Evaluation of the Resident Support Program

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FINAL REPORT

FOR DISABILITY SERVICES
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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
CLP	Community Linking Projects
DSQ	Disability Services Queensland
DSS	Disability Support Services
HACC	Home and Community Care
KSW	Key Support Workers
LCG	Local Coordination Group
QH	Queensland Health
RSP	Resident Support Program
UNSW	University of New South Wales

Notes on terminology

In this report, a distinction is made between the terms 'impairment' and ‘disability’. Impairment refers to the physical, sensory, psychiatric, intellectual or behavioural conditions people experience. These may be present from birth or acquired at any time; they may be sustained or intermittent; and may or may not equate with medically diagnosed conditions. Disability refers to the social experience imposed on people as a result of their impairments. In this understanding, disability is a social experience based on difference in the same way sexism and racism are understood. The experience results from the way social organisation fails to take account of support and access needs. This results in people with impairments facing physical, social, organisational, attitudinal and economic barriers to their participation in social, economic, political and cultural life. The experience of disability is also likely to be intensified when experienced in combination with other social disadvantages based on gender, Indigenous background, culturally and linguistically diverse backgrounds, age, sexuality and other economic disadvantages.

Acknowledging current usage in Queensland, people with these experiences are described as *people with a disability*. The term more consistent with the impairment and disability distinction and more widely used in other countries is disabled people.

In this report the term *RSP provider* refers to a non-government organisation funded to provide Key Support Workers, Disability Support Services or Community Linking Projects. Similarly *RSP provider staff* refers to staff of such organisations who are providing RSP services to residents.

Premises owners, operators or managers refers to those owning or managing boarding houses and hostels. *Premises staff* refers to those working for owners, operators or managers within the premises.

Private residential facility, as defined in Section 4 of the *Residential Services (Accreditation) Act 2002 (Queensland),* is a facility with a main purpose of providing accommodation in return for the payment of rent in one or more rooms, occupied or available to be occupied by more than four people.

Executive Summary

This is the final evaluation report for the Resident Support Program (RSP) pilot to November 2004. The evaluation was conducted by the University of New South Wales (UNSW) Consortium, managed by the Social Policy Research Centre UNSW, with additional researchers from the Disability Studies and Research Institute and the University of Queensland.

Description of RSP

RSP is a joint Disability Services Queensland (DSQ) and Queensland Health (Health) funded initiative that aims to provide support services to residents with a disability living in the private residential facilities. The three service types are:

- Strategies to support residents in mainstream community and leisure activities, Community Linking Projects (CLP) (funded by DSQ);
- Support with basic self care and presentation, Disability Support Services (DSS) (funded by DSQ); and
- Support with health and wellbeing, Key Support Workers (KSW) (funded by QH through the HACC program).

Non-government organisations are contracted to provide these services.

The RSP was implemented in identified private sector supported accommodation (hostels), boarding houses and aged rental accommodation facilities that are regulated by the *Residential Services (Accreditation) Act 2002*. The residents of hostels received priority in determining the delivery of the RSP. The program operates in five locations – Brisbane, Ipswich, Toowoomba, Gold Coast and Townsville. Two approaches were trialled:

- Individual approach: residents were identified for assistance (Brisbane, Ipswich and Toowoomba); and
- Premises approach: specific premises were identified and all eligible residents in them were offered assistance (Townsville and Gold Coast).

Local co-ordination groups (LCG) were established within each region. They provided a mechanism for the coordination and management of the RSP. DSQ Regional Officers, HACC Area Managers and RSP provider organisations were the principal members of LCG.

Evaluation Methodology

The evaluation was conducted over 18 months. Design was from October to December 2003; fieldwork from February to November 2004; and final analysis from December 2004 to March 2005. The methods included longitudinal interviews with residents and other stakeholders and quantitative data from services providing the RSP, coordinated through DSQ and Health.

This type of evaluation cannot comment on comparison to outcomes of alternative programs or a different level of investment in the program. It measures change over time to make inferences compared to no program. The pilot only operated on a small scale in five regions. Not all residents who were interested in these regions could

access the program. The pilot prioritised residents in supported accommodation services over boarding houses. The information from this type of evaluation is relevant to programs with similar goals and a similar level of investment per person. The analysis does not provide information to comment on the scale of benefit that could be expected from a higher level of investment for people living in such vulnerable situations.

