Report of Strathmont Centre Redevelopment and Community Living Project

(Phase 3: June- December 2009)

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Executive Summary

This document provides the final report on the Strathmont Redevelopment and Community Living Project Evaluation. Phase 1 was completed in December 2006 (final report submitted April 2007), Phase 2 was completed in July 2007 (final report submitted May 2008) and Phase 3, upon which this report is based, was completed in December 2009 (final report submitted September 2010).

In July 2005, Cabinet approval was obtained to implement the Strathmont Centre Redevelopment and Community Living Project. The purpose of this project is to enable 150 residents from Strathmont Centre to move to purpose built homes within the community, with 99 residents continuing to live on-site in improved accommodation.

The key goals of the project were defined as:

1. Provide an opportunity for 150 residents of Strathmont Centre to move to improved residential accommodation options within a community setting.
2. Construct purpose-built housing that will meet the provision of long term accommodation and better meet the National Standards for Disability Services.
3. Ensure that each group home be built to accommodate the significant support requirements of residents who require a high level of care and constant supervision due to severe multiple disabilities and high health needs, both now and into the future.
4. Ensure five persons with similar needs share a house together and that each person is provided with individual bedroom, adequate bathrooms, and living areas similar to most homes in the general community.
5. Ensure that Disability Services meets its current and projected service requirements by re-accommodating 150 residents into community group homes that better meet the needs of the residents, key stakeholders, families and staff, by providing high quality 24-hour support and enabling a flexible service response for future changes in client needs.
6. Ensure that appropriate levels of personal support, with care and supervision, are provided to all clients that satisfies their individual needs.
7. Ensure opportunities for family involvement are maximised throughout the Project.
8. Ensure methods and systems to reduce staff isolation issues are incorporated into the design of the housing model and the staff support model.
9. Ensure the staff recruitment and training schedule is implemented over the project term to meet additional staffing resources as required.
10. Ensure the staff support model maximises opportunities for residents to access and use local community-based facilities.
11. Ensure that residents have increased opportunities for community and social inclusion through living within local communities, accessing local community-based facilities and services, and through developing relationships with neighbours and other community members and groups.

The purpose of the evaluation was to assess the process of the devolution for the first 30 residents who moved from Strathmont to purpose built community houses, and to investigate whether the goals of the project had been successfully attained. This report presents our findings in response to the overarching evaluation question *'Is the devolution being done the best way to maximise the quality of life benefits for residents and minimise any potential negative impacts for residents, family and staff?'*

The evaluation measured the well-being and quality of life of the first 30 individuals who moved from the Strathmont Centre to purpose built homes in the community. Measures were also taken of the impact of the move on families, volunteers, relevant staff, and shift supervisors, based on the assumption that their roles as service providers and advocates for the residents played an important part in the satisfaction and well-being of the residents. Data collection required access to each participating resident, a staff member who knew the resident on a day-to-day basis, the residents' families, the residents' homes, and records concerning their health, services, and supports. The evaluation was conducted in three phases over a two year period.

Phase 1: baseline data were collected via face-to-face interviews, observations, mail out surveys, and review of relevant documents.

Phase 2: baseline data were collected via group staff interviews, observations, mail out surveys, and review of relevant documents. Data collection was less in-depth than in Phase 1 in so far as participants were only asked whether their perceptions regarding the move to the community had changed, and whether there had been any significant events in the first 6 months of community living that may have impacted on the participants.

Phase 3: baseline data were collected via face-to-face interviews, observations, mail out surveys, and review of relevant documents. Phase 3 assessed the overall impact of the community living project as well as any changes that may have occurred from Phase 2 to Phase 3. Where possible, comparisons were made between the findings of Phases 1, 2 and 3.

In phase 3, the numbers and percentage participation rates varied considerably between staff (30, 81%), shift supervisors (6, 100%) staff proxies for residents (27, 100%), families (13, 62%) and volunteers (7, 28%). There were similar differences for the three phases of the study combined: permanent staff (74, 78%), new / casual staff (7, 47%), staff proxies for residents (80, 94%), families (50, 78%) and volunteers (7, 28%).

Findings from the evaluation show that the relocation of the first 30 residents from the Strathmont Centre to the community has been associated with many benefits for the residents, their families, staff and volunteers.

Residents: The overall pattern of resident findings suggests that the move from Strathmont to the community has been associated with many lifestyle improvements for the residents, including increased family contact, more "home-like", less "institutionalised" living environments, being treated more as individuals, and an increase in their perceived life satisfaction. The residents' overall health has remained relatively stable during their two years in the community with notable decreases in reported illnesses and behavioural problems. They were reported to be in good or excellent health, and staff were of the opinion that the residents' health needs were being met in an appropriate and timely manner in the community.
On the negative side, the residents were purported to have little or no choice in selecting and participating in scheduled activities, the variation and frequency of which, have remained relatively unchanged since the move to the community. The scheduled activities were also found to offer little opportunity for the promotion of pro-social contact with non-disabled community members. Furthermore, most of the activities the residents participate in had a "disability" focus, with much of their time being spent within their own houses with little contact with neighbours or others from the outside world. None of the residents had a close friend who was not a staff member or family member, and only one resident was reported as spending time with people of a similar age who were not staff and who did not have a disability.

Two years after the move to the community all residents had a lifestyle plan, although not all of the plans were updated since leaving Strathmont. Documented goals in the lifestyle plans demonstrated a more individualised focus and were less generic than those documented prior to, and 6 months after, the move to the community. None of the goals, however, were focused on the development of adaptive behaviours, nor did they address important lifestyle domains such as personal care, domestic activity or social interaction. The goal plans also lacked descriptive information regarding the procedures that would be employed to assist the target resident to achieve the goals.
Observations of the residents revealed that they engage in very few social interactions and have relatively little to do during their waking hours. Across all of the community houses, residents were barely encouraged or assisted to participate in constructive activities or to socialise with other individuals. Moreover, the use of accommodations or adaptive devices which might be presumed to enable and/or encourage the residents to be more independent in their actions were not in evidence in any of the houses. It is important to note, however, that in spite of the limited social experiences afforded to the residents, their basic care needs appeared to be well considered. Their houses were clean and well maintained, and clearly less stigmatising and restrictive than their former accommodation at Strathmont. Moreover, most staff members appeared to be caring and genuinely concerned with the welfare of the residents under their charge.

Families: Findings from the Phase 3 evaluation indicate that the residents' families hold generally positive attitudes toward the community living project with nearly all families reporting that they were satisfied with their relative's current standard of accommodation and the quality of services provided. Families also reported that they were adequately informed of the programs and services being offered; that the support services met their expectations; and that their relative was being treated well by staff. These positive feelings also included those of some family members who had expressed apprehension regarding the benefits of community living prior to the move. Although families are generally satisfied and accepting of the move to the community, a number of concerns were expressed (e.g., reduced physiotherapy; staff turnover; communication difficulties with non-English speaking staff members; lack of meaningful activities and less stimulation for residents via interaction with other people; and fewer opportunities for families to interact with other families like they did at Strathmont).

Staff: Staff were found to hold moderately favourable attitudes toward their jobs. They express enjoyment in their interactions with residents and families, their involvement in the planning processes for the residents and the general nature of the work itself. They also indicated their satisfaction with the information they receive about their jobs and the residents' needs and programs. They generally feel less "institutionised" than when they were at Strathmont and expressed a decreased sense of isolation compared to when they first moved to the community. They reported moderate support for the new model of staff placement and supervision and also believe they have more autonomy and greater opportunities to provide residents with the support they need. There was evidence of improved relationships between staff and management since the move to the community, and importantly, they considered the move to the community as having beneficial outcomes for both themselves and the residents. Conversely, job-related training, relationships with other staff, increased workloads and greater responsibilities, lack of feedback on performance, and reservations about implementing an Active Support Program were reported as areas of concern.

Volunteers: Results from only seven of the 25 volunteers were available and accordingly, the findings need to be treated cautiously. All of the volunteers indicated that they enjoyed their work in helping residents, although their accounts suggested that their efforts mostly involved working for, rather than with, the residents. They helped residents with a wide range of activities and believed that residents enjoyed these activities, but emphasised that it was important to match resident abilities and interests to appropriate activities. More volunteers and more of the same activities as well as some additional types of

activities were recommended. They were satisfied with the adequacy of the volunteer service and with their orientation/induction training, and considered their interactions with staff to be generally satisfactory. Volunteers held varying opinions regarding the impact that living in the community had on residents. One volunteer thought they should not be living the community, another believed that some residents seemed isolated and had more activities when they were at Strathmont; one thought that living in the community did not have any impact on residents, and another did not know what impact it had.

Findings from the three phases of this evaluation suggest that the answer to the question '*Is the devolution being done the best way to maximise the quality of life benefits for residents and minimise any potential negative impacts for residents, family and staff?*' is a mixed one. The move to the community has been associated with many positive and important lifestyle changes for the residents, yet in many ways life in the community for the residents would appear to be relatively indistinguishable from their lives at Strathmont. The residents now live in new, smaller, less institutionalised and more home-like environments with higher staffing levels, and caring and genuinely concerned staff. These contextual arrangements are obviously necessary to reform in the delivery of residential services. Yet, data from the present evaluation would strongly suggest that for people with significant, multiple and challenging needs, such normalised arrangements are insufficient. That is, the attainment of quality outcomes in the community entails more than just the provision of more normalised environments. Real opportunities for residents with significant needs to achieve meaningful lifestyle outcomes appears to be dependent on the merging together of a range of factors: a general conceptual direction that is based on normalisation-referenced aims and training, opportunities to participate in meaningful, socially inclusive activities, individualised support and effective assistance, staff competence, and organisational commitment and monitoring to ensure desired outcomes are realised.

Overview of Recommendations (specific recommendations are provided in the body of the report):

Staff:

Staff training should be revised to include more emphasis on how to provide active support for, and be actively engaged with, residents. Staff should also be consulted about the kinds of training that should be provided to different staff, including new and established staff. Role descriptions should be reviewed and made more explicit, particularly with respect to decisions concerning residents and their access to, and active participation in, the community. Communications between management and staff should be reviewed with respect to management providing more (positive) feedback to staff. Communication should be encouraged and supported across houses to improve services and supports to residents. Recruitment information for new staff should state the desirability of a positive, outgoing personality, and a willingness to engage with, and provide active support for, residents on a daily basis. It is suggested that applicants be assessed for these characteristics via references and interview questions.

Residents:

Individual program plans should be devised for all residents, and used as a guide for the development and monitoring of programs, supports and activities. It is suggested that the plans provide more detail (e.g., behaviourally referenced time-framed goals and objectives, implementation and monitoring strategies outlined) and focus on the development of adaptive behaviours across a range of important lifestyle domains such as: community participation, health, domestic living, recreation, and social inclusion.

Families:

The process of informing families about the move of their family member from Strathmont to the community was successful and should be continued in future efforts, but with an initial phone call to proceed written information. Verbal and written updates of relevant information concerning each resident should be provided to their family, including information from individual program plans about activities, health, community participation and the development of adaptive skills and social relationships. Families should continue to be encouraged to visit the community houses and to have their family member at home whenever appropriate and convenient. Communication between families should be facilitated by providing general information about the project at meetings and by establishing a phone/address line to enable families to contact each other if they wish.

Volunteers:

Volunteers should be comprehensively surveyed to check the generalisation of their responses in this report. The volunteers should be provided with information about the purpose of moving residents to the community houses as part of their induction training, and as with staff, volunteers should be asked about the kind of ongoing training and support that they would find useful to assist them to work more with residents rather than just for them. More volunteers should be recruited, and increased opportunities provided for them to meet staff and each other to discuss ideas and reinforce positive realtionships. More opportunities should be fostered to develop and provide new activities.

Follow up Evaluations:

This evaluation has yielded considerable information that can, and should, be an important contributor to practice and public policy. The evaluation team commends the foresight of the initiators of the project and the thoughtful contributions of the participants. It is recommended that further similar evaluations and reports on progress in each of the houses should be carried out on a regular basis to ensure that services to residents continue to improve and that such progress is maintained. These evaluations should involve at least some interviews with staff, staff proxies for residents, families and volunteers plus time sampled observations of the daily activities of residents to ensure that service goals continue to be achieved.

Part 1: Residents

Aim

A central rationale underpinning the "move to the community" for people with significant disabilities is the desire to promote opportunities and access to a range of domestic and community activities typical of people without disabilities. For people who have difficulty performing such activities independently, support and guidance from others is of paramount importance. This support serves, in part, as a bridge that enables people with significant disabilities to engage in a broad range of activities despite the limitations they may experience. Furthermore, the degree to which people spend their time actively engaged in valued social, personal, domestic and community activities may significantly influence their quality of life. It is important to note, however, that participation does not occur in a vacuum – it is attained through supportive, consistent, and repetitive engagement in activities that enhance one's well-being and dignity. An extant research literature has demonstrated that movement from institutional into community settings may be a necessary, but not sufficient, factor in the enhancement of people's quality of life. While the physical attractiveness, size and "home like" qualities of a community setting are important factors contributing to a person's well-being, the nature and extent of meaningful activities and interactions that occur between the people within those settings are equally important co-influences to successful community living. Hence, the social interactions of residents and the arrangement of activities, services and environments that support the development of positive adaptive behaviours and personal well-being can be, and should be, important contributors of public policy.

Information regarding the residents' well-being was obtained through staff interviews and review of relevant resident records (i.e., Health Care Plan and Accommodation Files). Direct observations of the activities and social interaction patterns of each resident were also conducted. The overall aim of obtaining this information was to determine whether the quality of the residents' lives had changed as a result of moving from Strathmont Centre to the community setting.

Method

Staff Interviews and Review of Records

All of the residents who moved from Strathmont to the community had significant cognitive and physical limitations and were highly dependent on others to meet their basic needs. It is difficult to use subjective evaluations from people with limited cognitive and behavioural repertoires, and little or no communication skills. Thus, subjective evaluations regarding the residents were obtained by interviewing the staff member (proxy respondent) who was most familiar with each resident. House supervisors identified staff they felt were the most knowledgeable about individual residents. These staff members were asked to respond on behalf of the target resident and comment on the resident's community living environment; activities; relationships; choice making; health; and general quality of life. Where possible, a staff member who had known and worked with the resident at Strathmont was again interviewed. This protocol was not always possible due to high staff turnover and changes in staff assignments and configurations that had occurred during the transition to the community. Hence, some staff members were required to do several interviews. The selected staff members were asked to complete an interview that consisted of 40 questions concerning the lives of individual residents in the community. In addition to surveying staff, information from each resident's Health Care Plan and Accommodation File was also documented (e.g., health and medical reviews, lifestyle plans).

The 40 items of the resident interview focused on: the Community Living Environment; Activities; Relationships; Choice Making; Health; and overall Quality of Life. Each interview took approximately 45 minutes to complete. All interviews were conducted in the community houses.

Social Interactions and Activities

The social interactions and activities engaged in by the residents were observed during 15 minute sessions over a two month period. Observational data were recorded using a partial interval recording procedure whereby a resident's activities and social interactions were observed during a 10 second interval and the results recorded during the subsequent 20 second interval. This type of recording procedure has a relatively small measurement error. Observe-record intervals were cued to the observers by use of earphones and an audio-tape machine. Four 15 minute observation sessions were conducted for each resident for a total of 29 hours of observational data. Observations were conducted Mondays to Fridays at different times of the day between the hours of 9:00 am and 5:00 pm. Residents were not observed when engaged in any private activities such as getting dressed, bathing, or using the toilet or when they were participating in community activities. Observation sessions were randomly scheduled across houses and residents.

