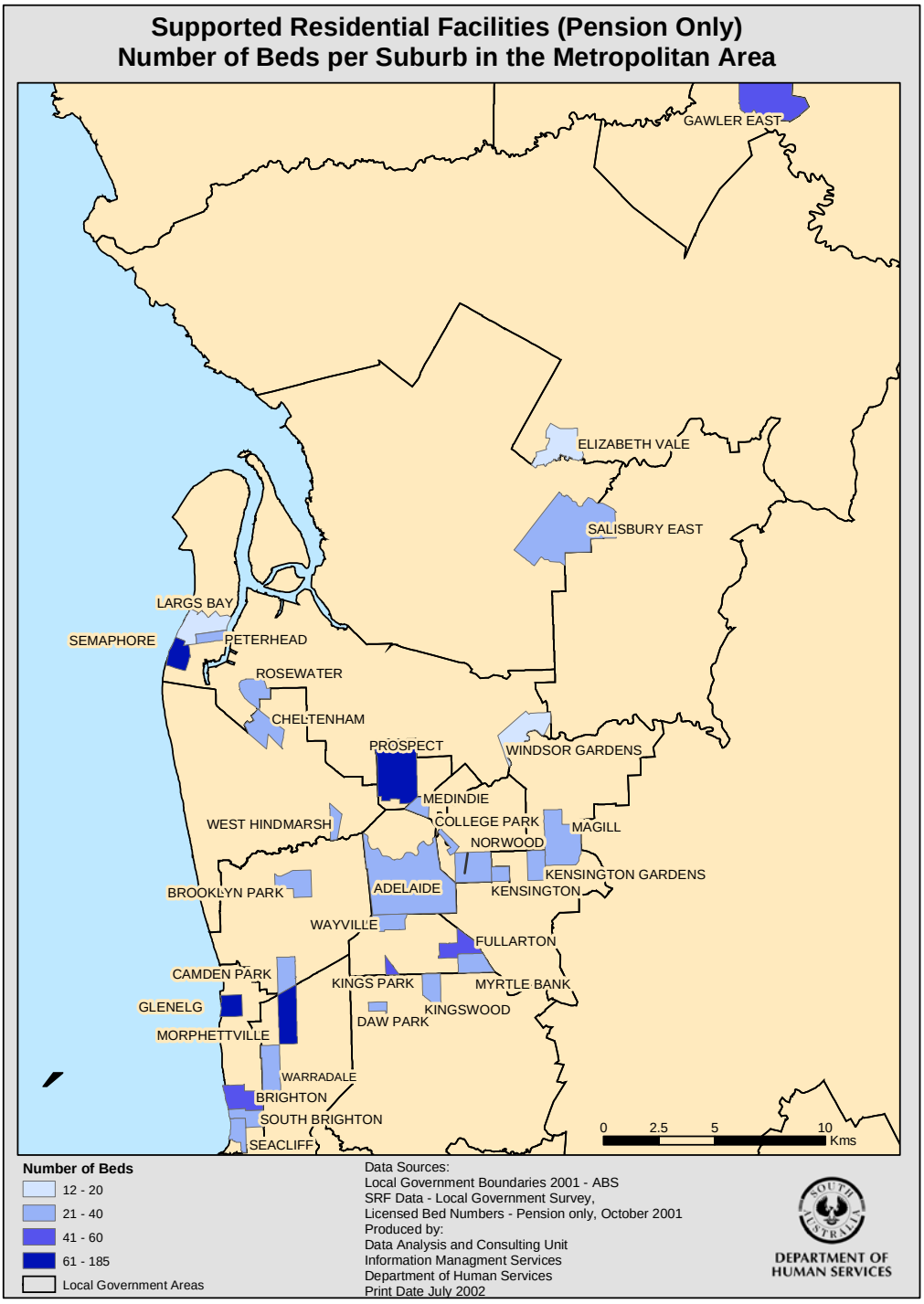
Table 3.1 Licensed bed numbers for pension-only SRFs

Licensed bed numbers, 'pension-only' SRFs, Region and LGA, South Australia

Council	N	%
Eastern Metropolitan		
Adelaide	26	1.7
Burnside	53	3.5
Cambelltown	34	2.3
Norw, Pay & St P	48	3.2
Prospect	125	8.3
Walkerville	32	2.1
sub-total	***318***	***21.2***
Northern Metropolitan		
Playford	12	0.8
Salisbury	35	2.3
Gawler	60	4.0
sub-total	***107***	***7.1***
Southern Metropolitan		
Holdfast Bay	161	10.7
Marion	98	6.5
Mitcham	53	3.5
Unley	173	11.5
sub-total	***485***	***32.3***
Western Metropolitan		
Charles Sturt	80	5.3
Pt Adelaide Enfield	274	18.2
West Torrens	56	3.7
sub-total	***410***	***27.3***
Country		
Alexandrina	61	4.1
Victor Harbor	30	2.0
Loxton Waikerie	11	0.7
Whyalla	33	2.2
Mt Gambier	41	2.7
sub-total	***176***	***11.7***
Total State	**1496**	**100**

Source: Survey of Local Government, Oct 2001

Figure 3.2 Pension-only SRFs, Number of licensed beds per suburb



3.5 Funding

There is no government funding provided to private facilities, apart from the Board and Care subsidy, which is provided to eight facilities as a subsidy for the cost of care for some or all of their residents. This arrangement dates from the time when mental health hostels were provided with this subsidy through the Mental Health Accommodation Program.

There is no other direct funding provided by government to Supported Residential Facilities. Some funds (mostly from the Home and Community Care program) have been directed to the sector for one-off projects and training.

4 NATIONAL DIRECTIONS IN SUPPORTED RESIDENTIAL CARE

Most Australian states and territories have private supported accommodation similar to South Australia's Supported Residential Facilities.[14] Over the last ten to fifteen years there have been significant shifts in some jurisdictions in the response of governments to these facilities. This chapter outlines the major changes that have taken place in Queensland, New South Wales and Victoria.

4.1 New South Wales

In New South Wales a major inquiry into Licensed Residential Centres (known as Licensed Boarding Houses)[15] occurred in 1993 following allegations of abuse, exploitation and sub-standard conditions at a large licensed hostel for people with disabilities. A resident profile survey found that 44% of residents in these facilities had psychiatric disabilities, 28% intellectual disabilities and 19% disabilities related to substance abuse. As well as catering for a population of people with significant and varying disabilities, the inquiry found a considerable proportion of residents were aged, and many were over-medicated.[16]

An economic study commissioned by the inquiry found most boarding houses appeared to be able to operate profitably, and, importantly, could continue to operate profitably if standards required of them were raised. A tightening of the licensing requirements, as well as more stringent fire safety standards, was recommended.

As a result of the inquiry a major reform process was set in train. As part of the process, the Task Force proposed that the principles of the Disabilities Services Act (1993) be adopted to guide the development of a new licensing system and the provision of alternative housing. It was noted that the operation of the licensed boarding house industry was largely inconsistent with these standards, notwithstanding the efforts of most operators to provide reasonable standards of care and a warm, supportive environment.

The application of contemporary disability services standards to the licensed boarding house sector effectively regulated the industry according to much higher standards. As a result, the process of decline of the sector was accelerated, with many facilities closing. At the same time, an extensive process of assessment of all residents was begun.

[14] Although these facilities are often known by different terms.
[15] **Report of the Task Force on Private 'For Profit' Hostels** (1993) Volumes 1 and 2, New South Wales
[16] ibid.

In 1995 the Boarding House Team was established to provide assistance and support to residents. Employing a multi-disciplinary team approach, clinicians and allied health providers went into licensed boarding houses in the Central Sydney area to provide a primary health service.[17]

In 1998 the state government provided $66 million over three years to fund reforms to the sector, which at that time contained approximately 1,800 residents.[18] The major components of the reform process were the re-location of some high need residents into community settings, and the provision of personal care and community integration services to those residents remaining in licensed boarding houses. The commitment to re-locate a target of 310 residents included capital funds to purchase or build new accommodation, plus funding for packages of support. Boarding House Support Managers were established in each health area to oversee the reform process.

Residents considered to be medium to low need are now eligible for a range of support services. Arrangements were made for the Home Care Service of NSW to provide assistance with showering, dressing and grooming to those residents requiring such care.

In 1999 a standardised *Boarding House Entry Screening Tool* was introduced in order to assess potential residents. This is administered by Aged Care Assessment Teams and aims to ensure high need individuals are not accommodated in licensed boarding houses. [19]

4.2 Victoria

Over the past ten or so years, a number of incremental changes have occurred in relation to the Supported Residential Services sector in Victoria. In 1987 a Ministerial Review of Special Accommodation Houses (as Supported Residential Services were formerly known) identified concerns about the standards of care and support for residents, particularly in relation to physical care and neglect; quality and quantity of meals; lack of disposable income; lack of individualised care and rehabilitation; and lack of privacy and personal space.[20] The review also recognised issues related to the on-going financial viability of those facilities that catered for the pensioner market and recommended measures to protect residents' financial and legal rights,

[17] The Central Sydney Area Health Service Boarding House Team has continued to operate and provides mental health nurses, a social worker, an occupational therapist, men's and women's health nurses, a psychiatrist, podiatrists, and a transport assistant providing support to residents across 19 licensed boarding houses in the CSAHS area.
[18] *What's new in boarding houses*, **Newsletter from the NSW Ageing and Disability Department**, Issue 2, July 1999, http://www.add.nsw.gov.au
[19] ibid.
[20] Green, Associate Professor David, **Advice to the Department of Human Services on Supported Residential Services**, August 2001

establish community based accommodation alternatives, and provide support services to residents.

In 1988 the term 'Supported Residential Service' was adopted and defined in the Health Services Act (1988). Minimum standards of safety and care for residents were prescribed under the Health Services (Residential Care Regulations) that came into effect in 1991. Further amendments to the Act and regulations occurred in 1997 in order to strengthen safety and care provisions and provide more substantial penalties for breaches.[21]

Bed Number Guidelines were introduced in 1998 in order to progressively reduce overcrowding and improve privacy in existing SRSs. The guidelines propose that there be no more than two people per bedroom and that each person should have a minimum bedroom space of 12 square metres (to be phased in by 2003).

New food handling and storage requirements were introduced in 1999, as were new minimum qualification and employment requirements for personal care coordinators in SRSs. As of 1 August 2002 all existing SRSs are required to have fire safety sprinkler systems installed, with facilities built since the mid-90's already required to comply. [22]

Over recent years there has been an increasing emphasis on the provision of support services to residents in SRSs. This has, in part, been led by local services initiating a response to SRSs and their residents, combined with policy-led initiatives, such as a focus by the HACC program in Victoria on vulnerable adults, including homeless persons and people living in boarding houses and SRSs; and funding allocations to community health services to provide dental services.

In 2001 the Victorian government commissioned an inquiry by Associate Professor David Green into Supported Residential Services in response to continued concerns raised by the Community Visitors (authorised under the Health Act 1988 to visit Supported Residential Services and report on appropriateness and standards). In their most recent annual report the Community Visitors summarised their key concerns about SRSs as relating to:

- The volatile mix of residents, with young people with psychiatric illnesses living together with frail aged people
- Poor quality service plans, and
- The vulnerability of residents, who are almost totally dependent on the proprietor of the facility where they live.[23]

[21] ibid.
[22] ibid.
[23] **Annual Report of the Community Visitors appointed under the Health Services Act 1988**, Victoria, 2001

The Green report focussed on the pension-only segment of the industry, proposing that these facilities are accommodating a client group with increasing dependency and high levels of need; whilst at the same time, operation at this end of the market is becoming increasingly unviable, and many facilities are closing. Green also viewed the role of the pension-only SRSs in the broader context of the range of overall support and housing services provided to people with disabilities and mental illness, and the appropriateness of this particular model of care.[24]

In this context he recommended that:

- government should expand and diversify the range of supported housing programs and the care and support provided to residents in supported housing on the assumption that current supported housing programs are not able to meet present demand
- poorly performing SRSs be phased out
- 'best practice' SRSs be encouraged to continue providing accommodation and support
- over time, some SRSs move to a rooming house model rather than continue as a residential care provider. In other words, the SRS would provide safe and secure housing for residents with their other needs met by specialist service providers and community agencies
- public subsidies should not be provided to operators; instead enhanced support services should be provided directly to residents
- alternative supported accommodation arrangements should be made available for the small group of residents with very complex clinical and care needs who require high levels of support and are inappropriately housed in SRSs. [25]

4.3 Queensland

In 2002 the Queensland government introduced new legislation to ensure minimum standards and accreditation for residential services.[26]

The new legislation applies to supported accommodation services, boarding houses and aged rental complexes. The Residential Services (Accreditation) Act 2002 requires facilities to meet minimum requirements and applies a three-tier accreditation process according to the nature of the facility. The

[24] Green, op.cit.
[25] Green, op.cit.
[26] media release Hon. Merri Rose, Minister of Tourism, Racing and Fair Trading, *Accreditation, Minimum standards for hostels, boarding houses*, 6 March 2002

Residential Services (Accommodation) Act 2002 provides regulation in relation to tenancy rights and responsibilities.

In association with these regulatory changes, a program of support services – the Resident Support Program – is being funded and implemented by state government. Components of the planned service provision are:

- A community linking program, which links residents to educational and recreational opportunities
- Key support workers, to be funded through the Home and Community Care (HACC) Program, whose role is to link residents with community based primary health and other services, and
- Personal care services to be delivered to persons with disabilities.

A financial assistance package for existing operators in the form of grants and a planned loan scheme is also being provided to assist operators with building upgrades to meet the new standards.

4.4 Common features across the states

Even a brief glance at the trends and developments in the sectors in other states highlights some common themes. These relate both to the profile of the sector, the issues government and community groups are grappling with, and subsequent legislative and policy responses. Common features include:

- *The decline of the private supported accommodation sector*

  Available data indicates that the number of facilities in some states has reduced considerably over the past ten to twenty years. For example, in NSW the number of beds has reduced from 2,200 in 1995 to 1,300 licensed beds in 2001.[27] Victoria shows a similar decline in the pension-only services estimated to have reduced from in excess of 5,000 beds in 1986 to about 2,200 beds in 2001.[28] An *Industry Economics and Financial Viability* study conducted in Queensland 1988 identified that there had been, and would continue to be, considerable attrition of facilities.[29]

  The displacement of residents is an obvious impact of closures. This is of most concern when facilities close suddenly and a large scale re-location of residents is required. For example, in Victoria 225 pension-only SRS beds closed in the LGAs of Port Phillip, Stonnington and Glen Eira over a

[27]. *Boarding House Team Information*, Central Sydney Area Health Service handout
[28] Green, op.cit.
[29] Hostel Industry Development Unit (1988) **Industry Economics and Financial Viability**, prepared by Price Waterhouse Coopers

18 month period, resulting in a loss of about 30% of beds, with no spare beds available to provide alternative accommodation. [30]

- *Increasing complexity and need of residents*

  There is some evidence to suggest that the type of people living in private supported residential facilities has changed to include younger residents with mental illness, disabilities and substance abuse issues. The Green report suggests an array of factors have led to this change. Reforms in aged care have led to aged people being able to stay in their own home longer, so only older people with higher levels of dependency seek care in SRSs, especially if these people are seen as 'problematic' and not able to obtain Commonwealth-funded aged care. Further, Green argues that a 'second wave' of de-institutionalisation in the early 1990's, combined with shorter lengths of stay in acute-care psychiatric facilities, has resulted in people with high needs being 'dumped' into SRSs and rooming houses.[31]

- *Issues regarding the viability of the privately provided supported accommodation sector*

  Whilst the economic study of licensed boarding houses conducted in NSW found these facilities were able to operate at a profit,[32] reductions since that time suggests that businesses became less profitable as regulatory requirements increased. The Green report indicates that, for Victorian facilities, in addition to the impact of compliance costs, facilities have also been affected by increasing rental costs and the non-renewal of leases as rented properties in inner city areas are able to realise a better return if sold or re-developed. [33]

  At the same time income from residents remains relatively fixed as people living in private supported accommodation are generally reliant on government income support.

- *Disparities in the care of vulnerable people living in private supported residential facilities compared to other vulnerable groups.*

  A consistent theme in any consideration of the role of private supported accommodation is the fact that this model requires vulnerable residents to fund their own care. Other people with comparable levels of disability live independently in the community and are eligible for a range of supports, largely publicly provided. People with disabilities living independently may also have lower costs of housing through public or

[30] Reid, R, McQueen, S, Wiseman, D, Brakha, S, Maddicks, D and Wright, J, **Future Accommodation Needs of Pension-level SRS Residents in the Inner South-East Area of Melbourne**, Inner South Community Health Service, September 1999
[31] Green, op.cit
[32] **Report of the Task Force on Private 'For Profit' Hostels**, op.cit.
[33] Green, op.cit

community housing. Alternatively, those living in publicly provided supported accommodation do not pay the full cost of care.

By comparison, pensioners in private supported accommodation facilities are paying a private provider to meet all or most of their care requirements. The evidence indicates that this level of funding is only adequate to purchase a 'fairly basic' level of care.

- *Discomfort about the appropriateness of the service model employed by private supported accommodation services*

  Private supported accommodation is based on a model of congregate accommodation and the expectation that, as well as providing meals and 'hotel services', facilities will provide personal care, a level of supervision, and meet residents' needs for recreation and rehabilitation.

  This has increasingly been regarded as an outmoded model. Relative to living independently in the community, it is a 'semi-institutional' form of accommodation. The physical facility and congregate care typically works against ensuring that residents can exercise choice and independence, and experience dignity, privacy and community integration. The situation whereby residents are wholly reliant on the proprietor or staff of the facility in which they live is inherently flawed and runs counter to contemporary best practice where 'accommodation functions' are separated from 'care and support', as well as disability services standards and legislation. It is also unrealistic to expect that private supported accommodation providers can undertake a rehabilitative role.

- *Recognition of the need for formal mechanisms to safeguard and advocate for the interests of residents*

  Official visitors programs now operate in most states in Australia. These programs function to safeguard the rights and interests of people with impaired capacities. As well as being able to take up resident's concerns and complaints, official visitors can inquire into the care of residents and have powers to report their findings to government.

Finally, in terms of trends, it is clear that governments have adopted a dual approach to the sector based on:

- **Increasing the stringency of regulations** in order to improve physical standards and living environments and promote care that is more consistent with quality of life objectives for people with disabilities; and

- **Increasing the provision of external support services** to residents in order to ensure needs are met.

5 RESIDENTS OF SUPPORTED RESIDENTIAL FACILITIES: PREVIOUS STUDIES

What do we know about the population of people living in Supported Residential Facilities, the disabilities they experience, their lifestyle and their quality of life? This chapter examines the information gathered in both interstate and South Australian studies.

5.1 Interstate studies

Available information indicates that the population of residents living in private supported accommodation consists almost entirely of people with some form of disability.