Resident Support Program Profile

From October 2003 to September 2004, the data indicate that 682 people used RSP services. Of these people, 349 used RSP services funded by DSQ (CLP and DSS) and 455 used RSP services funded by HACC (KSW). Thus there were 122 people (18 per cent of the total) who accessed RSP services through both DSQ and HACC The number of people using RSP services increased with the maturation of the program. Almost one quarter (23 per cent) of recipients used services in all four periods, while 38 per cent received services in just one period.

Almost two-thirds (63 per cent) of people who received RSP services were male. About two-thirds were aged between approximately 33 and 65. Thirty-four people (5 per cent) were identified in at least one of the data sources as being Indigenous.

The longitudinal study was of 36 people who had most recently begun receiving RSP assistance at the beginning of 2004. They were people experiencing psychiatric disability and multiple disability: psychiatric disability 73 per cent; physical disability 55 per cent; neurological and intellectual disability 42 per cent; and multiple disability 64 per cent.

Over the twelve months, the largest service type was CLP (estimated at 18,148 hours), compared with DSS (estimated at 14,482 hours) and KSW (6424 hours, plus 1969 transport trips, explained below). The program cost between $473,557 and $546,998 per quarter.

Implementation of RSP

The many people involved in establishing and implementing the RSP pilot achieved a relatively stable, recognisable program in which residents were pleased to be involved. Residents generally expressed high levels of satisfaction with RSP workers. The managers and workers in policy and service delivery responded to suggestions for improvement, within the constraints of the pilot design. Even the difficult task of resolving relationships between participants with different service principles was approached constructively by most stakeholders.

Within the constraints of defined service types, the services seemed to be reasonably well implemented and met their goals. Limitations for most residents included service gaps between the service types, such as suitable housing goals; an inconsistent approach to disability service principles; and limited flexibility and coordination problems between the service types to respond to resident need. Staff also identified resource constraints on providing the assistance required by residents.

Both the premises and individual approaches had advantages and disadvantages identified by stakeholders. In practice the main distinction between the approaches was the number and quality of the premises in which the RSP operated in the region and the number of people assisted in each facility.

Implementation in a pilot phase is always difficult because of its ground-breaking and potentially temporary nature. Added to this were a number of contextual constraints including barriers such as the historical accommodation context, the shortage of housing and human services, welfare reform and community attitudes. It was also in a time of rapid residential services sector reform. Despite this, the program remained viable and within budget and appears to have improved the lives of residents in all regions where it was piloted.

Impact on Residents

The lives of the residents who participated in the longitudinal resident survey at the first contact were characterised by isolation within the community, estrangement from family, detachment from the labour market, poverty and reduced mobility and a fatalism about whether their situation could ever improve.

Residents with RSP assistance increased their access to health, welfare and community services. CLP played a major part in improved resident satisfaction with social participation, with most people benefiting from increased social contact and the development of broader interests. Low income and physical access issues continued to militate against the success of community integration attempts for many residents. RSP providers worked with limited resources (eg. diminishing numbers of bulk-billing doctors, long waiting lists for subsidised services, disability employment services which exclude clients without stable accommodation and social support, social and leisure groups which will not accept residents).

The most significant benefits to residents were increased access to and effectiveness of health services and treatments. Residents' self-identified health and wellbeing improved substantially across the 9 months with many measures approaching population norms. KSW supported residents to access services, attend appointments and follow treatment instructions. This contributed to increased resident satisfaction with health professionals and treatments.

More residents participated in education, training and voluntary activity, but not paid employment. Some residents moved to more suitable accommodation with the help of RSP workers.

Impact on Premises Operators

Most premises operators reported a positive impact on workload. The RSP replaced or complemented some of the tasks that they or their staff had previously undertaken and this freed up time to concentrate on other work. The RSP created some work in coordinating between premises staff, residents and RSP providers, though they mainly felt that this initial work was worth it in terms of both benefits to residents and in a consequent reduction in their own workload, particularly around providing personal care. The RSP impact on financial viability was marginal for most operators. Besides the free time that they were able to direct to other activities, the cost savings were small.