Seven main categories of activity were recorded:
(1) Domestic: getting ready for or doing housework (e.g., washing clothes, cooking, gardening, setting or clearing the table, decorating)
(2) *Personal:* getting ready for or doing a self-care activity (e.g., brushing teeth, washing, drinking, eating)
(3) *Leisure*: getting ready for or doing a recreational activity (e.g., looking at magazines, playing games, listening to music)
(4) *Challenging Behaviour:* (e.g., aggression to others, property damage, self-injury, stereotyped movements, inappropriate vocalizations)
(5) *Watching Television:* (e.g., sitting in front of the television with eyes directed at the screen)
(6) *None:* (e.g., sitting doing nothing, waiting, pacing, no apparent purposeful activity)
(7) *Other*: any other activity or behaviour that did not fit into one of the other categories

Five main categories of interaction were recorded:
(1) *Positive:* receipt of praise, encouragement, or a sign of affection either physically or verbally
(2) *Negative:* receipt of disapproval, restraint, enforced movement or refusal/denial, verbally or physically
(3) *Training/Assistance:* verbal or physical prompts, demonstration or guidance to help a resident perform an activity
(4) *Neutral:* any interaction that is neither positive or negative or giving assistance (e.g., having a conversation)
(5) *No Interaction:* no one interacting with a resident either verbally or physically

Reliability of observational data was checked by a second observer observing simultaneously with the first observer for 10% of the sessions. Percentage occurrence agreement for each category was calculated by dividing the number of agreements of occurrence by the total agreements plus disagreements and multiplying by 100. Overall agreement measured 90.5%.

Results: Staff Interviews

Thirty residents were initially assessed in this project (15 males and 15 females). Two residents had died since Phase 1, and one more since Phase 2. Therefore, interviews were conducted for the remaining 27 residents in Phase 3. Residents were aged between 35 and 58 years (mean: 48 years). Twelve staff responded on behalf of the 27 residents. These staff had worked with the residents from 8 months up to 8 years. Only one of these staff members had responded on behalf of residents in Phase 1. Due to staff turn-over; rotation between houses; and rostering, it was difficult to match up residents and staff members across the three phases. Only one resident was assessed by the same staff member across all three phases and six residents were assessed by the same staff member across phases 1 and 2.

Individual Resident Questionnaire Results (Staff perspectives)

COMMUNITY LIVING ENVIRONMENT

Table 2.1 shows that most of the respondents felt that there had been a positive or very positive effect on the emotional well-being (66%) and material well being (70%) of the residents as a result of living in the community. However, less than half of the respondents (41%) believed that community living had produced any positive effects on the behaviour of residents, while a similar proportion (41%) felt that community living had had no effect on residents' behaviour. None of the respondents, however, indicated that community living had a negative impact on the residents.

Table 2.1. **Impact of community living on residents (highest percentages for each outcome are shown in bold)**

Overall impact of community living on residents'...	Very Negative	Negative	No Effect	Positive	Very Positive	Not Known
Behaviours	0	0	**11 (41%)**	5 (19%)	6 (22%)	5 (19%)
Emotional well-being/ sense of dignity	0	0	7 (26%)	**12 (44%)**	6 (22%)	2 (7%)
Material well-being	0	0	6 (22%)	**12 (44%)**	7 (26%)	2 (7%)

Table 2.2 presents responses to three items regarding resident-related issues in the community houses.

Table 2.2. **Issues in the community houses (highest percentages for each question are shown in bold)**

Have there been issues concerning...	Yes	No	Some	Unsure
Settling into the new community houses and/ or community environment	7 (26%)	**13 (48%)**	3 (11%)	4 (15%)
Health and safety	4 (15%)	**22 (81%)**	1 (4%)	0
Physical environment	4 (15%)	**17 (63%)**	6 (22%)	0

Twenty-six percent of the respondents believed that there had been settling in issues for the residents, while a smaller proportion (15%) thought there had been issues concerning health and safety or the physical environment of the community setting (15%). Approximately half of the respondents (48%) indicated that they believed there were no issues for the residents settling into the houses, while 11% indicated there were some issues and 15% indicated they were unsure. A majority of the respondents reported that there had been no issues related to the residents' health and safety (81%) or to the physical environment of the houses (63%).

ACTIVITIES

All staff indicated that the House Bus was used to transport residents to and from activities, expect one resident whose mother had requested that her child no longer ride on the bus as it distresses the resident. In some instances a taxi was used (however, this was usually quite rare). For any activities organised by external agencies (e.g. SCOSA), the organisation provided their own transport (i.e. their agency bus). Staff generally reported that there were no major issues with transporting residents and the system generally remained the same as it was at Strathmont (i.e., a 'Villa Bus' now being a 'House Bus ').

Respondents had disparate views regarding the extent to which there had been a change in the variety and/or frequency of activities for the residents since they moved to the community. Thirty percent of the respondents said they had increased, 30% indicated they had decreased, with 26% saying there had been no change. It is important to note, however, that the staff at the Sturt houses had indicated that there was a decrease in the variety and frequency of activities for 67% of residents (6 out of 9), whereas there was only a 14% (1 out of 7) decrease reported for residents at the Greenacres and Northfield houses). This may possibly be partly attributed to the geographical location and distance of the Sturt houses from the Strathmont Centre where many of the activities took place.

Fifty-two percent of respondents reported that the activity goals in residents' life style plans had been moderately or fully achieved, while 48% of respondents said the question was not applicable (in the Sturt houses) because the residents did not have updated lifestyle plans

Table 2.3 presents responses to questions regarding the nature of the activities for the residents. A majority of the staff respondents (81%) reported that community facilities had been accessed as part of the residents' activities. Fifty-six percent of the respondents indicated that activities were organised specifically for the residents. Nearly two thirds (63%) said that residents had no choice in activities, with only 26% indicating that residents were partly involved in choice of activities.

Table 2.3. **Information about activities** **(highest percentages for each question are shown in bold)**

	Yes	**No**	**Partly**	**Unsure**
Have community facilities been accessed as part of residents' activities?	**22 (81%)**	5 (19%)	0	0
Are there any activities organised specifically for the resident?	**15 (56%)**	10 (37%)	0	2 (7%)
Does the resident have a choice about which activities they participate in?	2 (7%)	**17 (63%)**	7 (26%)	1 (4%)

From a list of nine common community activities (e.g., going to a club/ group, a hotel/pub, a movie, a place of worship, watching live sporting events, interacting with people outside house such as neighbours and shopkeepers, eating out, visiting family or friends, or playing sport or going to a gym), respondents indicated that all but one these activities occurred less than once a month. Going to a club /group was the only activity that occurred, on average, more than once a month.

When asked to comment on activities residents particularly enjoyed, respondents said that residents typically had individual preferences for particular activities. The most popular activity that residents were seen to enjoy was swimming (26%). Activities that individual residents were perceived not to like included: Craft at Strathmont (3), Music (2), Massage (the relevant residents disliked being touched) (2), and Bus trips (2). Other individual activities residents disliked included: going out in the community, cooking, physical (ball) activities, and activities that involved loud noises and lots of people. Respondents were equally divided in their responses to the question of what activities residents might enjoy that they are not currently doing. Four staff said Massage, another 4 said music activities, and another 4 said the same activities residents were currently engaged in but more frequently. Other individual suggestions included, going to the beach and Art and Craft. None of the respondents identified activities that might involve non-disabled members of the community.

Residents were reported to spend the largest proportion of their time inside their house (20.6 hrs per day). Other situations and activities, such as watching TV, being outside in the backyard, and spending time in the presence of community members were reported to occur for an average of only 2.5 to 3 hours a day.

RELATIONSHIPS

Just overt half of the respondents (52%) believed that living in the community had provided residents with an increased opportunity to spend time with other people such as carers, residents, and family. While none of the respondents indicated that such opportunities had decreased since the residents had moved to the community, 33% believed there was no change. Once again there was a marked difference at the Sturt houses, with Sturt respondents indicating an increase in opportunities for 86% of the residents (in contrast to 50% increase at Greenacres and Northfield). This difference might be attributed to the fact that staff at the Sturt houses had received training in how to implement Active Support. Hence, they may be more likely to engage the residents under their charge in pro-social activities, whereas staff in the other houses had not yet received this type of training.

A large majority of staff respondents (93%) reported that none of the residents had a close friend who was not a staff member or family member. Only one resident was reported as spending time with people of a similar age who were not staff and who did not have a disability. Friendships are rapidly becoming recognised as an important dimension of quality of life, and one that has often been under emphasised or ignored by traditional providers of human services. Hence, this finding regarding the extremely limited existence of close friendships for the residents should be interpreted to be an important one for future monitoring.

Staff commented that, the main occasions for contact between families and their relatives living in the houses were visits to the community houses for the resident's birthday (30% of the residents), resident visits to the family home for Christmas (26%), and family visits to the houses at Christmas time (22%). Two residents were reported to visit the family home every week. Another resident was reported to visit the family home on a monthly basis, and one resident received a phone call on their birthday.

CHOICE MAKING

Staff were somewhat equivocal in their responses to the question of whether residents were provided with opportunities to make decisions about various aspects of their life. Forty-four percent of respondents believed that the residents were provided with such opportunities, 37% indicated that the residents were not given these opportunities, and 19% said they were unsure. The biggest differences across the houses were between Northfield, where respondents indicated that 80% (8 out of 10) of residents were provided with opportunities to make decisions, and Greenacres where 60% (6 out of 10) of residents were purportedly not provided with such opportunities. This difference may be due to respondents interpreting resident "decision making" in different ways, with some using a more rigid criterion (e.g., initiating a decision as distinct from giving assent to a staff question or request). Observations of staff also indicated that established routines in the houses and staff knowledge of the residents often resulted in staff anticipating or predicting need and/or choice rather than encouraging and allowing the residents to actively engage in activities and choice-making.

Fifty-two percent of respondents thought that there had been no change in opportunities for participation in decision making since the residents had moved to the community. Forty-one percent thought that such opportunities had increased, and 7% indicated that they were unsure if there had been any changes in opportunities since the move. Less than a third of the respondents believed that the residents should be provided with more opportunities to be involved in the decisions that affect their lives. Further investigation of these results is warranted to determine the extent to which they might be associated with staff beliefs about the capabilities of the residents or organisational opportunities for increased involvement in their decision making.

It can be seen in Table 2.4 that all respondents agreed that residents did not make independent decisions with respect to five of the seven listed activities. The only exceptions were decisions pertaining to the time to go to bed and which residents to spend time with, but even in these cases less than a fifth of residents were perceived to make such decisions.

Table 2.4. **Level of decision making the resident has in the following activities (highest percentages for each topic of decision making are shown in bold)**

	Decides by him/herself	Decide with others	Has no choice	Not capable of making a choice
Clothes to wear	0	2 (7%)	0	**25 (93%)**
Time to go to bed	3 (11%)	**12 (44%)**	4 (15%)	8 (30%)
Food to eat	0	**17 (63%)**	5 (19%)	5 (19%)
TV programs to watch	0	5 (19%)	0	**22 (81%)**
Residents to spent time with	5 (19%)	7 (26%)	0	**15 (56%)**
Group outings to go on	0	4 (15%)	6 (22%)	**17 (63%)**
Activity programs to attend	0	5 (19%)	6 (22%)	**16 (59%)**

It can also be seen in table 2.4 that while more residents made such decisions with others, in only one case, that of food choice, did more than 50% of residents make the decision with others. In all cases except time to go bed and foods to eat, most respondents believed that this lack of decision making was due to residents not being capable of making such decisions, although in three of the activities, food, group outings and

activity programs, approximately 20% of staff thought the resident had no choice. The response variation to levels of resident decision making suggests that this area should be further investigated to determine the resident, staff and situational factors associated with resident decision making.

HEALTH

Most of the respondents (67%) considered the residents to be in good or excellent health. Fifteen percent of respondents considered the status of the residents' health to be moderate and 19% thought it to be poor. Just over half (56%) reported that there had been no change in the residents' health since the move to the community, 19% thought it was better, 11% considered it to be worse or much worse, and 15% reported that they did not know about the resident's health. It should be pointed out that changes in health may not be related in a causal way to the move into the community, as the health status of the residents can change over time due to their disability, aging and/or to pre-existing medical conditions. Nearly all of the respondents (85%) thought that the residents' health needs were being met in an appropriate and timely manner in the community, with only three respondents indicating that this was partly the case and one who was unsure.

QUALITY OF LIFE

A majority of the residents (74%) were perceived by the respondents to be either satisfied or very satisfied with their lives, with 48% being rated as very satisfied and a further 26% being rated as satisfied. Fifteen percents of the respondents believed that the residents were moderately satisfied with their lives, with 11% reporting that they did not know the satisfaction level of the residents. No staff member rated the residents as either dissatisfied or very dissatisfied.

Respondents were asked to identify factors that they believed contributed to the residents' quality of life. Factors identified included: staff interaction and attention (10); family involvement (e.g. resident's mum visits the house) (7); community activities (4); food (4); a clean environment (4); being physically comfortable (3); time spent with other residents (2); and music (2). Some individual contributors to satisfaction with life included being alone listening to the radio, having a bubble bath and having choices.

Respondents also identified a number of factors that they believed contribute to the residents' dissatisfaction. These factors included: having interactions with unfamiliar people (3); being attended to in personal care activities (e.g. bathing/ shaving) (3); not getting what they want on time (3); physical discomfort/ incontinence (2). Other individual reasons for dissatisfaction included, sitting in a chair all day and noisy environments.

The above examples illustrate the wide range of individual differences amongst residents in what is perceived to contribute to their satisfaction and dissatisfaction. This finding strongly indicates that proposed activities need to be carefully assessed in terms of which residents appear to find them enjoyable and which they would prefer not to be involved in**.**

Comments from the respondents conveyed a general feeling that there was not much else that could be put in place to improve the residents' satisfaction with their lives, either because it was difficult to tell what the residents liked, or because they already received the best care they possibly could. For those who suggested something which could help improve the residents quality of life, more activities was the most frequent response (6); followed by increased staff interaction and one on one attention (3); and physiotherapy (2). Other individual suggestions included: involving residents more in daily routines,

flexibility in routine, keep residents occupied all day, and physical comfort (e.g. getting out of wheel chair more often).

Forty-eight percent of the respondents believed that the residents' quality of life had increased since being in the community. Thirty-three percent indicated that they did not know if there were any changes, and 19% thought that the residents' lives had stayed the same. There was no resident whose level of satisfaction with their life was considered to have decreased. Respondents indicated that since the staff to resident ratio is better than it was at Strathmont, it is easier for staff to see when a resident has an issue and act on it. For example, more seizures have been reported "because the staff actually see the residents now".

Most staff (85%) reported being either very confident or confident that their answers reflected the resident's opinions, with only two being partly confident and two being not very confident.