Data on pension-only SRS residents in Victoria indicate 73% of residents are aged 65 years and have the following disability profile:

Psychiatric disability	45%
Major sensory/physical	13%
Dual Psychiatric/Intellectual	12%
Acquired brain injury	10%
Intellectual disability	10%
No disability	7%
Dual psychiatric/acquired brain injury	3%.[34]

Similarly mental illness was found to be the dominant disability amongst licensed boarding house residents in NSW. Intellectual disability, followed by alcohol related brain injury, were the next most common. More than 40% of residents have multiple disability diagnoses. Almost 30% were aged 65 years or older.[35]

A profile of 20 residents of pension-only SRSs in the Inner South-East region of Melbourne indicated the extent of support residents require. Almost all were found to need some level of 24-hour supervision or support. Case workers assessed only one of the twenty as able to live independently, and only then with substantial assistance. Common support needs included:

- Assistance with planning and organising, and structuring of time
- Regular orientation to day, time and place
- Dealing on a day-to-day basis with psychiatric symptoms such as delusions and hallucinations

[34] Data from a Census of Supported Residential Services May 1998, DHS, reported in Department of Human Services Victoria, **Victorian Homelessness Strategy**, http://hna.ffh.vic.gov.au/vhs/pdfs/backresi.pdf.
[35] Data from a Census of Licensed Boarding House Residents, Jan-March 1998 reported in Green, op.cit.

- Assistance with medication and activities of daily living
- Protection from self-harm and/or sexual/physical abuse from others
- Monitoring of behaviour (eg wandering, violent outbursts)
- Assistance with, and motivation to join in, social and recreational activities, and
- General emotional support.[36]

As well, the 'typical' resident of a private supported accommodation facility is likely to have no supportive family network, and few friends. Many have a long history of institutionalisation, and challenging behaviours.[37]

Individual studies have documented the following specific issues amongst people living in licensed boarding houses in NSW:

- *Poor diet*.[38]
- *Poor physical health* – Residents often do not effectively monitor their own health issues, and may only receive cursory attention from General Practitioners. A health audit of the first 47 residents of boarding houses seen at the Balmain Clinic in 1998 indicated the presence of a wide range of serious medical problems previously undiagnosed or treated.[39]
- *Low vitamin D levels* – although very few cases of low vitamin D levels are found in Australia, five women in a licensed boarding house in 1998 were found to have low levels. Risk factors associated with low vitamin D levels include being housebound, having reduced exposure to sunlight, some medications and poor diet.[40]

Very little information is available to provide insight into the lives of residents according to their views and aspirations. One study[41] has explored resident perceptions of quality of life. It found that residents were generally satisfied with their accommodation and the services provided, and felt living in a boarding house gave them freedom and independence compared to

[36] Reid, R, McQueen, S, Wiseman, D, Brakha, S, Maddicks, D and Wright, J, op.cit.
[37] Reid, R and Wiseman, D, **Social Support for Pension-Level SRS Residents – A three-tiered model**, July 2000
[38] Dick, M, **How square are the three meals? Licensed Residential Centre nutrition and food service survey: a baseline descriptive study**, Boarding House Team, Central Sydney Area Mental Health Service, June 1998
[39] Carroll, L and Millard, J, *'Nobody ever asked me that before' Physical health needs of residents in licensed boarding houses*, paper presented to the Rozelle Hospital Winter Symposium , 1999
[40] Humphrey, B and Sheehy, R, *Are residents in licensed residential centres at increased risk of vitamin D deficiency?* **Geriaction**, vol 18 (2), June 2000
[41] Cleary, M, Woolford, P and Meehan, T, *Boarding house life for people with mental illness: An exploratory study*, **Australian and New Zealand Journal of Mental Health Nursing**, vol 7, pp 163-171, 1998

living in a hospital (although many had not lived in a psychiatric hospital for years).

Residents reported being involved in a range of activities, although it appeared these were more likely to be individual (eg reading the newspaper) than group. The communal environment of the boarding house was significant in providing interpersonal contact. Whilst some residents were involved in activities outside, most did not have contact with the wider community or receive visits from people other than paid workers. Almost half reported no family contact. In terms of their perception of the future, residents were unable to articulate future goals or plans: they saw life as a continuation of their present circumstances.

The study suggests people living in private supported accommodation have a level of satisfaction with their present circumstances and few aspirations beyond meeting basic needs. However, residents experience a relatively low quality of life – they have poor community integration and minimal family contact, and rely on the operators of the facility in which they live to meet their needs.

5.2 South Australian studies

There have been few studies conducted in South Australia documenting issues relating to people in Supported Residential Facilities. *'Fritz and White Bread'*, a review of the activities of the boarding house social work team conducted in 1991, reported on the support services that were provided at that time to people in boarding houses, some of which would today be considered Supported Residential Facilities.[42] This study found residents had very minimal life expectations beyond the basics of food, shelter and the desire to have more disposable income, and suggested this lack of expressed aspirations was linked to their sense of powerlessness and few, if any, alternatives and options.

5.2.1 Supported Residential Facilities Association data

Research conducted recently by the Supported Residential Facilities Association provides a snapshot of residents. [43]

Across all facilities surveyed, the average age was 65 years with approximately 60% aged over 60. However, a comparison between facilities attached to a nursing home or retirement complex and those unattached, suggests the disparities across the sector. Residents in 'attached' facilities had a mean age of 84 years compared with a mean age of 60 for those in 'unattached'. This indicates the two types of SRFs in South Australia – those

[42] Chapman, R and Provis, J, **Fritz and White Bread**, Report and Review of the Community Accommodation Support Service Southern Boarding House Social Work Team, August 1991
[43] Supported Residential Facilities Association of South Australia, **A Snapshot of Supported Residential Facilities and their Residents in South Australia**, undated

attached to nursing homes and retirement complexes that cater for the frail aged, and pension-only facilities with a different clientele, where mental illness is the predominant disability.

Considering residents from both types of facilities, the study reported the following breakdown of residents' conditions or diagnoses:[44]

Frail aged	44%
Schizophrenia/schizoaffective disorder	31%
Intellectual disability	26%
Dementia	18%
Alcohol/drug related problem/Korsakoff's syndrome	6%
Diabetes	6%
Personality disorder or anxiety disorder	5%
Major depression	4%
Bipolar disorder/Manic depressive psychosis	2%

Staff rated the time taken to care for residents and the number of Independent Activities of Daily Living with which residents required support in order to determine the extent to which residents required care. The study found that overall the majority needed assistance with three or more activities of daily living and most needed moderate to maximum care. In addition, some residents displayed behaviours that were difficult to manage and disturbing to others.

Residents were also found to have low levels of social activity and very little to do in the day. Typical activities were smoking and watching television; access to meaningful activity, rehabilitation or skill-building was rare.

The study also raised concerns about the adequacy of clinical assessments of residents, given that many had lived in their facility for years, the original diagnoses was outdated and/or disabilities had worsened over time. Only a minority appeared to have recent and comprehensive assessments.

5.2.2 RDNS Research project

An innovative project conducted in the western suburbs of Adelaide considered the incidence and health management requirements of people living in Supported Residential Facilities who had a mental illness and also issues with incontinence.[45] The project aimed to develop training materials for proprietors and pilot intervention programs and strategies.

The researchers found continence was a significant issue for both residents and proprietors. In a survey of 18 facilities accommodating about 600

[44] Note: more than one condition could be nominated.

[45] Royal District Nursing Service, **Development of a collaborative model of care for long term management of incontinence for people living in the community with mental illness – Final report**, RDNS Research Unit, South Australia, 2002

residents, 75% of residents had a diagnosis of mental illness (including dementia) and about 30% were experiencing incontinence (commonly associated with mental illness through factors such as medication, poor physical health and caffeine consumption).

The study also identified that many residents had co-existing health problems which were often poorly treated or unrecognised. For example, 30% were diagnosed as diabetic, yet few had proper management regimes in place.[46] As well, the study noted the complexity of inter-related health, disability and social issues facing residents (and their carers); whereby complex medical co-morbidities, mental illness and intellectual disability combined with drug and alcohol dependence, brain injury, and anti-social behaviours, often exacerbated by ageing and social and economic disadvantage.[47]

5.3 Summary

The available research into the residents of Supported Accommodation facilities both interstate and in South Australia indicates that residents:

- experience a range of disabilities, with those arising from mental illness the most common
- are people on low incomes, predominantly government benefits
- often have complex care requirements, functional impairments and unmet social and health needs
- include a high proportion of aged people, including frail aged
- have minimal community integration, and little access to rehabilitative, skill building or capacity development
- are likely to have a compromised quality of life.

[46] ibid.
[47] ibid.

SECTION 2 THE RESIDENTS

6 RESEARCH METHODOLOGY

6.1 Data collection instruments and processes

The primary sources of data used in the study were information provided by SRF owners/managers; and in addition third party assessments of 437 residents.

6.1.1 Information provided by owners/managers

Interviews were conducted with SRF owners/managers using a semi-structured interview schedule. The interview was generally conducted at the facility. In addition, owners/managers completed a two page Resident Information Sheet that provided a basic profile of all residents in their facility. Information gathered from both sources was entered into an Access data base for analysis.

Interviews with owners/managers varied in length from 20 minutes to about two hours. The time constraints of owners/managers meant that sometimes they were juggling talking with the interviewer with other tasks. For example, during the course of one interview lasting an hour and a half, the owner also dealt with a resident querying whether her debt problems had been sorted out; another resident asking whether he had peeled enough vegetables for dinner; another resident looking for a toothbrush; a phonecall regarding placement of an elderly resident into nursing home care; giving instructions to a relative who was taking an elderly resident out; and cleaning up an incontinent and wheelchair bound resident who had returned from an appointment. It is much appreciated that, despite being under pressure, SRF owners/managers still gave their time and assistance to the research project.

6.1.2 Third party assessments of selected residents

Information regarding selected residents was obtained through the use of an assessment tool known as the Service Needs Assessment Profile (SNAP). Socio-demographic information about each selected resident was also collected.

It was a condition of ethics approval that the collection of personal information only occur with the consent of those individuals. Residents of facilities participating in the research were approached regarding their consent. Hence resident participation was largely self-selection.

Data was gathered in relation to 437 residents for whom consent had been given. Informants were asked to fill out a questionnaire that contained 10 questions regarding the resident, and 29 items from the Service Needs Assessment Profile designed to assess levels of daily functioning for people

with disabilities. Information was collected either from a person from the facility or a key worker.

6.2 Recruitment and participation of facilities and residents

All pension-only facilities were invited to participate in the study. A number chose not to be involved in the study at all, and others were involved in only some aspects of the data collection.

In a few instances the researchers excluded facilities from one of the data collection elements, as follows:

- Three country facilities were excluded from the residents assessments because of the time and resources required to conduct these assessments. One metropolitan facility was also excluded due to low resident numbers.

- Three facilities were excluded from proprietor interviews; one because it had been used to pilot the interview schedule and the other two because the owner/manager had been previously interviewed (ie the owner/manager operated multiple facilities).

Of the 48 pension-only facilities, 37 participated in at least one of the data collection processes and 28 provided information for all of the data collection processes (Appendix 2).

Comparison of the participating facilities against the sample frame according to critical factors that might influence the representativeness of the data (such as type of resident, location of facility, size of facility and Private For Profit / Not For Profit) indicates that the profile of participating facilities is not divergent from that of pension-only facilities as a whole.

6.3 Service Needs Assessment Profile (SNAP)

The Service Needs Assessment Profile (SNAP) is an assessment tool designed to examine the support needs of people with disabilities.

SNAP includes soft-ware functions that can be used to rate functional capacity, estimate staffing support required, cost various support options, and plan and monitor service provision. It was originally designed to assist in the planning for accommodation services for people with intellectual and physical disabilities, but is intended to be applicable to persons with other types of disabilities and support requirements.

SNAP has been used extensively in New South Wales in a variety of programs in the disability sector, including as the assessment tool in the boarding house reform process.

Despite its applications in practice, SNAP has not yet been properly validated. One study has been undertaken which compared the results of SNAP assessments with the Vermont assessment tool. This study found that largely there was agreement between the two tools where the results would be used in research or group comparisons.[48] However the Vermont is also not a validated instrument. The Disabilities Research Unit of the University of Adelaide is currently conducting a two-year evaluation of SNAP which will provide a much more informed and comprehensive view.

6.3.1 Application of SNAP in the study

A number of issues became apparent in the application of SNAP in this study. Firstly, a considerable number of different assessors were involved. In order to facilitate rating consistency, a research assistant trained in the use of SNAP worked with and supported assessors in the completion of questionnaires.

The study also sought to interpret the SNAP items in a way conducive to assessing the target group. While broadly the items were considered to be relevant, some proved difficult to assess. For instance, assessing a person's ability to prepare meals and snacks, when this opportunity is not available to them, was an issue. In such instances, the assessor was asked to consider how well they thought the person may be able to perform the task. Similarly, some items assume that day activities and other programs are available, which is not always the case. Again, the assessor was asked to assume that such programs were available, and estimate the support a person would require to attend.

One SNAP item relating to the type of skill development options undertaken by the person was difficult to rate because of its failure to include considerations of age and frailty. Hence this item has been given a 'dummy' score (using the median score of 3) for all assessments.

6.3.2 Analysis of SNAP scores

About 20% of residents were assessed twice - by both a person from the SRF and a key worker.[49] These double assessments were undertaken to establish whether there was any variation in results of the assessments according to the type of assessor. Comparison found a significant difference in assessed hours between the two different types of assessors for some items, specifically the areas of Personal Care and Behaviour.[50] On the basis that SRF personnel were believed to have a more accurate knowledge of day to day care needs

[48] From confidential report commissioned by the Ageing and Disability Department, New South Wales, conducted by the Centre for Developmental Disability Studies

[49] 86 residents (19.7%) of the sample group of 437 were 'double-assessed'. Of all assessments (523 assessments) the double assessments comprised 32.9%.

[50] Paired t-tests found a significant difference ($p < 0.05$) for the average assessed hours for Personal Care and Behaviour, and consequently for the overall SNAP assessed hours. Regression analysis was used to determine the adjustment required in those areas indicating a significant difference in assessment results.

and behaviour, scores of workers in these two areas (and total assessed hours) were adjusted downwards to equate with those of SRF personnel.

6.4 Ethics approval, consent and the selection of residents

Ethics approval for the study was provided by the Department of Human Services Research Ethics Sub-committee.

It was a condition of ethics approval that personal information only be collected where residents (and their guardians where applicable) had given their consent.

There were a number of practical difficulties encountered in fulfilling this requirement. The people being canvassed comprised frail aged persons and people with mental health issues, intellectual and physical disabilities. In some instances it was difficult or inappropriate to approach people to explain the project and invite participation. For instance, some residents exhibited a level of paranoia and anxiety. Where it was apparent that seeking consent was distressing to the resident, it was not pursued.

Limited competency was also an issue, especially for residents who had no guardians to act on their behalf. In instances where residents were clearly unable to make an informed decision they were not approached. In other cases it was apparent that a person's competency was limited and it required particular skills and different approaches to explain the research and request consent.

Following verbal approval from the Chairperson of the ethics committee, the consent process was amended to include some representation of residents with limited competencies who had no guardians, as it was becoming apparent that the resident sample was at risk of being skewed towards those more cognitively-able. Hence, in instances where a person was regarded by the facility and the researcher as unable to make an informed decision, and they had no guardian to make the decision on their behalf, then, providing another health professional confirmed the view that the person could not provide informed consent, consent requirement could be waived and the resident included. This procedure was used for only a small number.

An experienced mental health social worker undertook all discussions with residents regarding their consent and the study.

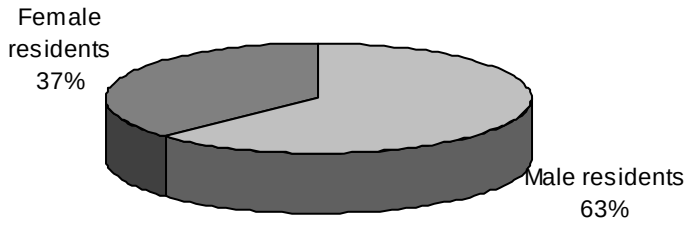
7 PROFILE OF RESIDENTS

The following chapter provides a picture of residents living in pension-only Supported Residential Facilities. Data were derived from information provided by SRF owners/managers about all residents in their facilities (Resident Information Sheets) and information about selected residents (Assessed Residents).

7.1 Gender and age

About two thirds (576 residents or 62.7%) of the residents are male.

Figure 7.1 Gender of SRF Residents



Data for 37 facilities; 919 residents (Resident Information Sheets)

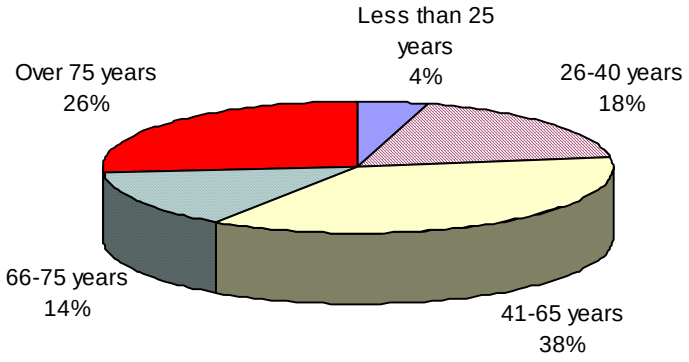
Residents of SRFs are predominantly an older group: most (77.3%) are aged over 40 years. There are very few young people in facilities – only 40 out of 919 (4.4%) were aged less than 25 years. Conversely, 41% were aged 65 years or over. Within this, there was a significant proportion of 'very aged' – 26.4% (243 residents) were aged over 75 years. The proportion of age groupings is shown in Figure 7.2.

7.2 Primary disability

Owners/managers were asked to indicate the primary disability of their current residents (Figure 7.3).[51] The predominant disability identified was mental illness – for 427 (53.7%) of 795 residents. Age-related disabilities were the next most common (183 residents or 23.0%), followed by developmental (intellectual) disabilities at 11.2%.

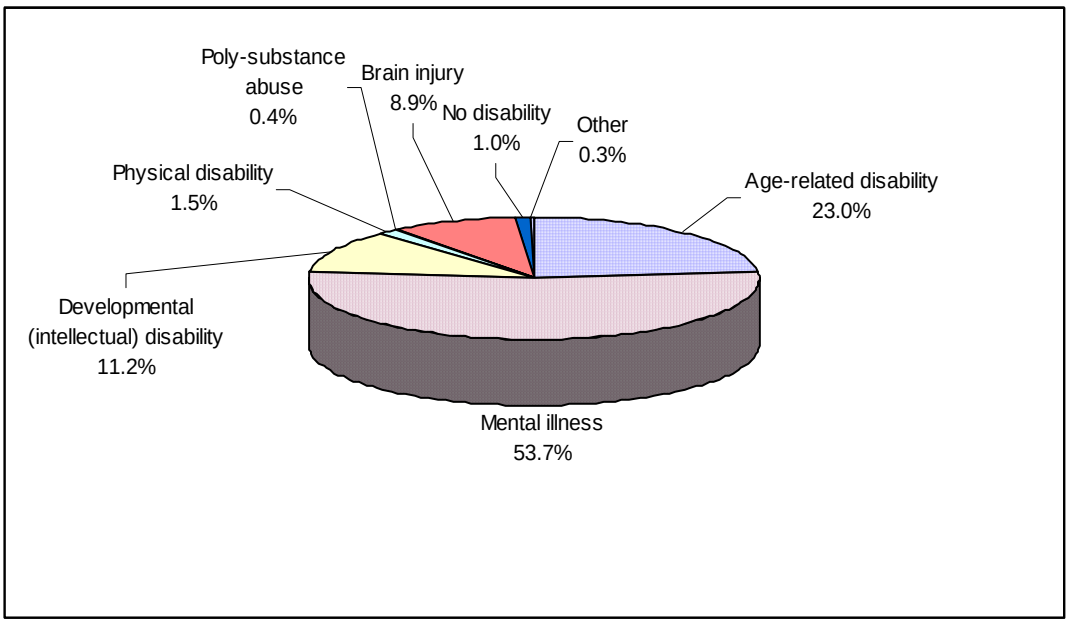
[51] It should be noted that this data does not represent any clinical diagnoses – it indicates the opinion or understanding that the owner/manager of a facility has about each resident's disabilities. Categories provided were: Age-related disability, mental illness, developmental (intellectual) disability, physical disability, poly-substance abuse, alcohol-related brain injury or acquired brain injury, no disability or other disability. Only one primary disability could be nominated per resident.