When asked about the future of the RSP the premises operators were unanimous that RSP should be continued beyond its trial phase, be expanded and be available to all those who might be entitled. They were concerned that residents who used the RSP pilot would be severely disadvantaged if the service were withdrawn. Many said that

this would also impact negatively on the quality of accommodation that they offered as they would not have the extra time resources that the RSP delivered.

Cost Effectiveness

By utilising financial data, MDS data and outcomes data, a cautious assessment of the inputs, outputs and outcomes of the RSP over a nine-month period (January-September 2004 for inputs and outputs and February-October 2004 for outcomes), can be made, recalling all of the caveats noted throughout this report.

Summary of RSP Cost-effectiveness Analysis (Jan/Feb – Sep/Oct 2004)

Costs (Inputs)	Outputs	Effectiveness (Changes in outcomes)		
$1,576,793 (total)	30,389 hours and 1360 trips (total)	Satisfaction with accommodation	Satisfaction with social and economic participation	Self-assessed health
$3986 per recipient[b]	76.1 hours and 3.4 trips per recipient[c]	+1.17 units per person	+3.13 units per person	+0.58 units per person
		= 5.8% of scale range (p=4%)	= 11.2% of scale range (p=1%)	= 14.6% of scale range (p=2%)

Notes:

a. January-September 2004 for inputs and outputs and February-October 2004 for outcomes

b. Sum of average quarterly costs per person across the three quarters. This provides an estimate of average cost for persons who participated in the program in each quarter, thereby corresponding with the outcomes data (annualised $5315).

c. Sum of average quarterly hours/trips per person across the three quarters. This provides an estimate of average hours/trips per person who participated in the program in each quarter, thereby corresponding with the outcomes data (annualised 101 hours and 4.5 trips).

This analysis suggests that the program was successful in achieving statistically significant improvements in participant outcomes in a number of important aspects of their lives: satisfaction with accommodation, satisfaction with social and economic participation and self-assessed health, at an average cost of $3986 per participant over a nine-month period in 2004 (annualised $5315). This method does not provide analysis to comment on the degree of change that could be expected with a different level of investment.

Considerations for Future RSP-type Programs

The report discusses considerations and implications for future RSP-type programs, within the constraints of the policy context.

Service Principles

While funding agreements were predicated on compliance with departmental philosophy and policies, this was not clearly or publicly articulated at any level in the program. Disability service principles did not seem to be operationalised in RSP structures and practice. These are principles such as those embodied in the Commonwealth and Queensland disability services legislation and the DSQ strategic plan.

The principles focus on an individual whole of life approach to service planning and delivery, including support and suitable accommodation; rights of individuals; a developmental approach to service provision; maximising independence; and decreasing vulnerability to abuse, neglect and exploitation. They promote a social model of disability that locates residents' individual whole of life support needs in relation to their participation in the community and the service sector.

Service principles could be more explicitly articulated in the goals of the program and incorporated in the operation of the program through contractual obligations and program and provider policies and procedures. This approach relies on the funding agency enforcing compliance.

Residents

A core consideration for the program is which residents can use the program. In the likely limited budget context, choices will be made to exclude some residents. Questions of access definitions, equity (between location, residents in one facility), resident mobility, amount of service and priority residents need to be answered in any continuation or extension of the program.

Responses could be to prioritise people referred or self-referred who are most vulnerable or in residential facilities where people are most likely to be vulnerable, referral or self-referral.

Another approach could be to limit to what needs could be met by type, hours or length of time in the program. This approach would depend on a service focus that prioritised referral to mainstream services (eg. HACC, ACAT) and disability-specialist services, with some mechanism such as brokerage to ensure access to using the service, rather than merely access to the waiting list.

In the pilot, only residents who met disability or HACC criteria were eligible. An implication was inconsistency and inflexibility, such as an older person with a disability only being eligible for KSW. The research suggests that eligibility should be based on a person's support needs and continuity of care, rather than administrative boundaries of other programs.

Service Types

The RSP pilot had three service types: DSS, CLP and KSW. In some locations these types were interpreted flexibility to respond to resident needs, in others they were rigidly interpreted to the exclusion of some residents and their interests. The mere presence of a regular personal service provider was described as one of the greatest contributions of the program, irrespective of the service type.