Findings from the Resident Records- Health Care Plan

Resident Characteristics

While the majority of resident folders did not have provide any information indicating the residents' level of disability (which was also found in the Phase 2 evaluation), it was obvious from observations and reviewing their records that they all had significant and multiple disabilities which impacted upon their daily living. In addition to their cognitive disabilities, other impairments that were noted in their records included: Spastic Quadriplegia, Cerebral Palsy; Down Syndrome; Rhett Syndrome; Maternal Rubella Syndrome; Perinatal Anoxia; Silverman's Syndrome; other chromosomal disorder; and cerebral genesis. Records also indicated that many of the residents experienced: epilepsy; anaemia; communication problems; sensory difficulties (vision/ hearing impairment); vitamin D deficiency; osteoporosis; scoliosis; difficulties with mobility; and hypothyroidism.

Medical Review

Medical reviews are required to be done yearly. Records indicated that all residents had an Annual Medical Review.

Health information

Table 2.5 summarises data relating to eight measures of resident health. It can be seen that there was little overall change between the average number of dental visits, hospital admissions, medications used or injuries incurred prior to the move, and six months and two years after the move to the community. For two of the measures, however, number of illnesses and number of behavioural issues, there was a rise in average numbers over the 6 month period after the move, followed by an average decrease to below the initial level after two years in the community. The average number of recorded resident illnesses reduced by 50% over the two year period, whereas the average number of behavioural issues reduced by 80%. This latter result would be consistent with behavioural problems increasing as a result of stress associated with the initial move and a subsequent marked decrease when residents became familiar with the more comfortable and less crowed and noisy environment of the community houses.

The average number of doctors' visits remained relatively stable from the period just prior to the move to 6 months after the move. However, the reported doctors' visits increased fourfold from an average of 3 at the 6 month period to an average of 12 at the two year period.

The nature of the illnesses tended to be similar across the time periods, ranging from common colds and coughs to more serious individual illnesses such as urinary tract infections, ear infections, viruses, constipation and pneumonia. The types of reported behavioural incidents were also similar across the periods of data collection and included self-harm, being overly vocal, agitation, and food refusal.

Health records indicated that the average weight of residents increased from 51.4 kg at the time of the move (September/ October 2006) to 53.3 kg 6 months after the move (March/ April 2007). Two years after the move to the community the residents had maintained their previous weight gains (i.e., 53.1 kg).

Table 2.5: **Comparison of Health details over the three phases of this project**

	In Strathmont Villa (Period of 6 months prior to the move to the community)	**In Community Houses (Period of 6 months after the move to the community)**	**In Community Houses (Approximately 2 years after the move to the community)**
Number of illnesses	Total for 20 residents: 116 Average: 4 Range: 0 – 12	Total for 23 residents: 183 Average: 7 Range: 0 – 30	Total for 21 residents: 58 Average: 2 Range: 0 – 11
Number of dentist visits	Total for 25 residents: 39 Average: 1 Range: 0 – 5	Total for 16 residents: 20 Average: 1 Range: 0 – 3	Total for 22 residents: 26 Average: 1 Range: 0 – 2
Number of doctor visits	Total for 24 residents: 109 Average: 4 Range: 0 – 11	Total for 23 residents: 83 Average: 3 Range: 0 – 9	Total for 27 residents: 316 Average: 12 Range: 4 – 28
Number of hospital admissions	Total for 8 residents: 10 Average: <1 Range: 0 – 1	Total for 4 residents: 4 Average: <1 Range: 0 – 2	Total for 7 residents: 15 Average: <1 Range: 0 – 6
Number of medications used	Total for 28 residents: 319 Average: 11 Range: 6 – 21	Total for 28 residents: 327 Average: 12 Range: 6 – 21	Total for 25 residents: 247 Average: 10 Range: 2 – 21
Number of injuries	Total for 8 residents: 13 Average: <1 Range: 0 – 3	Total for 9 residents: 15 Average: <1 Range: 0 – 3	Total for 12 residents: 32 Average: 1 Range: 0 – 9
Number of seizures	Total for 13 residents: 144 Average: 5 Range: 0 – 39	Total for 16 residents: 410 Average: 15 Range: 0 – 190	Total for 12 residents: 258 Average: 10 Range: 0 – 112 (NB: one resident had 112 seizures in this timeframe)
Number of behavioural issues	Total for 10 residents: 72 Average: 10 Range: 0 – 50	Total for 11 residents: 147 Average: 14 Range: 0 – 55	Total for 6 residents: 56 Average: 2 Range: 0 – 21

** NB: Averages are presented in Tables, but must not be interpreted in isolation, due to the effects of extreme values (outliers) as indicated in the very large increases in some of the ranges.*

Findings from the Resident Records- Accommodation File

Lifestyle Plans

Table 2.6 summarises information obtained from reviewing the residents' Accommodation Files. The review indicated that there were several different formats utilised for documenting goals and lifestyle plans, depending on which program coordinator was acting in the role at the time plans were developed. Hence, some plans provided more detail than others.

Individual lifestyle planning meetings are held annually for all residents in the Northfield and Greenacres houses. The purpose of these meetings is to review and, if necessary, revise each resident's goals and lifestyle plans. All residents had lifestyle plans for the 6 months prior to the move. Six residents had a second lifestyle plan dated during the first 6 months after the move. In the two years after the move all residents had a lifestyle plan.

At the time of the Phase 3 evaluation, the Lifestyle Plans for residents in the Sturt house had not been updated since prior to the move into community living. The Accommodation Service Manager stated that the reason the Lifestyle Plans had not been updated was do to the fact that staff felt that they were not necessary, and that it is more important to frequently discuss the needs of residents at the staff meetings each fortnight. This was a surprising finding, given that Lifestyle Plans are meant to serve, in part, as a documented guide for monitoring service and supports, and establishing responsibility, accountability and consistency of service provision.

Except for resident participation, little difference was noted in who attended the lifestyle planning meetings at the 6 month period and the 2 year period. Records of planning meetings indicated that 95% of the residents attended their own planning meetings at the 2 year mark compared with 79% who were reported to have attended at the 6 month date. However, recording of resident participation was not always clearly presented (i.e., residents may have attended but their attendance was not noted) hence this finding should be interpreted with caution.

All those residents with lifestyle plans (i.e., residents in the Greenacres and Northfield houses) in Phase 3 had written goals. Most of the goal statements (70%) indicated a timeframe of when the goal should be achieved. The average timeframe in which to achieve a goal was 5 months and almost all goals (95%) were specific to the individual. Sixteen percent of plans had goals that were reported as having been achieved, and for another 16% it was unclear as to whether or not the goals had been achieved (i.e., either there was no documentation of the goal having been completed; or it had been done, but not recorded; or there had been no specific action documented to achieve the goals). Five percent of the plans indicated that the residents' goals had not been achieved.

Most of the goals in the individual lifestyle plans were focused on individual leisure activities (e.g., visiting the zoo, sailing, attending a food festival, attending church or a circus, visits to family, and holidays). Other goals were concerned with physical comfort, such as acquiring new shoes and weight control. None of the documented goals were focused on the development of adaptive behaviours or the reduction of challenging behaviours, nor did they address important lifestyle domains such as personal care, domestic activity or social interaction. Moreover, all of the goals were written in a passive voice with no reference to active engagement or participation from the residents. The goal plans also lacked descriptive information regarding the procedures that would be employed to operationalise the goals (i.e., training methods and/or the use of adaptive equipment) and limited indication of when and where training or activities would occur.

Table 2.6. **Lifestyle Plans**

	In Strathmont Villa (Period of 6 months prior to the move to the community)	In Community Houses (Approximately 2 years after the move to the community)
PLANNING PARTICIPANTS		
Number of paid participants at lifestyle planning meeting	Range: 3 - 6 Average: 4	Range: 2 - 5 Average: 4
Number of relatives at lifestyle planning meeting	Range: 0 - 4 Average: 1	Range: 0 - 3 Average: <1
Percentage of residents who had family members attend lifestyle planning meeting	68% (19 residents)	60% (12 residents)
Percentage of residents who attended lifestyle planning meeting	79% (22 residents) (18% - 5 residents not indicated)	95% (19 residents) (5% - 1 resident was not indicated/ unclear)
GOALS		
Percentage of residents with written goals in plan	86% (26 residents)	100%
Number of written goals in plan	0 Goals = 4 residents 1 Goal = 13 residents 2 Goals = 6 residents 3 Goals = 2 residents (3 records of goals were not found in the file when data were collected)	1 Goal = 1 resident 2 Goals = 7 residents 3 Goals = 8 residents 4 goals = 3 residents 5 goals = 1 resident
Percentage of plans with goals specific to resident	54% (15 residents)	95% (19 residents)
Percentage of goals with timeframes indicated	36% (10 residents)	70% (14 residents)
Percentage of plans with goals achieved	21% (6 residents) (61% - for 17 residents achieved goals were unclear or unknown)	16% (3 residents) (63% - 12 residents had some goals achieved and some not; 16% were unclear of unknown and 5% were not achieved)

* NB: Averages are presented in Tables, but must not be interpreted in isolation, due to extreme values (outliers). Refer to text below tables for further explanations.

Contact/ Visits

Contact and visits before and after the move to the community are shown in table 2.7. It can be seen that there were nearly three times as many visits of family members to residents in the period six months after the move to the community, compared to the equivalent period at Strathmont prior to the move. Moreover,

approximately two years after the move to the community, there were still nearly twice as many visits as had occurred during the last six months at Strathmont. There was little change, however, in the average number of visits that residents made to their family home.

Review of records indicated that there was no documentation of visits from neighbours or others to a resident's home at either the 6 month or 2 year period. The number of visits documented may in some instances be dependent on the extent to which staff record such visits (i.e., activity logs and observations by the investigators indicated that volunteers and other professionals periodically visit the homes).

Table 2.7. **Contact and Visits for Residents Who Had Family/ Next of Kin**

	In Strathmont Villa (Period of 6 months prior to the move to the community)	In Community Houses (Period of 6 months after the move to the community)	**In Community Houses (Approximately 2 years after the move to the community)**
Number of family visits to residents	Total for 10 residents: 33 Range: 0 – 7 Average: 1.2	Total for 19 residents: 89 Range: 0 - 17 Average: 3.3	Total for 17 residents: 59 Range: 0 - 8 Average: 2.8
Number of residents visits to family homes	Total for 8 residents: 45 Range: 0 – 12 Average: 2.1	Total for 9 residents: 51 Range: 0 – 13 Average: 2.3	Total for 8 residents: 36 Range: 0 – 9 Average: 3.3
Number of visits by neighbours to residents homes	0	0	0
Number of residents who had visits by other people	2	0	0

Activities

Table 2.8 shows the activities that residents were reported to have participated in six months prior to leaving Strathmont, in the six months after leaving Strathmont, and in the six months period approximately two years after leaving Strathmont. It was observed in the Phase 2 evaluation that while the frequency of some activities remained relatively stable, many decreased so that the average number of times residents participated in activities had decreased by half (27.3 to 13.9) after moving to the community. It was suggested that this decrease might, in part, be explained by the large gap in the occurrence of planned activities surrounding the move. Before the move, residents attended activities on average, once per week. After the move, the residents' activity participation level decreased half to approximately once per fortnight. Only four residents had increased their activities after the move, by an average of 3 activities per 6 months. The other 21 residents with activity records decreased their activities after the move to the community, by an average of 16 activities per 6 months.

It can be seen that approximately two years after the move to the community, the overall activity average had returned to approximately the same level as when the residents were at Strathmont (27.3 vs 26.5). Looking across the wide range of activities, it can be seen that most had stayed approximately the same as when the residents were at Strathmont, but some, such as swimming and activities listed as "individually

tailored": and "private" had increased. While activity levels have tended to stabilise over the two year period, it is unclear as to whether the residents are actively engaged or participating in the activities offered, and whether the scheduled activities enable and promote pro-social contact with non-disabled community members.

It is important to note that in Phase 3 (June – November 2009) the Sturt residents attended activities arranged by private organizations such as the Spastic Centres of South Australia (SCOSA). These activities typically involved residents going to a hall to take part in activities, going on outings, and using a "Sensory Room". Sturt records also indicated that some residents attended activities arranged by the Highgate Centre. These activities were of a similar natural to those offered by SCOSA (e.g., craft, going on community outings, attending Church Hall music groups). It was also noted that Sturt residents no longer took part in the 'Out and About' program, because it was not considered to be an important need for the residents, and it is not feasible to arrange and organise when there are not two permanent staff on duty.

Table 2.8. **Residents' Activities**

	In Strathmont Villa (Period of 6 months prior to the move to the community)	**In Community Houses (Period of 6 months after the move to the community)**	**In Community Houses (Approximately 2 years after moving to community)**
Swimming	Total for 12 residents: 64 Range: 0 - 13 Average: 2.7	Total for 14 residents: 65 Range: 0 - 7 Average: 2.6	Total for 14 residents: 112 Range: 0 - 21 Average: 4
Out and About	Total for 18 residents: 67 Range: 0 - 21 Average: 2.7	Total for 10 residents: 43 Range: 0 - 13 Average: 1.7	(NB: now replaced by "Touring Adelaide") Total for 17 residents: 52 Range: 0 - 13 Average: 1.9
Leisure and Pleasure	Total for 5 residents: 24 Range: 0 - 14 Average: 1	Total for 10 residents: 13 Range: 0 - 3 Average: 0.5	0
Walks	Total for 3 residents: 8 Range: 0 - 4 Average: 0.3	Total for 1 resident: 1 Range: 0 - 1 Average: 0.04	Total for 10 residents: 18 Range: 0 - 4 Average: 0.64
Massage	Total for 22 residents: 228 Range: 0 - 29 Average: 9.1	Total for 25 residents: 156 Range: 0 - 13 Average: 5.6	Total for 20 residents: 182 Range: 0 - 26 Average: 6.5
Games	Total for 2 residents: 6 Range: 0 - 3 Average: 0.2	Total for 4 residents: 9 Range: 0 - 4 Average: 0.3	Total for 2 residents: 2 Range: 0 - 1 Average: 0.07
Music	Total for 11 residents: 70 Range: 0 - 13 Average: 3	Total for 15 residents: 30 Range: 0 - 5 Average: 1	Total for 10 residents: 28 Range: 0 - 7 Average: 1
Disco	Total for 1 resident: 7 Range: 0 - 7 Average: 0.3	Total for 0 residents: 0 Range: 0 Average: 0	Total for 1 residents: 1 Range: 0 - 1 Average: 0.04

Cooking	Total for 2 residents: 25 Range: 0 - 14 Average: 1	Total for 1 resident: 2 Range: 0 - 2 Average: 0.08	Total for 2 residents: 23 Range: 0 - 15 Average: 0.82
Karaoke	Total for 0 residents: 0 Range: 0 Average: 0	Total for 3 residents: 3 Range: 0 - 1 Average: 0.1	Total for 17 residents: 29 Range: 0 - 3 Average: 1.04
Activities organised with private organisation (*Sturt Houses only* – 10 residents)	N/A	Total for 7 residents: 9 Range: 0 - 3 Average: 0.4	Total for 6 residents: 23 Range: 0 - 7 Average: 2.3
Other "Toppers" Related Activities	Total for 5 residents: 25 Range: 0 - 8 Average: 1	Total for 2 residents: 8 Range: 0 - 4 Average: 0.3	0
Individually tailored activities	Total for 6 residents: 55 Range: 0 - 31 Average: 2.2	Total for 8 residents: 22 Range: 0 - 8 Average: .0.9	Total for 27 residents: 149 Range: 0 -26 Average: 5.3
Private Activities	Total for 1 residents: 5 Range: 0 - 5 Average: 0.2	Total for 9 residents: 12 Range: 0 - 4 Average: 0.5	Total for 13 residents: 93 Range: 0 - 20 Average: 3.32
Craft	Total for 2 residents: 14 Range: 0 - 8 Average: 0.6	Total for 5 residents: 7 Range: 0 - 3 Average: 0.3	Total for 3 residents: 5 Range: 0 - 2 Average: 0.18
Shopping	Total for 2 residents: 3 Range: 0 - 1 Average: 0.1	Total for 1 resident: 1 Range: 0 - 3 Average: 0.04	Total for 7 residents: 23 Range: 0 - 10 Average: 0.82
Grooming	Total for 2 residents: 27 Range: 0 - 24 Average: 1.2	Total for 0 residents: 0 Range: 0 Average: 0	Total for 1 residents: 1 Range: 0 - 1 Average: 0.04
Relaxation	Total for 6 residents: 45 Range: 0 - 18 Average: 2	Total for 4 residents: 4 Range: 0 - 1 Average: 0.2	0
Total number of activities for 6 months per resident	Total for all residents who took part in activities: 673 Range: 10 - 72 Average: 27.3	Total for all residents who took part in activities: 385 Range: 3 - 28 Average: 13.9	Total for all residents who took part in activities: 741 Range: 0 - 66 Average: 26.5

NB: Averages are calculated according to the total numbers of residents in each phase (i.e. 30 in phase 1; and 28 in phases 2 and 3). This ensures inclusion of residents who had not participated in that particular activity at all.