Figure 7.2 Age of SRF Residents



Data for 37 facilities; 919 residents (Resident Information Sheets)

Figure 7.3 Primary Disability



Data for 33 facilities; 795 residents. (Resident Information Sheets)
Missing data from 4 facilities

7.3 Language and Indigenous status

Owners/managers reported only a very small number of residents who tended to communicate in a language other than English – 22 out of 919 or 2.4%. A number of languages were specified, with German and Italian the most common.

Very few residents were of Aboriginal or Torres Strait Islander descent – 8 out of 437 assessed residents (1.8%).

7.4 Guardianship Board orders

The Guardianship Board may make Administrative orders (in relation to financial or legal matters) or Guardianship orders (appointing a legal guardian and/or in relation to other lifestyle matters. It may also make orders under the Mental Health Act in relation to treatment and detention.

Owners/managers indicated that half of residents (460 of 919, or 50.1%) were subject to administrative orders where their finances were managed by the Public Trustee or another person.

A quarter of residents (245 of 919, or 26.7%) were thought to be under other types of Guardianship Board orders. This would include various treatment orders as well as where another party was appointed as guardian.

A quite different picture emerged when information was obtained about selected residents. It is likely that this information is more accurate as the data collection process was more precise in determining where other people were *legally appointed* to manage aspects of a resident's care (as opposed to being a contact person and involved in decision-making).

Of the assessed residents, just under half (213 residents or 48.7%) were reported to have some kind of Guardianship Board order. Of these, most were administrative orders appointing the Public Trustee to administer their financial affairs. 44% of assessed residents were reported to have an administrative order, with the Public Trustee appointed in 95% of cases.

Only 24 residents were reported to have a guardianship order. The Public Advocate was the guardian for half of these (3% of assessed residents). Other types of orders (including treatment orders) were reported for a few residents. It is possible for a resident to have more than one type of order; however this was reported for only 13 (3% of assessed) residents.

Table 7.1 SRF Assessed Residents, Number of residents with Guardianship Board orders

Number of residents with Guardianship Board	N	% of residents
Legal guardianship	24	5.5
Administrative order	196	44.9
Other order	9	2.1
Total residents with order	*213*	*48.7*
Total residents without	224	51.3
Total residents	437	100.0

Note: A resident may have more than one order therefore percentages do not add up to 100%

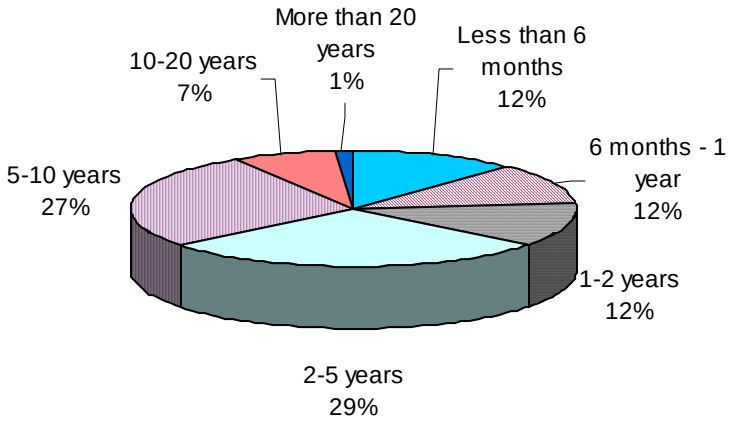
Data for 32 facilities; 437 residents (Assessed Residents)

7.5 Length of residency

Facilities provide a long-term home for many people: over half the residents (503 residents or 55.4%) had lived in their present facility for between two and ten years and another 8.8% (80 residents) for more than ten years (Figure 7.4).

About a quarter of the residents had lived in their present facility for less than a year, although when two transitional facilities and another facility that had recently relocated are excluded, this proportion drops to 17.5%.

Figure 7.4 Length of residency in current facility



Data for 37 facilities; 907 residents (Resident Information Sheets)

7.6 Accommodation history

Predominantly, residents had lived in congregate or institutional care (usually another SRF) prior to their current address Only a third had previously lived independently or with family or friends.

Table 7.2 SRF SNAP Residents, Type of accommodation prior to current

Accommodation prior to current	N	%
Own home /flat	114	26.1
Living with family or friends	32	7.3
Living in another SRF	132	30.2
Living in another form of supported accommodation	23	5.3
Mental health institution	58	13.3
Hospital	21	4.8
Other	18	4.1
Dont know	39	8.9
Total	**437**	**100.0**

Data for 32 facilities; 437 residents (Assessed Residents)

7.7 Pathways into SRFs

There appear to be different pathways into SRFs.

Older people were more likely to move into SRFs from their own home or flat; whereas 'non-aged' people (those aged under 65 years) were more likely to have previously lived at another SRF (Table 7.3).

Table 7.3 Assessed Residents, Type of accommodation prior by age

SRF Assessed Residents, Type of accommodation prior to current by age (%)

Accomodation prior	<25 years	25-40 years	41-65 years	65-75 years	>75 years	Total
Own home /flat	12.5	15.5	15.6	26.9	52.4	26.1
Living with family or friends	12.5	8.5	5.4	13.4	5.7	7.3
Living in another SRF	25.0	40.8	34.9	25.4	18.1	30.2
Living in another form of supported accommodation	25.0	2.8	6.5	6.0	2.9	5.3
Mental health institution	12.5	19.7	15.6	14.9	4.8	13.5
Hospital	12.5	4.2	6.5	3.0	2.9	4.8
Other	0.0	5.6	5.4	1.5	2.9	4.1
Dont know	0.0	2.8	10.2	9.0	10.5	8.7
Total	100.0	100.0	100.0	100.0	100.0	100.0
Total number	**8**	**71**	**186**	**67**	**105**	**437**

At the same time, most aged people had *not* entered the SRF recently (ie in the past two years or less (Table 7.4)). Thus, while SRFs cater for many aged people, most have lived at the facility for some time and thus have aged in place.

Table 7.4 Assessed residents, length of time lived in facility by age

SRF SNAP Residents, Length of time lived in facility by age (%

Length of time lived in facility	Under 65 years	65 - 75 years	Over 75 years	Total
Less than 2 years	39.6	34.3	37.1	38.2
2 - 10 years	47.9	41.8	43.8	46.0
More than 10 years	11.7	22.4	18.1	14.9
Unknown	0.8	1.5	1.0	0.9
Total	*100.0*	*100.0*	*100.0*	*100.0*
Total number	265	67	105	437

This suggests that many of the aged people living in SRFs are there for reasons of pre-existing disability. In many cases, ageing will have compounded other difficulties.

Fourteen percent of residents were living in a mental health institution prior to living at their current location, suggesting a pattern of people being discharged from such facilities to SRFs.

The more general trend is for residents to have lived at their current facility for some years, and another SRF prior to that, suggesting a history of living in this form of accommodation for significant periods of time.

Mary

Mary is a 40 year old woman who has lived at her current SRF for only a few months. She comes originally from a country town interstate; she has some family there and a teenage child who has not lived with her for some time.

Mary came to the SRF following some time spent in a drug and alcohol rehabilitation facility. Her placement was organised by her pastor from her home town.

When Mary came to the SRF the owner was informed she had a history of drinking; and that she had a mental health issues described as psychosis and depression. Mary's drinking has not been a problem – she has abided by the owner's requirement that she not drink whilst living at the facility.

However Mary has a pattern of self-harm and during her time of residence she has either cut her arm or threatened to harm herself on many occasions. There have been weeks where she has cut herself (or threatened to do so) three or four times a week, other weeks this may not occur. The owner and staff spend time with her each day, as towards afternoon and evening she 'hears voices' and can become distressed. There is a level of supervision provided by the SRF to monitor that she is not harming herself. If she does cut herself, or becomes too distressed, the SRF will call an ambulance to take her to hospital.

Mary's other major problem is financial. She has incurred debts (including a large amount for ambulance costs) which have required the SRF owner to sort out her finances and negotiate payment or waiver of the debt. The SRF owner is now co-signatory for Mary's credit card.

Mary has a mental health case worker and her GP is actively involved in her care. Her long-term prognosis is that she will remain in the facility unless there is an escalation of her mental illness. Other than being concerned about her self-harming behaviour and managing financial problems, the owner reports that she is a lovely person to have around and other residents have taken her under their wing. At her recent admission to hospital, Mary nominated the SRF owner as her 'next of kin'.

7.8 Summary

SRFs accommodate a range of people with a disability. Most commonly, however, residents are male; and have a primary disability associated with mental illness. The age profile is skewed heavily towards older groups. About half have a Guardianship Board order (predominantly an administrative order). Most residents have long histories of institutional or supported care: most have lived in their current SRF for over 2 years; and usually moved to the facility from another similar facility. There is a significant group of older people who have been long term residents, have pre-existing disabilities and have aged in place.

8 ASSESSMENT OF RESIDENT SUPPORT NEEDS

Information about the support needs of 437 residents was gained through the use of the Service Needs Assessment Profile. This chapter reports on the results of these SNAP assessments.

8.1 Overall SNAP scores

The SNAP questionnaire comprises 29 questions in the five areas of:

1. Personal Care Support (6 items)
2. Physical Care Support (6 items)
3. Behaviour Support (5 items)
4. Night Support (5 items), and
5. Social Support (7 items).

Each item is scored on a scale of one to five, resulting in an average raw score and a calculation of assessed hours for each area. An overall total raw score and total assessed hours are derived from these. For each assessed person, SNAP produces an assessment comprising:

- Total assessed hours of support per day (categorised as levels 1-4)
- Level of night support required
- Mental health status (derived from one of the behaviour support items) and
- Behaviour issues (also derived from one of the behaviour support items).

8.1.1 Assessed hours of support per day

Over half of all assessed residents were assessed to require 3.5 hours or less of support per day, and 30% required between 3.6 and 6 hours.

Table 8.1 SRF Assessed Residents, Level of support per day

Level of Support	N	%
Level 1 Complex support (up to 10 hours)	4	0.9
Level 2 High Support (6.1-8 hours)	22	5.0
Level 3 Moderate support (3.6-6 hours)	131	30.0
Level 4 Low Support (3.5 hours or less)	280	64.1
Total	**437**	**100.0**

Looking at the level of assessed hours in more detail shows that about half the residents were assessed to require between two and four hours of support per day.

Table 8.2 SRF Assessed Residents, Assessed hours of support per day

Number of hours	N	%
Less than 1.0	12	2.8
1.0 - 1.9	75	17.2
2.0 - 2.9	112	25.6
3.0 - 3.9	113	25.9
4.0 - 4.9	71	16.3
Greater than 5.0	54	12.4
Total	**437**	**100.0**

The average (mean) number of hours of support per day for assessed residents was 3.27 hours, ranging from a minimum of 0.2 hours to a maximum of 10.3 hours.

8.1.2 Night support

Most residents were assessed as not requiring any support at night.

Table 8.3 SRF Assessed Residents, Night support status

Night support status	N	%
Active	3	0.7
Nil	338	77.4
Sleepover	96	22.0
Total	**437**	**100.0**

8.1.3 Mental health status

The most frequently occurring mental health status was a stable condition requiring medication. However, close to the same number of assessed residents recorded no mental health issues. Overall 57.7% of residents were assessed to require some level of support for mental health issues.

Table 8.4 SRF Assessed Residents, Mental health status

Mental health status	N	%
No history of mental health issues	161	36.8
Previous mental health history not requiring support	24	5.5
Stable condition requiring medication	166	38.0
Active mental health issues requiring regular review	71	16.3
Acute mental health issues requiring regular treatment	15	3.4
Total	**437**	**100.0**

8.1.4 Behaviour issues

Sixty percent of residents were assessed not to have any behavioural issues. Of the remaining 40%, aggressive behaviour was the most frequently recorded item.

Table 8.5 SRF Assessed Residents, Behavioural issues

Behavioural Issues	N	%
No behavioural issues	266	60.9
Absconding	8	1.8
Aggressive	67	15.3
Self injury	18	4.1
Physically assaultive to others	15	3.4
Other behavioural issues	63	14.4
Total	**437**	**100.0**

About half of those people with 'other behaviour issues' displayed behaviour regarded as disruptive. This included agitated behaviour, attention-seeking behaviour, highly intrusive behaviour, sexualised behaviour, obsessive compulsive actions, frequent stealing and fire-lighting.

8.1.5 Personal Care Support

Personal care support examines the assistance a person requires in relation to bathing and hygiene skills, dressing, eating, meal preparation, household tasks and personal safety. Most residents were assessed to require up to 2 hours a day of such support.

Table 8.6 SRF Assessed Residents, Personal care hours per day

Number of hours	N	%
Less than 1.0 hour	88	20.1
1.0 - 1.9 hours	285	65.2
2.0 - 2.9 hours	58	13.3
3.0 - 3.9 hours	6	1.4
Total	**437**	**100.0**

8.1.6 Physical/health Care Support

This area assesses the support a person requires in relation to specific health issues – ambulation, on-going health needs, incontinence, mobility, pressure care and epilepsy. The study also included supervision of medication. The assessments of residents indicate that nearly all require less than one hour of support per day in order to maintain their health status.

Table 8.7 SRF Assessed Residents, Physical/ health support hours per day

Number of hours	N	%
Less than 1.0 hour	398	91.1
1.0 - 1.9 hours	36	8.2
2.0 - 2.9 hours	3	0.7
Total	**437**	**100**

8.1.7 Behaviour Support

The area of behaviour support assesses the extent to which behavioural problems need to be addressed, any risks associated with a person's behaviour, and the need for planned behaviour management strategies to address behavioural issues. Most assessed residents required less than one hour of support per day in this area.

Table 8.8 SRF Assessed Residents, Behaviour support hours per day

Number of hours	N	%
Less than 1.0 hour	352	80.5
1.0 - 1.9 hours	73	16.7
2.0 - 2.9 hours	8	1.8
4.0 - 4.4 hours	4	0.9
Total	**437**	**100.0**

8.1.8 Social Support

Social support refers to the assistance required by a person whilst in the accommodation environment and also in programs or activities outside of their accommodation. It includes assessment of the support required in the areas of communication, social skills, money, leisure, travel and participation in work activities and programs.

Just over half of assessed residents required less than 1 hour per day of such support (Table 8.9).

Table 8.9 SRF Assessed residents, Social support hours per day

Number of hours	N	%
Less than 1.0 hour	229	52.4
1.0 - 1.9 hours	190	43.5
2.0 - 2.9 hours	18	4.1
Total	**437**	**100.0**

8.2 Profile of resident need – SNAP clusters

Cluster analysis was used to establish whether, on the basis of their SNAP results, the assessed residents could be grouped in any particular way.[52] The analysis identified five distinct groups of residents (Table 8.10).

Table 8.10 SNAP clusters

Group 1: '*minimal care needs*'	Residents scored low (ie in general lower than other residents) for all areas of support. They generally had either no history of mental illness or no current mental health issues.
Group 2: '*minimal care needs and stable mental health issues*'	This group had lower support needs in all areas but also current mental health issues that were, in the main, stable, but ranged from stable to acute.
Group 3: *'frail and disabled'*	Support needs were mostly in the areas of personal care and physical/health, with some social support requirements. There were generally no current mental health issues.
Group 4: *'active mental health*'	Primary support needs were in relation to active mental health issues, requiring behavioural support.
Group 5: *'high and complex needs'*	Residents required higher levels of support across all areas, and had current mental health issues with an average level of stable.

The proportion of residents estimated in each cluster is shown in Table 8.11.

Table 8.11 SRF Assessed Residents, Cluster distribution

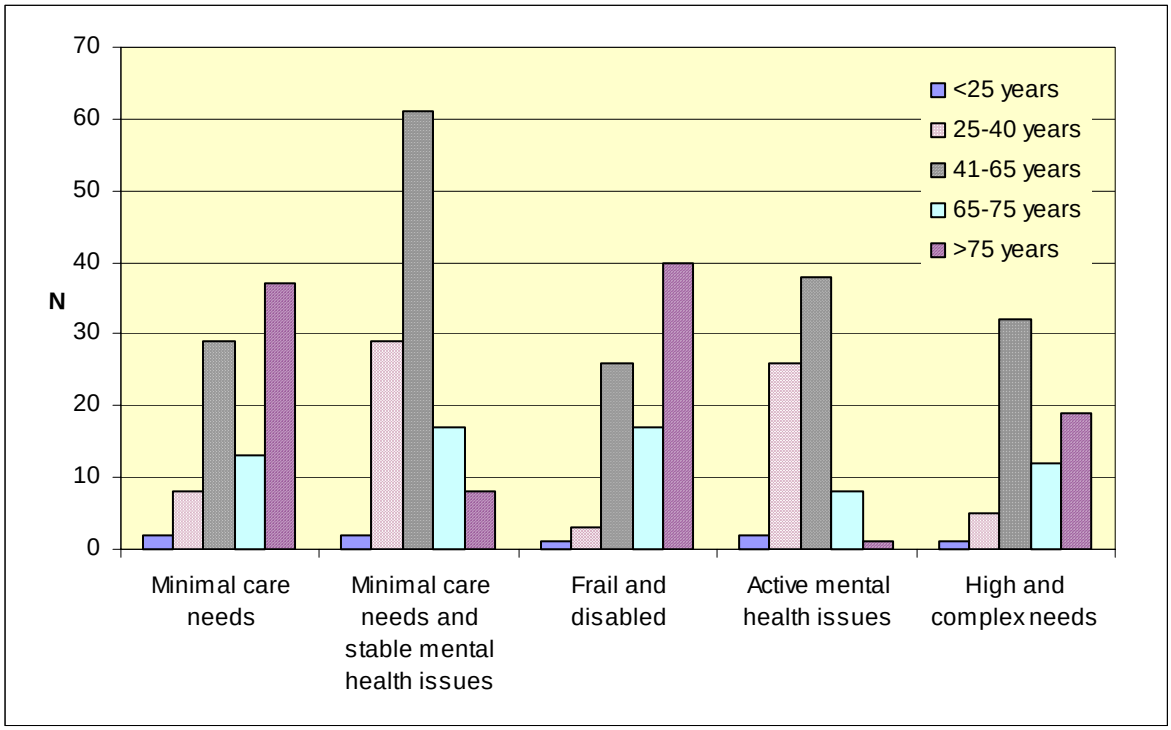
Cluster	Description	N	%
1	Minimal needs	89	20.4
2	Minimal needs, stable mental health	117	26.8
3	Frail and disabled	87	19.9
4	Active mental health issues	75	17.2
5	High and complex needs	69	15.8
Total		**437**	**100.0**

People assessed as having minimal care needs and stable mental health are the largest group of residents.