The implications of the findings were that the goals of all three strands address residents' needs and improve their quality of life. This is particularly so if the goals were applied flexibly in response to support needs, were integrated with the other RSP service types and other services and were applied with a developmental approach.

In summary, the goals within an individual whole of life framework can be framed as: independent personal care; social and community participation and engagement; and referral to use of mainstream and specialist services and alternative suitable accommodation. In practice, the program also incorporated a fourth goal of supported transport, in terms of both social support and available, accessible transport.

Additionally, the research suggests that brokerage to overcome chronic human services shortages would also be necessary to effect these goals.

Program Approaches

The RSP pilot had two approaches by which residents can access the program, based on particular premises or an individual resident. Each region only had one approach.

Considerations for assessing the two approaches or alternatives include flexibility from the perspective of the resident, individualising care, access, equity, mobility of residents and transience of facilities and cost. A preferred model would incorporate the benefits of both approaches and address the disadvantages.

The research suggests that any future programs should take an individual approach, consistent with principles of service provision in other DSQ and HACC programs. This could be administratively organised to take advantage of the benefits from both pilot approaches, such as support staff being allocated a cluster of premises in a manageable sized location, to maximise their familiarity with the premises and the profile of the program to the residents in those premises.

RSP Providers

Providers were selected through open tender. Criteria for future provider suitability should include experience and track record in disability, developmental training and a practical understanding of disability service principles. An understanding of community development techniques might be necessary to overcome the contextual limitation of community attitudes.

Considerations for which providers and how many would depend on the range of available of existing providers in the local area, staff availability, training and support, staff skills and experience, record of interagency collaboration and the historical relationship with premises operators.

One option would be to have one or fewer service providers per location. Potential advantages of this model would be efficiency, consistency of service and removing conflicts between providers. It would be more likely to facilitate flexibility, meaningful activity and responsiveness to whole of life needs of a resident.

The role of the key support worker in assessing and referring residents to other organisations for the care and support they require is in many ways the cornerstone of meeting needs in a more holistic manner. A more streamlined approach to referral and accessing required resources would cut down on the time required to coordinate with other workers (including other RSP providers) considerably.

Private Residential Facilities

In the premises approach, facility operators chose to apply for suitability. In the individual approach, all individuals in all private residential services meeting disability or HACC were eligible. During the pilot period, supported accommodation facilities were prioritised.

From the perspective of residents, all private residential premises involved in the registration process should be included, irrespective of the condition of the facility Restricting premises to only the ones applying for accreditation, for example, could exclude the most vulnerable residents.

Communication to operators and their staff should include information about the purpose and scope of the program, method of referral and relationship to the residential services reform process. Regular separate communication about progress in the reforms would also help address the confusion between the two initiatives.

Consideration also needs to be given as to how the registration and accreditation processes could change the criteria for premises to be classified as suitable for RSP as the reforms progress over time.

Management

The RSP pilot management structure had a number of inefficiencies, discussed in the implementation findings. A goal of improving efficiency is to increase the proportion of time and resources allocated to supporting people's needs rather than organising the program.

Alternatives to the joint management between DSQ and QH would be management by one agency entirely, or by one agency coordinating a whole of government approach to budget transfer or Memorandum of Understanding of available DSQ- and HACC-like funded services.

From the perspective of providers and regional managers, the program goals and contractual arrangements were similar to other DSQ and HACC programs. It could presumably gain efficiency by replicating the simpler management structure of other programs. The advantage of this model is integration of the program into other local support programs.

Alternatively, responsiveness could probably be improved by allocating responsibility to one central office person to whom all RSP providers report. The advantage of this model is that person is more likely to be aware of other residential facility reform considerations.

The pilot structure included many people at the level of local service planning and delivery. This necessitated management through Local Coordination Groups. Elsewhere, the evaluation referred to the shortcomings of this coordination structure. It was amended during the program to separate the operational function from the stakeholder advisory function. The research cannot comment on the completion and effectiveness of the change, however, the intended new structure responded to the difficulties raised by local participants. A simplified local structure, similar to other DSQ or HACC programs, would not necessarily need a coordination mechanism.