Observation Data on Social Interactions and Activities

Table 2.9 shows the percentage of time residents spent engaged in constructive activities in their homes. Engagement in activities varied threefold (3 - 9%) and averaged 7% across the total observational period. Slightly higher levels of resident activity were observed in the Northfield houses (avg. 36%) compared to the Sturt houses (avg. 23%) and the Greenacres houses (avg. 21%). The two activities that occupied most of the residents' time were those of a self-help or personal nature (e.g., eating, drinking) (avg. 9%) and viewing television (avg. 9%). Participation in the running of their own homes as evidenced by engagement in domestic activities was virtually non-existent (3%). Staff were observed to conduct household maintenance tasks largely independent of resident involvement. No incidences of challenging behaviour were observed. The residents were observed to have spent the majority of their time (73%) (44 minutes of every hour) without being engaged in any constructive activities.

Table 2.9. **Activities (the highest percentages of activities are given in bold)**

House	Domestic	Personal	Leisure	Television	Challenging Behaviour	Other	None
Greenacres 15	0%	5%	0%	17%	0%	0%	**78%**
Greenacres 19	2%	4%	0%	16%	0%	0%	**79%**
Northfield 3	0%	14%	21%	6%	0%	0%	**60%**
Northfield 5	5%	18%	10%	0%	0%	0%	**67%**
Sturt 3	7%	8%	6%	13%	0%	0%	**67%**
Sturt 5	3%	5%	5%	0%	0%	0%	**87%**
Average	3%	9%	7%	9%	0%	0%	**73%**

Table 2.10 shows that residents spent most of their time (avg. 85%) (51 minutes of every hour) in the living area of their own home. The percentage of time that residents spent in the living area of their home was similar across the settings (e.g., Greenacres houses (avg. 88%), Northfield houses (avg. 87%), and Sturt houses (avg. 80%)). Seventy-eight percent of the residents' time in the living area was spent in a group situation with other residents (47 minutes of every hour).

Table 2.10. **Where residents spent their time (highest percentages are given in bold)**

House	Living Area	Resident's Room	Front Room	Backyard	Front Yard	Other
Greenacres 15	**77%**	0%	15%	5%	0%	3%
Greenacres 19	**99%**	0%	0%	0%	0%	1%
Northfield 3	**89%**	6%	5%	0%	0%	0%
Northfield 5	**85%**	0%	11%	0%	0%	3%
Sturt 3	**64%**	4%	19%	13%	0%	1%
Sturt 5	**96%**	0%	0%	4%	0%	0%
Average	**85%**	2%	8%	4%	0%	1%

Table 2.11 shows that residents received attention from staff for an average of 11% of the observed times (7 minutes of every hour). Slightly higher levels of staff contact with residents were observed at the Northfield houses (avg. 14%) compared to the Sturt houses (avg. 11%) and the Greenacres houses (avg. 8%). Eighty-nine percent of the residents' time in the houses passed (53 minutes of every hour) with no constructive interaction with the social world of their houses.

Table 2.11. **Who interacted with the residents (highest percentages are given in bold)**

House	House Staff	Family	Medical Staff	Volunteer	Other Resident	Other	No One
Greenacres 15	6%	0%	0%	0%	0%	0%	**94%**
Greenacres 19	10%	0%	0%	0%	0%	0%	**90%**
Northfield 3	13%	4%	0%	1%	0%	0%	**83%**
Northfield 5	14%	2%	0%	0%	0%	0%	**84%**
Sturt 3	12%	0%	0%	0%	0%	0%	**89%**
Sturt 5	9%	0%	0%	0%	0%	0%	**91%**
Average	11%	1%	0%	0.2%	0%	0%	**89%**

While residents were more likely to receive attention from staff than other individuals (e.g. other residents, volunteers) while they were in their homes (avg. 11%), Table 2.12 shows that only a small percentage of this attention was in the form of training and assistance (avg. 7 %) (4 minutes of every hour). Slightly higher levels of training and assistance were observed at the Northfield houses (avg. 10%) compared to the Sturt houses (avg. 6.5%) and the Greenacres houses (avg. 5.5%). Across all the houses, however, residents were barely encouraged or assisted to participate in constructive activities or to socialise with other individuals. Moreover, the use of accommodations or assistive devices (e.g., hand or head activated micro-switches, sandwich holders, utensil grips, communication boards, switch activated page-turners) which might be presumed to enable and/or encourage the residents to be more independent in their actions were not in evidence during the observational sessions. While it is encouraging that few negative comments were observed to have been directed at the residents (2%), it is less heartening to report that the residents similarly received few positive comments from staff (2%).

Table 2.12. **Type of interaction (highest percentages are given in bold)**

House	Positive	Negative	Training/Assistance	Neutral	No Interaction
Greenacres 15	0%	0%	5%	1%	**94%**
Greenacres 19	2%	1%	6%	2%	**90%**
Northfield 3	2%	1%	11%	3%	**83%**
Northfield 5	3%	0%	9%	4%	**84%**
Sturt 3	4%	0%	7%	0%	**89%**
Sturt 5	2%	0%	6%	1%	**92%**
Average	2%	0.3%	7%	2%	**89%**

SUMMARY

The overall pattern of resident results from staff interviews and review of resident files suggests that the move from Strathmont to the community has been associated with improvements in resident-family contact, the physical quality of the residents' living environment and their perceived emotional well-being and general life satisfaction. The findings also indicated that most staff viewed the resident mix within the houses (e.g. age, gender, ability) as appropriate in enabling them to more easily provide support to the residents under their charge.

A review of resident health files indicated that all of the residents had received an annual medical review and that six of the eight measures of resident health as recorded in the files had remained relatively stable since the residents had moved to the community. The two other measures, illnesses and behavioural issues, had reduced by 50% and 80% respectively over the 2 year period. Furthermore, most of the proxy respondents considered the residents to be in good or excellent health and most were of the opinion that the residents' health needs were being met in an appropriate and timely manner in the community. This is an important finding that suggests strongly that medical needs are being addressed and supports can be, and are being, provided to individuals with significant and complex needs to enable them to live in the community.

Staff expressed uncertainty as to whether there had been a change in the variety and frequency of activities since the move to the community. However, a review of resident activity logs indicated that approximately two years after the move to the community, the overall activity average was approximately at the same level and range as when the residents were at Strathmont. It is important to note that the majority of residents were involved in the same activities as previously offered at Strathmont, activities that were perceived by staff in Phases 1 and 2 to be unsuitable and unenjoyable. Moreover, the residents were purported to have little or no choice in selecting and participating in activities. While variation and frequency of activities offered has remained relatively stable, it is unclear as to whether the residents are actively engaged or participating in the activities offered. Furthermore, it is difficult to see how the scheduled activities enable and promote pro-social contact with non-disabled community members given that there was no evidence that the residents use public transport for community outings; that most of the activities had a "disability" focus; and that much of the residents time is spent within their own houses with little contact with neighbours or others from the outside world. Sadly, the majority of proxy respondents stated that none of the residents had a close friend who was not a staff member or family member. Only one resident was reported as spending time with people of a similar age who were not staff and who did not have a disability. These findings underscore the social isolation of the residents within their own communities.

Respondents were generally of the view that residents were provided with the same (relatively limited) opportunities to make decisions in the community as they were at Strathmont. Moreover, they all indicated that residents did not make independent decisions on five of seven daily living activities. Prior to the move, most of the respondents felt that the residents should be provided with more opportunities to be involved in decision making activities, however, after 2 years in the community less than a third of the respondents believed that the residents should be provided with more decision making opportunities that affect their lives. The proxy respondents also expressed a general feeling that there was not much else that could be put in place to improve the residents' satisfaction with their lives. It is not clear from the data whether these findings are associated with staff expectations regarding the capabilities of the residents or organisational and/or contextual factors that might influence resident involvement in the decision making processes.

Two years after the move to the community all residents had a lifestyle plan, although not all of the plans were updated since leaving Strathmont. Records of planning meetings indicated that almost all of the residents who had updated plans attended their own planning meetings at the 2 year mark. This attendance rate represents a 16% increase in resident attendance over an 18 month period.

Documented goals in the lifestyle plans had more of an individualised focus and were less generic than those documented prior to, and 6 months after, the move to the community. However, none of the goals were focused on the development of adaptive behaviours, nor did they address important lifestyle domains such as personal care, domestic activity or social interaction. Moreover, all of the goals were written in a passive voice with no reference to active engagement or participation from the residents. The goal plans also lacked descriptive information regarding the procedures that would be employed to assist the target resident to achieve the goals. There was also limited information regarding when and where training or activities would occur. If these plans are meant to serve, in part, as a road map for the residents' future, then issues regarding the development and review of individualised habilitative goal plans, and overall professional and systems accountability will need to be addressed.

Observations of the residents revealed that they engage in very few social interactions and have relatively little to do during their waking hours. Their involvement and participation in the running of their own homes as evidenced by engagement in domestic activities was virtually non-existent. It is as if the residents are living in a "hotel" where staff relieve the residents of all responsibility for household management. On average, 53 minutes of every hour passed without the residents being engaged in any constructive interaction with the social world around them. Across all the houses, residents were barely encouraged or assisted to participate in constructive activities or to socialise with other individuals. Moreover, the use of accommodations or assistive devices (e.g., hand or head activated micro-switches, sandwich holders, utensil grips, communication boards, switch activated page-turners) which might be presumed to enable and/or encourage the residents to be more independent in their actions were not in evidence in any of the houses during the observational sessions.

A typical day for the residents consisted mainly of sitting in a group situation in the living area of their house with little physical or social engagement in any constructive activities. Staff were observed to spend the majority of their time in household maintenance and administrative duties, providing passive supervision and limited support to, and conversation with, the residents under their care. This lack of engagement may reflect an attitudinal perspective on the part of staff who may view domestic duties as their primary responsibility and not as an opportunity to assist residents in developing their domestic, community and social interaction skills. In fact, informal discussions with staff during the evaluation indicated that they were neither aware of the need for, nor did they have the knowledge and skills necessary to assist the residents in being more actively engaged in their material and social world. If staff see their primary role as being focused on household maintenance tasks, and if they do not believe that the residents are capable of acquiring new skills and more independence they are unlikely to work towards fostering and encouraging this in the context of their relationships with the residents they serve.

The low level of participation in constructive activities and meaningful social interaction would seem to represent a lost opportunity given the improved environmental context of the community houses. Moreover, the lack of meaningful engagement may produce a sense of disconnection between the residents and their physical and social world, and confirm that the residents have little, if any, control over their lives. It is important to note, however, that in spite of the limited social experiences afforded to the residents, their basic care needs appeared to be well considered. Their houses were clean and well maintained, and clearly less stigmatising and restrictive than their former accommodation at Strathmont. Moreover, most staff members appeared to be caring and genuinely concerned with the welfare of the residents under their charge.

The residents may have new addresses, yet in many ways life in the community would appear to be relatively indistinguishable (on many of the measures used) from their lives at Strathmont. It will be important to continue to monitor services to determine if improvements have been made on these measures and if the gains acquired are being maintained. However, without systematic and consistent strategies by staff and management to promote resident interpersonal and lifestyle skills there may be little reason to expect improvements in residential adjustment and well-being.

RECOMMENDATIONS

The following recommendations are not meant to stand in isolation, but should be viewed as complementing and enhancing many of the recommendations that were offered for staff.

1. **Goals:** The organisation's commitment to facilitating active engagement in meaningful social, domestic, and community activities of the residents it serves is more likely to be effective if it publicly adopts goals to that effect. Such goals may assure managers, supervisors, direct care staff and the community at large that the organization recognises that engagement in these activities is an important aspect of an improved lifestyle for the people it serves. Moreover, if staff are given the opportunity to engage in participatory decision-making processes regarding goals, they may be more likely to develop ownership for the decisions and promote the agreed upon outcomes than if decisions are imposed upon them. Clearly stated goals and performance feedback referenced to goals and job descriptions may also further encourage staff, supervisors and management to direct more of their attention toward these activities.

2. **Lifestyle Plans:** Individual Lifestyle Plans should specify the areas of need that may enhance a resident's well-being and lifestyle. At a minimum, each plan should ideally include at least one goal in each of the following areas: domestic living, community participation, recreation, and communication/social interaction. Each resident's plan should be current and based on a systematic evaluation of the abilities, preferences and needs of the individual (e.g., health, medical services, assistive devices, material needs), including prescriptive steps toward the attainment of increasingly independent levels of functioning. Staff meetings could also be used to identify weekly or fortnightly goals (that are not included in the Life Style Plans) that might directly or indirectly, result in improved social and activity experiences for the residents (e.g., lunch with a neighbour, setting the table, attending a local community event, host a dinner party). Individual staff members might also be encouraged to monitor specific goals or objectives for target residents and report on their progress at staff meetings. The vision of achievable goals that the Life Style team members have helped to identify and develop, should add significant impetus to their everyday efforts in supporting the residents they serve.

3. **Domestic Activities:** Given the significant and complex nature of the residents' disabilities, the findings suggest that the extent of direct staff assistance (i.e., nature and extent of staff-resident interaction) was an important factor in determining the extent of resident engagement in domestic activities. For example, all of the household maintenance tasks were accomplished by staff, leaving virtually no opportunity for residents to be engaged in these activities. There was also no evidence that residents were encouraged to participate in domestic activities within their own homes. Not wanting to stray too far from the data, it is not unreasonable to suggest that most members of staff do not believe that the residents are capable of acquiring new skills and thus do not work toward fostering and encouraging participation in household management activities. Efforts need to be taken to assist the residents to make more use of their new domestic

environments, and move beyond custodial care to a more constructive and enabling approach which emphasises resident participation – an approach that views the provision of support as being vital in assisting residents who may experience skill deficits that are presumed necessary to participate in, and accomplish, activities successfully. This approach also involves organising opportunities for residents to participate in activities and establishing and supporting a level of staff and organisational commitment, staff competence and managerial monitoring to ensure that residents do have regular opportunities to engage in meaningful activities. For example, household maintenance tasks (e.g., cooking, shopping, laundry, gardening, cleaning up) could be formalised as individual goals and integrated into everyday routines. Staff could also take advantage of informal/natural learning opportunities as they arise during the course of daily activities (e.g., unpacking groceries, cleaning up accidental spills, unloading the dishwasher) to involve residents. Attention to planning regular and meaningful activities for the residents, and the encouragement, training and support of staff to effectively assist the residents to more actively participate in a full range of everyday activities must become the hallmark of community placement for the residents.