[52] Analysis was conducted on 6 items - Mental Health rating, and average total scores for the five domains of Personal Care, Physical Health support, Behaviour support, Night support and Social support.

The age profile of assessed residents in the five clusters is shown in Figure 8.1

Figure 8.1 SRF Assessed Residents, Age by cluster group



Features of this data are:

- the predominance of 41-65 year olds with minimal care needs and stable mental health issues
- the number of over 75 year olds in the 'frail and disabled' cluster
- a similar number of over 75 year olds in the 'minimal needs'cluster, and
- a significant grouping of aged people (those over 65 years) in the high and complex needs group.

John

John is seventy five years old and has lived at his current SRF for four years. He is divorced; and keeps in contact with one of his sons who lives close by. He has worked hard and made money when he was younger but has 'blown it all' through drinking and now lives on a pension. His lack of money is a big issue for him.

John has some health problems. He has difficulty walking and uses a frame. If he wants to go to the shops he needs to catch a taxi because he can't walk that distance. He can shower and dress himself but needs monitoring in the shower to make sure he doesn't fall. His eyesight is quite bad which limits what he can do for himself. He is a heavy smoker and because he can't see very well he requires staff or other residents to roll his tobacco for him. He smokes in his bedroom despite this being against the house rules, a source of constant aggravation between John and staff. The combination of heavy smoking and bad eyesight results in John's clothes getting burnt, tobacco being dropped everywhere including in bedclothes, and holes being burnt in the carpet. The risk factors to both John himself, and the carpet and bedclothes, are a concern for the facility.

The SRF staff monitor certain behaviours of John's to avoid difficulties for him, them and other residents. For instance he gives other residents too much money to buy his tobacco and ends up being 'ripped off'. His tobacco expenditure takes most of his discretionary funds each fortnight and he has problems when he is out of pocket. Because of his eyesight he can't manage his own money anymore, so the SRF owner will withdraw his pension from the bank for him and give John his 'pocket money' after paying the SRF fee. The SRF monitors his pocket money expenditure as he has overspent on tobacco and at the chemist.

Staff monitor other anti-social behaviours such as spitting and urinating in the garden. They also monitor his intake of laxatives as he will take large amounts in an attempt to self-medicate his constipation problems.

John's son is involved in assisting his father; however after a recent quarrel about money John rescinded his authority for his son to manage John' money. It is now back to the SRF to do this. It is likely that John will continue to live at the SRF for some years yet unless his health deteriorates.

8.3 Summary

The assessment of resident support needs identified considerable variation across the population of residents. On average, residents required 3 hours of support per day. Most commonly, residents were found to require:

- Up to 2 hours per day of personal care support
- No support at night
- Support for mental health issues

Five clusters of residents are proposed, with estimated resident population in each group as follows:

6. The minimal care needs group (20.4%)
7. The minimal care needs and stable mental health issues group (26.8%)
8. The frail and disabled group (19.9%)
9. The active mental health issues group (17.2%)
10. The high and complex needs group (15.8%).

People assessed as having minimal care needs and stable mental health are the largest group of residents.

9 CONNECTION WITH THE SERVICE SYSTEM

SNAP assessments identify the type and level of support needs of residents. It is also, however, important to understand whether these needs are being met.

This is not easy to determine. The study sought to partially explore this issue by documenting whether residents received a service from health or other support services. However, a thorough investigation of the circumstances of individuals and discussion with residents themselves and those around them is required to fully assess whether individual needs are being adequately and appropriately met.

Data reported is derived from information provided by SRF owners/managers about all residents in their facilities (Resident Information Sheets) and information about selected residents (Assessed Residents).

9.1 Contact with GPs

384 of 437 assessed residents (88%) were reported to have regular contact with a GP. Just over half (54.5%) saw the GP at least once a month, and a third (32.7%) were reported to see a GP fortnightly or more.

Table 9.1 SRF Assessed Residents, Frequency of contact with GP

Frequency of contact	N	%
More than once a week	6	1.4
Weekly	34	7.8
Fortnightly	103	23.6
Three weekly	4	0.9
Monthly	91	20.8
Between 1 and 3 mthly	21	4.8
Bi-monthly	8	1.8
Three monthly	7	1.6
Six monthly	11	2.5
Annually	2	0.5
As required	78	17.9
Unknown	72	16.5
Total	**437**	**100.0**

Data for 32 facilities; 437 residents (Assessed Residents)

9.2 Contact with other formal services

Assessors were asked to identify the services with which assessed residents were in regular contact. Responses indicate that just over half (54%) had regular contact with a worker or service. Most commonly residents had contact with only one kind of service; however 48 (11%) had contact with two

or more. Of these, contact with both a mental health worker and a support worker[53] was the most common pattern (Table 9.2).

Table 9.2 Number of workers per assessed resident

Number of workers per resident	N	% of residents
No worker	*203*	*46.5*
1 worker	186	42.6
2 workers	46	10.5
3 or more workers	2	0.5
Total with worker	*234*	*53.6*
Total residents	437	100.0

Data for 32 facilities; 437 residents (Assessed Residents)

The most common service in contact with residents was a mental health worker (166 residents or 38%). Fewer (36: 8%) had regular contact with a disability worker[54], and a similar number with a support worker. Very few residents were in contact with either a Domiciliary Care worker or a District Nurse.

Table 9.3 SRF Assessed Residents, Number and Type of worker

	N	% of residents
Mental health worker	166	38.0
Disability worker	36	8.2
Support worker	33	7.6
District Nurse	6	1.4
Domiciliary Care worker	3	0.7
Other	41	9.4
Total residents with worker	*234*	53.5
Total residents without worker	203	46.5
Total residents	437	100.0

Note: A resident may have more than one worker therefore percentages do not add up to 100%

Data for 32 facilities; 437 residents (Assessed Residents)

Frequency of contact was variable. For those in regular contact with a mental health worker, 44% had very frequent contact (ie at least once a fortnight).

[53] 'Support worker' refers to a disability (including psychiatric disability) support worker from an agency such as Community Support Inc or Metro Access.
[54] 'Disability worker' refers to a case worker/case manager from a disability agency such as Options Co-ordination or IDSC.

Table 9.4 SRF Residents, Frequency of contact by worker type

Frequency of contact	Mental health worker		Disability worker		Support worker		Other	
	N	%	N	%	N	%	N	%
More than once a week	7	4.2	3	8.3	6	18.2	9	22
Weekly	30	18.2	8	22.2	22	66.7	8	19.5
Fortnightly	36	21.2	2	5.6	4	12.1	10	24.4
Three weekly	2	1.2	2	5.6	-	0	1	2.4
Monthly	20	12.1	7	19.4	1	3	4	9.8
Between 1 and 3 mthly	5	3	1	2.8	-	0	1	2.4
Bi-monthly	10	6.1	4	11.1	-	0	1	2.4
Three monthly	12	7.3	4	11.1	-	0	2	4.9
Six monthly	13	7.9	1	2.8	-	0	1	2.4
Annually	3	1.8	-	0	-	0	-	0
Occasionally	1	0.6	-	0	-	0	-	0
As required	25	15.2	3	8.3	-	0	1	2.4
Other	1	0.6	-	0	-	0	-	0
Unknown	1	0.6	1	2.8	-	0	3	7.3
Total	**166**	**100.0**	**36**	**100.0**	**33**	**100.0**	**41**	**100.0**

Data for 32 facilities; 437 residents (Assessed Residents)
Note: residents may have more than one worker.

Where residents have regular contact with a mental health worker or disability worker (46%) (excluding other types of workers) this is likely to indicate the resident receives a key worker service.

There is an association between age and contact with a worker. Older residents were more likely *not* to have regular contact with any service. Younger residents were more likely to have a worker, and also to have more than one worker.

9.3 Social contact

Nearly three quarters of assessed residents participated in regular social activities outside the facility, whilst one quarter had no such activities.

Table 9.5 SRF Residents, Frequency in participation in social activities outside facility

Frequency of participation	N	%
Once or more in a week	267	61.1
Once or more in a month	45	10.3
Other	9	2.1
Total	*321*	73.5
no social activities	110	25.2
Unknown	6	1.4
Total assessed residents	**437**	**100.0**

Data for 32 facilities; 437 residents (Assessed Residents)

9.4 Referral processes and entry criteria

Owners/managers were asked to identify the main sources of referrals to their facility. Mental health community based services (ie ACIS and community based teams) were the most common source; with referrals from psychiatric inpatient facilities (notably Glenside and including the psychiatric wards of RAH and FMC) and general hospitals (including RAH, QEH, FMC, Lyell McEwin, and Daw Park) also common (Table 9.6).

Human services agencies were much more likely to provide the conduit for entry into facilities than informal sources (eg family members). However these informal sources still played a significant role. Referrals from other facilities formed part of the referral network, with residents moving between facilities as referred or organised by owners/managers.

Table 9.6 Main source of referrals

Main source of referrals	N	%
Mental health service (ACIS/ community team)	24	70.6
Other hospital	17	50.0
Psychiatric hospital	14	41.2
IDSC/ Options Co-ordination	13	38.2
Aged care services	7	20.6
GP	3	8.8
Total source of formal referrals	*78*	*75.0*
Word of mouth	10	29.4
Family member	5	14.7
Self-referral	4	11.8
Total source of informal referrals	*19*	*18.3*
Other	6	17.6
Not sure	1	2.9
Number of facilities	34	

Data for 34 facilities; 856 residents. (Proprietor Interviews)
Note: facilities may have more than one source of referral.

Owners/managers were asked two related questions to establish how they assessed resident entry into their facility and if certain kinds of residents were included or excluded. The questions asked were *'Does your facility focus on, or specialise in, any particular resident group or area of disability?'* and *'What criteria do you use to determine if you will admit a potential resident to your facility?'*

Responses were fairly evenly divided between those facilities which indicated that they specialised in, or were appropriate for, certain client groups, and those that regarded their facility to be open in its entry criteria.

Facilities that indicated they *didn't* specialise said they would accept a range of clients. One facility included younger homeless as potential residents; another included people needing short term accommodation.

Where owners/managers indicated that they tended to specialise, this was usually in quite broad terms, ie residents were all people with mental illnesses or aged people. Generally, specialisation was more an indication of being equipped to cater for a certain kind of resident rather than a strict entry criteria. Specialisation also included not mixing groups with varying needs – as one owner/manager commented:

> "We're primarily for people with mental illness: it doesn't work to mix residents with mental health issues and people with intellectual disabilities."

A few facilities were more specific in the client group they focussed on (eg two nominated Korsakoff's syndrome as their client group).

Facilities also indicated other criteria for determining who they would accept. These primarily related to a) the level of resident need, b) resident behaviour and c) resident mix.

Facilities were quite careful in ensuring that they would not accept residents whose care needs (particularly physical care) were too high for them to manage. Different facilities 'drew the line' at different points. Some would not accept residents who required care such as showering or dressing. Others would accept residents requiring these services, but not accept people with other specific needs - mobility problems (those in a wheelchair) and people who were incontinent were often cited.

Resident behaviour was another major determining factor. Facilities were concerned about residents with violent or aggressive behaviour, and wherever possible would screen them out. (As one owner/manager said *"I can tell in the first 15 seconds if they're going to be trouble"*.) Several owners/managers said they had been physically assaulted or threatened by residents. Owners/managers also reported a range of other 'difficult' behaviours which were not accepted, including residents using drugs and alcohol. Tolerance to behaviour varied; for instance one facility said they did not take younger residents who might be too loud for the older clientele; at the other extreme one facility had banned several residents because they smeared faeces on the wall.

Thus whilst there was an understanding that residents would display some difficult behaviours associated with their condition or illness (*"that's what we're here for"*), there were limits about what could be accommodated especially where behaviour impinged negatively on others.

> "I'm very selective with younger residents. I've learnt the hard way not to accept those younger mental health persons with disruptive or manipulative behaviour. I've had problems with younger residents 'standing over' the older ones. I want to make sure a new resident will fit in and won't disrupt my current residents."

In contrast, a few facilities said they were prepared to take the 'harder' residents (eg younger people with mental illness or people with dementia). One owner gave examples of difficult residents in their facility who had been reportedly 'expelled' from community or government services for being too difficult.

Some owners/managers had particular strategies for screening residents to avoid the 'too difficult', such as only taking referrals from known social workers; not taking referrals from Crisis Care or CHAST; and not taking emergency referrals after 5 pm.

Considering how a prospective resident might fit in with current residents was also common. As one owner/manager said "*the hostel is like a family - new residents need to fit in*". Several owners/managers said they balanced the issue of resident mix with the economic imperative of maintaining or increasing occupancy.

9.5 Key workers

SRF owners/managers were asked to identify how many of their total residents had a key worker.[55] Information from 30 facilities indicates great variation across facilities in terms of whether residents have a key worker. The proportion of residents with a key worker ranged from 0% in four facilities to 100% in two. For 40% of facilities more than half the residents had a key worker. The highest number of residents with a key worker in any one facility was 32 residents (Figure 9.1).

Overall, proprietors reported that 296 residents (or 38.8%) out of a total of 763 had a key worker. In other words, 61.2% of residents were reported *not* to have a key worker.

It might be expected that facilities receiving the board and care subsidy had higher proportions of residents with key workers. Data about key workers was obtained from five of these: in two facilities, all residents had a key worker; in the other three facilities the proportions of residents with a key worker were 74%, 64% and 15%.

One facility (Not For Profit) requires all residents to have a key worker as a condition of entry.

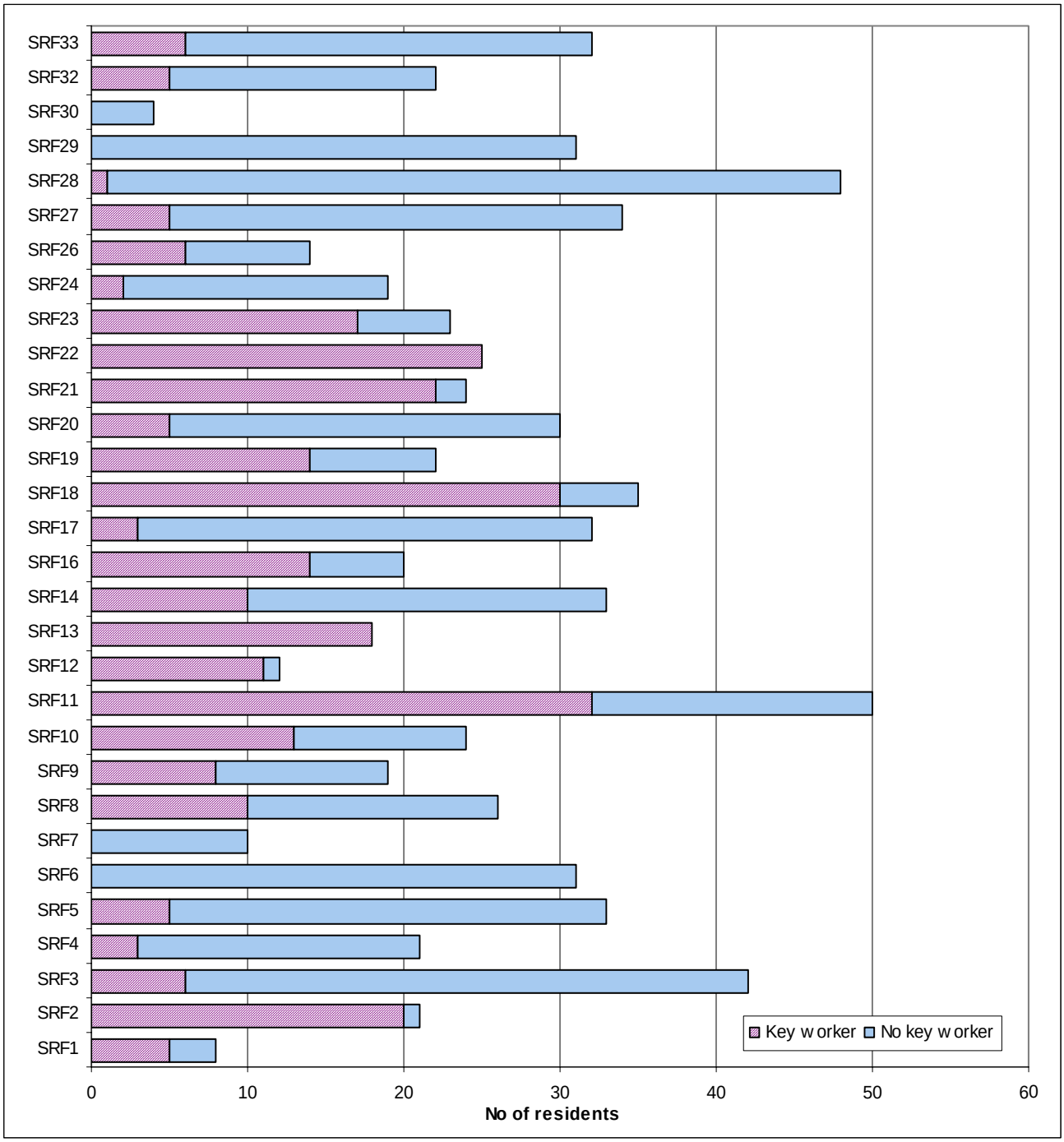
9.6 Case management

Owners/managers were invited to discuss their contact and working relationship with key workers.

[55] 'Key worker' refers to a primary worker or case manager.

There was no common view across the sample of owners/managers about this. Sometimes there were different perceptions about the regional service and even the same worker. Responses varied depending on 1) whether residents had workers or not, 2) the amount of contact the facility had with workers, and 3) expectations of the owners/managers of workers.

Figure 9.1 SRFs residents with a key worker



Data from 30 facilities, 763 residents (Proprietor Interviews)

Generally key workers were seen as responsible for particular tasks, such as making appointments for specialist assessments, organising support services and talking with the resident to sort out problems. Assessing medication needs and delivering and monitoring medication for residents with mental illnesses were commonly reported roles. Key workers were also called upon when there was some kind of emergency, particularly if a resident's behaviour or mental state suddenly deteriorated, or for organising financial matters. A common view of the sharing of tasks between key workers and facilities appeared to be that key workers would manage medication requirements and the facility would provide feedback to the key worker about the resident's behaviour and monitor their health. Outside of regular contact focussed on medication, the facility would manage most other issues and ring the key worker only 'if needed': *"it is quicker to do it myself than ring the social worker to ask them to organise something."*

Some owners/managers reported general satisfaction with key workers. This seemed most likely where the roles between the SRF and key worker were clearly defined; there was regular contact; and the key worker reliably responded to requests for assistance from the facility.

On the other hand, others expressed frustration and dissatisfaction. Commonly-reported issues were that the key worker did not undertake tasks that the owner/manager thought they should (eg managing issues with the Public Trustee) and left too much responsibility with the facility.