Support and Accountability

The RSP pilot was a developing program, in the process of drafting operational structures. Finalised structures should reflect the disability service principles and focus on resident interests. They should be operationalised in supporting policies and procedures; coordination structures; processes to address abuse and neglect; grievance processes (complaints mechanisms, advocacy, Community Visitors, OFT and RSSR); assessment tool; practice manual; referral and follow up processes to other DSQ and QH funded programs, other services and community opportunities; and stakeholder relationship protocols.

Externally, the community visitors have begun visiting these facilities. This is an opportunity to observe outcomes for residents who are and are not using RSP support.

Resources

Decisions about RSP will also rely on resources available to the program from both or either agency in terms of funding, staff and infrastructure. Beyond the pilot, the cost of a statewide program will presumably require rationing, targeting and waiting lists.

Choices about how additional resources could be allocated would include: increase the number of residents using the services; increase the intensity of services available to each resident; prioritise the most vulnerable residents and residents in facilities where they are most likely to be vulnerable; increase brokerage, crisis and alternative suitable accommodation funding; and increase the number of locations where RSP is provided.

If the number of locations was to be expanded, one consideration could be to prioritise areas with more premises on the grounds of efficiency of contact with the greatest number of vulnerable residents. Alternatively, the mechanism of regional roll out used for LAC, with metropolitan areas last would address the vulnerability of isolation and restricted alternative accommodation.

Links to Other Services

Links to other services are necessary in this type of program at two levels: individual referral to other services for residents using the program and policy links between agencies with similar goals.

Successful referral links rely on fieldworkers being aware of the whole life needs and rights of residents to access mainstream and specialist disability services, and their ability to facilitate access to the service rather than just the waiting list (eg. through brokerage funds). The researchers observed few instances of significant activity to refer residents to suitable accommodation or service support such as HACC services or Lifestyle Support Packages. In addition, below is a discussion of the need for whole of government policy commitment to address human service provision for these citizens.

Key government agencies with related policy goals include DSQ, Queensland Health HACC and Mental Health, and Housing. The latter two were not directly involved in the policy level at the beginning of the program. Mental Health became involved once it was clear so many residents had mental health needs and were unable to successfully access services. A new manual to facilitate better service provision was published (Queensland Health 2005) and Mental Health personnel are now involved in central and local implementation.

Housing did not become included in the pilot. RSP has the potential to address appropriate accommodation, the more fundamental question to improving quality of life, if agencies that contribute to housing policy were involved. Unmet demand for accommodation and support arrangements to meet the needs of people with a disability is high across the State, aggravated by the shortage of social housing.

A single agency responsible for program delivery is likely to improve program efficiency. There are also system advantages to a whole of government approach to the policy development that supports that program delivery. An agency responsible for the program has limited leverage to in commanding service support outside its budget responsibilities.

Summary of Implications

In summary, the findings from above indicate a preference for model options with one department primarily responsible; fewer or one provider in each region; an individual

approach to prioritise and follow vulnerable residents; and services to include the range of goals currently covered by the three types, whether configured as one type or more.

One option to respond to the delivery problems indicated in the findings is to further develop the key worker model. Modifications could include using the key worker position as a gatekeeper to other support services through a whole of life needs assessment. The key worker would then have the flexible options of allocating responsibility for service types as needed within their own organisation, referral to DSQ, HACC or other services, or if necessary, brokerage to other services with discretionary funds.

Under this model, the pilot community linking and disability support service functions would be incorporated into one organisation's RSP team, coordinated by the key support worker. Individual support workers would undertake the tasks currently completed by the CLP and DSS agencies in a more seamless manner from the point of view of the resident (for example, assisting a person to shower before going to an appointment, travelling with them to and fro and supporting them during the appointment.) The advantages of this type of option is a single point of entry; with an individual plan; flexibility to respond to individual needs with meaningful activity; and access to brokerage funding as necessary to overcome human service shortages. Programs similar to this model include the Community Aged Care Packages and Community Options programs (AIHW 2003).

Summary of the Evaluation Findings

The purpose of the evaluation was to research the process of implementation of RSP, the services provided to residents by the contracted support providers, residents' perceptions of the appropriateness of these services and impact on their quality of life, health and wellbeing, and the impact on residential facility operators and staff and other human services providers and Departments. The evaluation was also to review the cost effectiveness of the program to inform future resource allocation.

