Supported Residential Facilities – Supporting Residents to Stay or Move On?

by

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This thesis is dedicated to Branko & Jake.

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ABSTRACT

Many Supported Residential Facility (SRF) residents express a desire to live in more independent accommodation, however relatively few achieve this. Two of the issues preventing this are a lack of housing alternatives and support. This study examines the relevant literature and legislation, to gather documentary evidence and demographic data about South Australian SRFs and their residents. This is augmented by interviews with five key informants, to discover what other factors inhibit SRF residents from moving on to alternative accommodation. Findings indicate that recovery and rehabilitation are inhibited in SRFs and that current standards are barely sustaining people. Data suggests that legislation has a negative impact on residents and service delivery. This research recommends that the South Australian Government take up its legislative and ministerial responsibility to SRFs and their residents as a matter of urgency, especially in relation to fire safety. Secondly, that there is a review of The Legislation to incorporate citizenship rights and individualised care. And lastly, that in the interim, funding tied to service agreements is made available to SRFs, so that they become a place to recover and not the end of the line.
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CHAPTER 1

Supported Accommodation in South Australia –

‘Beyond the Supply Question’

O’Brien, Inglis, Herbert, Reynolds (2002:4)

Supported Residential Facilities & Their Residents

A supported residential facility (SRF) is a licensed facility which provides personal care services to more than three people as defined by the Supported Residential Facility Act, SA, 1992, Section 1(3). A SRF is a group home for twenty plus residents, where residents pay most of their income in return for board and lodgings. This is usually a government pension. Another type of SRF is incorporated into a retirement village where residents receive non-government pensions.

SRF residents usually have a disability, either mental, intellectual, age-related and/or physical. This description is in keeping with the findings of the Research Paper Somewhere to Call Home by Doyle, Hume, McAvaney, Rogers and Stephenson (2003).

Low Numbers of SRF Residents Moving On to Alternative Accommodation

A review of the supported accommodation literature suggests that there are low vacancy rates and high numbers of long term residents in SRFs in South Australia. The literature also suggests that increased funding for support services and the development of successful and sustainable supported housing models are vital to bring about change in the current housing situation for people
with disabilities. These are two of the factors that contribute to low numbers of SRF residents moving on to alternative accommodation.

Many residents who live in supported residential facilities express a desire to move to alternative supported accommodation however few achieve this (Petrie, 2003:3). A study called *More than Just a Roof* conducted in Victoria in 1988, outlined what residents said they would need to move to alternative accommodation (O’Brien & Peady, 1988). The profile of the participants in this study is similar to that of SRF residents in South Australia. This group stated that they would require supports to achieve more independent living related to practical items such as help with budgeting, cooking, cleaning, etc. However O’Brien and Peady did not examine other factors which may inhibit these residents from moving on.

This research will explore the reasons why SRF residents do not move on to alternative supported accommodation including the lack of alternatives and support. The research will examine whether people become ‘trapped’ in this setting and how this occurs.

Low numbers of SRF residents moving to more independent accommodation results in fewer places being available for people leaving hospital and other types of accommodation who require twenty-four hour support. It also suggests that SRFs do not enhance recovery. Despite this, evidence exists that some people who have lived in institutional environments for long periods of time can successfully live in the community, when appropriate supports are in place. While the main issues preventing people from moving on are a lack of housing alternatives and appropriate support, this thesis will examine some of the other reasons why this occurs.

**Housing Spectrum & The SRF Sector**
SRFs in South Australia are managed by different people and organisations, some for profit and others not-for-profit. For example, Housing Spectrum Inc. (Housing Spectrum) is a not-for-profit community housing organisation whose core business is managing community housing for people with disabilities. Housing Spectrum was also involved in the SRF sector as proprietor of three SRFs between 1998 and 2004 and I was an employee of Housing Spectrum between February 2003 and June 2004.

On 1 April 2004 Housing Spectrum announced to staff, residents, families, local members of parliament and other agencies involved in the care of residents that it would cease its involvement in the SRF sector as of 30 June, 2004. Housing Spectrum worked closely with Department of Human Services (DHS) to avoid the closure of the three SRFs. DHS entered into negotiations with other service providers to take over in a gradual transition process. Both Housing Spectrum and DHS were committed to assuring all key stakeholders that this was not a closure and that residents did not have to move.

At this time the SRF sector was in financial crisis resulting in the closure of many SRFs. In response to this financial crisis the South Australian Department of Human Services (DHS) announced funding of $11.4 million for SRFs. Part of this funding was for sustainment packages which were to financially support the existing SRFs and to slow this dramatic turn of events. If ignored, this crisis could have potentially caused the homelessness of a large percentage of South Australia’s disabled population (DHS Press Room, 2000:1). The other part of this funding was used to set up a closure task force to assist the SRF residents who had to leave their homes. Stories abounded of residents being “sold” between proprietors, buses arriving to remove people from closing facilities without warning and other circumstances which were far from appropriate in caring for vulnerable people.
Research Aim

The aim of this research was to examine the reasons why SRF residents do not move on, especially as alternative accommodation may offer a less restrictive living environment and greater independence.

The questions that were addressed about SRF residents related to their current profile, whether or not this has changed over time and if demographic data suggests that the majority of SRF residents are long term in SRFs and/or the sector. Questions about Legislation and service delivery incorporated the original principles, aims and intentions of the legislation and whether these are still relevant to the current models of supported accommodation and service delivery as well as how the legislation impacts on service delivery. This research has explored if recovery is inhibited or enhanced in the SRF environment and whether legislation needs to change.

Design of the Study

A combination of documentary research, anonymous demographic data and interviews with key informants made up the data for this study. Documentary research is a proven way of researching the social world without involving or affecting those who are being studied (Neuman, 2000:311). Silverman suggests that public documents provide a “goldmine” for social researchers as they are usually relevant to important issues and are easily accessible. He also argues that despite the potential of such work, it has been “sadly neglected by field researchers” (Silverman, 2003:68). Data was collected by searching through collections of existing information with particular research questions in mind. This allowed the information to be reassembled in a creative and new way to address the research questions (Neuman, 2000:300).
Relevant demographic data from Housing Spectrum was also examined to obtain information about residents’ length of stay, age, gender, primary disability and some other factors. Key informants working in the supported accommodation sector, both in government departments and other not-for-profit organisations were consulted. The data was examined to explore how SRF legislation impacts on service delivery and ultimately the SRF residents. Data also addressed whether or not SRFs (both for-profit and not-for-profit) have the capacity to provide an environment where recovery and rehabilitation provide residents with an opportunity to develop the capacity to move on, should they choose to do so.

Summary

The SRF sector in South Australia is currently in crisis. SRFs today are often institutional in nature and unable to provide an acceptable quality of life or any rehabilitation to residents (Clisby, 1995:5). They do not meet the standards of care required in other disability sectors and do not have equitable access to funding for disabilities.

Despite the fact that many SRF residents express a desire to move to alternative accommodation, few achieve this. One of the main reasons is the limited number of appropriate alternatives available in South Australia. O’Brien et al. agree that housing supply and support need to be addressed to improve housing outcomes for people with complex needs. They identify the need to develop an understanding of “what is required to support people to achieve stability in their housing, beyond the supply question” (2002:4).

Currently, both government and non-government organisations are interested in developing housing alternatives to suit people with disabilities. Professionals who work in the disability, mental health, housing, supported accommodation and government policy sectors agree that appropriate, non-clinical support is vital to enable people with disabilities to successfully move on to less restrictive living environments.
The current mental health policy, disability policy, supported accommodation projects and non-clinical support all focus on recovery and rehabilitation. Therefore it was timely and important to explore what the other factors are that inhibit SRF residents from moving to alternative accommodation.
CHAPTER 2

Congregate Accommodation for People with Disabilities -

*where people have “no real future” or its “sorta the end of the road”*

Warren & Bell (2000:199)

Supported Accommodation in South Australia

In 2003 the Social Development Committee of the South Australian Parliament conducted an “Inquiry into Supported Accommodation”. The South Australian Council of Social Service (SACOSS) made a submission to this Inquiry which stated that there were 1,500 people with disabilities being housed in congregate residential care settings with twenty-four hour support in South Australia (2003:11).

This submission noted that 60 - 80% of people living in this type of accommodation in the Western Metropolitan region of Adelaide would prefer to move to alternative housing (SACOSS, 2003:12). It also reported that there are two main contributing factors which inhibit people from moving out of congregate residential care, firstly, a lack of services to provide adequate assistance to find and maintain alternative accommodation and secondly, a lack of adequate and appropriate supported housing options in South Australia (SACOSS, 2003:5).
O’Brien & Peady also conducted a survey to identify the types of housing that people with disabilities preferred (1988:23). The authors acknowledged that it could be difficult for consumers to identify their “ideal type of housing” as their preferences may be limited by a lack of experience with more desirable housing alternatives. The results found that consumers would prefer their own flat or house although none had been able to achieve this in the preceding two years.

Another study called *An Exploratory Investigation into the Housing Preferences of Consumers of Mental Health Services* by Warren & Bell (2000:196) revealed that consumers have a strong preference for “normal types of housing”, similar to other people in society. Warren & Bell found that “large custodial settings, including boarding houses” are not “typically associated with residents’ satisfaction or a positive outcome” (2000:196). They quote several authors to give weight to this evidence such as Carling & Curtis, 1997, Minsky, Reisser & Duffy, 1995, Trainor, Morrell-Bellai, and Ballantyne & Boydell, 1994. Warren & Bell also state that participants indicated that “they perceived living in congregated housing as being equated with having no real future” (2000:199). One consumer said “those places (boarding houses) are sorta like the end of the road” (Warren & Bell, 2000:199).

O’Brien et al. state that many reports have found ‘overall Australian studies have shown that the least preferred options for most people with a mental illness are to live in a group setting or in housing lacking privacy, such as boarding/rooming houses” (2002:10). Most have indicated that living in a ‘private’ house or flat is the preferred option. In addition there was a strong preference not to live with others with a mental illness in a group setting (O’Brien et al., 2002:10).

Some Housing Spectrum SRF residents have spoken with me about their wishes to live more independently. For some, this is a something that they hope for in the future ‘when they get better’ while others express a strong desire to move immediately.
The SACOSS Report referred to above recommended that the South Australian government take on more responsibility in two areas. Firstly to increase funding to programs that assist people to find and maintain accommodation and secondly, to explore alternatives to congregate residential care in order to develop a “continuum of housing options” (SACOSS, 2003:8, Doyle et al, 2003:102).

**What is a ‘Housing Continuum’?**

The idea of a housing continuum in the supported accommodation sector is not unique to the SACOSS report. The Australian Housing and Urban Research Institute (AHURI) uses this term to describe a range of models of supported accommodation for people with disabilities (Bostock, Gleeson, McPherson & Pang, 2000:36). A housing continuum is representative of congregate/institutional-style facilities including ‘whole of life support’ at one end, and private accommodation with drop-in support at the other (Bostock et al., 2000:36). In South Australia however, supported accommodation for people with disabilities often occurs at one end of this continuum, the congregate residential type of care (Bostock et al., 2003:5) as alternatives are limited and people are not always able to work their way along a continuum.

The term congregate residential care is a broad description of congregate supported accommodation where there are twenty-plus residents and housing and support are packaged together (O’Brien et al., 2002:12). It is well documented that this type of supported accommodation may be institutional in nature, unable to provide all of the basic necessities of life, or any quality of life to its residents and allows little scope for rehabilitation (Chapman & Provis, 1991, McMahon, 1999, Doyle et al., 2003:99, Pluck, Clark & Mott, 2002:23).
People with Disabilities & Homelessness

Chamberlain and Johnson defined people residing in congregate residential care as the ‘tertiary homeless’ (2001:35). They describe one of Goffman’s theories about the particular stages and biographical transitions in a ‘career of homelessness’ which is relevant when exploring why residents do not move on from this type of accommodation. Goffman’s theory describes three stages and two biographical transitions of homelessness for adults (Chamberlain & Johnson, 2002:29). The first stage is the risk of homelessness, the second stage, the experience of becoming homeless and the third, chronic homelessness.

Goffman (in Chamberlain & Johnson, 2001) argues that the biographical transitions occur firstly during the period of time when adults realise they are homeless and a ‘sharp break’ occurs between being housed and being homeless. People either have a place to stay or they do not. The second transition denotes the acceptance of homelessness as a way of life. Hirst (1989), HREOC (1993) and O’Connor (1989) report that it is difficult to support people who have experienced the second transition through a change process as they no longer express a strong disposition to change their environment. This is also referred to as the ‘transition to chronicity’ by Chamberlain & Mackenzie (1994) when people become resigned to their living arrangements. However Chamberlain and Johnson report that a significant minority of adults are able to resist the ‘transition to chronicity’ even when they have been homeless for a sustained period of time (2002:29).