A common perception was that some residents who needed case management and specialist intervention simply did not get it, and other residents, whose needs were not as high, did. ("*Often the residents who need help the most are the ones who don't receive it.*") Some owners/managers said they advocated on their resident's behalf in order to access services, with no result. Community Support Inc (CSI) was the most frequently mentioned agency where owners/managers were concerned that a resident was deemed ineligible for service. (Access to CSI support is dependent either on self-funding or referral by designated key agencies which do not include SRFs).

Some owners/managers reported various types of formalised contact with key workers and other professionals. For example, one owner/manager was involved in three monthly case conferences with mental health staff to discuss the progress and care of residents. Several were involved with GPs in assessment and care planning processes undertaken through the Enhanced Primary Care initiative. These processes appeared (helpfully) to be based on the view that the SRF owner/manager was a partner in the on-going care, and should be included in planning and decision-making.

Many owners/managers did not report this kind of involvement, but did report being able to access either a key worker or other professional support when required:

"If I've got any problems I've only got to ring (them) and they'll help out straightaway."

On the other hand some had little contact with key workers or indeed with any service agencies. Several facilities reported that once a social worker had made the initial referral and placed a resident, that would be the last they heard from them. Some owners/managers reported social workers would only be called upon to assist with major issues (such as hospitalisation, psychotic episodes or a change of placement). Facilities usually had some contact, even if only minimally, with GPs.

Where there was no key worker, it appeared that the owner/manager adopted this role: *"We're expected to provide the support that social workers don't."* For many residents the owner/manager is also the Public Trustee liaison, adding to the sense that they have become *de facto* key worker.

9.7 Who gets a service from support agencies?

Arguably, not all people living in a Supported Residential Facility will require case management and there should be targeting of this service to those most in need. In this regard, the data indicates that some low need residents are receiving a services, whilst others with high and complex needs do not. Table 9.7 shows the number of assessed residents according to level of need (as indicated by cluster) who receive a service from support agencies.

Table 9.7 Assessed residents, Clusters by Type of worker

	Minimal care needs	Minimal care needs and stable mental health issues	Frail and disabled	Active mental health issues	High and complex needs	Total
Mental Health Worker	8	61	4	69	24	166
Disability Worker	12	7	9	5	3	36
District Nurse	1	3	1	1	6	12
Domiciliary Care	0	1	1	1	3	6
Support Worker	1	12	4	11	5	33
Other	10	10	5	7	9	41
Residents with a worker	26	76	24	74	34	234
Percent with worker	*29.2*	*65.0*	*27.6*	*98.7*	*49.3*	*53.5*
Residents without a worker	63	41	63	1	35	203
Total number	**89**	**117**	**87**	**75**	**69**	**437**

Note: residents may have more than one worker.

It appears that almost all people living in SRFs considered to be in the 'active mental health issues' group have regular contact with a worker. By comparison, only half of those residents with high and complex needs have

contact with a worker, when it could be argued that these people should be a high priority for case management or support.

Almost a third of resident with minimal care needs and stable mental health have a worker. Frail and disabled people are the least likely to have a worker. In itself, this raises concerns about the protective and planning mechanisms around these people, including guardianship orders.

9.8 Clients of the Department of Human Services

To further investigate the issues relating to key workers and contact between SRF residents and human services, the client records of various agencies were examined in order to match client records with the list of addresses for metropolitan pension-only SRFs. This process identified 506 residents of SRFs who were current clients of these services for the period 1999-2000 (Table 9.8). That is, approximately one third of residents were receiving a service from a DHS mental health or disability service, again suggesting issues of unmet need and an absence of external support, advocacy and planning mechanisms.

Table 9.8 Clients of Mental Health and Disability Services residing in SRFs

Clients of Mental Health and Disability Services residing in SRFs - Service by Age, 1999-2000

	<25 years	25-39 years	40-64 years	65-74 years	>75 years	Total
Community Mental Health	6	61	180	49	30	326
Brian Injuries Options Co-ordination	1	8	13	0	0	22
IDSC	12	49	69	14	8	152
Sensory Options	0	0	1	1	0	2
Adults with Physical and Neurological	0	1	3	0	0	4
Total	**19**	**119**	**266**	**64**	**38**	**506**

Of these, 62% were male and 38% were female. Schizophrenia was the diagnosis for 73% of the mental health clients in Supported Residential Facilities.[56]

A similar data analysis process undertaken by RDNS for the 21 month period 1999 to 2001 (as at 28/9/2001) identified 53 admissions for residents of Supported Residential Facilities. Most of these were for people aged over 65 years and for wound management (47.1%) followed by diabetic care (18.9%).

[56] Community Mental Health client assessments residing in metropolitan SRFs, diagnosis group by gender, 1999-2000

Fred

Fred is 67 years old and came to live at the SRF several years ago. Despite having a chronic mental illness he had lived independently in the community for many years, but as he aged he had increasing difficulty managing on his own. He found it hard to accept he was not managing and it took a lot of convincing for his case manager to be able to get Fred to agree to move into the SRF.

Fred would still prefer to live on his own. He gets angry with workers and staff at the SRF who assist him. He has no regular contact with his family. He still manages his own money but regularly runs out, meaning he can't buy cigarettes. He becomes angry and agitated without them.

Fred has quite severe spinal arthritis that causes him pain and limits his mobility. He also has severe Parkinsonian effects from long-term medication, so that it is becoming increasingly difficult for him to eat meals and attend to personal care and hygiene. However an ACAT assessment has determined that his level of disability is insufficient for entry to low level aged care.

Fred also has some unaddressed health issues. He has a chronic chest infection, exacerbated by heavy smoking, and, although his GP has referred him for a chest x-ray, Fred cannot get to the hospital by himself. He also has urinary continence issues which he ignores.

Because his chronic mental illness is stable Fred receives a limited case management service from mental health workers. Apart from his mental health worker, the only other support he receives is regular visits from his GP who manages his medication.

Fred is vulnerable in the community where his unusual clothing and inability to protect himself (both physically and psychologically) lead him to be victimised. It is likely he will stay at the SRF until he deteriorates to the point where he meets entry criteria for aged care, although factors such as his chronic smoking and unusual dress will make it difficult to find a residential aged care facility that will accept him.

9.9 Summary

In terms of their contact with the service system:

- Most residents had regular contact with a General Practitioner
- Almost half did not have regular contact with another kind of worker/service
- Of those who did have contact with a service/worker, this was most commonly a mental health worker
- Younger residents were more likely than older residents to have a worker and be in contact with a service
- Proprietors reported that most residents did not have a key worker; while contact with a mental health or disability worker indicated that 54% of residents did not have a key worker.
- Having contact with a service/worker does not necessarily correlate with a resident's assessed level of need

- DHS data suggests that about one third of SRF residents are active clients of mental health or disability services
- Mental health services were the main source of referral into SRFs
- In the many cases where residents do not have an active support worker, family member or guardian, the SRFs are likely to step into that role
- Owner/manager satisfaction with the involvement of key workers seems to hinge on clarity of role definition, regularity of contact and worker responsiveness and reliability

Given the level of vulnerability, disability and dependency and what is known from other research about the health and wellbeing profile of people in supported accommodation, this data suggests unmet needs and, for many residents, the absence of external mechanisms to provide support, services, advocacy, planning and protection.

10 THE RESIDENTS – KEY MESSAGES

This chapter summarises and discusses themes drawn from the information about residents.

10.1 Not a homogenous group

People living in Supported Residential Facilities are not all the same. There are significant variations in the type of disabilities people have, and the level of support they require. The level of daily support for those residents assessed by the study ranges from 0.2 to 10.3 hours per day.

The type of support required also varies. Some residents require mainly personal care support and do not need assistance with other aspects of their life. Other residents are physically independent but require assistance with social and behavioural aspects.

The SNAP clusters illustrate the heterogeneity of the population, with residents ranging from 'minimal needs' through to 'high and complex'.

10.2 A vulnerable and disadvantaged population

Residents are a vulnerable and disadvantaged population, not only by virtue of the more obvious factors of disability and low income. Residents have very little in the way of material possessions, usually just clothing and perhaps a television. They lack family support in many instances, are isolated from the broader community, and have few friends and significant personal relationships. They are also vulnerable in terms of their disability and the absence of external protective, advocacy, support and planning mechanisms.

These factors combine to create conditions for loneliness, lack of meaningful engagement with others, and an impoverished lifestyle. Many residents have had as lifetime of dependency on others, and thus, given the lack of self-protective skills exhibited by many residents, they are vulnerable to harm and exploitation.

10.3 The need for support

There can be no doubt that people living in Supported Residential Facilities have functional disabilities and require assistance. All require a 'baseline' level of support that typically includes the preparation of meals and household tasks, and often the supervision of medication. However most have support needs greater than this - 80% were assessed as needing more than two hours of support per day.

10.4 High and complex needs

Of concern is the portion of the SRF population that comprises people with very high support needs. Evidence of high support needs includes:

- over a quarter of residents require more than four hours of support per day.
- just under half of the SRF population are subject to Guardianship Board orders for their finances to be managed by another party, indicating limited mental competency.
- 40% of residents have behavioural issues
- 23% require some level (sleepover or active) of night support
- 20% have active or acute mental health issues.

Acute mental health issues, dual diagnosis and disability, and other health conditions are the factors that combine to lead to high and complex needs. 16% of residents are described by the residents clusters as having 'high and complex needs', requiring more hours of support across all areas of care than other residents.

10.5 Aged and ageing

There is a significant aged population in Supported Residential Facilities. Some aged residents are 'typical' frail aged people requiring some support in relation to age-related disabilities. However many aged SRF residents have pre-existing disabilities which are very likely compounded by the ageing process, and thus they have very different needs to, say, residents in low care aged accommodation and elderly people receiving HACC services at home. Aged people are the least likely to have a key worker or be in contact with outside services. This isolation is a concern.

The current age profile of the SRF population indicates that, as this 40-65 year old segment moves into old age, the proportion of over 65s in the SRF population will increase significantly, very likely posing major challenges to the facilities providing care for them.

10.6 Partly in, partly out of the service system

The picture regarding resident's contact with GPs and other kinds of workers/services, and the relationship between SRF owners/managers and workers in the service system, is not simple to interpret. It suggests a state of affairs where some residents have no contact with any care professional or support worker other than a GP. Alternatively other residents have regular,

and, for some, frequent contact with a key worker, and a small proportion may have more than one human services agency worker involved in their life.

SRFs themselves appear partly connected into the service system. Some SRFs report considerable direct contact with agencies and key workers, and there is a sense that the SRF is part of the broader care system that provides assistance to an individual resident. On the other hand, some facilities have little to no contact, on behalf of their residents, with agencies. Residents are in many instances reliant on SRF personnel to initiate a referral to services when this is required; hence it is important that SRF personnel have a knowledge of support services and the ability to link in with them and work together where possible.

'Partly in, partly out of' the service system also reflects the fact that there is little consistency between the level of a resident's need and whether they have regular contact with a worker from a support agency. Some residents with comparably lower need receive support services from mental health and disability services, while some residents with high needs do not receive support from these services.[57]

10.7 Unmet support needs

The evidence indicates that people living in Supported Residential Facilities have unmet support needs, principally in the areas of primary health care and social and recreational activities.

10.7.1 Primary health care

On the whole residents appear to have reasonable levels of reported contact with GPs, and some residents have very frequent contact. Anecdotal information, however, suggests some qualifications. For instance, sometimes residents do not have a choice of GP; there may not be a suitable area for consultations; and the GP visit may be more geared to prescribing and monitoring medication than providing thorough consultations, care management and health checks. In particular, there may be no care planning or coordination, preventative health checks (Pap smears, blood pressure, etc.) are unlikely to occur and other conditions may not be diagnosed or properly assessed and managed.

Managers/owners reported difficulties in arranging dental care and podiatry for residents. Problems in transporting residents to appointments also limited access to allied health services. SRFs also report difficulty in accessing equipment (such as walking frames, hand rails and toilet chairs) with residents unable to afford these aids themselves and deemed ineligible for subsidised programs.

[57] It is very likely that being in receipt of support services assists in maintaining individuals at a more effective level of functioning and therefore with lower assessed levels of need.

Overall it appears that residents have major health issues attended to, but there is little opportunity for prevention, screening and health monitoring, and a lack of allied health services.

Much remains unknown about the health needs of residents in South Australia. We do not know, for instance, what types of health problems residents experience, the level of undetected and/or untreated conditions, or whether residents have poor health compared with the rest of the community. It would be expected, however, that clinical assessments would reveal a range of health problems requiring attention, as has been the case in other jurisdictions and identified in previous studies.

10.7.2 Social and recreational activities

Most residents have opportunities to participate in social activities outside of the facility. Yet there was a strong indication from proprietors that residents do not have sufficient access to meaningful social activities, particularly activities that would aid in a sense of belonging to the community. In general it seems some residents have better access to social and recreational opportunities than others, for a range of ad hoc reasons – programs operate in some areas and not others, workers organise activities and transport for some residents and not others, some residents are eligible for support to attend social activities (through the assistance of CSI workers) and others are not.

Residents vary in their capacity to participate in activities. Some may never have had the opportunity to learn the skills required to participate, or been exposed to choices and situations which allow them to develop interests, hobbies or preferences.

Anecdotally, owners/managers and key workers reported that the low motivation of many residents with mental illness impeded their ability to participate in social activities. Considerable time, effort and skill may be required to assist amotivated residents to be involved.

Boredom is perhaps one of the consequences of congregate and semi-institutional care, where residents have limited opportunity to perform tasks, develop skills and interests or to engage in the community. Many SRF owners/managers recognise the need for residents to have something to do and most organise in-house activities as well as trips and excursions. However this cannot meet the needs of residents who are otherwise 'house bound' 24 hours a day, 7 days a week. A casual visitor to most SRFs would generally see residents sitting around with apparently very little to do.

SECTION THREE THE FACILITIES

11 DETAILS OF FACILITIES

This chapter summarises information provided by SRF owners/managers about the nature of their facility, such as size of the facility, the current number of residents, and tariff.

11.1 Capacity

Participating facilities varied in capacity from 4 to 54 residents with an average (mean) capacity of 28[58] (Figure 11.2).

11.2 Occupancy

Owners/managers were asked how many people were resident in their facility on the day of the interview. An occupancy rate was determined by calculating the number of residents living at the facility on the day as a proportion of total capacity (Figure 11.1).

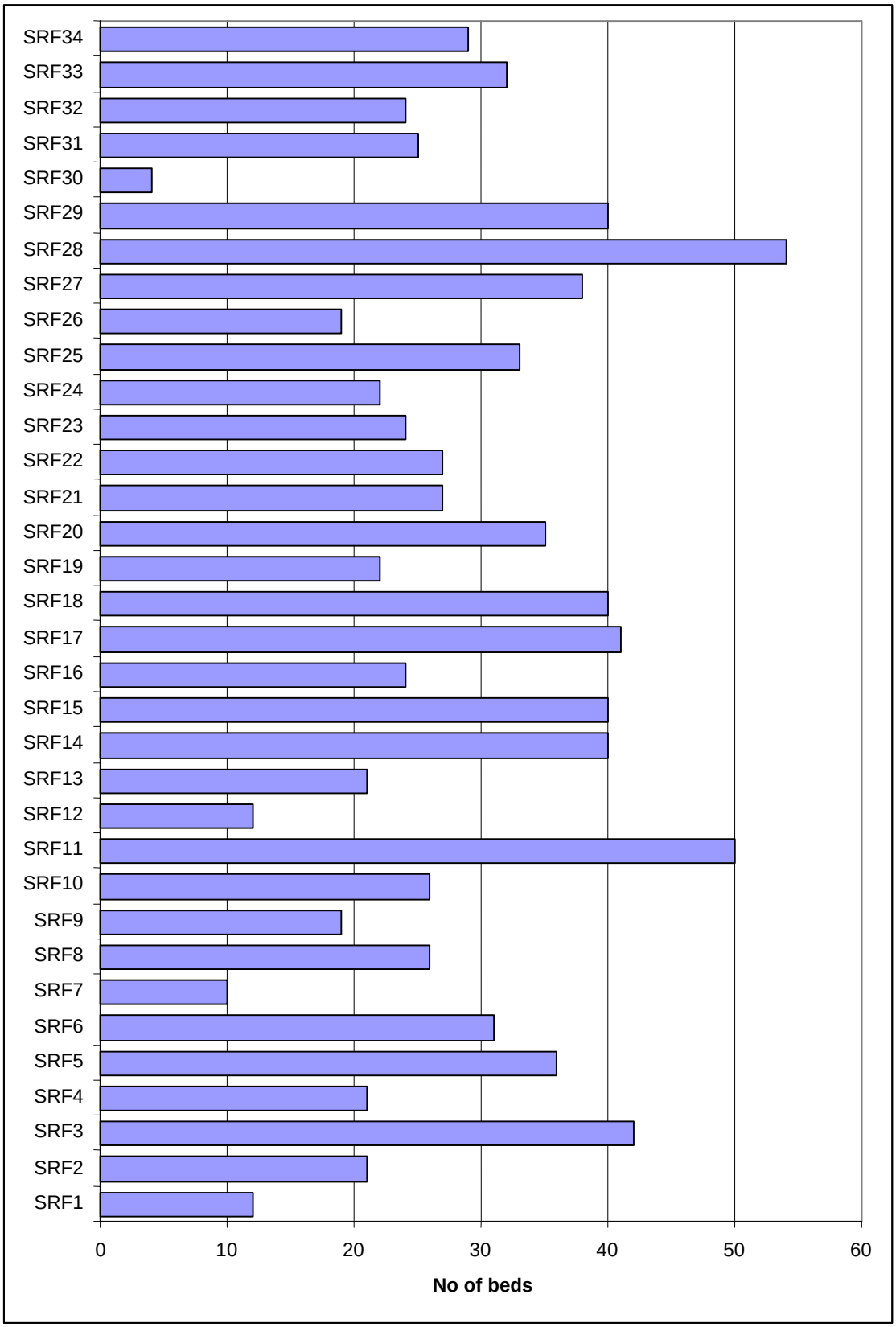
Figure 11.1 SRF Occupancy rates

Data for 34 facilities; 866 residents. (Proprietor Interviews)

Occupancy rates ranged between 66% and 100%. Twelve facilities were fully occupied and a further 6 had an occupancy greater than 90%. Thus, just over half (53%) had an occupancy rate greater than 90%, and another quarter were occupied at less than 85% of capacity.

[58] Average capacity calculated from Proprietor Interview data; this differs from the average number of usual residents calculated from Survey of Local Government, Oct 2001.

Figure 11.2 SRF, Number of beds per facility



Data for 34 facilities; 866 residents. (Proprietor Interviews)

11.3 Tariff

Facilities have different ways of organising tariffs. At the simplest level a facility might have a flat rate charged to all. However, many have a tiered rate system according to factors such as the degree of care a resident requires, and whether they are in a larger than usual room. One facility reported determining fees on a case by case basis; several facilities reported that, while they had set fees, they may also reduce fees in cases of hardship.

There was considerable variation in maximum and minimum rates charged.

Minimum rates ranged from $125 to $445 per fortnight. Half the facilities[59] charged between $325 and $399 as the minimum tariff, the median minimum rate was $358.10.

Maximum rates ranged from $285 to $476 per fortnight. Half the facilities[60] charged between $375 and $430 as a maximum tariff; the median maximum was $410.