The evaluation found measurable benefits to residents who use the program in relation to important aspects of their quality of life, including improved health and wellbeing, satisfaction with accommodation and social and economic participation. The cost effectiveness analysis showed that for people who participated in the program, measurable improvements were evident at a relatively low cost.

Residents were satisfied with the organisation of the program. Benefits were evident from each of the program types. The two program approaches, individual and premises, each had advantages. The main difference between the two was the ability of the individual approach to reach a wider range of residents and flexibly respond to residents moving between premises.

Administrative arrangements associated with the pilot evolved over the evaluation period. In its pilot form, the program had a number of inefficiencies associated with management by two agencies, at a central and regional level, provided by a number of organisations in each region.

In summary, the program has been a successful pilot from perspective of the people involved. Two major limitations on its impact were the context of accommodation that was unsuitable for some of the residents; and the shortage of mainstream and specialist services. The implementation and evaluation revealed many lessons relevant for future programs.

1 Introduction and Methodology

This is the final evaluation report for the Resident Support Program (RSP) pilot to November 2004. The evaluation was conducted by the University of New South Wales (UNSW) Consortium, managed by the Social Policy Research Centre UNSW, with additional researchers from the Disability Studies and Research Institute and the University of Queensland.

This introduction briefly describes RSP, the evaluation methodology and the structure of the report.

1.1 Description of RSP

RSP is a joint Disability Services Queensland (DSQ) and Queensland Health (QH) funded initiative that aims to provide support services to residents with a disability living in the private residential facilities. The three service types were:

- Strategies to support residents in mainstream community and leisure activities, Community Linking Projects (CLP) (funded by DSQ);
- Support with basic self care and presentation, Disability Support Services (DSS) (funded by DSQ); and
- Support with health and wellbeing, Key Support Workers (KSW) (funded by QH through the HACC program).

Non-government organisations were contracted to provide these services.

The RSP pilot was implemented in identified private sector supported accommodation (hostels), boarding houses and aged rental accommodation facilities that are regulated by the *Residential Services (Accreditation) Act 2002*. The residents of hostels receive priority in determining the delivery of the RSP. The program operated in five locations – Brisbane, Ipswich, Toowoomba, Gold Coast and Townsville. Two approaches were trialled:

- Individual approach: residents were identified for assistance (Brisbane, Ipswich and Toowoomba); and
- Premises approach: specific premises were identified and all eligible residents in them were offered assistance (Townsville and Gold Coast).

Local co-ordination groups (LCG) were established within each region. They provided a mechanism for the coordination and management of the RSP. DSQ Regional Officers, HACC Area Managers and RSP provider organisations were the principal members of LCG.

1.2 Evaluation Methodology

The evaluation was conducted over 18 months. Design was from October to December 2003; fieldwork from February to November 2004; and final analysis from December 2004 to March 2005.

The following methods were used during the evaluation:

- A longitudinal study of residents and resident focus groups;

- Interviews with RSP service providers (managers and staff) and discussions with and observation of RSP Local Coordination Groups;
- Interviews with premises owners, managers and staff and observation at premises;
- Interviews with other providers assisting similar clients: (eg. disability services, health and mental health services, HACC services and allied health);
- Interviews with representatives of peak and regional advocacy organisations and industry representatives (SAPA and BHOMA);
- An interview with a representative of the Office of the Public Advocate;
- Interviews with state office DSQ and Health managers and joint interviews with regional DSQ and HACC managers;
- The collection and transfer of quantitative data from all services providing RSP, coordinated through DSQ and Health; and
- Opportunities for submissions by other interested parties.

Sampling methodology and instruments used are described at Appendices A and B.

The evaluation plan and summaries of the baseline and two interim reports (March, September and December 2004) are at www.sprc.unsw.edu.au/reports/index.htm.

1.3 Report Structure

The report structure is as follows:

- Section 1 Introduction and Methodology
- Section 2 Resident Support Program Profile
- Section 3 Implementation of RSP
- Section 4 Impact on Residents
- Section 5 Impact on Other Stakeholders
- Section 6 Cost Effectiveness
- Section 7 Summary of the Evaluation Findings
- Section 8 Considerations for Future RSP-Type Programs

2 Resident Support Program Profile

This section presents a descriptive profile of the Resident Support Program using the available Minimum Data Sets (MDS), other data collected from RSP providers by DSQ and Health for the evaluation and qualitative interview data. The section includes a profile of the people receiving RSP services, the quantity of services provided and financial and resource data about the providers.