Current research and literature confirms that there is a direct link between homelessness and disability, in particular mental illness (SACOSS, 2003:4). The cyclic nature of mental illness contributes to loss of tenure, instability, transience in accommodation and increased hospital admissions. Adequate, affordable and secure housing is critical to recovery (SACOSS, 2003:4).
This is reflected in the South Australian Department of Human Services Social Research Agenda 2002-2005 which identifies the issues associated with housing access for people with complex needs as a priority area for research as well as housing access for people with complex needs, improving access to housing for homeless people and pathways into and out of homelessness (DHS, 2003-2005:21,22). For housing to be adequate such an environment must have a capacity to enhance recovery.

Two of the key tenets of DHS policy for the provision of services and supports for people living with a disability are to promote and support choice and independence to facilitate people reaching their independent living potential (DHS Social Research Agenda 2002-2005:16). *A Positioning Paper on Deinstitutionalisation and Housing Futures* prepared for the Australian Housing and Urban Research Institute by Bostock et al.(2000:9) states that very little research has been conducted in this area in the Australian context and that many disabled people continue to live in congregate institutional care.

The South Australian Department of Human Services (DHS), Supported Housing Unit (SHU) confirms that many people with disabilities are currently homeless or living in inappropriate or unsustainable housing. Generally the people who fall into the category of living in inappropriate or unsustainable housing have little choice but to live in congregate residential care in order to receive the support they need to manage their day to day lives (DHS, SHU, 2002:3).

**Deinstitutionalisation, the Effects of Institutionalisation & Social Role Valorisation**

People with disabilities have often had little or no choice about where they will live since the deinstitutionalisation movement began in the 1960s. Erving Goffman (1961) wrote about his concerns for appropriate accommodation for people with disabilities, their care, humane treatment and access to human rights
at this time in a book titled “Asylums”. Goffman believed that institutions were dehumanising and served little rehabilitative purpose. His criticisms of institutionalisation revolve around the notion that mental hospitals actually perpetuate deviant behaviour rather than cure it and reinforce alienation from the community.

Goffman coined the phrase “total institution” to describe the common themes of the institutions he studied as he developed a critique of the experience of life and self-identity of the inmates of an institution. He noted that individuals usually sleep, play and work in different places, with different people and no overall plan (1961:17). He comments that the central feature of a total institution is that the barriers ordinarily separating the above three spheres of life are broken down and a total institution becomes a place of both residence and work, contains a large number of “like-situated” individuals, is a place where residents are cut off from wider society and that residents lead an enclosed, formally administered “round of life” (Goffman, 1961:17).

An overarching feature and one of the most alarming aspects of Goffman’s description of a total institution is that of the “civil death” which occurs to inmates and relates to irrevocable losses in the area of human rights and opportunities for child rearing, courting, education and career (1961:25).

There are clear links between Goffman’s work and that of Russell Barton who wrote about “institutional neurosis” in 1959 (in Jones & Fowles, 1984:71). Barton listed the clinical features of this neurosis as being a loss of interest in the outside world, submissiveness, resignation, no interest in the future, deterioration of personal standards and habits, and a characteristic posture. He noted that these features “may be indistinguishable from symptoms of schizophrenia” (in Jones & Fowles, 1984:72).

Barton identified seven factors in an institutional environment which could contribute to institutional neurosis being loss of contact with the outside world,
enforced idleness, bossiness of staff, loss of personal friends, possessions and events, drugs, a drab and depressing atmosphere and finally the loss of life prospects (in Jones & Fowles, 1984:72).

Goffman was one of the major contributors to changing people’s minds about the treatment of the mentally ill and his book marked the beginning of the de-institutionalisation movement, at a time when most people struggled with the notion of people with disabilities living in the community.

One of the original aims of the deinstitutionalisation movement was to reduce the number of people living in congregate residential care. The term used to reflect this aim was ‘normalisation’ for people with disabilities. This was later re-named ‘social role valorisation’ (Shannon & Hovell, 1993). Social role valorisation embraces the notion that people with disabilities have the right to access the ‘least restrictive living environment’. This describes an ‘ideal’ living environment for people with disabilities where care needs are met appropriately with minimal restrictions to individual freedom. For disabled people this embodies the right to live as “normal a life as possible” within the broader community (Madison, 1998). Chenoweth (2000) writes that disabled people should have the opportunity to live in “ordinary housing arrangements in regular communities” rather than being segregated into institutions.

The theme of normalisation is also reflected in The National Housing Strategy written in 1991. This document promotes the notion that disabled people should receive individualised funding in order to be able to “choose for themselves the type of housing that they want (and can afford) and the types of supports they wish to use within the range of available options, just as any other member of the community” (1991:8).

In 1992, all Australian State and Territory Health ministers agreed to adopt a national mental health strategy and policy was developed which outlined “the direction of mental health reform” highlighting a shift from “institutional care” to
'community care'. This strategy reinforced the need for improved linkages between health and other services such as housing, employment and income support for people with disabilities. (SACOSS, 2003:7)

In 1993 the Burdekin Report was released. This report highlighted the continued significant abuse and neglect of people with a mental illness living in congregate residential care. Burdekin concluded that the most significant obstacle to wellness in the lives of these people was the absence of adequate, affordable and secure accommodation (Burdekin, 1993). He further commented that the institutional nature of many of the large group homes destroy what is left of the human spirit and all dignity. The National Inquiry Concerning the Human Rights of People with Mental Illness heard numerous complaints about hostels, especially private ones, and concluded that in terms of human rights, the Federal Government has a responsibility to protect these extremely vulnerable Australians (Human Rights and Equal Opportunities Commission, 1993:399).

Criticisms of privately run SRFs have included the lack of quality of life, disregard for legislation, institutionalisation, abuse and that for-profit or business motives will outweigh quality care and support. A desire to keep SRFs full for financial reasons is in opposition to the principles of recovery and rehabilitation.

Housing Spectrum, a not-for profit organisation, charged considerably less board and lodgings per fortnight than some other SRFs. It also made efforts to increase the quality of life of residents, to involve them in the management process and attempt to raise their awareness of alternative housing options. Despite this and a not-for-profit philosophy, the Housing Spectrum SRFs were not different in terms of a minimal capacity to provide personal care services or assist people to move along a housing continuum to alternative supported accommodation.

When large numbers of people live together it is possible that life will be institutional in nature regardless of whether there is a for-profit or not-for profit
proprietor. While I worked for Housing Spectrum I became aware that institutionalisation, dependency and a loss of living skills could still occur in not-for-profit facilities as the needs of the many often outweigh individual needs.

After spending time with Housing Spectrum SRF residents it also appeared that some still experienced the “stages of homelessness”, did not receive adequate community support, support and accommodation services were not separate and that there was little on offer in terms of alternative supported housing. It appeared that Housing Spectrum SRF staff were providing the majority of non-clinical support and accommodation services to residents. This is in keeping with literature in this area.

**SRF Sector & Financial Viability**

Both the for-profit and not-for-profit SRF proprietors have lobbied for government funding to provide adequate supported accommodation and have increasingly made it clear that their sector is under financial pressure (Doyle, Hume, McAvaney, Rogers, Stephenson, 2003:11). Doyle et al (2003:29) also commented that the private supported accommodation model is outmoded and that it is unrealistic that these providers can undertake a rehabilitative role in the current climate. This research will explore this theme by commenting on how the Legislation impacts on service delivery.

*Financial Analysis - SRFs in South Australia*, prepared for DHS by Hunter (2003) describes a 40 bed facility with 90% occupancy as the model which is financially viable. However most of the SRFs operating today are smaller than this and therefore are not financially viable whether they are for-profit or not (Hunter, 2003:vii). During the last two years there has been an increasing number of closures of these facilities which suggests that they are not financially viable.
**A Shift in Mental Health Policy**

A large percentage of SRF residents have a mental illness. The focus of mental health policy is shifting to that of rehabilitation and recovery (Scarborough, 2002:iii). This is noted in the DHS discussion paper titled *Mental Health Rehabilitation and Recovery Model for South Australia* (D6-02) released in January 2002. Anthony (in Scarborough, 2002:2) defines the concept of recovery as that of ‘offering a person with a mental illness hope of recovery and return to participation in the meaningful activities of life”. Scarborough (2002:1) writes that it is “understood that this model is part of a continuum of care for clients across all mental health services” and that it is essential that the “agreed model is integrated with other services to achieve the best outcomes”.

The key principles behind the rehabilitation and recovery model embody the notion that every person with a mental illness has a capacity of physical, emotional, social and spiritual development and that in providing care regard should be given to the lease restrictive alternative possible (Scarborough, 2002:3). This is similar to social role valorisation and the least restrictive living environment promoted by the disability sector. These principles suggest that everyone has the capacity to develop and change to improve their quality of life.

An example of this is a longitudinal study conducted by Newton. Her report titled *Self and Illness: Changing Relationships in Response to Life in the Community Following Prolonged Institutionalisation* describes the study which involved a group of hospitalised psychiatric patients who were given the opportunity to move into mainstream society (2001:166). She spent six months with a group of people with prolonged mental illness living in an old ‘decaying Victorian style institution”, speaking with them on a daily basis. She then spent the next two years with the same group of people after they were discharged into a range of supported accommodation settings. Newton concluded that despite persistent mental illness, “deinstitutionalised patients developed new roles and
new identities, a new sense of independence, new coping abilities and a capacity
to articulate future goals and desires” (2001:166).

This is of importance to this research as even though SRF residents are not
hospitalised, they may still be institutionalised. Living in an institutional setting
deprives people of the normal roles and responsibilities they would have in more
independent accommodation. Skills and coping abilities are quickly lost and
replaced with dependence and despondency. Newton’s study proved that such a
group of people were capable of successfully living in more independent
accommodation with appropriate supports in place.

Newton attributed the success of the group of people she studied to adequate
funding, social support provided by staff, residents and community members and
a commitment to change (2001:179). O’Brien et al. also provide evidence that
“many people who experience psychiatric disability and have a history of
homelessness can achieve stable housing” and quote other literature to give
evidence of this, for example Keck, 1990, McDonald, 1993, Center for Mental
Health Services, 1994, Commonwealth Advisory Committee on Homelessness,
1998, Rosenheck & Morrisey, 1998, Culhane, Eldridge, Rosenheck & Wilkins,
2000.

Any supported accommodation projects funded by The Government for people
with disabilities will also utilise a rehabilitation model. As stated above,
currently congregate style supported accommodation allows little scope for
rehabilitation. It will be argued that changes in legislation and licensing of SRFs
will need to occur if they are to embody the principles of a rehabilitation and
recovery model.

**How have Other States & Territories Responded?**

Magor-Blatch (2003:9) reports that various states and territories have set up a
number of strategies in response to concerns about the supported
accommodation sector. These address its viability and decline, more complex resident needs, disparities between this type of accommodation and that provided to other vulnerable groups, the appropriateness of the service model and the need for formal mechanisms to safeguard the interests of residents.

The states and territories have employed various strategies to do this, including changes in regulation, licensing and procedures, increased funding and support to residents and active and assertive advocacy processes and structures to protect residents’ rights. All strategies have advocated for an increased role of government and not-for-profit sectors with a separation of ‘accommodation’ and ‘care’ functions.

Summary

Affordable, appropriate and secure accommodation is critically important to people with disabilities as is access to appropriate support to find and maintain accommodation. People with disabilities have the right to lead normal lives and live in an environment that ensures minimal restrictions to individual freedom. In addition current mental health treatment focuses on recovery and rehabilitation. This is reflected in reports prepared by the housing sector, mental health services, government, human rights advocates, SACOSS and in the literature across different disciplines.

However, many people with disabilities continue to live in accommodation and receive support services at one end of a housing continuum, namely the more institutional end of SRFs. This is despite the rhetoric and direction of current social policy in this area and statistics which show that many disabled people aspire to more independent living. Doyle et al. (2003), SACOSS (2003) and Bostock et al. (2000) all argue that there is a need for research to be conducted into supported accommodation to inform how a continuum of supported housing might be developed in order to provide a range of housing and support options to suit people with a disability, other than SRFs.
It is acknowledged that increased funding for support services and the
development of successful and sustainable supported housing models are vital to
changing the current housing situation for people with disabilities. However it
will be argued that there are other factors that influence the ability of people to
reach their independent living potential.
CHAPTER 3

Residents of SRFs: Relevant Literature & Legislation

This chapter will introduce a number of reports, including the SRF legislation and regulations in order to provide information which is relevant to the research questions. These reports were chosen to build a picture of past and present information about congregate residential care, the profile of residents and relevant legislation.

More than Just a Roof: Housing with Support Services for Adults

O’Brien and Peady wrote a report called “More than Just a Roof: Housing with Support Services for Adults” in 1988. This study was conducted in Melbourne. It is of interest as it was written before legislation encompassing residential facilities was introduced in South Australian or Victoria.