A number of facilities commented on the 'rule of thumb' for tariffs being set at 85% of the pension. However, 85% of pension equates to a tariff of $430.[61] Only five facilities charged any resident more than this, and most facilities (19 of 29) charged less.

In one facility, rates ranged from $125 to $442 per fortnight. The lower rate appeared to be more of a flat room and board rate for people with minimal disabilities, with $442 the more common rate.

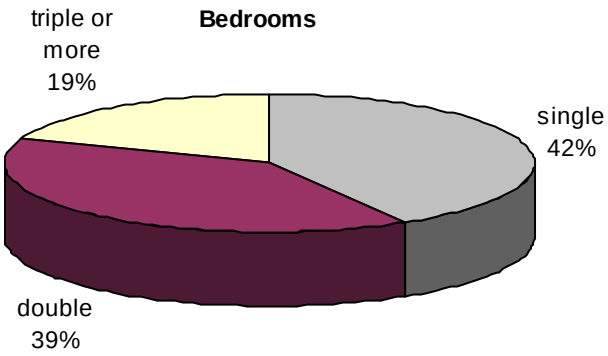
11.4 Bedrooms

Owners/managers were asked to specify how many of their current residents were in single, double or triple bedrooms (ie sharing with one or more people) (Figure 11.3). Just over half the residents were sharing a bedroom with at least one other.

Most facilities had a mixture of single, double and triple bedrooms. In roughly a quarter of the facilities (9 of 33) all residents had a bedroom to themselves. On the other hand, two facilities did not have any single rooms (Figure 11.4)

[59] 25-75% inter quartile range
[60] 25-75% inter quartile range
[61] Calculated using a base rate of $410.50 per fortnight for a Single Pensioner, plus $5.80 per fortnight Pharmaceutical Allowance and $89.60 per fortnight Rent Assist.

Figure 11.3 Number of persons per bedroom



Data for 33 facilities; 856 residents. (Proprietor Interviews)

11.5 Community houses

Four facilities had off-site accommodation, generally referred to as 'community houses'. This accommodation was not included as part of the license of the facility, although one intended to request that this occur at the next licensing inspection.

Kasey

Kasey is a 40 year woman who has a diagnosis of schizoaffective disorder and is a client of mental health services. She has two children who have been removed from her care and with whom she has little contact. Until a few years ago she had been homeless for many years, living in the Parklands. During this time Kasey would appear occasionally at Glenside Hospital for a meal and would accept medication for her mental illness only at these times.

Over the past three years Kasey has lived in a number of SRFs. Largely this was successful and during this time she had no admissions to hospital in relation to her mental health status. However about a year ago things began to go downhill. Kasey would 'take off' from the SRF for days at a time. She tends to do this in times of stress, and can place herself at considerable risk when doing so. She has been physically assaulted on a number of occasions, and is not able to care for herself.

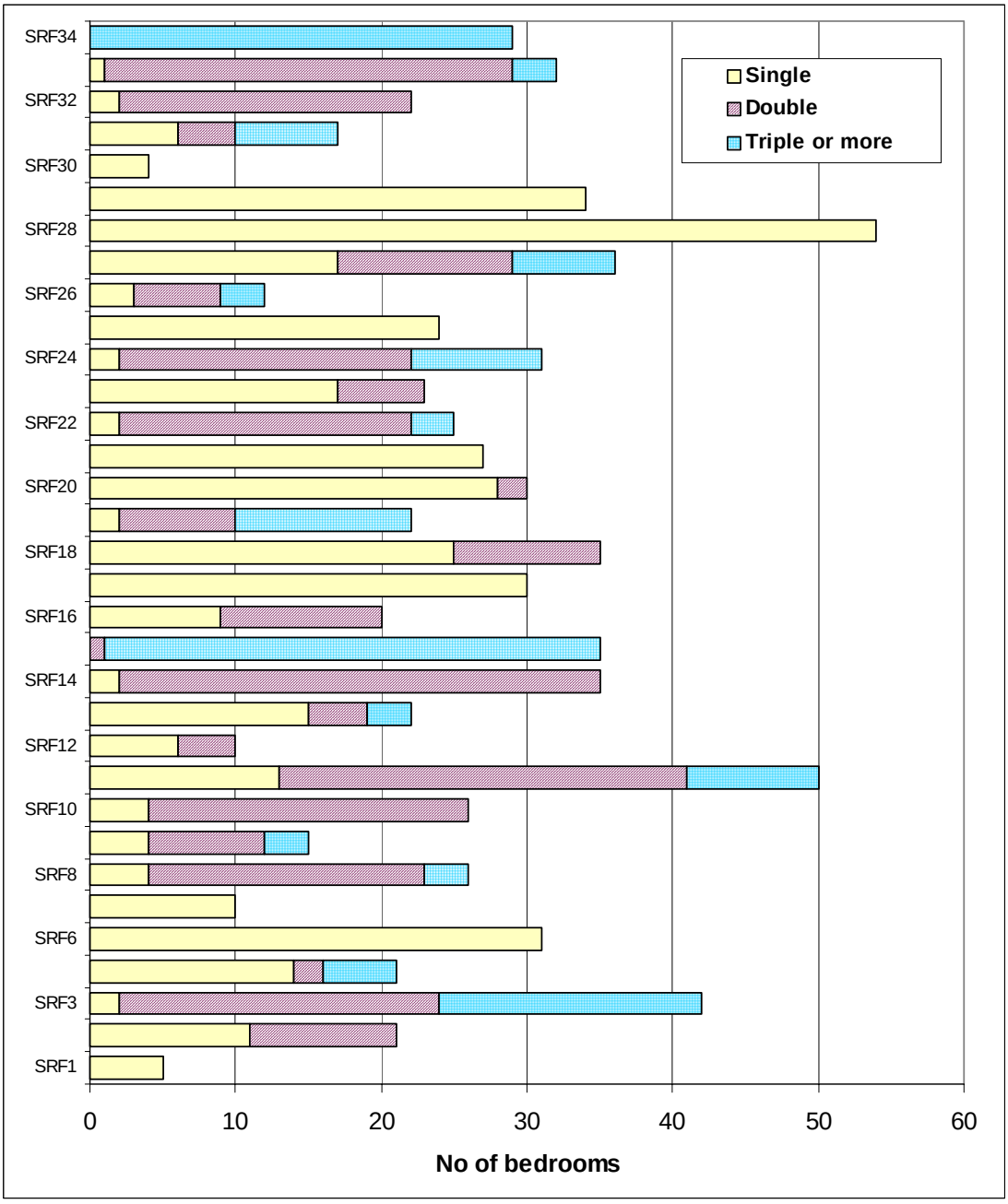
She also became violent towards the staff on several occasions, to the point where, although the SRF were committed to supporting her, they could no longer tolerate her behaviour and after a stay of some months in Glenside, decided they would not accept her back. She is, in fact, no longer welcome at several SRFs.

She is now living again in a SRF where she has lived previously. Her main risk factors currently relate to her self-harming behaviour – for instance she has previously overdosed, set fire to herself, and thrown herself off a balcony. Her sexual activity also places her at risk of non-consensual sex and harmful relationships. She is now a little more stable than she has been in the past – she is less inclined to use non-medicinal drugs, and has developed some insight into her need for medication. She has also largely accepted that her desire to have another child would not be helpful to her and is more compliant with contraception.

Kasey still 'takes off' from time to time, when she will sleep rough (for instance she lived in a drain pipe for several days) hitch rides with truckies, and end up somewhere (often interstate) with no way to get 'home' again. She will be in a delusional state at these times.

It would appear that Kasey will continue with this lifestyle – living in Supported Residential Facilities until she becomes unwell and either becomes homeless and out of contact with support services, or is hospitalised until she becomes more stable and can return to supported accommodation in the community.

Figure 11.4 Bedroom type by SRF



Data for 33 facilities; 856 residents. (Proprietor Interviews)

11.6 Summary

There is a great variation in the size of SRFs; and also in occupancy levels and tariffs. Most residents will be sharing a bedroom with at least one other person.

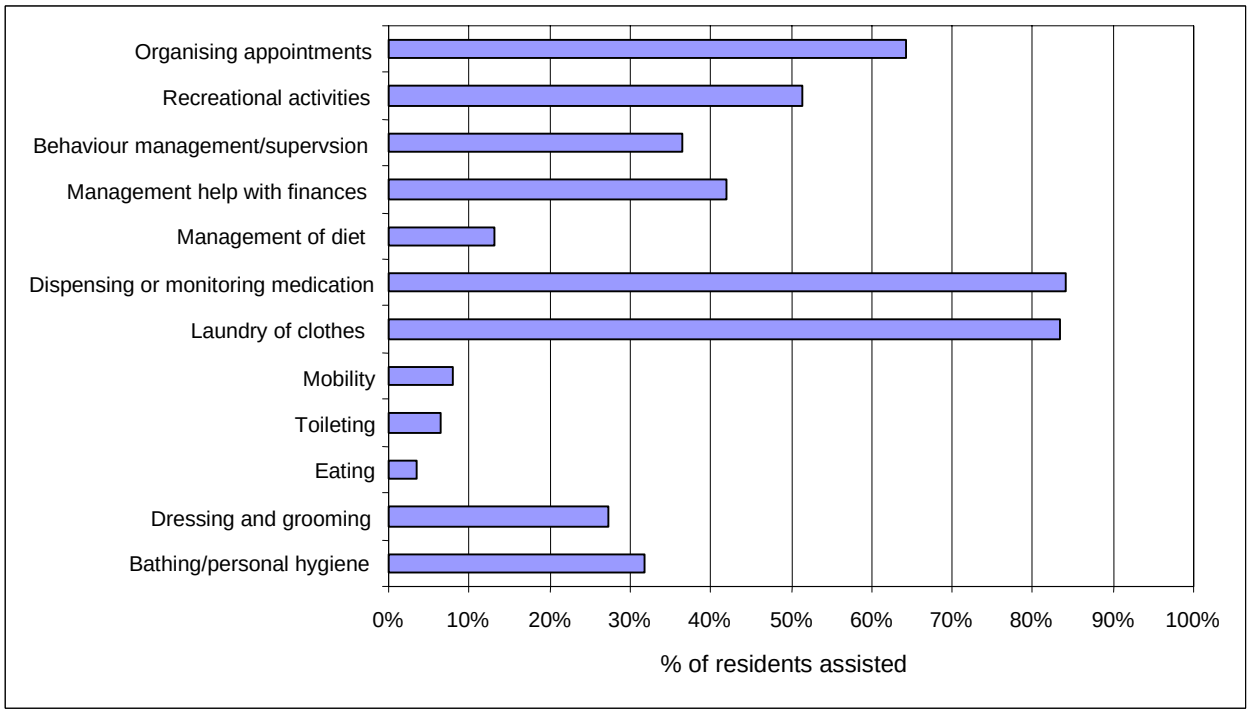
12 FACILITIES AND THEIR RESIDENTS

This chapter describes facilities according to the type of resident they accommodate, and outlines the support provided by facilities to their residents.

12.1 Assistance provided to residents

Facilities were asked to indicate the types of assistance they provided to current residents, and the number receiving such assistance (Figure 12.1)

Figure 12.1 Assistance provided to residents



Data for 37 facilities; 919 residents (Resident Information Sheets)

A very high proportion of residents were assisted with laundry and had medication dispensed to them or monitored by the facility. The other most commonly-provided services were organising appointments or transport to appointments, and recreational activities.

Help with bathing/personal hygiene was reported for about a third of residents and help with dressing and grooming for slightly less. Assistance with eating, toileting and mobility occurred for less than 10% of residents.

Owners/managers reported providing behaviour management or supervision of behaviour for over a third. Almost all facilities (31) indicated that they undertook such a role. This generally consisted of:

- Dealing with aggressive behaviour (verbal and physical)

- Monitoring and intervening with other anti-social behaviours (stealing, rudeness, 'standing over' other residents and substance abuse)
- Maintaining the house rules (eg smoking outside)
- Monitoring and managing residents' interactions with each other and with staff where that affected others (shouting, slamming doors, pinching others, going uninvited into other resident's rooms)
- Observing and monitoring behaviour in relation to mental states (changes in mood, depression, escalation of symptoms of mental illness).
- Reassurance, calming residents, and talking through problems.

Owner/managers also identified a wide range of other supports which they provided including hairdressing, handing out cigarettes, help with clothes (purchasing, sorting, mending etc), shopping, and emotional support.

12.2 Variation in resident profiles across facilities

Most facilities accommodate a mix of residents of varying ages, disabilities and length of residency, as well as a mix of men and women, although males usually outnumber females. Exceptions to these trends are:

- Some facilities accommodating only people with mental illness
- A number of facilities comprised solely or mostly of aged people
- Two transitional facilities where all residents were short-term.

The SNAP clusters also indicate that SRFs have a mix of people with varying levels and types of support needs. Some facilities have a predominance of certain clusters – for instance 'high and complex needs' residents were found in almost all facilities but, at three facilities, roughly 50% of assessed residents were in this category.

More details are provided below.

12.2.1 Gender

Of the 37 participating facilities, three were comprised solely of males. For about three quarters of the facilities (28 of 37), males comprised more than half the resident group. By contrast, females comprised more than half of the resident group in only 11 (30%) facilities. No facilities accommodated solely females.

12.2.2 Age

Individual facilities varied in terms of their age profile with most having a mix of the aged and non-aged. Only four of the 37 facilities were totally comprised of aged persons (ie over 65 years). A further 9 facilities had more than half of their residents in the over 65 years age group. Most facilities mainly accommodate residents aged under 65 with a sub-group of aged.

Table 12.1 Proportion of residents aged over 65 years per facility

% over 65 years	N
100%	4
75-99%	4
50-74%	5
25-49%	8
1-24%	14
Nil	2
Total	**37**

Data for 37 facilities; 919 residents (Resident Information Sheets)

The very aged – those over 75 years – lived in 28 facilities, ranging from a minimum of one in one facility to a maximum of 30 in another.

About half the facilities (18 out of 37) had younger residents (ie those aged less than 25 years), and usually only one or two people in this age range.

12.2.3 Length of residency

Long-term residents (ie living more than ten years in their present SRF) were clustered in certain facilities. Six had residents who had lived there for over 20 years, and 17 had residents who had been there for between 10 and 20 years. Most had medium term residents (who had lived between two and ten years in the facility).

12.2.4 Type of disability

In terms of the distribution of primary disability across the participating facilities, the data indicates the following:

> *Developmental (intellectual) disability:* In two facilities over half the residents were people with an intellectual disability, with a maximum number of 13 in one. The remainder of people with intellectual disability lived in 17 other facilities.
>
> *Mental illness:* 6 facilities had a resident group totally comprised of persons whose primary disability was mental illness, and a further 11 had more than half of their resident group with mental illness. In other words, over half the facilities have a majority of residents with a

primary disability of mental illness, and only four facilities did not have any residents with mental illness.

Age-related disability: Residents with age-related disabilities lived in just over half of the participating facilities. However there was one facility totally occupied with residents with age-related disability and in a further seven the majority had age-related disabilities. The maximum number of residents with age-related disabilities in any one facility was 31 residents.

12.2.5 Management of finances

Over half the participating facilities (20 out of 36 facilities) had a majority of residents whose finances where being managed by the Public Trustee (or similar).

The number of residents in any one facility whose finances were being managed in this way ranged from zero (two facilities) to 49 residents in one facility.

12.2.6 Other orders

One facility reported that all residents were under other Guardianship Board orders; however most facilities (30 of 36) reported that less than half their residents were under other Guardianship Board orders.

The number of residents in any one facility who were under other Guardianship Board orders ranged from zero in nine facilities to a maximum of 37 residents in one facility.

12.3 Summary

SRFs are not all the same: the report has previously identified differences between facilities in terms of factors including bedrooms and access to key workers. The data in this chapter also reveals considerable diversity in the profile of residents between facilities, along dimensions including gender, age, disability type, length of stay, levels and type of need and mental competancy.

Glenda

Glenda is a 32 year old woman with a diagnosis of Schizoaffective disorder. Since first becoming unwell in her early twenties she has moved between boarding houses, supported residential facilities and supported independent living situations.

Glenda has always wanted to live independently and has attempted independent living several times, but with no success. Each attempt has resulted in a reemergence of her psychotic symptoms and admissions to inpatient care.

On her last attempt this occurred despite visits each day from a mental health worker and 8 hours per week of disability support. In order to live independently, Glenda would require much higher levels of support than is currently available. She has been assessed as having significant functional deficits with respect to her everyday living skills.

Glenda's illness is unstable. She experiences persistent psychotic symptoms such as delusions and auditory hallucinations. For instance she can believe that people have crept into her room at night and cut her hair. At times she can place herself and others at risk. In terms of mood disorder, she can be either agitated and 'hypo-manic' or depressed and very low.

Typically Glenda is very withdrawn. She has no social supports external to the SRF in which she currently resides. The SRF staff work hard to draw her into social interaction with other residents at the SRF. They also assist her with everyday living tasks and support her to attend appointments and groups.

Glenda receives an intensive specialist mental health service from a Mobile Assertive Care (MAC) Team. The SRF staff work closely with the MAC team to monitor Glenda's mental health status and to support her in taking medication.

13 BUSINESS ARRANGEMENTS

This chapter reports on information provided by owners/managers about the functioning of their facility and its operation as a business.

13.1 Business structure

Of the 34 participating facilities, 30 were Private For Profit and 4 Not For Profit. Most (31) were 'stand alone' facilities (ie the SRF was the sole facility on site and was not part of a larger complex). Of the other three, two were attached to a nursing home and one to a retirement village.

Generally, 'stand-alone' facilities (24) were also sole business entities. However, some were part of a larger management structure. Three were part of a larger Not For Profit organisation that provided other services, and 4 were operated by a private proprietor who owned more than one facility.

Most commonly properties were being purchased by the proprietor.

Table 13.1 Property arrangements

Property arrangements	N	%
Owned by SRF proprietor	3	8.8
Being purchased by SRF propietor	17	50.0
Leased by the SRF proprietor	12	35.3
Dont know	2	5.9
Total	34	100.0

Data for 34 facilities; 866 residents. (Proprietor Interviews)

13.2 Management and staffing

13.2.1 Managers

The owners of facilities are generally also the full-time managers (26 or 76%). The manager was an employee at another 7 facilities and one was run by a volunteer (ie unpaid) manager.

Managers had been in charge of their current facility for times ranging from less than a year to twenty-eight years. The most common length of time as manager was 4 years; and the average time was 6 years.

Managers came from a variety of backgrounds. Most had previous experience in owning or managing other supported residential facilities or a background in nursing, aged care or similar. About a third previously worked in unrelated occupations, although some of these had a husband or wife with relevant care experience. Managers' backgrounds could be summarised as:

Manager has nursing, aged care or disability care background	++++++++++++
Manager has previously owned or worked in other SRFs (or hostels and rest homes) or family involved in running SRFs	++++++++++++
Manager has no previous experience in the SRF industry and no background in nursing, aged, or disability care	++++++
Manager has no background in nursing, aged or disability care but their husband or wife has relevant qualifications	+++

13.2.2 Relevant qualifications

According to regulations under the SRF Act, registered nursing qualifications are not required unless the facility is a nursing home or provides nursing care. 'Nursing care' is not defined.

In two thirds of facilities neither the proprietor or an employee was currently a registered nurse. Some had a nursing background but had not maintained their registration.