DSQ and Health provided RSP data from the Commonwealth State/Territory Disability Agreement National Minimum Data Set (CSTDA NMDS) and the Home & Community Care Minimum Data Set (HACC MDS) for three quarters (October-December 2003, January-March 2004 and April-June 2004), as well as incomplete data for a fourth quarter (July-September 2004)

The CSTDA July-September 2004 data is incomplete due to problems with the new online data collection tool for the CSTDA NMDS. As a result, only six new CSTDA service users in the September quarter were identified. Apart from these six exceptions, CSTDA data were only collected for those people who had received a service in the previous two quarters. It is likely that there were missing records even within this subset of service recipients. Other data quality considerations that could affect the analysis in the following sections include how the RSP service data was identified, missing data and linked records. Each of these considerations is described in Appendix A.

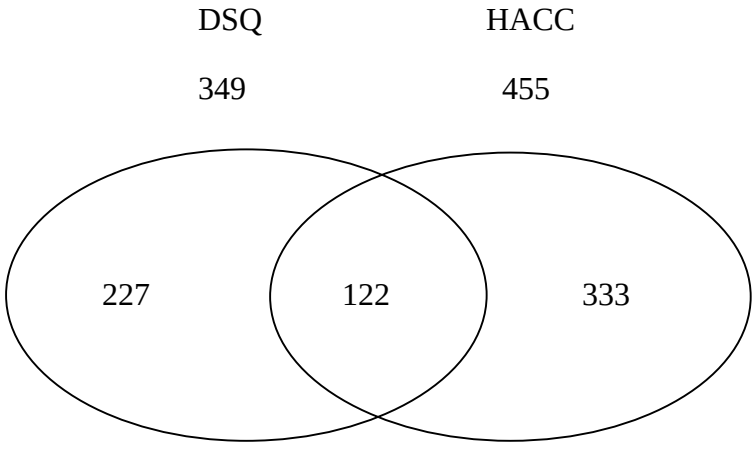
2.1 Resident Profile

From October 2003 to September 2004, the data indicate that 682 people used RSP services.

Residents use of RSP by funding agency

Of these people, 349 used RSP services funded by DSQ (CLP and DSS) and 455 used RSP services funded by HACC (KSW). Thus there were 122 people (18 per cent of the total) who accessed RSP services through both DSQ and HACC (Figure 2.1).

Figure 2.1: Number of People Receiving RSP Oct 2003-Sep 2004 by Funding Agency



Residents by service type and location

Table 2.1 is a detailed summary of how many residents used which service types and location. The number of people using RSP services increased with the maturation of the program. Despite the incomplete data for the July to September 2004 quarter, more people were recorded to have used RSP services in that quarter (423) than in previous quarters (415 in April to June 2004, 350 people in January to March 2004, and 336 people in October to December 2003). Almost one quarter (23 per cent) of recipients used services in all four periods, while 38 per cent received services in just one period.

Table 2.1: Number of People Using RSP by Quarter, Service Type and Location

	Brisbane*	Gold Coast	Ipswich	Toowoomba	Townsville	All
Oct-Dec 2003						
Community Linkage Projects	39	24	22	38	12	135
Disability Support Services	58	3	20	13	21	115
Key Support Worker Services	87	26	36	49	32	230
Total Oct-Dec 2003	136	41	52	70	37	336
Jan-Mar 2004						
Community Linkage Projects	33	21	32	40	16	142
Disability Support Services	59	3	20	17	1	100
Key Support Worker Services	88	11	26	38	19	182
Total Jan-Mar 2004	150	30	67	77	26	350
Apr-Jun 2004						
Community Linkage Projects	31	22	25	30	25	133
Disability Support Services	54	11	31	19	19	134
Key Support Worker Services	110	24	32	43	30	239
Total Apr-Jun 2004	172	38	78	77	50	415
Jul-Sep 2004						
Community Linkage Projects	31	17	23	20	16	107
Disability Support Services	43	11	32	19	19	124
Key Support Worker Services	124	37	32	45	36	274
Total Jul-Sep 2004	181	44	79	70	50	423
Total Oct 2003-Sep 2004						
Community Linkage Projects	59	27	43	52	29	209
Disability Support Services	67	11	42	24	41	185
Key Support Worker Services	230	50	57	59	60	455
Total Oct 2003 -Sep 2004	304	58	124	106	94	682