O’Brien and Peady’s report acknowledges that at this time it was difficult to define ‘housing with support services” because of the breadth of options this covered. ‘Housing with support options” was seen as including any ‘housing option where there were support services received by the consumer, enabling the person to meet other daily living needs, and therefore maintain their accommodation” (O’Brien & Peady, 1988:4).

These authors identified the groups of people as being in the most urgent need for this type of accommodation in three main groups (1988:10-12). These were single adults with psychological disabilities, single adults (mostly women) with alcohol-related problems and older single persons. Other characteristics included poverty and different ethnic backgrounds.
Heffernan conducted a *Review of Boarding & Lodging Accommodation in Metropolitan Adelaide* in 1988. He reported that many residents were living in boarding and lodging accommodation because of an absence of alternatives, rather than because of choice (Heffernan, 1988:1). He recommended that new government strategies should take this into consideration, acknowledging that many residents may prefer independent housing. He said that any new strategies should maintain a balance between boarding and lodging initiatives and the expansion of more independent housing options (Heffernan, 1988:2).

Heffernan recommended ‘funding for accommodation and support services to suit the changing nature of the clientele and trends towards providing accommodation for the disabled’ (1988:3). He called boarding and lodging accommodation the ‘last resort’ for groups with few other alternatives. He concluded that this type of accommodation was a ‘backwater’, picking up those excluded from the mainstream and that this had been the case for at least the past forty years.

**Psychiatrically and Intellectually Disabled Residents in Boarding Houses**

Ward wrote a report for the South Australian Human Services Committee of Cabinet titled *Psychiatrically and Intellectually Disabled Residents in Boarding Houses* in 1988. He found that 49% of the surveyed residents have received treatment for psychiatric or intellectual disabilities and a further 6% have such a disability in the opinion of the proprietor (Ward, 1988:1). He also found that 73% had been in their current accommodation for more than one year.

Ward proposed that there were two broad categories of residents. Firstly the older, disadvantaged residents who had been discharged into the community after many years of institutionalisation. Secondly he wrote about the “new”,...
young, chronically mentally ill population who are just as disabled as the first
group but whose problems are frequently compounded by drug and alcohol	abuse (1988:1).

_Fritz and White Bread_

_Fritz and White Bread_ (Chapman & Provis) was written in 1991. It provided a	brief description of identifiable groups of boarding house residents which is still	relevant today. The groups included those with chronic psychiatric disability, a	protracted history of institutional care and people who stay for a short time and	then move to another boarding house. Chapman & Provis described residents	whose level of income immediately precluded them from living outside a	boarding house and those whose residency in a boarding house represented the
text of a downwards slide.


The South Australian government responded to concerns about quality of life for
texts with disabilities living in congregate residential care by introducing	legislation in this area in December 1994. The _Supported Residential Facilities	Act, 1992 (S.A.)_ and The Regulations 205 of 1994 aimed to provide some quality	control and to regulate some of the congregate residential care facilities. At this
time, the responsibility for licensing supported residential facilities (SRFs) in	accordance with The Act was handed to local government.
Reasons for The Legislation

The general objects and principles of The Act were to establish standards for the provision of personal care services in SRFs, to recognise and protect rights, to provide residents with access to information about the scope, quality and cost of care, to regulate the responsibilities of service providers and ensure accountability. The following summary is taken from *Somewhere to Call Home – SRFs in South Australia* (Doyle et al., 2003:15) and demonstrates the original intention of The Act:

Prior to the introduction of The Act in 1994, such facilities were referred to as hostels, mental health hostels, rest homes and boarding houses. The *Review of Psychiatrically and Intellectually Disabled Residents in Boarding Houses*, conducted in 1988 by the Human Services Committee of Cabinet, found that boarding houses were accommodating many people with psychiatric and intellectual disabilities following the de-institutionalisation of in-patient facilities.

The Review was very concerned that such people were being housed in minimal conditions without adequate treatment or care, and recommended that new legislation be introduced to bring boarding houses accommodating people with disabilities and mental health issues under licensing provisions.

The Act: Principles

The original principles of The Act in relation to the care of residents were as follows:

- high quality care
- informed choice
- reasonable levels of nutrition, comfort and shelter
- safety
- dignity
- respect
- privacy
- independence
- freedom of choice
- an entitlement to manage own financial affairs and not be subject to exploitation
- freedom to comment about accommodation and personal care

**Personal Care Services**

Personal care services were defined in The Act according to what services SRFs were providing at the time it was written. Today, the services that are provided are very basic and facilities choose what personal care services they will offer. This reflects what is realistically possible within the current financial situation of the sector and highlights the disparity between what once may have been provided and what is currently provided.

In addition to licensing and inspection powers being granted to local government, the legislation aimed to ensure that its principles were upheld by including these principles within prescribed documents. Under the heading of ‘Rights of Residents, Division 1 - Documentation’ (The Act, 1992:21) there are several documents which proprietors and managers are obliged to prepare for residents to comply with legislation. These include a Prospectus, Schedule 3, Service Plan and Resident Contract. Proprietors are required to go through these documents with residents or their representative and have them signed by both parties when a new resident enters an SRF or circumstances change.
The Act prescribes the information which the Prospectus must contain, including the details of personal care services provided or offered at the facility. The Resident Contract is made between the proprietor and the resident and is an agreement that the resident will accept the supported accommodation as outlined in the Prospectus, any rules or policies that will apply to the resident and a draft of a personal Service Plan for consideration. A Schedule 3 statement is “effectively a disclosure, providing enough detail for a resident to understand clearly the nature of accommodation and services being offered by the facility and to understand the costs and fees payable” (SRF Advisory Committee, 1997:25). The schedule constitutes an ‘offer’ of supported accommodation to the prospective resident.

A Service Plan should set out details of the personal care services that will be provided to the resident and legislation makes it the responsibility of proprietors and managers to prepare, implement and review them.

Under the heading of “Interpretation” on the first three pages of the legislation there is a list of definitions for the purposes of The Act. The Act states that “these may include any of the following” – broadly they are the provision of, assistance or supervision with nursing care, personal hygiene, showering, toileting, continence management, dressing, eating, mobility, medication, and personal finances. The “provision of substantial rehabilitative or developmental assistance” is the last personal care service listed in The Act (1992:2).

The Act does not prescribe any or all of the services defined as personal care services that must be provided but only what they ‘may’ include. It does not prescribe how services will be provided. Therefore different SRFs are not obliged to provide the whole range of personal care services and can decide how they are delivered. For instance, some of the SRFs surveyed by Hunter (2003) did not include a registered nurse on staff as they did not choose to provide nursing care. Many SRFs do not ‘choose’ to provide rehabilitative or developmental assistance.
The definition of personal care services in The Act is not reproduced in the Guidelines and Standards, 1997. This omission diminishes the importance of rehabilitation assistance. Definitions are not explicit but are alluded to in the sample Service Plans and methods of reviewing these as they give examples of headings and areas that may be included and refer to goals, actions and timeframes. This reference to goals is the only instance of any provision of rehabilitation and developmental assistance. Therefore facilities can choose to offer these services or not. A reference to goals in all areas implies that achieving goals is important, however it is not prescribed.

The Standards and Guidelines state that the purpose of a service plan is to ensure that facilities ‘recognise and respond to the needs and potential of individual residents’ (SRF Advisory Committee, 1997:41). They also state that the preparation of a service plan ‘is not an inherently difficult process requiring specialised skills and training’ (SRF Advisory Committee, 1997:45). A service plan is described as a ‘personal and social history of a resident, containing personal details, significant information on the person’s previous experience, current need for services, potential requirements and his/her expectations’ (SRF Advisory Committee, 1997:41). The Standards and Guidelines state that ‘review and revision must occur if the resident experiences or suffers a significant occurrence or deterioration that adversely affects his/her health or well-being’ (SRF Advisory Committee, 1997:41). There is no reference to residents achieving their potential, planning to reduce dependence on services or reviewing or adjusting services plans when positive change and events occur.

The only paragraph in the Standards and Guidelines which makes reference to the resident’s ‘goals’ states that ‘in both assessing and reviewing needs and service response, it is important to ask what the specific goal or aim is and whether the responses tend towards the realisation of this aim’ (SRF Advisory Committee, 1997:47). The examples given of goals are to ‘maintain a person’s mobility’ and to ‘maintain a resident’s emotional equilibrium’ (SRF Advisory
Committee1997:47). Goals are inherently based on maintenance rather than rehabilitation.

The sample Service Plan in the *Standards and Guidelines* (1997) gives examples under the headings of hygiene, mobility, social. Under the heading of ‘Action Taken/Service Provided” for hygiene are as follows:

- provide prompts and assistance as necessary with showering, shaving and oral care to encourage independence
- to shower at least four times per week
- to shave every two days
- oral care after each meal
- nails – attends podiatrist 6 weekly

The sample then lists a date for review of identified needs. Under the column ‘Staff Member Responsible’ there is no example and this is left blank. There is no column for resident responsibilities. Samples for mobility and social are similar.

The Act does not specify qualifications that are required to own or operate a facility unless nursing care is provided, in which case registered nursing qualifications are required. Staffing levels, qualifications and professional backgrounds of managers vary considerably (Doyle et al., 2003:6). However, it will be argued that the qualifications and experience needed to properly assess a client, develop a support plan, then implement and review the plan would normally be the role and function of a social worker, clinical or non-clinical mental health worker, support worker or other experienced human service worker. The provision of individualised support would be required to ensure its success.

The specific skills required to prepare a rehabilitative service plan depend on the attitudes of proprietors. Proprietors reported that they viewed Service Plans as
“useless red tape serving no purpose” (Doyle et al., 2003:22). Proprietors complained that there was no help from Mental Health staff to prepare them and make suggestions, there were no external services that could be planned for, no-one monitored whether they were implemented and that staff in the facility knew the residents and their care requirements without a written plan.

Proprietors also stated that it is probably not correct to say that residents are encouraged to manage their own medication and that it would be difficult to achieve compliance with personal finances as many residents are under Public Trustee or pay board and lodging via Centrepay and most spending money is held in cash, not a separate account (Doyle et al. 2003:22).

Despite the introduction of legislation there are several authors who argue that quality of life continues to be compromised for people living in this type of accommodation, there is little scope for rehabilitation and that institutionalisation still occurs. The Act is comprehensive and it aimed to establish proper standards of care in SRFs and ensure that facilities are of high quality, safe and that the dignity, privacy, independence and freedom of choice for their residents is respected. However it does not explicitly prescribe how services should be delivered to enhance recovery. I will argue that it is more about maintaining and/or managing people with disabilities.


At the time Legislation was being written there were several other events occurring and reports being produced relevant to congregate residential care which provided further momentum to produce legislation to protect vulnerable people. This information was gathered from the Legislative Council of South Australian Parliament Hansard Reports. Mental health hostels were inspected by South Australian Mental Health Service officers and a Mental Health Accommodation Licensing Committee was in operation. Hillcrest Hospital (a
psychiatric hospital) was closed down and the *Mental Health Act, 1977* and the *South Australian Health Commission Act, 1976* were under review. In 1988 the South Australian Health Commission was also conducted a review of the needs of disabled persons in boarding houses.

A reference group was formed and then a working party to produce a draft Bill relating to licensing boarding houses as a result of the findings of the above reports. This was distributed widely for comment. Between March and May 1991 the working party received sixty-five submissions relating to the draft Bill. Some of these submissions raised debate and posed questions about training and qualifications for local government officers to regulate and licence SRFs and issues around funding and fines for licensing and non-compliance. One of the submissions asked for an advisory committee to be formed to produce guidelines to accompany The Act and one of the questions raised was around the responsibility of SRFs when the health of residents deteriorates.

**SRF Residents’ Rights Project – Final Report**

The nature and climate of the SRF industry and an ongoing concern for appropriate support and care for this vulnerable section of the community prompted a project funded by the Supported Residential Facilities Unit of the Department of Human Services in Adelaide, South Australia. This project was conducted during the last half of 2001 by a not-for-profit community group called the Mental Illness Advocacy Scheme (MIAS). The Project was called “The SRF Residents’ Rights Project” (Pluck, Clark & Mott, 2002). The Project officers visited every SRF in South Australia, fifty-seven facilities in all. At this time approximately 90% of these facilities were privately owned.

I was one of the two Project Officers involved in this project and also a member of the Management Committee of MIAS who contributed to writing this report. I have a particular interest in supported accommodation and sharing this experience with several hundred SRF residents has deepened my knowledge in
this area and my commitment to assisting this vulnerable section of the community.

As one of the two Project Officers, we spoke with seven hundred and eighty seven residents about their rights and responsibilities. An unintended outcome of these meetings was that residents shared information with us about their lives and the way things were. We were disturbed about the number of instances where residents’ rights were being eroded and the lack of quality of life. It was also apparent that many of the SRFs were institutional in nature. The following anecdotal story is about one of the SRFs involved in the Project:

This SRF appeared extremely drab and depressing. The Manager explained that ‘the guys just don’t like nice things’. She suggested that the visit was pointless as the residents would not understand. The Manager went on to say that one of the residents is extremely disruptive, is awake all night, steals from other residents and is verbally and physically aggressive. The residents at this SRF were dressed untidily, many with no footwear. They were sitting on chairs positioned in a line against a wall in a small courtyard at the back of the building.