4. **Social Relationships:** Friendships are increasingly becoming recognised as a very important dimension of quality, and one that has often been under emphasised or even ignored by many traditional human service systems. Hence, the findings that none of the residents had a close friend who was not a staff member or family member, and that only one resident spent time with people of a similar age were was not staff and who did not have a disability should be interpreted as important ones. These findings underscore the social isolation of the residents within their own homes and communities. It is suggested that friendships, relationships, and community connections be considered as dimensions for close, on-going monitoring by families, staff, and management. It is further suggested that the nature and depth of resident relationships is an area in need of urgent concern and further investigation.

   The social lives of the residents are usually experienced within the context of the day-to-day activities they engage in. Hence, the activity patterns of the residents should be reviewed to determine if they offer opportunities for social interaction with a range of people (e.g., people with disabilities, non-disabled individuals, paid and non-paid service providers). Various strategies are available for facilitating and maintaining the social relationships of the residents. Many of these strategies complement and intersect with those previously suggested for enhancing community relationships (see staff recommendations) (e.g., joining local clubs and community organizations, "matching" residents with local community members to share similar interests, assisting neighbours with chores, teaching the residents to perform activities, or parts of activities that may enhance their social lives, including "social" goals within each residents' Lifestyle Plan, scheduling regular "in-house" social events for members of the community). Again, the effectiveness and appropriateness of any particular strategy is dependent on a range of factors (e.g., community location, staff competencies and motivation, local resources, managerial orientation, organizational expectations).

5. **Monitoring Performance:** An important issue for staff, management, and policy makers to consider is the apparent lack of any transparent and effective process to measure and monitor performance and achievement of resident goals. We could find no evidence of a systematic mechanism for the implementation and ongoing assessment of practices and procedures that are consistent with the espoused organizational goals of assisting residents to enhance their skills, social relationships, community participation and personal sovereignty. Moreover, there was no system in evidence whereby these outcomes are measured and reported in a systematic manner to senior management. We believe this is a serious shortcoming and, until it is resolved, there can be little confidence that genuine, positive outcomes for the residents will become a reality. What we have found to date is that there is evidence of some good practices occurring and there is evidence

of some less than adequate practices occurring. Our findings also suggest that there may be limited opportunity for staff, management, and policy makers to have any confidence that improvements, or otherwise, are occurring through a system that establishes goals, yet seemingly lacks a mechanism for actualising and systematically monitoring those goals and publicly reporting on their achievement. It is our view that this is a serious omission, and one that may seriously impede the attainment of enriched quality of life outcomes for the residents being served. It is suggested that the Department should establish a rigorous monitoring and reporting framework for resident outcomes. The United Nations Convention on the Rights of Persons with a Disability would be the most appropriate starting point for developing such a framework (e.g., Rule 13, Standard Rules on the Equalisation of Opportunities for Persons with Disabilities).

Part 2: Family

Aim

Families have been actively involved in the deinstitutionalisation process in many different ways. Families, often with the support and assistance of professionals, provided a large part of the early momentum for deinstitutionalization. However, they have also expressed strong opposition and emotional reactions to the closure of institutions and the concomitant transfer of their sons/daughters to smaller community settings. Finding a caring, respectful, and permanent place for a relative to live is one of the major concerns and challenges many families face. Not surprisingly then, family responses to the prospect of deinstitutionalisation vary considerably, depending on the extent to which they perceive these factors to be available for their son or daughter in either an institutional or community-based living arrangement. Many families have resisted the deinstitutionalisation movement on the basis of negative perceptions of the effects of community living on their relative with a disability. Many families also believe that their relative needs 24-hour supervision and medical care, and question whether this could be provided adequately in a community setting.

Interestingly, an extant literature has documented that most families change their views dramatically after their son or daughter has moved to a community setting, with very few reporting negative feelings about placement outcomes for their relative. After the move, the majority of families express overwhelming surprise and delight with the quality of services provided. They report that their relative had made noticeable and relevant gains in adaptive behaviour, they were pleased with the staff, and they perceived an increase in their relative' s happiness. [1]

Given that family presence, participation and interest in their relative's life can be an important safeguard for security and service quality, it is important that policy makers recognise that planning for such involvement can be an important element in success.

Family members who participated in Phase 1 and/or Phase 2 of the project were surveyed to assess their perceptions regarding the move to the community. Specifically, the survey sought family views regarding the planning process for the move to the community and the subsequent impact of the move on their relatives and themselves.

1. [e.g., Spreat, S. & Conway, J (2002). The impact of deinstitutionalization on family contact. *Research in Developmental Disabilities, 23, 202-210* and Ford, J. & Barlow, J. (1994). The Ru Rua family impact survey. *Australia and New Zealand Journal of Developmental disabilities, 19, 121-138*]

Method

Residents' families were sent a letter explaining the purpose and objectives of Phase 3 of the project. Two weeks later, families were sent a letter of invitation to participate in Phase 3 of the project and a 21-item questionnaire to complete and return to the research team in a reply paid envelope. The questionnaire contained questions about the family's involvement in the community house; their relative's satisfaction with his/her life; the family's satisfaction with: the community house and its programs, the staff at the community house, and their overall perceptions of the community houses. Family members were also given the contact details of the research team so that they could request assistance with completion of the questionnaires if needed, or alternatively to complete a phone or face-to-face interview if this was the preferred option.

Results

Eighteen of the 20 families who participated in Phases 1 and/ or 2 were again invited to participate. Two of the families who had participated in previous surveys were not contacted as their relatives had died. Thirteen family members (72%) returned their completed questionnaires. The mean age of the respondents was 75 years (Range: 60 to 88 years). Nine respondents were mothers; two were fathers; and two were brothers of the residents.

FAMILY'S INVOLVEMENT IN THE COMMUNITY HOUSE

Family members were asked to indicate the nature and frequency of contacts with, or concerning, their relative. In table 3.1 it can be seen that most families (12 of the 13) reported that they visited their relative at least once a year, with four indicating that they visited each week and five indicating a visit each month. The next most common forms of contact were by phone or program planning visits to the houses, with nine respondents indicating that they phoned their relative on a weekly or monthly basis and nine reporting that they were involved in program planning/life style meetings on at least a yearly basis. Few other forms of contact were reported. Aging, illness and living interstate or overseas were reported to be the major impediments to visiting relatives more frequently.

Table 3.1. **Number of family contacts during the past year**

	Daily	**Weekly**	**Monthly**	**3 Monthly**	**6 Monthly**	**Yearly**	**Rarely or Never**
Telephone calls	0	3	6	0	0	0	4
Mail	0	1	0	1	1	1	9
Visited the house	0	4	5	2	0	1	1
Took for an outing or to our home	0	2	1	2	1	1	6
Program planning/ Lifestyle meetings	0	0	1	0	5	3	4
Consultation / consent for medical care	0	0	1	0	3	0	9
Other forms of contact	0	0	1	0	0	0	12

SATISFACTION WITH COMMUNITY HOUSE AND ITS PROGRAMS

Table 3.2 shows that families were generally positive in their responses to the community houses and the programs offered. Most respondents indicated that they were either satisfied or very satisfied with the setting and location of the house, the activity programs, the medical services, and their involvement in setting goals and making major decisions regarding their relative's life. It is noteworthy that while there were eight responses indicating satisfaction with the extent to which their relative is encouraged to make decisions about their life, there were five that indicated they were undecided or that the question was not applicable. This later result may reflect a lack of knowledge on the part of the family member about their relative's involvement in any decision-making activities concerning their life or a view that their relative is not capable of making such decisions.

Table 3.2. **Satisfaction with the community house and its programs (highest numbers are given in bold)**

How satisfied are you with...	Very dissatisfied	Dissatisfied	Partly dissatisfied	Partly satisfied	Satisfied	Very satisfied	Undecided or N/A
Setting and location of the community house	0	0	0	0	4	**9**	0
Activity programs	1	0	0	3	**5**	3	1
Medical services	1	1	0	1	**6**	4	0
The extent your family member is encouraged to make decisions in his/ her life	0	0	0	1	**5**	2	**5**
Your involvement in setting goals for your relative	0	0	0	1	**8**	4	0
Your involvement in making major decisions about your family member's life	0	0	0	2	**6**	5	0

Five items asked respondents to give a "Yes", "No", or "Unsure" response to questions regarding their satisfaction with the community houses and the programs offered. The results are shown in Table 3.3. Most respondents indicated that the support services met their expectations and that they had been adequately informed about programs and services provided in the houses. In each case, only two of the 13 participants said no. However, responses were divided almost equally between those who felt that their family member was happy with their daily program/activities and those who were unsure. A similar division existed between those who thought their family member was happier living in the community house than at Strathmont and those who were unsure. It is noteworthy that nearly all respondents indicated support for moving residents to the community houses, with only one saying they would not support it, and one who was unsure.

Table 3.3. **Family satisfaction with the community house and its programs (highest numbers are given in bold)**

	Yes	No	Unsure
Support/services/activities meet your expectations?	**9**	2	2
Been adequately informed about programs and services provided in the community house?	**10**	2	1
Family member (resident) happy with their daily program/ activities?	**7**	0	6
Family member (resident) happier living in the community house than Strathmont?	**7**	1	5
Do you support the move of residents like your family member to community houses?	**11**	1	1

Family members were invited to comment on any issues regarding their satisfaction with the community houses. Most comments focused on the need for more activities (e.g. *"I was not informed of cut in physio… Should be receiving physio daily- not 3 times per week… it's crucial to my son's wellbeing", "Have always felt [resident] should be doing more physical exercise and especially water activities which she enjoys", "She would like to be taken for more walks, spend more time outside") and* the care, friendliness and dedication of staff (e.g. *"Overall I am delighted with the standard of care and the personnel", "The staff members and I have a very good rapport and so the support is well balanced", I believe that staff are caring, loving, friendly, and dedicated").*

Four respondents commented on how well treated and happy the residents were; both at Strathmont and in the community houses. Other respondents commented on the varied experiences of residents in transition from Strathmont to the community (e.g. *"before she moved from Strathmont, she was very withdrawn and quiet. Since then, she has blossomed into the happy cheerful person she used to be", "Have had many problems- at first complained a lot and didn't settle in well. Since May this year his health has deteriorated- is slowly starting to improve", "at Strathmont, more people [e.g. staff, cleaners, therapists, managerial staff etc.] came and went in the villa and [resident] loved that stimulation. The community house environment is much quieter but very loving nonetheless", "[resident] is happier because the environment is better than Strathmont – more room to walk around, better planned, and more personnel to attend to individual needs").*

SATISFACTION WITH STAFF AT THE COMMUNITY HOUSE

Table 3.4 shows that nearly all family members reported that they were either satisfied or very satisfied with their relative's case coordinator, the frequency with which staff contacted them, and the responsible and competent way in which staff interacted with their family member.

While the responses regarding staff were overwhelmingly positive, there were also some individual concerns expressed (e.g., *"Would like more of the staff on a permanent basis", "…because of staffing levels sometimes it is difficult to carry everything out", "Full time staff are caring and do good work but I*

can see the problems they are having with casual and inexperienced staff especially those whose English is limited").

Table 3.4. **Family satisfaction with staff (highest numbers are given in bold)**

How satisfied are you with...	Very dissatisfied	Dissatisfied	Partly dissatisfied	Partly satisfied	Satisfied	Very satisfied	Undecided or N/A
How often staff have consulted you about your family member's situation	0	0	1	0	**8**	4	0
Your family member's case coordinator	0	1	0	0	**6**	5	1
How responsible and competent staff are in their interactions with your family member	0	1	0	1	**6**	5	0

THE RESIDENT'S SATISFACTION WITH THEIR LIFE

As can be seen in Table 3.5 most family respondents (10 of 13) were of the opinion that their relative was generally satisfied with their life. While three of the 13 respondents were undecided or considered the question not applicable, none of the respondents rated their relative as being dissatisfied.

Table 3.5. **Family rating of family member life satisfaction (highest number is given in bold)**

How would you rate your family member's current satisfaction with their life?	Very dissatisfied	Dissatisfied	Partly dissatisfied	Partly satisfied	Satisfied	Very satisfied	Undecided or N/A
	0	0	0	2	**5**	3	3

When asked about what they thought contributed most to their family member's satisfaction, the most common response offered was staff interaction/attention directed toward the relative (e.g. *"Stimulation is a very necessary 'ingredient' for [resident] and in general [resident] and staff have lots of fun", ". . .he is content to be talked to or touched by staff").* Some respondents indicated that the severity of their relative's disability made it difficult to know for sure what contributed most to their presumed satisfaction (e.g. *"It is hard to know as he cannot express his views at all. But generally speaking, I believe he is content").* There was a range of other responses made by a few respondents indicating that they believed that the home-like environment, family involvement, and outings and routine were all factors contributing to their relative's presumed satisfaction.

Family members were asked what they thought would help improve their relative's level of satisfaction. A range of options was mentioned by individual respondents including: more activities, more family involvement (although it was recognised that this is not always possible) and increased volunteer involvement (eg *"I feel there is a sense of isolation, more interaction with other people may be able to change this", "More volunteer involvement would help if it was not a hindrance to their role in the house and the responsibilities they undergo each day").*

BENEFITS OF MOVING TO THE COMMUNITY

Most respondents (7 of 13) stated that the greatest benefit of community living for their relative was the better environment – having their own bedroom; home cooked meals; a more peaceful atmosphere (e.g. *"facilities are clean and comfortable and to good community standards", "Visiting a home not an institution").* Three comments were made about the homes being closer to family, thus enabling more family visits. There were also a number of individual comments made about staff being considerate and caring and taking the time to know the residents' likes and dislikes, and that the residents were better looked after and happier in the community setting than they were at Strathmont.

NEGATIVES OF MOVING TO THE COMMUNITY

Family respondents did not collectively identify any particular negative aspects of community living. Instead, a number of different aspects of individual concern were identified, such as: staff turnover, not being able to understand the non-English speaking staff members on the phone, lack of family to family interaction, and less activities for the residents and interaction with other people - hence less stimulation. There was also a comment made about the regular doctor not turning up sometimes, when called.

Overall, most respondents (9 of 13) said they preferred the community house to a large centre like Strathmont, none said they preferred a large centre, but four were undecided. An example of a comment showing how one respondent had changed their mind in favour of the community house was: *"I was not in favour of [resident] moving as I thought she wouldn't get the same care and attention but I was proven wrong in a very big way".*

SUMMARY

Most of the families who participated in Phase 1 of the project again participated in Phases 2 and 3. The reason for the high response rate was, in part, attributed to the research team individually telephoning family members to encourage their participation, and the concerted efforts of management and staff to provide families with relevant, personalised and consistent information regarding their relatives and the move to the community.