Most owners/managers (29 of 31 respondents) indicated that either they or their staff had other relevant qualifications (summarised below).

First Aid certificates	++++++++++++++++
Certificate III	++++++++++
Enrolled nurse (current /prior)	++++++
Formerly registered nurse	+++++

13.2.3 Staffing

Most facilities are family businesses jointly operated by a husband or wife, in a few cases with adult children also working in the business. Of the 26 managed by the owner, only two are operated by a sole owner without any other family members involved.

The staffing model generally relied on both husband and wife working full-time in the business, or at least one partner working full-time with some part–time assistance from the other. All owners who were full-time managers also employed some staff, although the extent of staffing varied considerably.

It is difficult to report on staffing levels across facilities as hours of employment vary, as do conditions – for example, night staff may not be paid but may receive free accommodation in return for duties.

What can be reported are some examples at the lower and higher end of staffing, as follows:

Lower end:	
Facility with 26 residents	1 passive night sleepover person; casual staff equivalent to 1 FTE
Facility with 24 residents	1 F/T employee; owners sleep on property to cover nights
Mid range:	
Facility with 33 residents	1 cook F/T; 3 carers P/T; 1 cleaner P/T; 1 kitchenhand P/T; 1 laundry person P/T
Facility with 22 residents	1 cook/careworker F/T; 1 cleaner P/T; 2 careworkers P/T
Higher end:	
Facility with 34 residents	3 staff F/T; live in caretaker (nights)
Facility with 50 residents	2 F/T staff; casual staff equivalent to 1 F/T; cook P/T; laundry person P/T; maintenance person P/T; accountant P/T

In facilities where the manager is an employee, there is again variation in the level of additional staff:

Lower end:	
Facility with 10 residents	Casual carers equivalent to 3 FTEs 1 handyman/gardener
Higher end:	
Facility with 32 residents	Housekeeper F/T Carer F/T Cook F/T Nurse P/T Carer P/T Night person F/T

13.3 Financial viability

The forthcoming *Financial Analysis Study of Supported Residential Facilities* will provide a comprehensive examination of costs and other factors affecting economic viability. At a simpler level, this study sought to identify key viability issues and gauge how owners/managers viewed the economic performance and future of their facility.

Owners/managers were asked whether they thought their facility would continue to operate in its current form. Most (27 or 82%) thought it would; four said it would not, and a further two were unsure.

Three of the four who anticipated change thought their facility would either close, be sold or cease to operate in its current form either as a result of lack of viability or lack of demand for the type of service offered.

Overall, there was a high level of concern expressed about financial issues, with only a very few not concerned about their financial viability:

> "Financial position is a bit critical – we're only just earning a living."
>
> "Facility will continue for another twelve months but concerned about the longer term."
>
> "Financial position is OK as long as there aren't any changes to the regulations requiring upgrades."
>
> "Facility not viable and has been cross-subsidized by nursing home – very likely to close in next 6 months."
>
> "Facility is able to keep going only because it does not pay owners/managers a wage – if wages were paid the facility would not be viable."

Nearly two thirds of private manager/owners said their profit margin had decreased over the past twelve months.

Table 13.2 Profit margin over the past twelve months

	No. of facilities	Percent
Decreased	17	63.0
Stayed about the same	6	22.2
Increased	1	3.7
Don't know	3	11.1
Total	27	100.0
Notes		
Number of SRFs - Not for profit	4	
Number with missing data	3	

Data for 34 facilities; 866 residents. (Proprietor Interviews)

Respondents were also asked to predict what they expected for their profit margin over the next twelve months. Generally, owners/managers thought their profit margin would either continue to decline or stay about the same.

Table 13.3 Profit margin over the next twelve months

	No. of facilities	Percent
Decrease	9	36.0
Stay about the same	7	28.0
Increase	3	12.0
Don't know	6	24.0
Total	25	100.0
Notes:		
Number of SRFs - Not for profit	4	
Number with missing data	5	

Data for 34 facilities; 866 residents. (Proprietor Interviews)

The most commonly reported costs impacting on business viability were labour, utilities, and goods and services (predominantly food and goods such as cleaning items).

For those facilities where labour costs were not an issue, this was in part due to the fact that owners/managers minimsed labour costs by the owner working nights, evenings or weekends to avoid penalty rates for staff.

Owners/managers reported that utility costs utilities had risen considerably – one reported an electricity bill of $6,000 for a quarter that had previously been $1,800; another reported cost increases of $2,500 from the previous year. (According to operators, utility consumption is increased by resident behaviours such as leaving taps running and heaters on.)

Table 13.4 Key costs impacting on business viability

Key costs	No. of facilities	Percent
Labour costs	16	47.1
Utilities	16	47.1
Costs of other goods and services	15	44.1
Rates and taxes	8	23.5
Property maintenance/upgrading	8	23.5
Costs of servicing debt	5	14.7
Costs of leasing property	4	11.8
Resident equipment or service	1	2.9
Other	13	38.2
Total no. of facilities	34	

Respondents also suggested that the cost of property maintenance and refurbishment was an issue because residents tended to be hard on furniture

and fittings. This includes repainting (one owner reported painting rooms six times in the past three years); plumbing (toilets blocked by residents dropping items in them); and replacement costs for mattresses, bedding furniture and carpets.

Capital costs were also identified: one facility had spent $63,000 on air conditioning; another had spent $20,000 on gas heating and had built new bathroom/toilets and several ensuite bathrooms; another had installed ducted air conditioning. Other key costs identified included insurance, GST and fire safety systems.

Given that costs are rising and that the income that can be derived from residents is fixed, it is clear that any profit margin is being squeezed.

Occupancy rates were another key issue impacting on viability. Facilities were conscious of the need to maintain a certain level of occupancy and particularly their 'breakeven' point:

> "At 23 residents the alarm bells are ringing, at 26 residents I get paid."
>
> "If we slip under 30 the business is in trouble."

One owner/manager reported that her business was so finely balanced that if her numbers were down by one person, staff hours had to be cut back accordingly. Another reported the facility needed to run at 100% occupancy to be viable – if there were more than two vacant beds (in a 40 bed facility) it was unviable.

Finally some respondents reported their financial viability to be affected by the needs of their residents, having to meet the costs of items (such as continence pads) because residents could not afford to pay for them.

It is unclear whether being in receipt of the DHS board and care subsidy mean facilities are more viable. However, one facility which expected closure within six months is in receipt of the subsidy for some of its residents and another indicated they were under financial pressure and the subsidy should be increased. A third said that '*if not for the subsidy we would be in trouble*'.

13.4 Summary

SRFs are generally private, family-run businesses. Staffing levels, qualifications and professional backgrounds of managers very considerably, with no consistency across the sector.

Most facilities are concerned about their financial viability, indicating rising costs and a falling profit margin, with income largely fixed.

14 TRENDS AND VIEWS

This chapter reports on comments made by owners/managers about the nature of their business and the difficulties they experience in operating a Supported Residential Facility.

14.1 Changes over time

Owners/managers were asked if there had been changes over time in either the type of residents accommodated or the level of disability. Changes reported included:

- aged residents were now more frail
- facilities that had previously accommodated older residents were now accepting a different profile of resident (younger and with mental health issues)
- facilities caring for those with mental illnesses were seeing younger residents with more acute mental illness and higher levels of associated behavioural difficulties.

Overall it was felt that the level of resident need had increased.

14.2 Difficulties for facilities and the need for assistance

The interviewers discussed with owners/managers what improvements they saw as required in order to maintain or enhance their care for residents.

Three major issues were consistently identified, namely the need for:

1. financial assistance or subsidies to assist facilities to operate
2. improved access to recreational, social and supported employment opportunities and programs for residents, and
3. improved access to primary care and health services.

These are discussed below.

14.2.1 Financial assistance / subsidies

Most facilities were of the view that financial assistance was required. A wide range of views were expressed about the purpose of subsidies and how they ought to be provided.

Several thought that SRFs had the same reasons for receiving funding as nursing homes - government subsidises the care of the frail aged in

institutional care for the public good. Similarly it was pointed out that the cost of care to enable people with disabilities to continue living in their own home was subsidised by government, as were other forms of supported accommodation for people with disabilities.

There was some support for the view that a subsidy should be 'attached' to a resident and follow them from facility to facility. One owner/manager thought that a subsidy for each resident should be individually assessed according to the resident's needs; funding attached to a person could be applied flexibly as a 'package' and be called upon as needs varied and fluctuated. Another owner/manager thought only high need residents should attract a subsidy.

There was some comment that the present Board and Care subsidy system was discriminatory, as only residents in certain facilities were eligible.

Other forms of indirect financial assistance suggested were: that facilities be eligible for the concessions that pensioners living in their own homes receive; that facilities should be charged residential, instead of business, rates for utilities; and that facilities should be exempted from paying land tax.

14.2.2 Recreational, social and supported employment opportunities and programs for residents

Half the participating facilities reported that their residents needed better access to recreational, social and supported employment programs and activities. While some facilities had access to various programs, they still felt more was needed. Other facilities reported their residents had little or no access to programs which could provide them with meaningful activity, rehabilitation, skill development, social opportunities and the chance to participate in activities outside of the facility and engage in the wider community.

> "Proper rehabilitation needs to be provided – these residents are hanging around, lying around all day and smoking, with nothing constructive to do".

> "What's missing for residents currently is social skill programs, employment programs, vocational programs – in other words, anything that can take them out of the facility and interact with the broader community, to provide an interest and hopefully motivation, and to provide networks and increase skills."

Residents have varying capacities to be involved in social activities, and lack of motivation is a big issue impeding participation, even when activities are available. Thus owners/managers felt opportunities should be provided within the facility, as well as outside. A great deal of support might be required to assist some residents to participate – for example, one owner/manager reported that one of his residents hadn't been outside the front gate in four years.

Owners/managers thought that residents needed to have opportunities to *"do the normal things other people do"*, like go out shopping and to the movies. While facilities tried to provide such activities, they said there was a limit to what they could organise. Some suggested access to a bus, or help with transport costs, would assist. There were numerous instances recounted where owners/managers took groups of residents out in their own car or hired a bus. Facilities also reported taking groups away on holidays, where residents were able to afford it. Owners/managers also gave accounts of the social activities they organised within the facility, such as birthday parties, musical events and Christmas parties.

Access to formal programs was highly variable, depending on what was available in a local area, and eligibility and referral criteria (eg some programs were only available to persons with intellectual disability or mental illness, or referrals had to be made by a key worker). Consequently, in one facility some residents might have access to programs whilst others did not.

A particular lack was noted by owners/manager in relation to suitable and meaningful day activities or supported employment programs for younger residents.

14.2.3 Primary care and health services

Facilities commonly reported that they found it difficult to access health and primary care services. Services most often sought were dental care, podiatry and assistance with showering.

Whilst a few facilities were happy with residents' access to Domiciliary Care and RDNS services, others were concerned that their residents could not afford the fee; or thought they were given low priority. Some reported that they were not able to access these services at all. One facility said that they treated a resident's ulcer themselves rather than pay a fee to RDNS.

Inconsistencies in access to primary care and health services was also a source of frustration. Residents who held a Department of Veteran Affairs Gold Card were eligible for a range of home support-type services such as showering and podiatry. However, others with similar needs could not access these services. Similarly, Community Aged Care Packages were seen as an appropriate form of funding support for residents. However, because residents were being cared for in a facility and not in their own home, proprietors believed, or had been informed, that their residents were not eligible.

Inconsistencies in access to HACC services in general were reported – as one owner/manager said:

> "We're not allowed to use the HACC-funded bus located at the hospital and our residents aren't eligible for HACC-funded Domiciliary Care services, but they can attend the HACC-funded day care centre".

Difficulties in accessing the mental health Assessment and Crisis Intervention Service (ACIS) was also cited.

Other issues identified as affecting the quality of care are discussed below.

14.2.4 Transport and attending appointments

It is both costly and difficult to arrange transport for residents to attend appointments. Some residents are too frail or unable to travel and attend appointments alone (eg go to the doctor and accurately report symptoms), so the owner/manager is required to accompany them. This takes valuable time. As an alternative it is common for owners/managers to call upon their family members (eg the owner's husband or daughter) to provide transport.

14.2.5 Advocacy /support

It was noted that often residents had no-one outside of the facility to advocate on their behalf. Many residents were not in contact with family had no-one apart from the facility in their life. They were thus extremely isolated and highly dependent upon the facility and its staff.

14.2.6 Public Trustee

Several facilities reported difficulties in dealing with officers of the Public Trustee particularly around decisions about residents' expenses and how money should be spent.

14.2.7 Lack of disposable income

Facilities reported that residents don't have sufficient disposable income which means they cannot meet the cost of basic items such as clothing or items for their care (such as continence pads). Owners report buying residents clothes at opportunity shops, and also providing other care items as required. The lack of funds to pay for a funeral was also of concern.

14.3 Summary

Proprietors reported that the level of resident need has increased over recent years, especially with more aged (including those who are ageing in place) and also younger residents with complex needs. The three major issues which proprietors saw as key to improving the current situation were:

1. Financial assistance/subsidies

2. Better access to opportunities and programs for residents, and

3. Improved primary care and health services.

15 QUALITY OF FACILITIES

The issue of quality and standards of facilities – how well Supported Residential Facilities provide accommodation and care for their residents – is an important one. Both interstate and in South Australia, the sector has been dogged by concerns that the physical environment and care of residents is sub-standard. A prime function of the introduction of the Supported Residential Facilities Act was to improve standards.

This study did not assess standards or appropriateness of the care. However a survey of local government authorised officers, conducted in October 2001 by the SRF Unit, sought a range of information from authorised officers about the Supported Residential Facilities in their area, and provides some information about quality.[62]

The role of authorised officers is to monitor and assess compliance with the standards and provisions of the Supported Residential Facilities Act. Thus authorised officers were asked a range of questions in the survey relating to compliance with key aspects of the Act. Authorised officers were also asked to identify any kinds of assistance that might help SRF owners/managers in meeting the social and care needs of their residents.

15.1 Building conditions

Commonly, facilities operate in a building that was either formerly a private residential home (53%) or another residential/institutional facility (26%). Very few (13%) are purpose-built. Facilities are generally older buildings, with about half being over 50 years old (although extensions may be newer).

Table 15.1 Type of building by age

Building type	5-20 years	over 20 years	over 50 years	Don't know	Total
Purpose built facility	4	1	1	.	6
Formerly private residential home	2	2	15	6	25
Formerly other residental/institional facility	3	1	7	1	12
Other	.	2	1	.	3
Don't know	.	1	.	.	1
Total	**9**	**7**	**24**	**7**	**47**

Survey of Local Government

The physical structure of the building was reported as appropriate for its use in most instances (83%) and the current fit-out and furnishings of the facility appropriate for most facilities (70%). 11% of facilities were thought to have on-going structural problems, and 60% were thought to need some

[62] The information in the survey relates to all (N=47) pension-only SRFs licensed at the time of the survey.

improvement or up-grading – 13% of buildings a major upgrading and 47% minor improvement.

15.2 Fire safety compliance

By and large, regular triennial fire safety inspections are taking place, and over half of facilities have had a fire safety inspection since January 2001.

Table 15.2 Reported date of last fire safety inspection

Year of last safety inspection	N
1996	1
1999	1
2000	14
2001	27
Not known/ not reported	4
Total	**47**

Survey of Local Government

Responses suggest a variety of practices are used in conducting fire safety inspections, including inspections by a council building officer, council fire safety committee, or State government Fire Safety officer.

Around half (52%) of facilities were required, as a consequence of their last fire safety inspection, to undertake modifications or improvements. These covered a variety of issues including exits and lighting, smoke detectors, compartmentation, fire sprinklers, training for staff, emergency procedures and drills, and maintenance of equipment such as fire reels, hoses, and extinguishers. For one facility, license renewal was conditional on compliance.

15.3 Access to community based services

Authorised officers were ask to rate facilities according to the extent of access they thought residents had to visiting health/community services. Results indicate that, on the whole, access was considered to be good or better. Access to outside recreational and social activities was considered to be favourable.

Table 15.3 Rating of access to community based services (%)

Community Based Services	*Excellent*	*Good*	*Average*	*Poor*	*Very poor*	Total	Total Number
Resident access to visiting medical and nursing care services, if required	25.5	57.4	17.0	0.0	0.0	100.0	47
Resident access to specialist support workers (eg mental health worker) if required	25.5	57.4	17.0	0.0	0.0	100.0	47
Resident access to outside recreational/social activities, if required	14.9	42.6	34.0	8.5	0.0	100.0	47

Survey of Local Government

15.4 Aspects of personal dignity and safety

Authorised officers were asked to rate facilities according to how well they felt they provided for a number of aspects of personal dignity and safety. Whilst most facilities were considered to provide an average or better standard of provision, the few which rated poorly are of concern.

Table 15.4 Rating of aspects of personal dignity and safety (%)

Personal dignity and safety	Excellent	Good	Average	Poor	Very Poor	*Total*	Total Number
Storeage for personal belongings	8.5	51.1	34.0	6.4	0.0	*100.0*	47
Safe from harassment or harm from other residents	14.9	38.3	42.6	4.3	0.0	*100.0*	47
Provision for reasonable degree of privacy	10.6	34.0	38.3	14.9	2.1	*100.0*	47

Survey of Local Government

15.5 Standards of resident care

Authorised officers were asked to rate standards of resident care (Table 15.5). On the whole, most facilities rated average or better on all aspects. A minority rated poorly in certain aspects; most noticably in terms of community integration and involvement of residents, and social and recreational opportunities. The provision of a 'home-like' environment is one of the core requirements of the SRF Act - six were considered poor in this respect.

Table 15.5 Rating of standards of resident care

Physical standard of facilities	*Excellent*	*Good*	*Average*	*Poor*	*Very poor*	*Total*	Total number
Physical care including medication, personal hygiene, mobility	23.9	47.8	26.1	2.2	0.0	*100.0*	46
Social and recreation encouragement	10.6	25.5	44.7	19.1	0.0	*100.0*	47
Promotion of resident's rights and independence	8.5	23.4	57.4	10.6	0.0	*100.0*	47
Emotional wellbeing of residents	8.7	45.7	39.1	6.5	0.0	*100.0*	46
Community integration and involvement	2.1	34.0	38.3	25.5	0.0	*100.0*	47
Regular monitoring of resident care	13.0	45.7	37.0	4.3	0.0	*100.0*	46
Maintenance of service plans for residents	14.9	36.2	44.7	4.3	0.0	*100.0*	47
'Home-like' environment	8.5	34.0	44.7	12.8	0.0	*100.0*	47

Survey of Local Government

15.6 Physical standard of facilities

Most facilities rated average or better in relation to specified physical standards. Again a handful rated poorly, most noticeably in relation to heating and cooling, but also around the adequacy of bedroom, lounge and bathroom facilities.