In the centre of the courtyard was a clothesline, full of what appeared to be rags. Residents refused an offer to sit closer together so that they could all hear one another. When asked why this was the case, they said that they would ‘get in trouble’ if they moved the chairs. They also refused to sit inside as they said that they needed to watch their washing dry, so that it would not be stolen. Contrary to the Manager’s suggestion, residents did understand the purpose of the visit and complained about a lack of privacy, with several saying that they would like to live somewhere else, preferably on their own.

They also complained that they never see their mental health key workers and that it was ‘no use asking them for help as they would just drug you’.

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They also complained that they never see their mental health key workers and that it was ‘no use asking them for help as they would just drug you’.
One man said that he has been on the same medication for twenty years and asked ‘do you think I'll ever get better?’.

A female resident stated that she had been raped several times in her bedroom by both people who have walked in off the street and by other male residents. She wore a pair of white socks with a name written on them in large black writing. She said that she has not seen her children for many years and asked if she would ever see them again.

The Project Team prepared a report for Department of Human Services at the beginning of 2002 which commented on the legislation and licensing of the SRFs. The report also commented on the facilities run by private providers and the tensions this created between earning a profit and caring for disadvantaged people in contrast to facilities run by not-for-profit agencies.

The conclusions in the Executive Summary of this report were that licensing methods and legislation should be reviewed in order to ensure that residents’ rights were consistently being upheld and that legislation could easily be translated into service delivery. It also recommended that standards were developed in keeping with legislation so that wide variations between the quality of care in facilities was brought under more scrutiny. Finally the report acknowledged that there were significant numbers of residents who were inappropriately placed and whose needs could not be met by SRFs under current arrangements. This was expressed with a concern regarding the for-profit nature of the majority of SRFs.

*Somewhere to Call Home*

The aim of the research paper *Somewhere to Call Home – SRFs in South Australia* was to inform key government policy and planning agendas about the housing, care and support needs of ‘vulnerable adults with complex and chronic needs”, in particular SRF residents (Doyle et al., 2003:1). It identifies and
describes the profile of people living in SRFs. The report agrees with other recent literature, in that the current profile of SRF residents is diverse in age, disability and its effects, institutionalisation and complex support needs.

Previous research reviewed by Doyle et al. (2003:3) in this report indicates that residents experience a range of disabilities, with mental illness the most common, are people on low incomes (predominantly government benefits) and often have complex care requirements, functional impairments and unmet social and health needs. Doyle et al. conclude that residents do not have access to community integration or rehabilitative activities. This means that residents are likely to have a compromised quality of life.

SRF Proprietors report that the level of resident’s needs has increased over recent years, especially with more aged residents and also younger residents with complex needs (Doyle et al., 2003:6). On average residents require three hours of care per day (Doyle et al., 2003:99).

As stated above, generally SRF residents have long histories of institutional care. Doyle et al. (2003:3) reported that most residents have lived in their current SRF for over two years and have usually ‘moved to the facility from another similar facility’.

The same report states that ‘fourteen percent of residents were living in a mental health institution’ and other forms of congregate care for ‘significant periods of time’ prior to moving into the SRF (Doyle et al., 2003:44).

Doyle et al. state that the needs of SRF residents have become increasingly complex (2003:2). Magor-Blatch (2003:9) prepared a Discussion Paper for the National Mental Health Working Group and agrees that this is one of the consistent themes to emerge ‘over the past ten years from reviews of supported accommodation sectors in Victoria, New South Wales, Queensland and South Australia’.
It’s No Palace – Boarding Houses: the sector, its clientele and its future

It’s No Palace by Anderson et al., (2003) is a recent report prepared about the boarding house sector. Although it excluded facilities licensed as SRFs and their residents similarities can be drawn between the profiles of residents included in this study and the transient nature of their accommodation, often including SRFs. This report describes the ‘changing nature of the clientele’ and that residents are increasingly people ‘on the margins, both physically and socially, and that ill health, poverty and disability as well as loneliness and a lack of significant relationships and support characterise the lives of many residents’ (Anderson et al., 2003:2). Other studies have found that residents have low expectations of housing and that many would prefer other, self-contained accommodation.
CHAPTER 4

Methodology, Methods & Analysis

If information is power (Francis Bacon noted that “knowledge itself is power”), then the possibilities of being able to effect change are enormous when one has access to secondary data.

In Royse (1995:212)

Methodology

This research will primarily use qualitative methodology and some quantitative data about SRF residents to assist in addressing the research question. This data will be used as evidence to prove that many SRF residents are long term and come to reside in this type of accommodation after living in similar types of congregate or institutional care.

A combination of documentary research, anonymous demographic data and interviews with key informants will provide a balanced mix of data for this study. A combination of methods will add strength to the findings and rigour of this research. Patton refers to this as ‘triangulation’, involving different methods of data collection (1990:187).

This research is applied research because it aims to inform action, enhance decision-making and to apply knowledge to solve human and societal problems (Patton, 1990:12). The purpose of this research is to ‘contribute to knowledge that will help people understand the nature of a problem so that human beings can more effectively control their environment’ (Patton, 1990:153). Patton goes on to say the ‘source of questions is the problems and concerns experienced by
people”. An applied research approach provides rigour and theoretical insight into the problem being researched (Patton, 1990:160).

Patton also refers to “legislative monitoring” (1990:111) which may include descriptions of staff selection, the nature of services offered to clients, descriptions of actual service delivery and whether or not they fail to meet legislative intent in implementation. Hence monitoring legislation is integral to this research.

The problems this research addresses are the reasons why residents do not move on, creating low vacancy rates, and residents living in SRFs long term. Its aim is to discover what factors influence these problems as well as the lack of housing alternatives and funding for support. The research has focussed on legislation and service delivery.

Methods

The methods used in this research were specifically chosen so that SRF residents were not directly involved as participants. A study that did involve residents was carried out in 1988 by O’Brien & Peady and this provided insight into the practical things people said that they would require to move to alternative accommodation. However, O’Brien & Peady’s work did not address questions about other factors which may inhibit residents from moving on.

Royse (1995:205, 206) calls the analysis of secondary data “unobtrusive” as it does not involve interaction with research subjects and therefore does not produce any unanticipated effects on research subjects. He sees asking respondents to provide information about themselves as “intrusive” and gives examples of this as participants who refuse to answer questions or complete surveys (1995:206). Royse also states that even with cooperation, there is the “possibility that merely asking questions may have some inadvertent effect upon
respondents” (1995:206). I particularly did not want to directly involve SRF residents in any way.

Royse goes on to further define unobtrusive research as archival research or secondary data analysis (1995:206). He states that the intent of secondary data analysis is not to find fault with another study, but to explore questions not examined in the original reports and to provide “knowledge, interpretations and conclusions beyond those stated in the original study” (Royse, 1995:207). He also finds that most research efforts begin with at least some secondary research and that “existing information provides a foundation for problem formulation, for the design of new research, and for the analysis and interpretation of new information” (Royse, 1995:207).

Duffy (1987:53) writes about “The Analysis of Documentary Evidence” and would agree with Royse (1995) that most research projects will require some analysis of documentary evidence. He states that it may be used to supplement information obtained by other methods while it may also form the central or exclusive method of research (Duffy, 1987:53). He further states that it is most useful when “access to the subjects of research is difficult or impossible” (Duffy, 1987:53). This is relevant to this research which has sought to avoid direct contact with SRF residents.

The various reports analysed for this research were chosen because they are relevant to the research questions of this study and were readily accessible. They relate to the past and current status of the sector, the future formation of government policy and planning, details about the sector, its residents, their needs and importantly, their unmet needs. They also illustrate current inequities between the SRF sector and other disability sectors in terms of funding and access to support services. The legislation, Hansard reports and the Standards and Guidelines (1997) have been included as they are also relevant to the research questions, in stating the expectations and how these will impact on residents, service delivery, staffing and the licensing process.
The Pluck, Clark & Mott (2002) and SACOSS reports are of particular importance as they were written by non-government organisations, providing a balance to those produced by DHS, a government agency.

After selecting the above reports they were carefully re-read with the research questions in mind. Relevant data, sections, quotes, themes and recommendations were then selected in order to provide a sound basis for this research.

The Housing Spectrum demographic data and other documents relevant to residents were included as this is a not-for-profit organisation and it was accessible. By studying not-for-profit SRFs, comparisons can be drawn between them and the data gathered by Department of Human Services, offering some insight into similarities and differences of service delivery by the for-profit and not-for-profit sectors.

Five key informants participated in this study and they all have a breadth of experience and knowledge of the supported accommodation sector, especially the SRF sector, past and current, government policy and planning, legislation and research, and new service delivery models. They are employed by both government and non-government organisations, which again provides a balance in this area. They are workers at a senior level and have the capacity to provide informed consent and to understand the aims of my research and the research questions. The questions asked of key informants are attached as Appendix A.

**Research Questions**

When data was gathered it was analysed to answer the research questions which were grouped under two main headings with sub-headings as follows:
SRF Residents – Demographic Data

- What is the current profile of SRF residents?
- Has the profile of SRF residents changed over time?
- Does demographic data suggest that the majority of SRF residents are long-term?

Legislation & Service Delivery

- What were the original principles, aims and intentions of the legislation?
- Are these still relevant to the current preferred models of supported accommodation and service delivery?
- How does the legislation impact on service delivery?
- In this environment is recovery inhibited or enhanced?
- Does legislation need to change to better enhance the recovery of residents?

Ethical Considerations

Analysing documentary evidence involves less ethical issues than research with vulnerable participants. However ethics approval was sought and given by University of South Australia Divisional Ethics Committee (See Appendix D).

Consent was gained from the Housing Spectrum Board to collect anonymous demographic data from Service Plans and other documentation relevant to SRF residents stored in the Housing Spectrum office. As stated above, this method of collection and the nature of such anonymous data does not involve SRF residents. The Housing Spectrum Board is not a ‘dependent group’ and were provided with an outline of the research to assist them in their decision-making process. An explanation was also provided for the reasons to involve a not-for-profit proprietor.
While Board members had verbally indicated support for this research in the past and have shown an understanding of the current issues in the supported accommodation sector, they were approached to give formal approval to collect anonymous, non-personal Housing Spectrum data (see Appendix E).

The anonymity of Housing Spectrum SRF residents was preserved by removing any identifying material from the data as it was collected. Data was collected in hand-written form and transcribed to a computer. Some data was conveyed electronically by the key-informants. Audio tape recordings were made of interviews with key informants as a technique of data collection. However it was not transcribed verbatim. Themes were identified and are included in the findings of this research. All data is stored securely in a locked filing cabinet.

Key Informants were invited to participate and informed about the nature of this research. They signed Consent Forms and a copy of the form is attached as Appendix B. They were assured that there would not be any negative consequences of their refusal to participate and that they would not be identified in any written material related to this thesis.

The Key Informants were all in management and/or policy and planning positions. Hence they were responsible for the information they provided in keeping with their professional roles. All the participants had previously verbally expressed interest, support and willingness to participate in this research. They commented on the timeliness of a study which examined the legislation in this area. They were re-assured that their participation would not be a time-consuming task.

The Housing Spectrum Board and key informants were contacted verbally in the first instance and were then provided with letters and/or e-mails with an outline of this research. All participants were invited to contact The University of South Australia Divisional Ethics Committee or the University research supervisor
should they require further information. No participants required further explanation before giving consent.

Background statements and questions were e-mailed to key informants prior to the interviews. One key informant brought her colleague to the interview to assist her in addressing the complexity of the issues.

Research findings have the potential to be of a political nature because they comment on organisational practices, government policy and legislation. These findings have been monitored to ensure that they are not damaging to anyone involved. It is unlikely that any of the findings will have any commercial or competitive implications as Housing Spectrum has left the supported residential facility sector.

**Data Analysis**

The Housing Spectrum demographic data was analysed, organised into a table format and compared with the data collected by DHS. Research questions were developed from the literature review and an analysis of the data. Documentary data was analysed by reviewing each report after careful re-reading with the research questions clearly in mind. Data provided by key informants was analysed for themes that were similar or different. This additional data informed the documentary and demographic data to ensure reliability and validity, and provide rich, textured information.

**Bias & Limitations**

During qualitative data collection and analysis it is impossible to completely eliminate the effect of the researcher on findings. It is intended that a personal insight and understanding of the SRF sector have enhanced the depth of this research and show that any prior beliefs or assumptions have not unduly influenced the results of this research.
There was the potential for my role as a researcher to be confused with my professional role in this area. Careful thought and consideration was given to clearly separate the two roles. All my communication with the key informants and previous co-workers has been conducted openly and honestly, explaining the reasons for doing this research and how it was separate from my professional working role. This approach assisted in making the research process less problematic.