Results from the surveys, including participants' qualitative comments, indicated a generally positive attitude toward community living with nearly all families reporting that they were satisfied with their relative's current living situation and the quality of services provided. Families also reported that they were adequately informed of the programs and services being offered; that the support services met their expectations; and that their relative was being treated well by staff that they believed were dedicated,

friendly and caring. It is important to note that these positive feelings included those of some respondents who had felt uncertain prior to the move and/or who were initially not convinced that residents were better off in the community houses.

Although the general tone of the responses suggest that the family respondents are generally satisfied and accepting of the move to the community, a number of justifiable concerns were expressed (e.g., reduced physiotherapy; staff turnover; communication difficulties with non-English speaking staff members; lack of meaningful activities and less stimulation for residents via interaction with other people; and fewer

opportunities for families to interact with other families like they did at Strathmont). These concerns highlight important areas that deserve systematic attention by policy makers and service providers.

RECOMMENDATIONS

1. **Contacting families**: Consider phoning families rather than sending written information regarding an initial announcement of relocation of relatives to community houses. A number of families indicated that they felt confused and stressed when they first received a letter about their relative's pending move to community accommodation. It was only once they had talked to a staff member that they felt less anxious about the move.

2. **Providing information**: Continue to provide general information to the families about the project (e.g., goals, rationale, process, schedules**)** and specific information on how the project might impact upon a family's relative (e.g., settling in issues, house mates, daily activities, staffing, health, medical services, community participation). Provide regular and personalised updates to families on progress toward goals, daily programs, and community activities. Ensure that information is provided to families in both written and verbal formats to ensure that it is conveyed in a format that is most appropriate and relevant to family needs.

3. **Family visits to houses:** Invite families to visit both new and established homes and to talk with, and observe, staff and residents as early as possible in the process. These visits might help to alleviate some of the initial anxiety that some families might experience. Give families a reason to want to continue visiting the houses (e.g., specially sponsored activities and/or opportunities for families to participate in ongoing activities, assistance with transport if necessary).

4. **Contacts between families:** Establish a phone/address line for families so that they may contact other families if they wish.

5. **Monitoring family satisfaction:** Systematically assess family satisfaction with service provision in the community houses on a regular basis. This should include phone or personal interviews with family members and records of family visits to the community houses and time spent by residents in their family home and with family members in the community.

Part 3: Staff

Aim

Increasing attention is being directed to the roles, responsibilities, and working conditions of direct services staff in residential settings for persons with significant disabilities. This attention serves, in part, to acknowledge the growing realisation that services can not be considered effective if they do not pay attention to the needs of the support providers at least as efficiently as they do to the needs of the people receiving the support. In residential services, the values and goals for each program, the needs and characteristics of the residents, and the qualities and characteristics of staff are all inextricably interrelated. Hence, the experiences, behaviours and attitudes of staff members may be viewed as crucial determinants of the social ecology of residential environments and the quality of life of the residents being served.

Engagement in meaningful activities or passivity, inactivity and isolation in community residential settings for people with significant disabilities strongly reflects policy directives and support, and the expectations

and performance of staff. Staff mediate access and use of the opportunities presented in the home and community settings through the manner in which they provide assistance and encouragement to the residents they serve. They make it more or less likely that residents will experience the benefits and challenges intrinsic to an activity by the level of assistance, feedback and reinforcement they provide.

Direct services staff in residential settings are expected to provide training, supervision, opportunities for social inclusion, and direct care and support to the residents under their charge. They are also frequently asked to serve in the role of counselor, advocate, friend, cleaner, cook, and chauffeur. Despite these critical and often demanding roles and responsibilities, the majority of staff in community residences are para-professionals and are often the least educated, trained, or experienced in providing habilitative and support services to individuals they serve.

It would seem apparent that meeting the support needs of residential staff can influence the quality of services provided to residents as well as assist in the retention of qualified, motivated, productive and satisfied staff. Few would deny that providing quality services in community settings is a labour intensive process requiring staff who are competent, highly motivated, and satisfied with critical aspects of their jobs.

Regular direct services staff from each of the six community houses (i.e., two adjoining houses at Northfield, Greenacres, and Sturt) were interviewed to assess their perceptions regarding the move to the community. Specifically the survey sought information from staff regarding: job-related training; job-related information; involvement in decision-making; their job in the community houses; benefits of living and working in the community houses; and overall comments on the community living project.

Method

Participants

Staff members who were employed on a permanent basis (including shift supervisors) and had worked at the community houses for at least three months were interviewed. Individuals who were rostered on a casual basis or who were on leave were not invited to participate in the survey. Thirty-six staff (including six shift supervisors) were identified and interviewed. There were no marked differences found between permanent staff and shift supervisors' responses and accordingly their responses are combined in the analyses. The respondents were predominately female (81%) and middle aged (mean age: 45 years). Most were employed on a full-time basis (94%). The average length of time that respondents had worked in the community houses was 26 months (range: 4 – 36 months). Twenty-eight of the respondents (78%) had previously worked at Strathmont for an average of 12 years (Range: 1 – 34 years).

Procedure

Semi-structured interviews were conducted with all regular staff to determine their perceptions on working in the community houses. Interviews were conducted by a member of the research team at each of the houses between 22nd September 2009 and 26th January 2010. Interview questions were developed by the research team and underwent an external review by the management team at Strathmont. These team members were asked to suggest structural changes, and additions and deletions to the questionnaire. The final questionnaire reflected changes recommended by the management team. Interviews took approximately 45-60 minutes to complete. Management and/ or shift supervisors distributed questionnaires and reply paid envelopes to night staff.

Results

The following account of the results includes percentages of those who answered yes or no to the questions. While staff could indicate that they were unsure about their answers, relatively few indicated this and accordingly these responses are not commented on in this part of the report. This means that percentages of yes and no responses do not always add up to 100. The numbers of staff making particular comments in relation to each question are indicted in brackets following the description of the comment.

It should be noted that even though this was the third and final evaluation of the project, it was clear in interviews that some participants were not informed about the nature of the project. This resulted in some participants indicating that they were reluctant to say what they thought because they were not sure where the information would go, despite assurances from the interviewer of anonymity.

JOB-RELATED TRAINING

Most of the staff respondents (67%) indicated that they had received induction training before they started work in the community houses, while 28% said they had not received such training, and 5% were unsure. Just over half of the staff who had received induction training (58%) agreed that the training had provided them with the knowledge and skills they needed to work in the community houses. However, a significant minority (29%) indicated that the training had not adequately prepared them to work in the community, and 13% reported that they were unsure.

A number of suggestions were offered on how the induction training could be improved. Many respondents suggested that the training should be more "practical" and "hands on". The focus of many of these suggestions was on household maintenance and cooking duties (e.g., cleaning, housework and cooking training for new staff – especially those staff who did not speak English). A few respondents reported that they already knew how to cook and that the training they had received was not relevant to their needs. Training via a buddy system for new staff was also a suggestion made by four respondents (*"Need to have a buddy system when we start", "New staff need to be shown the right way, otherwise they will go on the wrong track").* Other suggestions for improving the induction training included a more intense focus on manual handling and communication training so that new staff can better communicate with residents.

Two thirds of the respondents (67%) indicated that they had received training after they started work in the community houses, with a considerable minority (31%) indicating that they had not received such training. Of those who had received training, most (79%) reported that it provided them with the knowledge and skills needed when working in the houses. Twenty-one percent of the respondents, however, indicated that the training had not provided them with the skills and knowledge necessary to work in the houses.

The types of training that staff had received after they started work in the community houses included: first aid, fire training, medication, food safety, meal preparation, peg feeding, manual handling, active support and OH&S.

A number of suggestions were offered for improving the training after starting work in the houses. It was again suggested that training experiences should be "practical" and "hands on", and utilise a buddy system. Other suggestions included more training in active support, manual handling, and more direct training of support staff by professionals instead of by shift supervisors. Individual suggestions included evaluating staff skills when they start in the houses, some optional training for experienced staff in time management and bookwork/reporting (e.g. how to write case notes), dealing with emergencies (such as seizures) and conflict resolution when working with other staff.

JOB SATISFACTION

Table 1.1 shows the relative levels of satisfaction of staff with aspects of their work, including information about their job, information about residents, and the quality of their working relationships. In general, most respondents indicated that they were satisfied or very satisfied with these three broad areas of their work. Adding percentages for satisfied or very satisfied responses shows that between 53 and 84% of staff were either satisfied or very satisfied with their jobs. While the percentages of those who were partly satisfied ranged from 11 to 25%, the percentages of those who were either dissatisfied or very dissatisfied were all less than 9%. Areas that offered the greatest satisfaction to staff related to information they received about the residents (e.g., medical and physical needs, day programs, family visits) (84%) and their relationships with families (77%) and residents (75%). Areas that staff were most dissatisfied with involved staff- management relationships (22%) and staff-staff relationships (20%).

Table 1.1. **Staff Satisfaction (highest percentages for each aspect of work are shown in bold)**

How satisfied are you with...	Very dissatisfied	Dissatisfied	Partly dissatisfied	Partly satisfied	Satisfied	Very satisfied	Undecided or N/A
Information about your job (e.g. roles & responsibilities)	0	3 (8%)	4 (11%)	6 (17%)	**11 (31%)**	**11 (31%)**	1 (3%)
Information about residents (e.g. medical needs, day programs)	0	1 (3%)	1 (3%)	4 (11%)	**19 (53%)**	11 (31%)	0
Quality of the work relationships between:							
• Staff and Staff	2 (6%)	1 (3%)	4 (11%)	7 (19%)	**15 (42%)**	5 (14%)	2 (6%)
• Staff and Management	0	3 (8%)	5 (14%)	9 (25%)	**13 (36%)**	6 (17%)	0
• Staff and Resident Families	1 (3%)	0	0	5 (14%)	**16 (44%)**	12 (33%)	2 (6%)
• Staff and Residents	0	1 (3%)	1 (3%)	7 (19%)	10 (28%)	**17 (47%)**	0
• Staff and Volunteers	0	2 (6%)	1 (3%)	5 (14%)	**14 (39%)**	6 (17%)	8 (22%)

Staff made a number of comments about each of the three broad aspects of job satisfaction.

Information

No comments were offered regarding resident-related information. However, comments directed at job related information, were generally balanced between those providing a positive view regarding the adequacy and availability of the information received and those offering suggestions on how the provision of job-related information could be improved. Many respondents expressed frustration and confusion about role information and information overload (*e.g., "It [the information] gets overwhelming at times", "It's confusing because different staff tell you different things", " Everyone does their job their own way, even supervisors"*. Other relevant comments included: *"No one is trained how to use their paper work", "You learn through mentors and depending on mentors things can go wrong", "Too much unnecessary paper work... For example, we write the same thing in 3 different places - it could be simplified.", "I liked the 'flick card' system at Strathmont with basic details and summaries of residents").*

Work Relationships

The majority of comments regarding the relationships between staff indicated a sense of frustration and disappointment. Respondents commented on the perceived lack of teamwork and often referred to other staff as being "bitchy" or "not good" (e.g., *"We have communication training with residents, but need communication training amongst staff - in a beneficial and positive way", "Many staff think their way is the right way", "We have lots of conflict and dysfunction - impacts on quality of staff engagement while at work").*

The comments related to relationships between staff and management frequently mentioned the professionalism, easy communication, and sense of teamwork that existed between the two groups. However, respondents also indicated that they would like management to acknowledge their efforts and provide them with more consistent feedback and encouragement (e.g., *"Some management come in, make suggestions, and walk out. It puts staff off", "It would be good if they give staff more credit for what they know", "We see the shift supervisor daily but rarely see manager", "They should make a bigger effort to make contact").*

With respect to relationships between staff and family, most comments indicated that the respondents did not have much communication with family members, but that they were satisfied with those they had met. Some comments suggested that the respondents felt that the houses provided a better environment for family members (e.g. *"This system is very good for those transitioning to new housing; family didn't feel comfortable to go visit at Strathmont - it's more natural here [in the community houses]", "We have an environment to interact with clients naturally (Strathmont was not like that) - it was us and them").*

Comments concerning relationships between staff and residents were generally positive in terms of staff indicating that they know the residents' needs and look after them (e.g. *"Lots of laughter", "They [residents] relate to staff and are relaxed with staff"*). However, there were also a number of comments made about some staff having poor attitudes and poor relationships with residents (e.g. *"Some staff talk over residents and others don't talk to them").*

Most comments about relationships between staff and volunteers indicated that volunteers were not present in the respondents' houses or that they do not interact with them. Those who did comment on the volunteers said that they were "OK" and/or "helpful" and that some volunteers were good and some not so good, with those not so good being rude and domineering (e.g. *"It's hit and miss with volunteers. They are there for activities but the Volunteer Centre is often short of volunteers", "Some just do it their way"*, "*Asked* [volunteers] *not to feed a particular resident junk food when they are out because she* [the resident] *is putting on weight but they just ignore staff "*).

INVOLVEMENT IN DECISION-MAKING

Table 1.2 shows that most staff reported being satisfied or very satisfied with their involvement in decision-making. Combining these two response categories shows that staff reported the greatest satisfaction (72%) with their involvement in the planning process for daily routines. Just over half of the respondents reported being satisfied or very satisfied with their involvement in decisions regarding the residents' goals / objectives (59%) and the feedback they received from managers (56%). Less than 9% reported being dissatisfied or very dissatisfied with their involvement in decision-making.

Table 1.2. **Staff satisfaction with involvement in decision making (highest percentages for each activity are shown in bold)**

How satisfied are you with...	Very dissatisfied	Dissatisfied	Partly dissatisfied	Partly satisfied	Satisfied	Very satisfied	Undecided or N/A
Involvement in planning process for daily routines	0	1 (3%)	5 (14%)	2 (6%)	**17 (47%)**	9 (25%)	2 (6%)
Involvement in residents' goals/ objectives	1 (3%)	2 (6%)	2 (6%)	5 (14%)	10 (28%)	**11 (31%)**	5 (14%)
Answers/ feedback from supervisor/ manager, after making a decision, suggestions, query	0	3 (8%)	2 (6%)	9 (25%)	**15 (42%)**	5 (14%)	2 (6%)

Comments about involvement in decisions regarding the planning process for daily routines were generally very positive (e.g. *"Choice on where to go on activities", " No one looking over shoulder all the time", "We've set the tasks we want to do - we're given guidelines to begin with and can make it work how we want too - manager allows that freedom"*).

Respondents also commented positively on their involvement in decisions concerning the residents' goals and life-style plans (e.g. *"These things [goal setting] are set at lifestyle meeting - we all are involved", "All staff get a say - all listened too")* and the fact that they were encouraged to contribute (e.g., *"Staff have a pretty big impact- they make the decisions and are often encouraged to do so").*

However, there were some comments indicating a desire for more involvement in the decision-making process (e.g., *"Would like to be more involved", " Since I have been here more & more work has been put on staff with no consultation", " Often schedule things in lunch break", "Would like to do more - take them* [the residents] *out more often, but the Program Coordinator organises these", "Whichever section is on at the time [of planning] gets to go to the meeting and have their say. Other sections need to have more input")*

Comments regarding feedback from supervisors/managers suggested that the feedback respondents received was valued and supportive (via phone, verbal, and/or written means). However, some comments were more equivocal (e.g. *"There can be clashes and it can all be a bit muddled", "Shift Supervisor loses a sense of reality, because staff are hands - on and Shift Supervisors are not, but they are supportive when staff would like to do something").*

JOBS IN THE COMMUNITY HOUSES

Supervision Model

Respondents expressed moderate support (58%) for the supervision model (i.e. floating shift supervisor) operating in the community living houses, with a further 25% feeling partly supported. Only 8% said that they did not feel supported and 8% were undecided.