Table 15.6 Rating of physical standard of facilities

Rating of physical standard of facilities	Excellent	Good	Average	Poor	Very Poor	*Total*	Total number
Adequacy of bedroom facilities	8.5	46.8	38.3	6.4	0.0	*100.0*	47
Adequacy of lounge/recreational facilities	10.6	38.3	42.6	8.5	0.0	*100.0*	47
Adequacy of bathroom facilities	12.8	38.3	40.4	6.4	2.1	*100.0*	47
Heating/cooling	8.5	42.6	29.8	19.1	0.0	*100.0*	47
Cleanliness	14.9	48.9	34.0	2.1	0.0	*100.0*	47
Emergency procedures	10.9	45.7	39.1	4.3	0.0	*100.0*	46
Disabled facilities provided if required	7.7	51.3	35.9	5.1	0.0	*100.0*	39

Survey of Local Government

15.7 Assistance to proprietors to better meet resident needs

Authorised officers were asked whether they could indicate anything that would assist proprietors to more effectively meet the social and care needs of residents. Common themes were:

- *Activities for residents* – greater provision of recreational/diversional programs both going into and outside of the facility; and training to increase staff awareness of the social needs of residents.
- *Assistance with continence issues of residents.*
- *Life skills programs* for residents which encourage self-management and self-development.
- *Financial assistance to facilities* – to meet capital costs and repair/upgrading costs, to provide for relief staff, and to employ additional staff.

- *Staffing* – provision of training for staff, especially in relation to care needs; and training programs for managers.

15.8 Summary

According to local government authorised officers, most SRFs are of an appropriate standard and complying with the requirements of the Act. However, there are exceptions, including failure to provide a 'home-like' environment, failure to provide for aspects of personal dignity and safety, and poor physical standard. Most SRFs are in older properties, with a built form often unlikely to enhance their capacity to provide appropriate care. Generally, authorised officers propose better access to activities and life-skills programs for residents; assistance with continence issues; financial assistance to facilities and training for staff as strategies to improve care.

16 THE FACILITIES – KEY MESSAGES

There are some consistent themes and messages contained in the information gathered about facilities. These are summarised below.

16.1 Diversity of facilities

SRFs are not all the same. Facilities vary according to a range of facility characteristics such as the size of facility, the type of services provided to residents, the standards of physical facilities (building structure and amenity), and tariff. Facilities also differ according to their resident profile, in factors such as age of residents, gender, type of disability, level of support need, and extent of support they receive from services/agencies.

From the information provided to the study, it can be inferred that facilities vary in terms of their capacity to meet resident need (in relation to skills, staffing, and 'fit' with their resident profile), their business status (how financially sound their business is) and their capacity to continue operating at their current level without compromising standards of resident care.

16.2 Mix of residents

Having said that facilities vary in the types of residents they care for, it is important to note that, within this, typically facilities care for a mix of residents. Most facilities accommodate and care for residents of both sexes and with varying ages, disabilities, and level and type of support needs. Some residents have difficult and anti-social behaviours that are a challenge to manage in a group environment and impinge to a certain extent on the everyday life of other residents. While owners/managers aim for a 'compatible' mix of residents, the overall profile of residents in each facility is quite divergent. With an average capacity of 28 residents per facility, it is inevitable that there are difficulties in managing the care of a diverse and often difficult group.

16.3 A 'pretty basic' form of accommodation

The built form of facilities does not aid in the provision of high quality care. Many facilities are older and provide a more institutional form of accommodation. Bedrooms are usually shared, as are common spaces.

Some proprietors have undertaken major work at a significant cost to redress the liabilities of an older style building, such as installing en suite bathrooms and turning double rooms into singles. However, much of the accommodation would have to be described as 'pretty basic' in its level of amenity. In terms of contemporary standards of accommodation for people

with disabilities, or even what is acceptable in the general housing market, shared bedrooms stand out as a major discrepancy.

The reports of authorised officers indicate that while most facilities rate at the 'average or better ' level, a handful are poor on a range of standards such as the adequacy of bathrooms, bedrooms and lounge facilities, heating and cooling, cleanliness and a 'homelike environment'.

16.4 Future viability

Most Supported Residential Facilities are private businesses run, typically, by an individual or couple. Employee costs are contained by the hands-on involvement of the owner and family members, and generally there are only a few, often part-time, employees.

Generally, owners/managers indicated business was 'tight' – costs had risen, some facilities were battling low occupancy rates, and the type of care required by residents was costly and time-consuming. Five facilities in the study indicated that the possibility of closing in the very near future was quite real. Operating a Supported Residential Facility was considered to be a less profitable business now compared to previous years.

16.5 The role of the SRF as 'primary carer'

Owners/managers undertake a range of care functions for residents. SRFs are, to all intents and purposes, the primary carer, taking responsibility for many daily care functions as well as 'whole of life' needs including recreation and community integration. Some of these functions are the sorts of things families might otherwise perform for their disabled relative (taking them to the hairdresser or doctor, shopping, managing money). The apparent confusion about whether residents are eligible for personal care and support services (such as HACC) and the lack of availability of these services adds to the demands on proprietors.

Given the limited financial means of residents, who cannot pay 'extra', and the limited time of SRF personnel, much of this support is provided on a shoe-string or 'in-house'. Owner/managers cut hair, 'do' feet, provide clothes and even organise funerals.

Some owners/managers have also taken on an advocacy and *de facto* case manager role in the many cases where there is no-one else to assume this responsibility. Residents who have case managers and support workers are in a better position, but the professional role is limited, with much still left up to the SRF.

The multiple roles of the SRF are not without significant difficulties and the potential for a conflict of interest between the roles of primary carer and business operator. To varying degrees, residents are dependent on the SRF to

provide for their needs, act on their behalf and protect their interests, with some totally dependent on the facility for all aspects of their care and life. This degree of dependency, and the absence of external support, relationships, planning and services, can result in a relatively basic level of care and leaves residents open to the possibility of exploitation or harm. It also means residents are largely 'hidden' from the community and missing out on many services which other people with disabilities receive.

It is also an outdated service model. One of the criteria of best practice in the care and support of people with disabilities is that the range of support needs should be met by a number of different people. In fact, the South Australian Disability Services Act 1993 requires services for people with disabilities to be designed and administered

> 'to ensure that no single service provider exercises control over all or most of the aspects of the life of a person with a disability (Schedule 2(1) (d)).'

The absence of other supports and relationships in the lives of residents contravenes this policy standard, places inappropriate responsibility on SRF owners/managers to meet 'whole–of-life' needs, and puts residents at risk.

SECTION FOUR IMPLICATIONS

17 CONCLUSIONS

17.1 Residents of Supported Residential Facilities – a vulnerable group

There is really just one main overwhelming finding from this study – that people living in Supported Residential Facilities are a highly vulnerable and disadvantaged group who are not receiving care which meets current policy and standards.

On the whole, residents in Supported Residential Facilities have impaired cognitive ability, little power to choose where or how they live, few supports, receive few services and have a greatly reduced ability to protect themselves from exploitation or harm. Lack of income and minimal family support adds to the general impoverishment of their circumstances and lifestyle.

The study suggests that, while some residents receive services from (primarily) disability and mental health services, the level of current service delivery, and the degree of assessment and case management of residents, is not adequate. Those residents who do receive such support may not be those most in need. Hence a vulnerable group of people with few resources and significant disabilities does not receive a coordinated and targeted human services response. Similarly there is an absence of mechanisms to protect the interests of residents.

It would seem that often services and support will be provided to residents who are in perhaps a more active or acute phase of care. There are, however, residents who have lived long-term in SRFs (or their precursors) who may be quite institutionalised, have minimal capacity for independent living, and are ageing in place, largely in isolation from the community and with little attention, aside from the SRF, to their needs, and no planning for their future. The needs and dependency levels of these residents will continue to increase as they age.

It is also of concern that many residents have very limited competency, but no active guardian or other person outside of the facility, involved in their care.

17.2 Up to standard?

This research indicates that the model of supported accommodation fails to meet a range of disability standards, principles and expectations in relation to privacy, dignity, consumer choice and decision-making, community participation, independence, rehabilitation, skill development, housing quality and health care.

This occurs despite considerable efforts by facilities to provide adequate and appropriate care. The model that appears to have evolved by default, where private facilities meet the 'whole of life' needs of the people living in their facility, on a 'for profit' basis, in an semi-institutionalised model, with few professional supports and with care entirely self-funded, is inherently flawed.

The semi-institutional model of care limits the capacity of residents to be as self-sufficient and independent as possible, and to exercise choice. Inevitably there are practices such as routines for meals and medication, rules about vacating rooms for cleaning, 'bed-times' and curfews. This can perpetuate dependency and increase isolation from the community.

On the whole, people living in Supported Residential Facilities do not have access to supports that enable adequate opportunity for community integration. Residents have very limited opportunities to develop skills, interests, independence and participate in the community in a normalised manner. Rehabilitative opportunities, or chances to move into more independent forms of supported care, appear to be highly inadequate.

The variable standards, practices, quality of facilities and resident populations across the sector must also be noted. It is to be expected that care within the sector will range from 'very good' to 'very bad'. It is of concern that facilities identified by local government as below standard in key areas are still operational. Some facilities, given the nature of their resident population, face particularly difficult burdens of care. There are currently few industry development and support strategies aimed at improving care.

The SRF sector has evolved over years, and what was accepted years ago may now be viewed differently. Thus we now have a model of privately-provided, for-profit supported accommodation that does not reflect contemporary approaches to the accommodation and care of people with disabilities and mental illness; there is an absence of a comprehensive response to providing health care and disability support services; and a lack of government policy and funding focus on this group.

There also appears to be a situation of 'unequal care', where some people with disabilities receive government funding and support, to accredited standards and in line with disability policy; whereas others are required to self-fund their care. The evidence indicates that the resources a person on low-income or government benefit has available to them cannot purchase other than a 'fairly basic' level of care.

17.3 South Australia in the national context

Consistent themes emerge from a review of policy and planning in supported care in other jurisdictions (Chapter 4), namely:

- The decline of the private supported accommodation sector

- The increasing complexity and needs of residents
- Issues regarding the viability of the privately provided supported accommodation sector
- Disparities in the care of vulnerable people living in private supported residential facilities compared to other vulnerable groups
- Discomfort about the appropriateness of the service model employed by the private supported accommodation services
- Recognition of the need for formal mechanisms to safeguard and advocate for the interests of residents.

These issues are also common to South Australia. However, the jurisdictions of New South Wales, Queensland and Victoria are also arguably ahead of this State in their responses to these issues, which include:

- Changes in regulation, licensing and procedures determining functions of facilities (including in terms of admission and resident assessment)
- Increased funding and support services to residents, including through the designation of residents as a priority group for HACC funding and assertive outreach into facilities by multi-disciplinary primary care teams
- Active and assertive 'watchdog' and resident advocacy structures (such as Community Visitors) to improve resident protection and scrutiny of care
- An increased role of the government and not-for profit sectors
- Increased separation of the 'accommodation' and 'care' functions
- Funding for sector reforms, including for building upgrades.

17.4 Conclusions

The approximately 1,500 residents of Supported Residential Facilities have largely been a 'hidden' group to the South Australian community, living in facilities which many do not know exist. They have also arguably been hidden in relation to service policy, planning and delivery, and thus have failed to benefit from reforms and advances in supported accommodation, disability and mental health. This study indicates that there are fundamental policy, funding and service issues which should be considered in relation to Supported Residential Facilities in South Australia. This should include the following areas:

> ***Policy***: Aside from the responsibilities in relation to the Act, it is not clear how Supported Residential Facilities 'fit' in relation to the

Department of Human Services's functions in terms of policy and planning in relation to disability, ageing, housing and mental health. The lack of integration of the SRF sector into a broader framework gives rise to inconsistencies and a lack of focus. This is exacerbated by the disconnection of regulatory responsibilities (the role of Local Government) from the broader state and federal government-led policy in the disability, ageing, housing and mental health areas.

Funding: SRF residents are currently outside the range of funding to disability and aged care services, and their self-funding of their own care is an anomaly.

***Regulation*:** The study raises questions about the adequacy of the current regulatory regime, given that some facilities appear to fall below an adequate level in meeting the standards spelt out in the Act.

***Service provision*:** There are significant areas of unmet need in relation to disability support, primary health care, and recreational/ community integration needs of residents, suggesting that a targeted response that provides assessment, case management and the provision of a range of appropriate services, could be considered. Access to specific services available to others in the community (such as HACC, CSI and aged care support) also needs to be addressed.

Safeguarding interests of residents: There is an absence of mechanisms to protect the interests of residents, whether that be key workers or an independent consumer advocacy and protection role (such as Official Visitors) which now exist in other jurisdictions. The particular issues for residents with impaired competency and no active guardian also require consideration.

***Development of alternative models**:* The findings call into question the model of supported accommodation that is provided by the Supported Residential Facilities sector, and suggest that alternative models should be considered. The development of any alternative models needs to recognise the need for a continuum of options, from independent living to fully supported residential accommodation, acknowledging the diversity of needs and preferences.

The needs of long term residents: The development of alternative models will largely benefit the 'potential' rather than existing clients of SRFs (ie people moving into housing with support, rather than those already in accommodation) especially where existing residents are largely hidden from the service system and unlikely to be considered for placement. Consideration needs to be given to the long-term population of SRFs who are ageing in place, often without a key worker, involved family member or external supports, and without access to the range of aged care and other services which exist in the

community. The care and support needs of this population must increase over time.

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19 APPENDICES

Appendix 1 All Supported Residential Facilities, South Australia

Name	Address	Suburb	Council
City Gardens Rest Home	252 South Tce	Adelaide	Adelaide
Arcadia	13 The Strand	Pt Elliot	Alexandrina
Pt Elliot Residential Care Service	9 Barbara St	Pt Elliot	Alexandrina
Carmel Court	39 Myall Ave	Kensington	Burnside
Ellesmere Lodge	2 Leonore Ave	Kensington Garden	Burnside
Auldana Rest Home	4 Adelaide St	Magill	Cambelltown
Bellara Village	98 Newton Rd	Cambelltown	Cambelltown
Falcoln Lodge Retirement Village	695 Lower Nth East Rd	Paradise	Cambelltown
Palm Gardens Rest Home	122 Reid Ave	Magill	Cambelltown
St Elizas	6 James St	Cheltenham	Charles Sturt
Sunflower Lodge	108 South Rd	West Hindmarsh	Charles Sturt
Sutherland Court Retirement Village	17 Woodville Rd	Woodville	Charles Sturt
Thomas Hutchinson Retirement Village	9 Bishop St	Gawler East	Gawler
Brighton "Ocean Grove" Rest Home	39 Beach Rd	Brighton	Holdfast Bay
Brighton Supported Care Services	23 Edwards St	South Brighton	Holdfast Bay
Glenelg House	37-39 Sussex St	Glenelg	Holdfast Bay
Glenelg Supported Care Services	26 Byron St	Glenelg	Holdfast Bay
Grace Lands Aged Care	51 Kauri Pde	Seacliff	Holdfast Bay
Russell House	16 Byron St	Glenelg	Holdfast Bay
Murray Mudge	7 Raymond Grove	Glenelg	Holdfast Bay
Sturt Palms Retirement Village	48 Sturt Rd	Brighton	Holdfast Bay
Eagle's Nest Retreat	lot 94/17 Kapunda St	Kapunda	Light Regional Council
Warrawee Lodge	53 Elders Way	Waikerie	Loxton Waikerie
Amber Lodge	4 Gordon Tce	Morphetville	Marion
Ashley Court Retirement Village	96 Bowker St	Warradale	Marion
Kingswood Hostel	26 Cambridge Tce	Kingswood	Mitcham
Mowbray House	44-46 Kingston Ave	Daw Park	Mitcham
Lambert Lodge	87 Gray St	Mt Gambier	Mt Gambier
Osmond Terrace Boarding House	32 Osmond Tce	Norwood	Norwood, Payneham & St Peters
Palm Lodge	10 Baliol St	College Park	Norwood, Payneham & St Peters
Wynwood Rest Home	77 Sydneham Rd	Norwood	Norwood, Payneham & St Peters
Vailima Gardens Rest Home	63 Hackney Rd	Hackney	Norwood, Payneham & St Peters
Unity Retirement Village	38 Taylors Rd	Aberfoyle Park	Onkaparinga
Warekila Lodge	39 Campus Drive	Aberfoyle Park	Onkaparinga
Tregenza House Transitional Unit	19/21 Knowles Rd	Elizabeth Vale	Playford
Clifford House	4 Farrant St	Prospect	Prospect
Emily Grove Supported Residential Facility	20 Barker Rd	Prospect	Prospect
Prospect Residential Care Services	6 Dean St	Prospect	Prospect
TLC Rest Home	2 Miller St	Prospect	Prospect
Kelvin Hall Hostel	81-87 Hall St	Semaphore	Pt Adelaide Enfield
Mandeville Lodge	296 Military Rd	Largs Bay	Pt Adelaide Enfield
Palm Manor	67 Hall St	Semaphore	Pt Adelaide Enfield
Rosewater Lodge	7 Lincoln St	Rosewater	Pt Adelaide Enfield
Rudd's Semaphore Hostel	164 Military Rd	Semaphore	Pt Adelaide Enfield
Sunnydale Rest Home	247 Military Rd	Semaphore	Pt Adelaide Enfield
Sunrise Supported Accommodation	22 Whyte St	Peterhead	Pt Adelaide Enfield
Windsor Grove Lodge	1 Windsor Grove	Windsor Gardens	Pt Adelaide Enfield
Bartonvale Lodge	1 Friar St	Enfield	Pt Adelaide Enfield
Bartonvale Village	Ellis St	Enfield	Pt Adelaide Enfield
Blind Welfare Residential Care Units	1 Grant Ave	Gilles Plains	Pt Adelaide Enfield
Cleaiew Manor House	1-7 Leicester St	Clearview	Pt Adelaide Enfield
Alexam Place Rest Home	24 Hazel Rd	Salisbury East	Salisbury
Harwin Estate- Palm Gardens	Frost Rd	Salisbury Nth	Salisbury
Elm Tree Lodge	2-4 Gladstone St	Fullarton	Unley
Kings Court Retirement Village (Auscare)	262 Cross Rd	Kings Park	Unley
Rose Terrace Hostel	102 Rose Tce	Wayville	Unley
St Michaels Rest Home	494 Fullarton Rd	Myrtle Bank	Unley
Genesis Care	51 Franklin Pde	Encounter Bay	Victor Harbor
Miramare	18 Crozier Rd	Victor Harbour	Victor Harbor
Kiama	Cnr Bay & Tabernacle Rd	Victor Harbour	Victor Harbor
Walkerville Lodge	11 Northcote Tce	Medindie	Walkerville
Brooklyn Supportive Care	377 Henley Beach Rd	Brooklyn Park	West Torrens
Camden Park Village	407 Anzac Highway	Camden Park	West Torrens
Amaroo Lodge	Hawdon St	Whyalla Norrie	Whyalla

Note: Data current as at September 2002.

Appendix 2 Participation of facilities in study

Data collection process	Proprietor Interviews	Resident Information Sheet	Assessed Residents
Information provided by	Owners/ managers	Owners/ managers	Key workers & managers
Type of informant	26 owners 7 employees 1 volunteer manager		68% manager/staff 32% key worker
Number of facilities	34	37	32
Number of residents	866	919	437
Location of facilities	28 metropolitan 6 regional	31 metropolitan 6 regional	
For profit status	4 NFP 30 PFP	6 NFP 31 PFP	
Size of facilities	4-50	4-50	
In receipt of board and care subsidy	6	6	
% of residents in each facility			30% to 100%.
% of total residents in participating facilities			53%