There are limitations in this study such as the limited reference to other State legislation and the changes which are occurring to the supported accommodation sector. The addition of this material would have added weight to the argument that South Australia is lagging behind in many areas in the provision of supported accommodation and government responsibility.

Also it could be argued that the selection of Key Informants may have biased this research. However time restrictions precluded a wider selection, including informants from other relevant policy and service areas.
CHAPTER 5

Findings

‘Now he lives in a normal house in a normal street.”

Key Informant about a man who had lived in an SRF for twenty years

Introduction

A combination of documentary research, the collection of anonymous demographic data and interviews with key informants has been collected for this study. Some of the Housing Spectrum demographic data will be presented in table form with notes to provide explanation where this is required. Key informants were consulted about their experiences and views of SRF residents, service delivery and legislation. This has been collated and analysed. The background statements to each question asked of Key Informants are included in Appendix A.

Housing Spectrum Data

SRF Residents

This information was gathered from the Service Plans of residents at two of the Housing Spectrum SRFs to describe the profile of the residents. Data was gathered in July 2004. The third Housing Spectrum SRF was not included as it has only been in operation since September 2003. In a small number of instances where there were gaps in the information, I consulted with SRF staff.
Table 5.1 – SRF Resident Ages in Years

The majority of residents were aged between 30 and 59 years of age.

<table>
<thead>
<tr>
<th>Years</th>
<th>No. of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 to 29</td>
<td>5</td>
</tr>
<tr>
<td>30 to 39</td>
<td>9</td>
</tr>
<tr>
<td>40 to 49</td>
<td>8</td>
</tr>
<tr>
<td>50 to 59</td>
<td>8</td>
</tr>
<tr>
<td>60 to 69</td>
<td>2</td>
</tr>
<tr>
<td>70 to 79</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>

This data is slightly different from the data collected by Doyle et al. (2003) as there are fewer aged people represented.

Table 5.2 - Gender Breakdown

There were more males than females.

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>23</td>
<td>10</td>
</tr>
</tbody>
</table>

Table 5.3 - Primary disability

The majority of residents had a mental health diagnosis. The most common disability was schizophrenia.

<table>
<thead>
<tr>
<th>Primary Disability</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>18</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>6</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>4</td>
</tr>
<tr>
<td>Schizophrenia &amp; Obsessive Compulsive Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Bi Polar Mood Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Bi Polar Affective Disorder</td>
<td>1</td>
</tr>
<tr>
<td>Manic Depression</td>
<td>1</td>
</tr>
<tr>
<td>Manic Depression &amp; Intellectual Disability</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>33</strong></td>
</tr>
</tbody>
</table>
Table 5.4 – Source of Resident Income

All residents received a government pension as their only source of income

Table 5.5 - Length of Residency

The data gathered from Housing Spectrum indicates that the majority of residents are long term and have come from other types of institutional-style accommodation. There is one resident who has lived at the same SRF since 1987 and two who arrived in 1988. Prior to this the SRF was not operating as a hostel.

The records of entry between 1988 and 1995 are incomplete and the some of the dates after 1995 reflect the year that Service Plans were renewed. Housing Spectrum took over one SRF in 1995 and the other in 2001. This accounts for the high number of residents whose date of entry is recorded as 2001. The recorded dates of arrival confirm that the majority of residents have resided in their current accommodation for more than two years.

<table>
<thead>
<tr>
<th>Date of Arrival</th>
<th>Number of Residents</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1987</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>1988</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>1995</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>1996</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>1997</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>1998</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>1999</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>2000</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2001</td>
<td>9</td>
<td>3</td>
</tr>
<tr>
<td>2002</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2003</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>2004</td>
<td>4</td>
<td>-</td>
</tr>
</tbody>
</table>

Total Residents 33
Table 5.6 - Where did residents live before coming to the SRF?

The majority of residents lived in another SRF or other congregate care.

<table>
<thead>
<tr>
<th>Type of Accommodation</th>
<th>Number of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>With Parents</td>
<td>3</td>
</tr>
<tr>
<td>Private Accommodation</td>
<td>3</td>
</tr>
<tr>
<td>South Australian Housing Trust</td>
<td>1</td>
</tr>
<tr>
<td>Housing Spectrum Community Housing</td>
<td>1</td>
</tr>
<tr>
<td>Another SRF</td>
<td>12</td>
</tr>
<tr>
<td>Boarding House</td>
<td>5</td>
</tr>
<tr>
<td>Glenside</td>
<td>4</td>
</tr>
<tr>
<td>Minda Housing</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total Residents</strong></td>
<td>33</td>
</tr>
</tbody>
</table>

This evidence is in keeping with Doyle et al. (2003) and highlights residents moving around the sector rather than out of it.

Table 5.7 - Other Issues Affecting SRF Residents

Of the 33 residents, 26 smoked and 23 were not responsible for managing their own medication. Thirty in all had a clinical key worker, this reflects the Housing Spectrum policy that all residents must have a key worker. In contrast there is only one resident with a non-clinical support worker. People with drug and alcohol issues are not the youngest residents, but are spread across age groups (data from Service Plans).

<table>
<thead>
<tr>
<th>Other Issues Affecting Residents</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smokers</td>
<td>26</td>
</tr>
<tr>
<td>Smokes doled out</td>
<td>3</td>
</tr>
<tr>
<td>Medication management</td>
<td>23</td>
</tr>
<tr>
<td>Pocket money</td>
<td>9</td>
</tr>
<tr>
<td>Public trustee</td>
<td>15</td>
</tr>
<tr>
<td>Medication orders</td>
<td>3</td>
</tr>
<tr>
<td>Clinical key worker</td>
<td>30</td>
</tr>
<tr>
<td>Non-clinical Support worker</td>
<td>1</td>
</tr>
<tr>
<td>Secondary Alcohol-related issues</td>
<td>5</td>
</tr>
<tr>
<td>Secondary Drug-related issues</td>
<td>8</td>
</tr>
</tbody>
</table>
Table 5.8 - Personal Care Services Provided by Housing Spectrum SRF Staff

The following services were listed in the Housing Spectrum Prospectus.

<table>
<thead>
<tr>
<th>Personal Care Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of three main meals each day</td>
</tr>
<tr>
<td>Linen service</td>
</tr>
<tr>
<td>Cleaning</td>
</tr>
<tr>
<td>Prompting with personal hygiene</td>
</tr>
<tr>
<td>Medication management</td>
</tr>
<tr>
<td>Pocket money</td>
</tr>
<tr>
<td>Doling out Cigarettes</td>
</tr>
</tbody>
</table>

Residents Moving On

Since 1998 sixteen residents have moved on to alternative accommodation, twelve were male and four were female. Six residents moved into Housing Spectrum community housing and of these, five have sustained their tenancies. The sixth person is now in Glenside ‘never to be released’. Anecdotal evidence suggests that she was overwhelmed by the move and that this caused her to become very unwell. Four residents moved to South Australian Housing Trust accommodation. One of these residents married and moved into a house with his wife and another moved in with his partner. One resident moved into an aged care facility and another a nursing home. Three residents moved to another SRF and another was admitted to Glenside.

Changing Issues for SRF Staff

Housing Spectrum SRF staff report that in their experience people entering the SRFs in recent years have more complex needs and issues than those who have been there longer term. They report that they are generally younger, more unwell upon entry, experiencing more symptoms of their illness (ie hearing voices), psychotic more often, and that they have more challenging behaviours.
It is therefore more difficult and takes longer for staff to build relationships with people.

Staff also complained that a lack of background information makes it difficult to work successfully with new residents. They said that clinical key workers think that they may refuse to accommodate residents if they are fully aware of their complex problems and purposely withhold information. Housing Spectrum SRF staff reported that some of the newer residents are more likely to have drug-related issues such as drug or alcohol abuse, doctor shopping, methadone program or use of marijuana. They report that this can create difficulties with other residents who may not otherwise be exposed to such practices.

Key Informants Data

1. Do you think that there is other evidence to suggest that the profile of residents has changed since SRF legislation was introduced in 1994? If so, what evidence?

All key informants strongly agreed that there is no evidence that is comparable in terms of the level of detail provided by Doyle et al. (2003). A theme emerged that nobody really had an understanding of who was in SRFs before the legislation was written. Key informants reported that some proprietors suggest that residents’ needs have generally become more complex while others think that the residents are the same as they always have been, but there are many who are now ageing.

Key informants talked about a ‘board and care subsidy’ which was paid by the government to eight facilities prior to legislation being introduced. This was to support residents with mental health issues and highlights the profile of some SRF residents at the time.
One key informant said that SRFs are now operating as ‘quasi hospitals’ and that if the legislation was written now and framed around this it would be quite different and perhaps this is an indication that the population of residents has changed. She stated that for this reason, the legislation written in the early 1990’s is inadequate. She said that if it was the same population as we have now and there was an adequate understanding of their needs and their vulnerability, legislation would have been framed differently and would need to include a statement of duty of care.

All participants agreed that expressions of concern by families and other visitors to SRFs about standards of care have increased and that this may be another indicator of a change in profile of residents.

One key informant thought that deinstitutionalisation had probably displaced the population of people who were residing in SRFs prior to the introduction of legislation.

Another theme to emerge was that at the time of deinstitutionalisation there was an underestimation of the role the institution played in serving ‘whole of life’ needs. No funding accompanied people into the community to meet their needs. The intention to meet people’s needs differently in the community did not occur.

Four of the five key informants commented on how the mix of residents has changed over time. In the past hostels may have been occupied by groups of people leaving Hillcrest Hospital who were institutionalised and who were accustomed to living in congregate care. Today residents are referred to SRFs from many different sources such as mental health institutions, intellectual disability organisations and correctional services and there are frail, aged residents living with people as young as eighteen
who are experiencing acute symptoms of mental illness and who may have aggressive or other challenging behaviour.

One key informant suggested that the way we define needs has changed over time and that it is unrealistic that people living together with such a wide variety of needs will thrive if they are largely left to ‘fend for themselves’.

2. *Demographic data compiled by Doyle et al. (2003) also suggests that the majority of SRF residents are long-term at their current accommodation (over two years residency) and have entered the SRF from other congregate residential-type accommodation, boarding houses, other SRFs or hospital.*

- *Do you agree or disagree with this statement? Please explain your reasons.*
- *What do you think are the implications of this for people wishing to move from SRFs to more independent accommodation and people wishing to exit institutional care into SRFs?*

All key informants agreed with this statement and discussed the implications of long-term residents and others who simply move around within the sector. The notion of residents moving around the sector was discussed by the majority of key informants with the suggestion that people do become trapped within it. It emerged that there is a strong sense of proprietors ‘holding onto the quiet ones’ and protecting their financial interests by keeping the residents who ‘fit in’ to an SRF without requiring too much attention or causing disruption to others. At the same time, proprietors often ‘assist’ other residents to move on, ‘getting rid of the ones who are trouble’. One key informant stated that a move for residents rarely happened in a positive way. Some of the quotes from this section include:
• proprietors help the difficult ones to move, just to another SRF
• The SRF was the most available choice at the time, but then they get trapped
• Residents do not have the financial means to move on
• There is nowhere else to go
• People get stuck
• People get trapped
• SRFs become a dumping ground for a whole bunch of people who are unwell
• If those who wanted to move could, others could move in

All agreed that there are difficulties of moving on for some people, especially the frail aged. One key informant commented that SRFs were not set up as transitional accommodation. The remaining key informants felt that people should be able to choose to stay or go to more appropriate or desirable accommodation regardless of whether they are living in transitional or permanent accommodation. Most thought that people should not become trapped just because of a lack of alternatives.

All but one key informant agreed that this situation causes a blockage in the supported accommodation sector with few vacancies available for those wishing to enter the sector.

One person told a story of a man who had lived in an SRF for twenty years in Port Elliot, when the facility closed without warning. He secured independent accommodation and has access to twenty hours of support each week with basic activities of daily living such as shopping, cleaning and cooking. She said that now he lives in a ‘normal house in a normal street’ and that his family report that he is ‘living better than he has done in twenty years’.
3. What is your understanding of the original principles, aims and intentions of the SRF legislation?

One key informant refused to comment on this question as she said that she was not involved in the sector at this time. The others thought that The Act reflects assumptions about the people who were living in SRFs prior to the introduction of legislation. They felt that assumptions made about the SRF population do not fit with today’s residents and that Legislation about the current population would need to include some duty of care statement which reflects the residents’ level of vulnerability. This may suggest that in the past residents were not as vulnerable.

Key informants thought that a changing social and economic environment combined with a difficult population of residents has negatively impacted on proprietors and their commitment and ability to provide a good standard of care.

One key informant explained that The Government endorsed The Legislation with an intention of wanting to work with proprietors rather than simply demanding that they comply. She said that The Government also recognised that the sector lacked resources. The Legislation gave responsibility for licensing and monitoring to local government. It was The Government’s intention that local government take on an educative and supportive role in the SRF sector. Key informants agreed that this has not occurred.