The availability of the Shift Supervisor was an aspect of the supervision model that was viewed favourably by many of the respondents (e.g. *"There is always someone available", "Shift Supervisors are here to*

support staff but let staff do their job", "Shift Supervisors now have 'non contact' hours… where they are in house, but doing paperwork and have a staff member to cover them. This works well").

A number of staff, however, said they would like to have the Shift Supervisors in the houses permanently (e.g. *"The biggest mistake they ever made was to take the supervisor off site - that's the only negative thing", "Some staff bickering wouldn't happen if a supervisor was here", "Things would be done properly if constant supervision was in place - this is frustrating and getting worse").*

When asked if the supervision model had assisted in resolving any staff isolation issues, most of the respondents (67%) reported that there were no isolation issues. A further 20% said that the model had helped or partly helped, with only 13% indicating that the model had not been of assistance in resolving these issues.

Comments regarding staff isolation suggest that staff are feeling less isolated than when they first moved to the community (e.g., *"Supervisor or extra support is just a phone call away", "When staff first moved into the houses, they didn't cope and there was a shift supervisor there all the time, there was different management then. Now [manager] is more supportive of staff going out and they feel less isolated", "There have been isolation issues at times; there should always be a supervisor at the houses at any given time").*

Job Satisfaction

Respondents reported that the most satisfying aspects of their jobs involved interacting with the residents and providing a quality service that assisted the residents' personal development (e.g. *"Doing for them [residents] what they can't do for themselves", "People with disabilities are getting a quality of life", "You say hello and they smile back at you").* Other satisfying aspects of their jobs included the homely environment, team work, taking residents out into the community, developing good relationships with families, no bosses looking over their shoulder with more freedom and independence for staff.

Overwhelmingly, comments on the least satisfying aspects of their job focused on staff issues such as having to train other staff; low morale; bullying; conflict between staff not having been dealt with appropriately; pettiness/ bitchiness/ gossip/ trouble makers; no punishment for staff doing the wrong thing; staff not understanding the job requirements/criteria; not being a team player (e.g. *"Staff complaining about each other", "A lot of pettiness between staff", "Vindictiveness and negativity").* Other areas of concern involved the long and inflexible hours; too many appointments on one day; and the large workload and low pay.

Many respondents offered a number of suggestions for making their job more satisfying. These included the need for efforts to be directed at improving staff attitudes (i.e. being more positive and supportive toward residents and other staff) and options for more team building.

Suggestions for Improvement

Suggestions with respect to management included management/ supervisors having university degrees in disability, better communication and relationships between management and staff (e.g. *"Management need to listen to staff who have known clients for a long time, and take on board suggestions for the better care of clients"*) and more praise and acknowledgement for doing things right (e.g.*" it would be nice to get a pat on the back to know you're doing something right").*

With respect to the job role, there were suggestions for more training (e.g. manual handling, medication, workplace bullying), improved rostering, supervisors on site, better pay and more specific job descriptions (posted in each house), (e.g. *"It is difficult to resolve staff bickering because there is nothing to specify whose job is whose. Like, one day you will do the cooking and the next day the other person will. You can't complain because you still have to work with them. It is not like in an office where the roles are specified").*

Changes in Working Conditions

Just over half of the respondents (59%) indicated that there had been changes in working conditions over the time that they had been working in the community houses. However, a sizable percentage (41%) did not believe that any changes had occurred.

Many positive changes were mentioned. These included more management positions, more activities and choice for residents (e.g. *"Clients now have activities (with outside organisations as well) and they didn't before the move", "Clients can now stay up till between 7-8pm when they are used to going to bed earlier", "Used to have two menus, now have three"),* adequate staff to get the extra work done, updates with training, changing routines for OHS reasons, updating and consistency of healthcare across the houses, and easier personal shopping for clients via the internet.

Negative changes in working conditions included staff roles which had increased in workload with more responsibility (e.g. *"We need to do our job plus someone else's", "Supervisors' used to fill out the records for maintenance but now staff need to do it", "I feel that management is asking us to do a lot of house work and not much time to attend to clients' personal care and needs").* Respondents also identified changes in staffing configurations, such as less educated staff being employed and high turnover (e.g. *"Educated staff only work for short time until they find better job, which pays them more money*"), reduced physiotherapy for residents (e.g. *"They [management] say it has dropped off because of lack of staff")* and lack of constant supervisor support in the houses as being problematic.

BENEFITS OF LIVING AND WORKING IN THE COMMUNITY HOUSES

As indicated in Table 1.3, most of the respondents believed that there were benefits for residents (69%) and staff (72%) living and working in the community houses.

Table 1.3. **Staff perceptions of benefits to residents, staff, community (highest percentages for each group are shown in bold)**

Are there benefits for...	Yes	No	Partly	Not indicated or n/a
1. Residents	**25 (69%)**	1 (3%)	8 (22%)	2 (6%)
2. Staff	**26 (72%)**	1 (3%)	5 (14%)	4 (11%)
3. Members of the community (eg. Neighbours, shopkeepers etc)	8 (22%)	**17 (47%)**	10 (28%)	1 (3%)

Twenty-two percent of staff respondents believed that there were only partial benefits for residents, with 14% indicating that staff only received partial benefits from working in the community. Staff members were more ambivalent in their responses to the question of benefits to the community as a result of the residents living in the community houses. Nearly half of the respondents (47%) said that there were no benefits, while 50% believed that there were benefits or partial benefits to the community.

Residents: benefits and disadvantages of community living

Respondents were asked to comment on the benefits and disadvantages of community living. The general consensus was that the most beneficial aspect of community living for the residents was the physical environment of the houses (e.g. more home-like; less institutionalised; residents having their own room and a yard; privacy). Other beneficial aspects mentioned by many staff were the opportunities for more activities and outings in the community, the removal of age-inappropriate activities and greater acceptance of residents in the community.

Another benefit identified by the respondents was greater "one on one" staff attention for residents. This was due to an improved staff to resident ratio and the fact that new staff were younger and considered to be more open minded (e.g. *"Having less clients means that staff get more time to see each client", "We can determine the cause of anxiety in clients", "Both people don't have to do a 'production line").*

Other benefits for the residents included "home cooked" meals (e.g. *"If they [residents] don't like something, we can make something else", "The clients get to smell and see food being cooked"),* more independence and more recognition of where they are; more "normality", and better services (e.g., *"Massage and physio come to the houses"*), more family contact (e.g. *"families feel more comfortable coming here"),* improved behaviour, more active support, and an overall better quality of life.

While there were many benefits identified for the residents, there were also a few disadvantages mentioned by some staff. These included: a belief that more activities were available at Strathmont - where all facilities/ services were on campus; a sense of isolation within the community; less physiotherapy (e.g., *"It was daily, now it's weekly", "It impacts on how we bath them; because the people needing it* [physio] *increased... it's more work on the carer", "Any physio needs have been done by staff").* Some respondents also believed that the residents still have a routine and regimented lifestyle in which they have no say (e.g., *"It's just like a mini institution", "They [residents] have to get up at the same time, and go to activities that are really of no benefit to them... just because it looks good on paper*").

Staff: benefits and disadvantages of working in the community

The most commonly mentioned benefits by a majority of staff were the environment and, in particular, the better work conditions (e.g., *"Treat the house here as you would your own house"),* and the more relaxed and flexible working conditions with more choice (e.g., "*We [staff] don't have someone [manager] watching over our shoulder 24 hours per day; therefore we can make more decisions, and can impact on residents more").*

Other comments mentioned included a less institutionalised environment (e.g. *"Feel more part of community"***,** *"Don't feel institutionalised or like in a hospital", "Away from the Strathmont mentality").* Also mentioned were better staff relationships (e.g. *"Can build friendships easier with other staff because you only work with four staff at a time"),* having fewer residents (e.g., *"Having less residents means that when someone [staff member] is not pulling their weight it's obvious... it was easier to get away with it at Strathmont... there is more accountability here"),* and being better resourced (e.g., *"Have access to*

*everything you want to do with the clients... we have the bus here"***,** *"Equipment is all here - more than at Strathmont").*

Comments made about the disadvantages of working in the community included: the physical nature of the job (e.g., *"The disadvantage is that it is physically more demanding taking residents out places", "Staff need to be strong and physically active to do the job", "Staff should get reimbursed for developing body strength"),* an increased work load, staff isolation, and lack of supervision (e.g., *"Sometimes feedback doesn't get taken up (repeat same things over and over)", "Would like to tell big boss direct").*

Community: benefits and disadvantages

The most commonly mentioned benefit to the community was increased public awareness due to residents being seen more in public (not hidden behind closed doors) and the community becoming more used to and accepting of the residents (e.g. *"They [community] probably just think they are people with different needs", "Neighbours sometimes say hello to the client" "It's to their [neighbours] advantage because they're [residents] not noisy and they're in bed early, they don't pose any problems").* Other benefits for the community included money for businesses including shopping centres, food deliveries, maintenance men, leisure centres, pharmacies and doctors.

Respondents also perceived a number of disadvantages to the community which included: complaints from neighbours about cars, vans and ambulances backing in and out of driveways and parking in front of the houses and noisy residents (e.g. *"The neighbours are always complaining about noisy clients especially at night").*

Some staff reported that school children had thrown stones over the fence, although complaints from staff fixed the problem (eg *"The Shift Supervisor has rung the school across the road and there have been no problems since then [they used to torment staff too]").*

Some staff also felt that there was little benefit to shops due to the increased use of online shopping by staff in houses and that generally there was no involvement of neighbours (e.g. *"Neighbours are not all that friendly and receptive... they're a bit standoffish", "We might get a nice neighbour, but there are no benefits to them", "Have heard people say "they shouldn't be living there", "Community attitudes don't change much unless directly involved").* One respondent felt that duty of care issues were making it difficult for neighbours to be more actively involved with the residents (*"The old manager was very 'old school' [institutionalised], like when the neighbour wanted to sit with a resident and talk, but the old manager said she needed a police check").*

Combining residents together: benefits to residents and staff

A majority of respondents (86%) thought that the mix of residents was appropriate (e.g. age, gender, ability), that they got on well together and that the mix made it easier to provide support and services. Some respondents, however, did comment that residents who are "totally dependent" interact very little with each other and that the only time these individuals are together is during meal times and when watching TV. Individual comments included: *"This one is a heavy house in terms of support but personality wise, it is a good combination", "One resident is too active for this house"* and *"Some clients that have been in the same unit at Strathmont were not kept together".*

STAFF COMMENTS ON THE COMMUNITY LIVING PROJECT

Staff were asked whether they believed the residents were better off living in the community houses than at Strathmont. Twenty-eight percent of the respondents indicated they had not worked at Strathmont and therefore could not offer a comment. For those staff members who had worked at Strathmont, most (77%) felt that the residents were better off in the community houses. Nineteen percent felt that the residents were only partially better off in the community setting. Only one staff member felt that residents were not better off.

Positive individual comments associated with this question were very much in line with the staff's responses to the question about benefits to residents, as described previously, in so far as many respondents once again commented on the better physical environment in the community, which they described as more pleasant, cleaner, more comfortable, more homely, and with better food than Strathmont (e.g., *"Residents have more freedom and they are not 'locked up' like they were at Strathmont", "Strathmont was inhumane to live and work in", "Wouldn't go back to Strathmont!!").* Other positive comments emphasised the increased involvement of parents in the community settings and that staff can more readily address family concerns.

Some respondents felt that Strathmont had more of a community feel, with greater interaction between villas and different departments (e.g. physios) and that medical assistance was more readily available (e.g. residents have limited physio in the community settings).

Some staff were equivocal in their comments, arguing that whether residents were better off depended on the individual resident (e.g. *"Some clients are suited to the community and others aren't... there is still a need for institutions for some people, such as people with high behaviour issues or mental health issues", "Sometimes decisions are made without taking into consideration that they [residents] have had something for 40 years", "Some clients would benefit being back at Strathmont because they haven't adjusted to the change... like the blind clients can't touch around.").*

Staff were asked if they had any additional comments they would like to make about the community project. These comments have been grouped under the following headings:

Recruiting new staff

Some respondents felt that there are far too many casual and new staff, who were described as having little interest in the work at hand, do not listen, and who are not quick enough (e.g. *"Please choose staff carefully in the future", "As a family and community department, all staff should be educated to a Certificate 4 level in the future", "Better educated staff are more polite and understanding to people with disabilities and to other staff").* Others believed that current staff members were fine (*e.g. "It's good to have new and younger staff here", "They are all proactive and not institutionalised like at Strathmont").*

Active Support

Staff comments on active support indicated that while they were positive about it as a concept and were willing to implement it, they also had reservations about the extent to which residents were capable of benefiting from it (e.g., *"Getting clients involved in their own lives, like talking about the cooking… it helps with their self-esteem", "Active Support helps with the residents' behaviour - they like helping", "There used to be a hotel mentality at Strathmont", "I try to encourage clients to do it [active support principles] now, like when I answer the door; however, some clients don't have the mental comprehension for it… they won't understand to answer the door", "It's good for clients who understand, but for other*

residents it's not necessarily good", "Happy to implement it but it will be extra work… other staff say that it is rubbish and they won't do it", "It won't necessarily work in practice", "Some staff do not think it applies to these clients. They think it is demeaning because it just makes more evident what they cannot do").

The manner in which Active Support is introduced into the houses was also identified as a concern. As one respondent stated, "*Active support was framed the wrong way… at first they told us you have to do it or 'you get the sack. Therefore many staff came into it with the wrong approach - but the psychologist at the training said 'we're finding our way' - it used to be there but we lost it. I know that it is important to engage the residents - even if they [resident] drop the sheet and pick it up 10 times… it's about stimulations".*

The utilisation of Active Support was evidenced in one of the community houses during observations of resident activities. It was noted on one observational session that a staff member actively demonstrated very effective examples of Active Support. On this particular occasion, the staff member was observed to tailor support to assist a number of residents to participate more actively in daily activities (e.g., eating, setting the table, after meal clean-up, personal hygiene). The staff member interacted with residents in a respectful and engaging manner that demonstrated sensitivity to the residents' needs and abilities (e.g., talking to the residents during activities, providing prompts to promote participation, giving positive feedback on performance). Importantly, the staff member appeared to presume competency on the part of the residents. This one example suggests that some staff have been able to effectively apply what they have learnt from the Active Support training program and that it is possible with further training and mentoring to introduce this package of procedures more widely throughout the houses. The need for this type of training was made even more apparent given that although a total of 29 hours were spent conducting observations of resident activities, this was the only instance of active support observed.

Service issues

Individual comments were made about an excess of medication errors by staff (e.g. *"At one stage, there were 71 medication errors in one month")* and the lack of the physiotherapy that was previously provided at Strathmont (e.g. *"When we first came to the community two physios came per day… then it went down to one per day, then two per week, then nothing").* A few staff suggested that the reason for this decline was that the assigned physiotherapist had a workplace injury and there was no replacement. Staff had been told to provide the necessary services, but they objected because the services to residents were not supposed to diminish when the residents moved to community.