There was a general consensus that The Act is not very prescriptive and does not impact on standards of care.

Anecdotally, twenty SRFs ceased to operate at the time legislation was brought in as they could not comply with the standards. There have been
a number of SRFs close over the past few years (see Table 5.9). Data provided by key informants indicates that this has been due to a combination of financial pressures and cancelled licences because of failure to comply with legislation:

Table 5.9 – Number of SRF Closures 2001 to 2004

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Closures</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>4</td>
</tr>
<tr>
<td>2002</td>
<td>4</td>
</tr>
<tr>
<td>2003</td>
<td>5</td>
</tr>
<tr>
<td>2004</td>
<td>2 (at end of August)</td>
</tr>
</tbody>
</table>

4. In what ways do you consider that the original principles, aims and intentions of SRF legislation are still relevant (or are not relevant) to current preferred models of supported accommodation and service delivery?

One key informant considered that such issues are about the model of supported accommodation rather than the legislation, but if anything were to change there should be an increase in the protective and regulatory role of local government.

Others thought that the relevance of the original principles and aims of the legislation were ‘beginning to move into negative gear’. One key informant said that rehabilitation and recovery were ‘not invented’ at the time the legislation was written. The remaining key informants agreed that there is ‘no capacity for the current sector to follow a rehabilitation and recovery model’ partly because ‘SRFs are run on a shoestring’.

SRFs do not fit neatly into the contemporary understanding of supported accommodation. The Act is based on providing support and accommodation together and would need to change to prescribe their separation.
Key informants expressed concern that if SRFs are here to stay they must be required to change. Four key informants agreed that for this to happen legislation must address the protection of individual rights and changing service systems and structures.

There was a strong sense that citizenship rights were missing from current legislation and that The Act should change to explicitly incorporate these. This would go some way to ensuring that people receive individualised disability support that enabled them to meaningfully participate in the community and have some control over their own environment.

Some proprietors are ‘getting around’ the legislation by separating support from accommodation. One proprietor known to two key informants has secured a number of independent houses and flats and has moved people from his SRF into them. He has formed a separate company to provide them with support and therefore is not bound by any legislation.

5. *In regard to personal care services, do you think a disparity exists between the ideal and the reality and if so, how do you consider that SRF legislation impacts on service delivery in SRFs?*

There was overwhelming agreement that a disparity does exist between the ideal and the reality in terms of personal care services and their provision. The legislation does not prescribe how people’s needs will be met, how services should be provided or required staff competencies. One key informant stated that much of service delivery is about the minimum required to obtain and keep a licence. All agreed that self-funded care cannot realistically provide adequate services and one key
informant stated that ‘legislation does not impact on service delivery at all’.

One key informant said that when legislation was written it reflected services being provided at the time and the services listed in The Act were intended to be a minimum range of services. Another participant stated that she is currently unaware of any proprietor providing any rehabilitative or developmental assistance. She said, ‘That is one of the things that you just do not see happening in SRFs at all’.

Service plans were discussed and it was agreed that if these are completed, it is not known whether they are implemented or how they are implemented and that ‘no-one is checking’. It was thought that these should not consist of a list of tasks to maintain people in their current state but should include proper goal planning and reviews and be conducted by people with some level of professional training, such as qualified social workers. The participants agreed that Authorised Officers are not trained to assess service plans and related stories of visits only once per year to conduct audits for licence renewals.

One key informant raised the issue that it is the responsibility of proprietors to provide reasonable assistance to residents to get the supports they need and referred to Sections 41 and 42 of The Act. She stated that needs are not identified and even if they were, the majority of SRFs do not comply with legislation in this area as there is no attempt to assist residents to have all of their needs met. Proprietors say they do not have the financial capacity to do this much less provide all of the services listed in The Act.

The new Sustainment Packages are provided to SRFs after proprietors sign service agreements which specify how the funds will be spent. Many proprietors have returned the service agreements to The
Government asking for amendments to reflect the fact that they cannot provide any extra services.

6. If such a subsidy was in place, please discuss whether an MLM SRF and its staff would have the capacity to provide 'substantial rehabilitative or developmental assistance' or meet accreditation standards in place for other comparable aged care or disability facilities.

One key informant did not comment on this section, however the remainder agreed strongly that such a subsidy would result in little, if any, improvement in terms of meeting people’s needs. They said that this is because providers are not skilled in preparing and implementing service plans and that the money would probably be absorbed in other ways if it was not accompanied by a service agreement or some other form of contract with a focus on building capacity for rehabilitation. It was generally agreed that this would need to happen in conjunction with changes to legislation and monitoring procedures.

One key informant stated that it would be an improvement if award wages and minimum qualifications were made possible but there would still be little real improvement in terms of individual care planning. She felt that the needs of the many would continue to outweigh individual needs and that the physical environment, abilities to work with individuals and the increased paperwork would overwhelm staff who would not have the time or the skills to make any difference. She said that such an SRF would still be ‘way off meeting any similar accreditation standards’ as there are already ‘such huge deficits’ in resources.

Another key informant talked about Sections 41 and 42 of The Act again, saying that most SRFs do not assist residents to get the care they need and that generally they cannot and do not meet legislative requirements,
offering sub-standard care and continuing to operate in a low, user-pays economy. She said that ‘nobody gets the right standard of care’.

7. **Do you agree or disagree that special skills are required to successfully work with people with disabilities to assist their rehabilitation?** If you agree, what skills might workers require? If you do not agree, please discuss why?

All key informants agreed that special skills are required. These included:

- support needs to be tailored to individual needs
- individual needs are important in care planning and goal setting
- building relationships is ultimately at the base of good rehabilitation work
- good communication skills
- a belief in the capacity of all people to recover at their own pace and within their capabilities
- ability to engage people in such a process
- to lend vision
- understand individual strengths and limitations
- to be realistic
- ability to break goals down into achievable steps
- systems negotiation

The majority of key informants agreed that there is no recognition of this within the SRF sector and that currently, if service plans exist, they are very much about maintenance rather than recovery. It was also pointed out that many SRF workers are also institutionalised and do not have a belief that people can ever change and grow, seeing any small gains people make as unimportant. Staff are dealing with a wide range of
issues around mental health, intellectual and physical disability, sexual dysfunction, behavioural issues, health issues as well as practical day to day things like catching public transport – without the skills or time required to manage such issues. One key informant said that ‘nobody has time to develop service plans’ much less implement them and focus on rehabilitation.

8. Do you think that recovery is inhibited or enhanced in the current SRF environment? Please discuss your reasons.

Key informants agreed that recovery is inhibited in the current SRF environment. Quotes include the following:

- Recovery is inhibited
- There is no such thing as recovery in the SRF environment
- A focus on maintenance is barely sustaining people
- The Act needs to be assertive about a whole range of things
- Rehabilitation and recovery is ludicrous in this environment

They thought that the attitudes of workers, their working conditions and poor pay, a lack of exit points, no individualised attention, and regimented routines impact on this. One key informant talked about a negative sense of self that occurs when people are surrounded by others who have not moved on for years who are losing skills and who are despondent about their situations.

9. Does legislation in South Australia need to change to better enhance the recovery of residents? If yes, what areas would you recommend for change?

One key informant stated that she would not change the legislation at all. The remainder agreed that legislation does need to change in some of the
following areas. They said that The Act should be more prescriptive about standards of care and service delivery, professional skills required by staff and staff to resident ratio. They thought that Legislation should be more explicit about the qualifications and experience of proprietors and managers to ensure that suitable people enter into the sector and the definition of ‘reasonable assistance to residents to meet their needs’.

Participants also said that The Act should be re-written within a framework of citizenship rights as this is what the recovery model is based on. They thought that this would make care more responsive to individual needs and embrace the capacity for individuals to meaningfully contribute to their environment. One of the key informants said that The Act should ‘be about the people who live in SRFs and what they need, not just about licensing’. All agreed that The Act should prescribe the separation of support and accommodation.

They stated that any funding should be tied to individual outcomes and recovery indicators and that State Government should take responsibility for the enforcement of The Act. One key informant said that the sector is ‘unqualified, broke and doesn’t understand’.

10. *Do you have any other relevant comments that you wish to add?*

Only one key informant had an additional comment about the Government’s responsibility to ensure that The Act is enforced. She said that the government has been completely tardy and negligent in enforcing The Act. She stated that ‘government needs to bite the bullet’ as currently SRFs have no capacity to provide appropriate supported accommodation for this population of people. Stories of abuse, negligence, fire danger, stealing, rape and taking advantage of disabled people continue.
The same person talked about her concerns around current fire safety standards in SRFs. She stated that despite the fact that SRFs fall under the Building Code of Australia, they are not fire safe. As many residents have a diminished capacity to evacuate themselves in the event of a fire, SRFs should be required to have active night staff and/or automatic sprinkler systems. SRF proprietors do not have the financial capacity to provide either of these. She reflected on past fires which have occurred in boarding houses in every State in Australia and the tragic consequences of these. She was of the opinion that unless this situation is rectified immediately, ‘deaths will surely occur’.
CHAPTER 6

Discussion

“SRFs – a dumping ground for difficult people”

Key Informant

SRF Residents

There has been a marked change in the profile of residents since the days that boarding houses and hostels provided ‘respectable’ accommodation for travellers and workers. Three categories of hostels evolved – private rest homes for aged people, mental health hostels for people with psychiatric disabilities and aged care hostels operated by charitable organisations (Doyle et al., 2003:15). Following de-institutionalisation and the closure of Hillcrest Hospital, many people with psychiatric and intellectual disabilities moved into this type of accommodation and it increasingly became a sector involved in housing people with disabilities.

One of the themes that emerged during the collection of the data for this study was that at the time of de-institutionalisation it was thought that people could be cared for in a more appropriate way in the community. However appropriate funding did not follow people into the community and many disabled people were left to fend for themselves in hostels. There was also an underestimation of the whole of life role that institutions played in the lives of people with disabilities. In addition to physical shelter, hospitals had qualified staff to identify and respond to whole of life needs such as rehabilitation activities, medication, physical health issues, nutrition and a safe environment. These services were not provided or funded in hostels and the SRF legislation does not
advocate for this. Green wrote “deinstitutionalisation was not accompanied by an adequate conceptualisation of the essential requirements of housing, healing, care and protection of vulnerable people in the community” (2003:3).

Doyle et al (2003) provide detailed data about the current profile of SRF residents and report that SRF proprietors say that resident needs are more complex today than in the past. The findings of this study as well as anecdotal evidence provides some support for this argument as there has been an increase in complaints and concerns by people visiting SRFs and families of residents about poor standards of care and accommodation. The analysis of data for this study suggests that a different mix of residents is due to ‘referrals’ to SRFs from a wider range of sources including Mental Health Services (incorporating Glenside Hospital), Intellectual Disability Services Council and Correctional Services. This results in SRFs accommodating residents experiencing a wide range of ages, disabilities, needs and behavioural issues. Today there are also some younger people living in SRFs who are experiencing more acute symptoms of mental illness which may be exacerbated by drug and alcohol misuse or addiction.

Apart from the findings in this research, there is no comparable evidence to prove that resident needs are more complex now than they were at the time of deinstitutionalisation. Various reports written in 1988 such as Ward, Heffernan and O’Brien & Peady and in 1991 by Chapman & Provis prove that little has changed in terms of the profile of residents and their needs. The Supported Residential Services Census prepared by Victorian Department of Human Services in 1987 reported that the number of residents with a psychiatric diagnosis has remained constant after examining evidence as far back as 1987 (Victorian DHS, 1998:24). These reports indicated that the majority of residents had mental health issues, that many were long term and that there was also a presence of a younger, more unwell population at this time. This has not changed.
Analysis of data for this study suggests that the way human services look at identifying and addressing needs, the principles around service delivery and the concept of rehabilitation and recovery, have brought the needs of SRF residents to the fore. It is unclear if the profile of SRF residents and their needs has changed. More research is required to answer this question.

**Long-term Residents & Those Who Move Around within the sector**

The findings of this study provide evidence that many residents are either long term in a particular SRF or have entered SRFs from other similar types of accommodation. This is not a new discovery. Again, Ward (1988), Heffernan (1988), O'Brien & Peady (1988) and Chapman & Provis (1992) all commented on this up to fifteen years ago. Key informants agreed that this is the case. Participants suggested that residents who are easy to care for and do not place high demands on SRF staff are encouraged to stay, while those with challenging behaviour and more complex needs are ‘assisted to move on’. They also agreed that this rarely results in a positive move to more independent accommodation. There was a sense that the ‘quiet’ residents subsidise the more transient group in this way.

One of the themes that emerged from interviews with key informants was that SRFs are a ‘dumping ground for difficult people’ who have nowhere else to go. They agreed that people do become trapped in the SRF sector and the combination of long term residents and those moving around the sector causes a ‘blockage’ in the supported accommodation system. If those who wished to move on to more independent living could do so, people leaving institutional care could enter the sector.

Housing Spectrum data, key informants and the literature confirm that SRF residents can be successful in making this transition if they receive appropriate support.
**Principles, Aims & Intentions of SRF Legislation**

One key informant suggested that when SRF legislation was written it was The Government’s intention to work collaboratively with proprietors, recognising that they catered for a ‘difficult’ clientele in a sector with few resources. This may be one of the reasons The Act is not prescriptive about what services will be provided, how they will be provided and the qualifications of people providing them. The Government also intended local councils and authorised officers to take an educative and supportive role in the licensing process. The majority of key informants agreed that this has not occurred and provided anecdotal evidence of authorised officers only visiting facilities once a year.

Another key informant said that legislation appears to reflect assumptions, rather than evidence, about the profile of residents, at the time it was written. These assumptions do not appear to realistically reflect the profile of past or current residents and their needs. It differs from the evidence that was gathered before legislation was written.

**Accommodation & Support Packaged Together**

The Act prescribes that accommodation and support will be provided by one entity. This is in direct conflict with the current principles embraced by policy in the supported accommodation sector - the separation of support and accommodation services (DHS, 2002). Currently the SRF staff provide most of the support and personal care services. This is as a result of housing and support being packaged together, requiring a person to live in a certain type of accommodation to obtain a certain level of support (Bostock et al, 2000:33). In theory, a separation of housing and support services allows people to access support services wherever they live and can be seen as a way of “giving greater force to tenants rights and control” by individual service users (Bostock et al, 2000:33, Brown, 1996:3).
According to the *Supported Housing Projects Manual* (DHS, 2002) current models of supported accommodation and service delivery embody a partnership approach to service delivery. This approach combines clinical support, non-clinical support and housing management. Each partner has clearly delineated roles with an expectation that each partner will work together towards enhanced outcomes for consumers. The model is built around the principles of a developmental or rehabilitation model of support delivery and a consumer focus. It incorporates individual planning and a strengths based approach, with the aim of focusing on an individual’s capacity and wellness in all life domains in conjunction with the provision of appropriate housing. The data from this research indicates that this is not happening in South Australian SRFs.

**Legislation & Service Delivery**

Current services provided to residents were outlined by Hunter (2003). It is important to include these as they indicate the types of personal care services commonly provided by the SRFs participating in his study. The main services are very basic and include meal provision, cleaning, bed linen, continence support, holding resident medication and doling out pocket money.

The findings of this study indicate that two of the Housing Spectrum SRFs provided such basic personal care services. The majority of Housing Spectrum residents’ are smokers. Having enough cigarettes to last all day or all week is important to these residents. A small number of residents voluntarily give packets or cartons of cigarettes to staff so that staff can ration their cigarettes to prevent residents from smoking all their cigarettes in an hour or a day. This type of assistance is not covered under Personal Care Services or mentioned in the legislation. In addition, once such arrangements are in place they are rarely modified to reduce the residents’ dependence on staff.

Other areas not specifically covered by The Act are the social, behavioural and emotional support provided to residents. Housing Spectrum SRF staff
considered that these are the areas that they spend the most time supporting residents.

The original principles, aims and intentions of the legislation are still relevant today as they encompass the right to quality care and personal care services and aim to uphold some very basic human rights. Data collected for this study suggests that in reality, service delivery continues to focus on an illness model rather than a recovery and rehabilitation model (SACOSS, 2003:7). The provision of accommodation and some personal care services by SRFs and the language of ‘care for disabled people’ included in The Act does not embody the notions of support, development, rehabilitation or recovery and is directed towards maintaining individuals in their current state. One key informant stated that SRFs are now operating as ‘quasi hospitals’.

Key informants agreed that difficulties have arisen in translating the spirit of The Act into implementation and service delivery and that the principle of rehabilitation is completely lacking. Further impacting on this is current licensing processes which do not ensure compliance with legislation. Key informants recommended that legislation should be based on the principles of citizenship and prescribe individualised responses to people’s needs.

**Service Plans & Rehabilitation**

Key informants discussed how service plans and service delivery could incorporate a developmental focus. Service plans would need to include goals, how both worker and client would work towards achieving these (even if this was very slow and incremental), worker and client responsibilities under each heading and a time-frame for each step to occur. Goals would be clearly identified so that it would be apparent to both worker and client when these are achieved.
People with severe disabilities might have very basic and simple goals, however if a rehabilitation model supports the notion that everyone is capable of growth and change, these goals should be addressed and acknowledged as important.

**Implementation of Service Plans with a Rehabilitation Focus**

Recovery for people with a mental illness has been defined as ‘offering a person with a mental illness hope of recovery and return to participation in the meaningful activities of life” (Anthony, 2002). Mental health rehabilitation is an intervention provided by specialist mental health services in the context of a multi-disciplinary team. The emphasis is on ‘returning the individual to an optimum level of functioning” (Scarborough, 2002:2).

Key informants in this research agreed that mental health workers in this area require specific skills and training. They indicated that to be effective workers require an understanding of psychiatric disability, each individual person, what gives them meaning and specific skills to engage a person with complex needs. They must also be prepared to start where the individual is at and understand the range of factors that may jeopardise a person’s housing - actively addressing these. It is important to manage a balance between the person’s right to make a decision and to do things that may place some aspect of their life at risk as sometimes this is a method of learning to make different choices. Effective workers need to be able to make sound judgements about people’s abilities to effectively make informed decisions. Other desirable attributes are accessibility, innovative service delivery and flexibility around support. These findings are similar to O’Brien et al.’s work (2002:xi).

In assisting people to achieve independence, the roles of practical skills development, material aid and emotional support were highlighted by O’Brien et al. as being important, particularly in accommodating fluctuating periods of disability (2002:xi). The link between ‘important support and sustainable housing is not always found in tangible assistance with housing matters but in
the help that reinforces and assists people to cope with the challenges of daily living and often gradually increases their ability to live independently” (O’Brien et al., 2002:xi).

Most facilities cater for a mix of residents of both genders and of varying ages and disabilities. Without any external mechanisms or people to fulfil the roles of clinical and non-clinical support, the SRF staff are likely to step into this role, attempting to provide for the diverse needs of all residents. The multiple roles which SRF staff assume in the lives of residents, without appropriate qualifications, plus the absence of external mechanisms can bring inherent role conflicts as well as risks for the resident and increased demands on proprietors. This data is supported by Doyle et al. (2003:5) and Hunter (2003:6,7).

**How Does The Act Affect Service Delivery**

The Act is focussed on maintaining people rather than supporting them to develop their potential and does not impact on residents at the service delivery level.

Key informants identified a lack of prescriptiveness in The Act in several areas. The Act does not insist that personal care services are delivered within a rehabilitation framework. This is compounded by a lack of understanding by staff of the importance of service plans which might incorporate rehabilitation. The Legislation does not prescribe the skills, qualifications or level of staffing which would be required to develop, implement and monitor service plans adequately. No overarching emphasis on citizenship, individualised care and rehabilitation results in The Act having little effect on the quality of life of residents.

The variable standards in practices and the quality of facilities is apparent across the sector. Pluck et al (2002:37) reported that the various personalities, experiences, motives, values and skills of SRF proprietors and managers greatly
affected service delivery, access to rights and the quality of life in the various facilities visited by project officers. They also reported that wide variations in the personalities, experience, values and skills of authorised officers further impacted on the lives of residents in terms of complying with legislation and licensing (Clisby, 1995:ii). The Act does not succeed in assuring any service delivery standards.

Key informants discussed the factors that impact on service delivery. One of the key points was that care is self-funded and that this is not adequate to provide an appropriate range of services within a rehabilitation framework in the current financial climate of SRFs. Support and accommodation services packaged together go against the principle of separating these which aims to ensure that rights are upheld. A lack of outside people visiting SRFs also impacts on this. Lastly, key informants talked about how a focus on maintaining people creates dependency.

With only basic personal care services in place, key informants discussed a lack of a meaningful role for residents in the provision of their own day to day needs. At Housing Spectrum’s SRFs, a few residents worked in sheltered employment, but the majority had little or nothing to do. This is a common factor across SRFs. If people wish to help in the kitchen, tidy their own rooms, or look after their personal laundry it can be argued that this is on a token basis, with little meaning or reward. There is no focus on building or learning skills. Further impacting on this is the general lack of motivation experienced by people with mental health issues. Key informants talked about the lack of motivation experienced by SRF staff and how they can also become institutionalised, especially when there is nowhere else for residents to go. Legislation should explicitly embody a model which allows people to meaningfully contribute with a focus on skill and capacity building and growth in these areas.

People who become institutionalised have had basic personal care services delivered to them for the majority of their lives and become dependent upon the
provision of these services. They are not motivated or supported to take any responsibility to learn new skills or become more independent. Within existing SRF settings and taking into account the current climate of the SRF sector, the capacity to put other models into practice which focus on rehabilitation and recovery is limited.

Can Subsidies Improve Service Delivery without Changes to Legislation?

The Financial Analysis – SRFs in South Australia (Hunter, 2003) described the hypothetical ‘preferred model’, named the ‘Minimum Legal Model’. This is defined in the Background Statement & Questions for Key Informants (Appendix A).

Hunter concludes that such a model would require an annual subsidy of $269,148 to break even and that even with a subsidy in place it would not meet accreditation standards in place for other comparable aged care or disability facilities (2003:viii).

Key informants agreed that even if this type of facility received the above subsidy, it would still not have the capacity to provide ‘substantial rehabilitative or developmental assistance’ (The Act, 1992:2). Data showed that while award wages and minimum qualifications would be an improvement there would be little real change in the service provision without funding being tied to service agreements and outcomes, accompanied by changes to legislation. They said that money would be ‘absorbed in other ways’ as there is already such a ‘deficit in resources’.

Is Recovery Inhibited or Enhanced?

All key informants agreed that recovery is inhibited in the current SRF environment and that very few SRF residents successfully move on to more independent accommodation. The findings also suggest that there are structural
factors which inhibit their rehabilitation and recovery apart from a lack of supported accommodation options and funding for appropriate support.

Analysis of the data suggests that current legislation does not support a model of service delivery which is able to include rehabilitation and recovery support, activities and programs or access to alternative housing options. It does not prescribe staffing levels or qualifications and does not demand good working conditions or industrial protection for staff. The Act does not require proprietors to have appropriate qualifications or background checks to be deemed as suitable for this sector.

SACOSS reports that the dominant focus on an illness model has disadvantaged people with psychiatric disabilities and denied them access to services (2003:10). Inequality between population groups is evident when we consider people living in SRFs, the majority of whom are people with psychiatric disabilities, who are outside the range of funding for disability and aged care services. Despite funds allocated through the Commonwealth State/Territory Disability Agreement for psychiatric disability, South Australia does not allocate any of this funding to people with psychiatric disability (SACOSS, 2003:10). The current self-funded model in South Australia is detrimental to high quality support and accommodation.

**Does The Legislation Need to Change?**

The SRF Advisory Committee has requested that the South Australian Government conduct a review of the Supported Residential Facilities Act, 1992, however the Review and the Terms of Reference have not yet been announced. SACOSS (2003:12) and Pluck et al. (2002:37) also recommended that the licensing and monitoring of SRFs be reviewed. Pluck et al. recommend that a review should cover licensing methods, inconsistency in practical application, unmet resident needs and the for-profit nature of the sector and how this impacts on vulnerable people (see Chapter 3).
Key informants recommended that The Act be reviewed to be more prescriptive about standards that protect individuals. They would like The Act to be written within a framework of citizenship to allow SRF residents to meaningfully participate in their own lives and the community. They would like to see people’s needs being identified correctly and met appropriately, with staff qualifications and duties sufficient to achieve this. Participants also recommended that monitoring and licensing be taken over by State Government

By introducing the Sustainment Package, conducting research into the sector and developing new models of supported accommodation, the South Australian government has begun to acknowledge and address the issues to bring about change in keeping with current supported accommodation and disability policies. However, South Australia is lagging behind some of the other states by bringing about change to positively impact on the lives of SRF residents.

Summary

Hunter’s recommendation is that a policy decision ‘should be made regarding the role of private SRFs in the provision of accommodation in this sector’ and that unless there is a decision that there is no role, “SRFs should be supported by adequate levels of funding where appropriate” (2003:xi).

Key informants stated that any funding would have to be accompanied by changes in legislation and service agreements tied to outcomes for SRFs to become a place to recover and not ‘the end of the line’.

One key informant talked about the current situation around fire safety in SRFs. She stated that despite the fact that SRFs fall under the Building Code of Australia, they are not fire safe. As many residents have diminished capacity to evacuate themselves in the event of a fire, SRFs should be required to have active night staff and/or automatic sprinkler systems. SRF proprietors do not
have the financial capacity to provide either of these. She reflected on past fires which have occurred in boarding houses in every State in Australia and the tragic consequences of these. Recommending that The Government take responsibility for this as a priority, she stated that unless this situation is rectified immediately, ‘deaths will surely occur’.