General comments on the Community Living Project

The last part of the survey asked respondents if they had any additional comments regarding the Community Living Project. The predominant tone of the respondents' comments expressed a very positive view about working in the houses and the services provided (e.g. *"Staff have more freedom to take residents on outings than when at Strathmont", "Couldn't do what we do at Strathmont, because routine was much more rigid. Also have a bus now so have more freedom", "Feel less institutionalised out here", "Staffing seems to be getting more stable and this is good for our clients", "I like the staff and clients I work with", "On the whole, they've done well. The staff and residents have benefited more out there", "Staff are more excited and it's a big plus for residents being out there when compared to Strathmont").*

Although the general tone indicated a positive attitude toward the move to the community, a few respondents offered suggestions for improving the working conditions for staff (e.g., "*We need a clear job*

description posted in each house to direct new staff to look at these", "Management should have higher education qualifications, so that they can effectively educate staff and develop lifestyle plans for residents", "We need more education and training", "Staff should be provided with the opportunity to do Certificate 4 so that they can become better in their work", "More job rotation would be good... it's good to move around, otherwise... it becomes "our" house [rather than residents' house]").

SUMMARY

Findings from the staff interviews suggest that they generally hold moderately favourable attitudes toward their jobs, with work incentives reported in their interactions with residents and families, their involvement in the planning processes for the residents and the general nature of the work itself. They also indicated their satisfaction with the information they receive about their jobs and the residents' needs and programs. The respondents also frequently expressed values that reflected respect and concern for the residents. Conversely, job-related training, relationships with other staff, increased workloads and greater responsibilities, lack of feedback on performance, and reservations about implementing an Active Support Program were reported as areas of concern.

It is heartening that the respondents are expressing a decreased sense of isolation compared to when they first moved to the community. They also feel less "institutionised" than when they were at Strathmont and believe they have more independence and greater opportunities to provide residents with the support they need. Staff expressed moderate support for the new model of staff placement and supervision. There was also evidence of improved relationships between staff and management. Importantly, they considered the move to the community as having beneficial outcomes for both themselves and the residents. It is of concern, however, that staff felt the move resulted in relatively few benefits for members of the local communities.

RECOMMENDATIONS

The following recommendations focus on support strategies that can be used at an organisational level, and support strategies that may be used by house managers and direct care staff.

1. **Training:** Staff may require specific information, training and/or technical assistance in order to be more effective at improving the quality of life of the people they serve. In fact, many of the staff who were interviewed for this project indicated that they valued the opportunity to participate in professional development activities that enhanced their abilities to effectively support the residents they served. Importantly, many of them recognized deficits in their own knowledge and skills and were readily able to identify their own training priorities. Building on this apparent awareness, staff should be encouraged to take a more active role in the design and delivery of training programs that are timely, flexible, convenient, and relevant to their needs. Staff bring different experiences, expectations, skills and knowledge to their positions. Hence, the training opportunities should to be sensitive to, and directed at, different levels of need (e.g., induction, awareness, skill development, application, maintenance). The use of "user friendly" training experiences should also be considered (e.g., self-instruction modules, on-line applications, small groups, visits to other programs). Furthermore, it will be important to continuously shape a program of staff development experiences that address a wide range of changing needs for both staff (e.g., coping strategies, team-building, community engagement) and residents (e.g., activities, health, skills development, community participation). Moreover, formal and informal mechanisms should be developed to enable staff to provide feedback on the relevance and effectiveness of training opportunities for

their job responsibilities. If possible, training opportunities should also be developed to include a mentoring component and be designed within a career development format that offers incentives for participation and demonstrated competency.

2. **Job Descriptions:** Providing support services in community setting to individuals with significant and multiple disabilities is a challenging and complex task. This task can be made more difficult and confusing when staff are given a considerable degree of autonomy and responsibility in their jobs without a clear understanding of their expected roles and responsibilities. Many staff members expressed a sense of frustration, confusion and ambiguity regarding their roles and responsibilities (e.g., household maintenance duties and/or the provision of individualised support for the residents). If staff are expected to achieve organization goals and objectives related to supporting people with disabilities in community settings, their roles and responsibilities should be clearly delineated. This may require the systematic analysis of the functional requirements of their job (e.g., physical, cognitive, social, decision-making, academic). Without such descriptions direct services staff (and other professionals) may have difficulty discerning which responsibilities are of priority and which are legally and ethically their own. If job descriptions are revised to include responsibilities for improving the quality of life outcomes (general and specific) of residents, then staff may be more inclined to focus their attention and energies in this area. Of course, staff should also be supported and encouraged to adopt working methods designed to enable and facilitate desired resident outcomes that are related to organisational goals. A revised job description should also specify the need to engage positively with, and provide active support for, residents and this information should be provided to applicants for staff positions and used to select those suitable for this role. Such information could be obtained from relevant questions to referees and in recruitment interviews.

3. **Feedback:** Staff indicated that they received little systematic or constructive feedback, or evaluation of their performance. Constructive feedback that is referenced to goals and job descriptions is paramount if staff are to successfully assist the residents they support to achieve meaningful outcomes. Performance feedback also serves as an important component for acknowledging and encouraging efforts, accomplishments, improved performance and creativity, and for building satisfying and supportive work environments. Feedback should acknowledge groups as well as individuals in order to highlight the importance of (and pride in) collaborative team efforts. However, providing effective supervision and constructive and positive feedback to staff is a complex activity that often requires the supervisor(s) to serve as instructor, role model, manager, and counselor. Hence, in some cases, supervisors, like the staff they support, may also require training, support and feedback in ways to effectively provide constructive and positive feedback.

4. **Communication:** Open communication within and across the community houses should be encouraged and supported. If staff are to work toward the goal of an improved lifestyle for the residents, they must have access to information that will assist them in this endeavour. Staff should be encouraged and supported to consider openly the social, domestic and community experiences of residents in other houses, to share effective strategies, to build mechanisms to deal with the most likely practical problems (e.g., balancing domestic duties and resident duties, lack of community engagement, access to meaningful activities, facilitating skill development, working as a team) and to discuss these issues regularly with other staff who face the same challenges, and share the same visions. These types of discussions also offer the opportunity to nurture an atmosphere of "team work", where staff work together toward common goals and support and acknowledge one another. Newsletters that feature articles on staff members, their accomplishments, and their innovative

ideas might also serve a motivational mechanism and acknowledge their individual and collective efforts.

5. **Community Relations:** Facilitating and maintaining community relations should be part of an on-going plan for improving the social inclusion and community participation of the residents and staff. In isolation, the strategies for enhancing community relations may not be critical, but the cumulative effect of several strategies may mean the difference between residents who attain mere "physical presence" in their local communities and residents who achieve a true sense of acceptance and belonging. The establishment of community relationships should be seen as an important part of staff members' roles and responsibilities (e.g., getting to know the neighbours, becoming known in local establishments). Various strategies are available for facilitating and maintaining community relationships (e.g., patronising local businesses, assisting neighbours with chores, making community presentations to local organizations, attending local community events, scheduling regular "in-house" events for members of the community). The effectiveness and appropriateness of any particular strategy is dependent on a range of factors (e.g., community location, staff competencies and motivation, prior experiences with people with disabilities, local resources) which need to be carefully considered before they are adopted for implementation.

Part 4: Volunteers

Aim

Volunteers serve in many capacities within organizations by contributing time, energy or talent that may extend and augment the work of paid staff and help to fulfil an organizations' mission. Volunteers often bring new insights to the work and may generate enthusiasm and interest and help to create a positive image of the organization in the community. Communities often benefit from the contributions of volunteers in that the services they provide help individuals, families and the community to address a range of often challenging needs. Greater enthusiasm and rapport often develops when volunteers share their enthusiasm for the work they are doing and the organization they are affiliated with. Moreover, they often encourage others to become involved in community work.

The success of a volunteer program may be determined from two perspectives. One perspective focuses on the positive impact that the volunteers' time and efforts have on the host organization and the individuals being served. The second perspective is concerned with the impact that the act of volunteering has on the volunteer.

Volunteers were an integral part of the activities program provided to residents at Strathmont and they have continued to fulfil this role as part of the services provided by the community houses to their residents. The presence, participation and interests of these volunteers in the daily lives of the residents can be an important indicator of service quality. Hence, in the present evaluation, volunteers in the community houses were surveyed to assess their perceptions regarding their involvement in the new settings.

Method

Individuals who were volunteering in the community houses were surveyed. Twenty-five volunteers were identified and sent a letter of invitation to participate in the evaluation and a 23-item questionnaire to complete and return to the Volunteer Coordinator in a reply paid envelope. The questionnaire contained items about the volunteers' involvement in resident activities; their satisfaction with their involvement in

the volunteer program; and their overall perceptions of the community living project. Volunteers were also given the contact details of the research team so that they could request assistance with completion of the questionnaires if needed.

Results

Seven volunteers returned their completed questionnaires. The mean age of the respondents was 52 years (Range: 17 to 67 years). Four of the respondents had previously worked as volunteers at Strathmont. None of the respondents reported any other experience working as a volunteer. The volunteers had worked in the community houses for an average of 18.9 months (range: 3 to 36 months), and spent between 8 and 96 hours per month (average: 42 hours) volunteering in the houses.

WORKING AS A VOLUNTEER AT STRATHMONT

The four volunteers who had previously worked in the Kalaya house (at Strathmont) reported that what they most liked about their volunteer work at Strathmont was taking residents to, and helping them to participate in, the activities, and the sense of familiarity they established with residents and staff. They also liked the fact that Strathmont was easily accessible for both themselves and the residents (i.e., being able to walk the residents from the villas to the activity areas). When asked about what they disliked about working at Strathmont, responses included: working with staff who were disrespectful or harsh to residents; seeing that some residents had no scheduled activities and thus did not go out at all; and that sometimes residents were not prepared for activities or their unavailability for activities was not always communicated to volunteers.

BECOMING A VOLUNTEER

When asked how they became a volunteer, one person said that they followed in the footsteps of their grandfather who had been a volunteer. Another, who had a son with a disability, had become a volunteer when they retired and another had seen an advertisement in the Messenger Press and thought the work sounded interesting. The remaining three volunteers had come to the work from Centrelink and the Job Network programme. All of the volunteers said that they enjoyed the work and intended to continue providing this service for the residents.

ACTIVITIES

When asked what kind of activities they were involved in with residents, responses included cooking, games and karaoke in the houses, walking for leisure, and driving residents from community houses to swimming and other activities in the community (e.g., church, art and craft, family visits, shops, and games such as darts, eight-ball and table tennis).

When asked which of these activities the volunteers preferred for residents, commonly mentioned activities included karaoke and supper dances “Because the clients really get involved and have fun”, and outdoor recreational activities such as walking. All of the respondents believed that the residents enjoyed, to various extents, the activities provided.

Responses varied when asked how much choice volunteers had with respect to activities, with one saying a great deal, three indicating quite a bit and one each indicating some, a little and not at all. Similarly, their

degree of satisfaction with the activities ranged from one being very satisfied, three being satisfied, two were partly satisfied and one was partly dissatisfied.

The volunteers were of the opinion that most of the scheduled activities were useful or beneficial to the residents, although some respondents indicated that they believed that outdoor activities were more beneficial because "They get the residents out of the house – they see new things - meet new people - enjoy the great outdoors" and because "No one wants to be couped up all the time". One the respondents believed that "As long as the residents abilities and interests were matched with appropriate activities for them, then all activities were beneficial". Games were the only activities that were viewed (by one volunteer) as not being useful because "The residents don't like them".
When asked for suggestions for activities, volunteers mostly indicated more of the same types of activities (e.g., walks, art and crafts, cooking and swimming), but they also mentioned going to see the Christmas lights and going to plays in the community.

TRAINING FOR VOLUNTEERS

All of the volunteers, except one, were satisfied with the orientation/ induction that they received when they commenced work as a volunteer. When asked whether volunteers need ongoing training, four said yes and two said no. Suggestions concerning training included having meetings with staff and other volunteers so that ideas can be shared, letting volunteers work with other volunteers to get new ideas, and refresher courses in basic first aid, epilepsy procedures and workplace safety.

VOLUNTEER SATISFACTION

All of the volunteers indicated that they were satisfied with the adequacy of the volunteer service offered to residents. The social aspects of volunteering such as having the opportunity to interact with other volunteers and with staff were considered to be important for the volunteers. Interactions with staff, however, were considered to be either satisfactory or very satisfactory by four volunteers with three being only partly satisfied.

When asked what was good about the volunteer services, the most common response was being able to help the residents to enjoy a good quality life style. Responses also included friendship with the residents and helping them to go out in the community. One volunteer recommended the volunteer work because of the personal satisfaction that it provided. The only improvement suggested was having more volunteers.

Volunteers gave mixed responses when asked if they would prefer to work in the community houses or in a large centre, with two preferring the community houses, one a large centre and three being undecided. All volunteers said they had no problems travelling to and from the community houses and to and from activities in the community.

VOLUNTEER ATTITUDES TO RESIDENTS LIVING IN THE COMMUNITY

When asked to consider the impact that living in the community had on residents, there was a mixture of positive, neutral and negative comments. Negative comments included one volunteer who thought they should not be living the community "Because not all of them like a change", and one who thought that some residents seemed isolated and had more activities when they were at Strathmont. Neutral comments came from two volunteers, one who thought that living in the community did not have any impact on

residents, and another who did not know what impact it had. Positive comments included one that the residents seemed to be quite satisfied with their new residences and another that the impact had been very positive with the smaller staff to resident ratio providing "More personalised attention which should assist in more readily identifying health problems and structuring suitable activity programs".

SUMMARY

Results were available from only seven of the 25 volunteers surveyed, which means that they may not represent the views of most volunteers. Accordingly, they should be interpreted with some caution. However, those responses obtained suggested that the volunteers enjoyed their work and felt that the variety of activities provided were generally worthwhile for residents. The volunteers were generally satisfied with their training and with their interactions with staff. Suggestions for improvements to their work included more activities and more volunteers to help residents to access activities. There were mixed views about residents living in the community houses rather than at Strathmont suggesting that more information should be provided to volunteers in their training about the potential benefits for residents living in the community houses rather than in an institutional environment like Strathmont.

RECOMMENDATIONS

1. **Surveying volunteers:** A more comprehensive survey of volunteers is required to check the findings from the limited number of respondents in this study. Given the various roles volunteers play in assisting residents, it will also be important to assess the impact of the volunteer services on resident satisfaction and outcomes and the organizational goals.

2. **Recruiting volunteers**: Volunteers indicated a need for more volunteers so that more activities can be provided for residents. It is suggested that the community program spend time considering why it wants to work with volunteers and developing a philosophy for the overall engagement of volunteers. Volunteers should never be considered as "free help." They should be viewed as extensions of professional and paid staff engaged in the fulfilment of the organization's mission.

3. **Training:** Induction training should include more information on the reasons for moving residents into the community. The training should also offer the opportunity for volunteers to participate in active support training to encourage them to work with, rather than just for, residents. Ongoing training should also be reviewed with consideration given to the training issues identified by volunteers.

4. **Communication/Involvement**: Increased opportunities should be arranged for volunteers to meet each other and to discuss ideas with staff, and further facilitate and enhance volunteer-staff relationships. Provide regular and personalised updates to volunteers on progress toward the community project's goals, daily programs, and community activities.