The same key informant felt strongly that if there is a continuing role for SRFs, The Government needs to take up its ministerial responsibility immediately to enforce The Act as well as providing an adequate level of funding. They need to make a strong commitment to bringing about change in this sector by allocating appropriate levels of funding tied to service agreements and ‘overhauling the legislation’ so that it reflects contemporary understandings of rehabilitation and recovery and current models of supported accommodation, in keeping with services provided to other disability sectors.
CHAPTER 7

Conclusions

_The SRF sector is ‘unqualified, broke and doesn’t understand’_

Key Informant

The residents in supported residential facilities are a vulnerable group amongst the disabled population of South Australian citizens. Many SRF residents would prefer alternative accommodation and there is evidence that some residents can move successfully if they are supported adequately. However, there are low numbers of residents who achieve this and low vacancy rates in the SRF sector.

Many residents become trapped in the SRF sector and either stay long term or move around within the sector. It is acknowledged that a shortage of suitable alternatives and a lack of funding for support services are two of the main reasons why this occurs. This situation causes a blockage in the supported accommodation system.

This research has examined the other reasons why SRF residents rarely move to more independent accommodation. Findings are unclear if the profile of SRF residents has changed over time or if today their needs are being identified more accurately, reflecting concerns that many are inappropriately placed and have unmet needs.

Recovery is inhibited in the current SRF environment. A model of care which is self-funded does not have the capacity to provide quality care, support and
accommodation for people with disabilities. SRFs continue to fail to meet a range of disability standards which are in place for other vulnerable people in the community. The current financial situation for SRF proprietors is dire and this is reflected in the number of recent closures. The Government recognises this situation and has tried to reduce its impact by introducing a Sustainment Package. Despite the good intentions of some proprietors and the Sustainment Package, SRFs are still struggling to break even financially.

This research has examined SRF legislation and has found that it negatively impacts on SRF residents and inhibits recovery. A lack of prescriptiveness in The Legislation in a number of areas has been identified and South Australia is lagging behind the other states and territories in reviewing legislation in this sector.

The Legislation does not prescribe appropriate qualifications and experience of proprietors and managers or the number of staff that should be employed per number of residents or the qualifications and skills that staff should have. This, combined with the current financial situation of the sector, means that anyone can own or manage an SRF. Currently SRFs are under-staffed with workers who do not have the appropriate qualifications to care for disabled people, especially with a rehabilitation focus. This is contributing to the current problems for residents.

The nature of congregate residential care means that the needs of the majority continue to outweigh individual needs and residents do not have the opportunity to meaningfully participate in activities of daily living. Any daily living skills are quickly lost in this environment.

The results of this research suggest that the way SRFs are licensed and monitored by local government is inadequate and does not ensure quality of care, a rehabilitation focus or compliance with The Legislation.
Combining support and accommodation goes directly against the current principles of supported accommodation. It is this fundamental issue which needs to be addressed if the needs of this vulnerable group of people are to be met.

Referrals from a wide range of areas has resulted in a mixture of residents residing at the same SRFs. The Act does not offer any protection for residents living in SRFs if new residents are disruptive or unwell. The findings of this research indicate that the current standard of care in SRFs is unacceptable and inhibits the recovery of residents. Regardless of whether there will continue to be a role for SRFs in the future, State Government must at least take responsibility for meeting its Legislative requirements immediately. It is urgent that fire safety standards are addressed before fire-related deaths occur.

Summary

It is recommended that the South Australian Government undertake a review of the legislation within a framework of citizenship and individualised care and take on the licensing and monitoring role, in keeping with other States and Territories.

Any legislative review is a lengthy procedure and could take years to impact on SRFs and their residents. In the interim, it is recommended that SRFs receive suitable funding as quickly as possible. Funding should be provided to SRFs in conjunction with service agreements and contracts which specify what services will be provided, who will provide them and how they will be provided. These should be based on achieving tangible positive outcomes to meet residents’ needs more appropriately. Funding also needs to be provided to allow outside supports and expertise to be provided in SRFs. Until this occurs, SRFs are barely sustaining people and have no capacity to enhance the recovery and rehabilitation of their residents.
References


O’Brien, A., Inglis, S., Herbert, T., Reynolds, A. (2002) Linkages Between Housing and Support – What is Important from the Perspective of People Living with a Mental Illness, Australian Housing and Urban Research Institute, Swinburne/Monash Research Centre.


Reynolds, A., Inglis, S., O’Brien, A. (2003) Improving Housing and Support Service Co-ordination for People Living with a Mental Illness, Australian Housing and Urban Research Institute, University of New South Wales and University of Western Sydney Research Centre.


Appendix A – Background Statements & Questions for Key Informants

Background Statements & Questions
For Key Informants

Supported Residential Facility (SRF) Residents

1. Contemporary policy and discourse around SRF residents suggests that the profile of residents has changed over time and that today, their needs are more complex. SRF proprietors agree with this statement. This is also reflected in current supported accommodation projects for ‘people with complex needs’. Certainly the profile of residents has changed since the days that boarding houses were home to travellers and workers looking for a temporary place to stay.

Demographic data about SRF residents collected by Doyle et al. in 2003 for the Department of Human Services “Somewhere to Call Home – Supported Residential Facilities in South Australia” is extremely detailed and useful as little comparable data has been collected over the last ten years.

Do you think that there is other evidence to suggest that the profile of residents has changed since SRF legislation was introduced in 1994? If so, what evidence?

2. Demographic data compiled by Doyle et al. (2003) also suggests that the majority of SRF residents are long-term at their current accommodation (over two years residency) and have entered the SRF from other congregate residential-type accommodation, boarding houses, other SRFs or hospital.

- Do you agree or disagree with this statement? Please explain your reasons.
- What do you think are the implications of this for people wishing to move from SRFs to more independent accommodation and people wishing to exit institutional care into SRFs?

SRF Legislation

3. Broadly, the general objects and principles of The Act were to:

- establish standards for the provision of personal care services in SRFs;
- recognise and protect the rights of residents;
provide residents with access to information about the scope, quality and cost of care; and
regulate the responsibilities of service providers and ensure accountability.

What is your understanding of the original principles, aims and intentions of the SRF legislation?

4. Mental health policy and current models of supported accommodation focus on rehabilitation and recovery and promote the separation of support and accommodation services.

In what ways do you consider that the original principles, aims and intentions of SRF legislation are still relevant (or are not relevant) to current preferred models of supported accommodation and service delivery?

5. The focus of this research is on service delivery and how legislation impacts on residents. Therefore the provision of personal care services is of importance to this question. By defining ‘personal care services’ the legislation gives some idea of a range of ideal services that people with significant disabilities might require on a regular basis, however it is not prescriptive about the provision of these services. The services that are actually provided by SRFs and the way they are provided, reflect what personal care services facilities choose to offer, as well as their capacity for quality care and may also indicate what is realistically possible within the current financial situation of the sector.

In regard to personal care services, do you think a disparity exists between the ideal and the reality and if so, how do you consider that SRF legislation impacts on service delivery in SRFs?

6. Personal Care Services are defined under the heading of “Interpretation” on the first three pages of The Act. However The Act does not prescribe what personal care services must be provided or how they should be provided and this is up to each facility to decide. A specific personal care service that I wish to draw attention to is that of “the provision of substantial rehabilitative or developmental assistance”. The Standards & Guidelines (1997) do not explicitly mention this and SRFs are not obliged to provide this as a service. The language in the Guidelines is more about maintenance than recovery.

Hunter (Financial Analysis - Supported Residential Facilities in South Australia, 2003) describes the ‘Minimum Legal Model’ (MLM) SRF as follows

- a forty bed facility
average charge to residents of 85% of pension including maximum rent assistance
employment of staff who were paid award wages, had the lowest levels of appropriate training (Community Services Certificates 3 or 4) and were employed for the hours that were required to meet resident need based on DHS SNAP assessments, adjusted down for congregate care
payment of superannuation at 9% and Workcover at 6%
The payment of an imputed market rent
All other expenses in line with the typical model, increased for the increase in residents from 38 to 40 where the expenses are variable

The Financial Analysis concludes that a model such as this would require an annual subsidy of $269,148 to break even (Hunter, 2003:viii).

If such a subsidy was in place, please discuss whether an MLM SRF and its staff would have the capacity to provide ‘substantial rehabilitative or developmental assistance’ or meet accreditation standards in place for other comparable aged care or disability facilities.

7. In order to provide substantial rehabilitative and developmental assistance SRF staff would require special skills. Specialist skills are not prescribed by The Act. I acknowledge that much of this problem is caused by a lack of external supports, however:

Do you agree or disagree that special skills are required to successfully work with people with disabilities to assist their rehabilitation? If you agree, what skills might workers require? If you do not agree, please discuss why?

8. Do you think that recovery is inhibited or enhanced in the current SRF environment? Please discuss your reasons.

9. The South Australian government has made a commitment to reviewing The Act, however the review and its terms of reference have not been announced. Other states and territories have set up a number of strategies in response to concerns about the supported accommodation sector, including:

- its viability and decline;
- more complex resident needs;
- disparities between this types of accommodation and that provided to other vulnerable groups
- the appropriateness of the service model; and
- the need for formal mechanisms to safeguard the interests of residents.
Does legislation in South Australia need to change to better enhance the recovery of residents? If yes, what areas would you recommend for change?

10. Do you have any other relevant comments that you wish to add?
Appendix B – Key Informant Consent Form

CONSENT FORM

Project Title: Supported Residential Facilities – Supporting Residents to Stay or Move On?

Researcher: Alice Clark

Supervisor: Margaret Brown

- I have read the Information Sheet, and the nature and the purpose of the research project has been explained to me. I understand my involvement in the research and agree to take part.
- I understand that interviews will be audio-recorded as a technique of data collection. Interviews will not be transcribed word-for-word and audio-tapes will be erased after data analysis is completed.
- I understand that I may not directly benefit from taking part in the project.
- I understand that I can withdraw from the study at any stage and that this will not affect my status now or in the future.
- I confirm that I am over 18 years of age.
- I understand that while information gained during the study may be published:

  Please tick your preference

  - I do not wish to be identified in any way and would like all personal details to remain confidential.
  - I consent to being identified only by my position title and employer.
  - I consent to being identified by my name only.
  - I consent to being identified by my name, position title and employer.

Name of Participant: __________________________________________

Signed: __________________________________________

Date: __________________________________________
Appendix C – Information Sheet

School of Social Work & Social Policy
University of South Australia

Supported Residential Facilities – Supporting Residents to Stay or Move On?

Contact Person       Alice Clark
                      Bachelor of Social Science
                      btsoda@picknowl.com.au
                      Telephone 041 35 999 81

While some of you know me from Housing Spectrum I am also a student at University of South Australia completing my Honours Degree in Social Science. I am currently doing an honours degree which requires a research thesis.

My topic is to examine the reasons why residents of supported residential facilities do not move on to less restrictive living environments.

I would like to invite you to participate in my research as a ‘key informant’ and attach a summary of my research.

All key informants I have invited to participate are currently employed in senior management positions in either government or non-government organisations in the supported accommodation sector and have considerable knowledge and experience in this area.

If you agree to participate, I will arrange to meet with you again to discuss the issues associated with my research topic. All information that you give will remain confidential and I will only include your name if you agree.

I may contact you at other times to clarify points however it will not involve very much of your time.

However I will ask you to sign the Consent Form attached. All information collected must be kept for seven years. All data I collect will be stored in a secure place, in a locked filing cabinet in the researcher’s home office.

If you are interested in the results of my research a copy of my thesis will be available in the University of South Australia library at the Magill Campus.

If you have any questions or concerns you may contact my Supervisor at University of South Australia (Margaret Brown 8302 4711) or the Executive Officer (Rhonda Porter 8302 0341) of the Divisional Ethics Committee, Division of Education, Arts & Social Sciences at University of South Australia.

Yours faithfully,

Alice Clark.
Appendix D – Ethics Approval

Division of Education, Arts & Social Sciences
Divisional Human Research Ethics Committee
Y3-39 Academic Services, City West Campus
Ph 8302 0341
Fax 8302 0334
Email rhonda.porter@unisa.edu.au

15 June 2004

Alice Clark
Email btsoda@picknowl.com.au

Dear Alice

Project Title: Supported residential facilities - supporting residents to stay or move on

Thank you for the amended information provided to DHREC about your research project. Your submission was assessed by the Committee and has been approved as being in accordance with the guidelines set by the Divisional Human Research Ethics Committee.

Best wishes for your study.

Yours sincerely

Rhonda Porter
Executive Officer
Divisional Human Research Ethics Committee

Cc Supervisor
Chair - DHREC
Appendix E – Housing Spectrum Letter of Consent