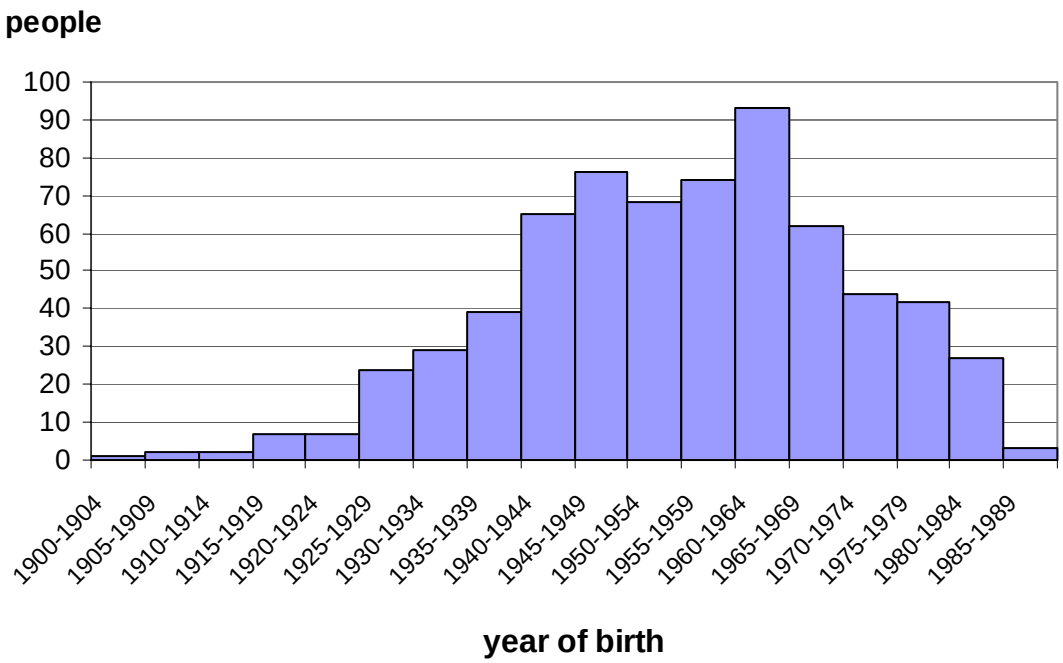
Notes: * Includes North and South Brisbane combined.
Row and column totals do not necessarily equal the sum of components, as residents may have accessed services in more than one period, location and/or service type.

Resident sex and age

Almost two-thirds (63 per cent) of people who received RSP services were male.

The distribution of residents by year of birth is shown in Figure 2.2. While this distribution is quite broad, about two-thirds (65 per cent of valid responses)[1] were born between 1940 and 1969 (aged between approximately 33 and 65 at the time the services took place).

Figure 2.2: Number of People Receiving RSP October 2003-June 2004 by Year of Birth



Resident Indigenous status

Thirty-four people (5 per cent) were identified in at least one of the data sources as being Indigenous (22 as Aboriginal but not Torres Strait Islander origin, seven as Torres Strait Islander but not Aboriginal origin, and five as both Aboriginal and Torres Strait Islander origin). The data item was missing for 104 people (15 per cent), while the remaining people were listed as non-Indigenous.

Characteristics of residents in the longitudinal study

The methodology of the longitudinal resident study is detailed in the evaluation plan (Abelló et al 2004a). At the first wave, 32 residents were recruited to the study (Table 2.2). At the second wave, 26 of these residents were re-interviewed, along with four more recruits to the study. At the third wave, 28 residents were re-interviewed. These included the four people who were recruited at the second wave.

The cohort was chosen from people who had most recently begun receiving RSP assistance at the beginning of 2004. Discussions with RSP and accommodation providers and advocacy organisations verified that the cohort was typical of the overall RSP service recipient population.

[1] There were thirteen people whose age was not recorded validly in any data set.

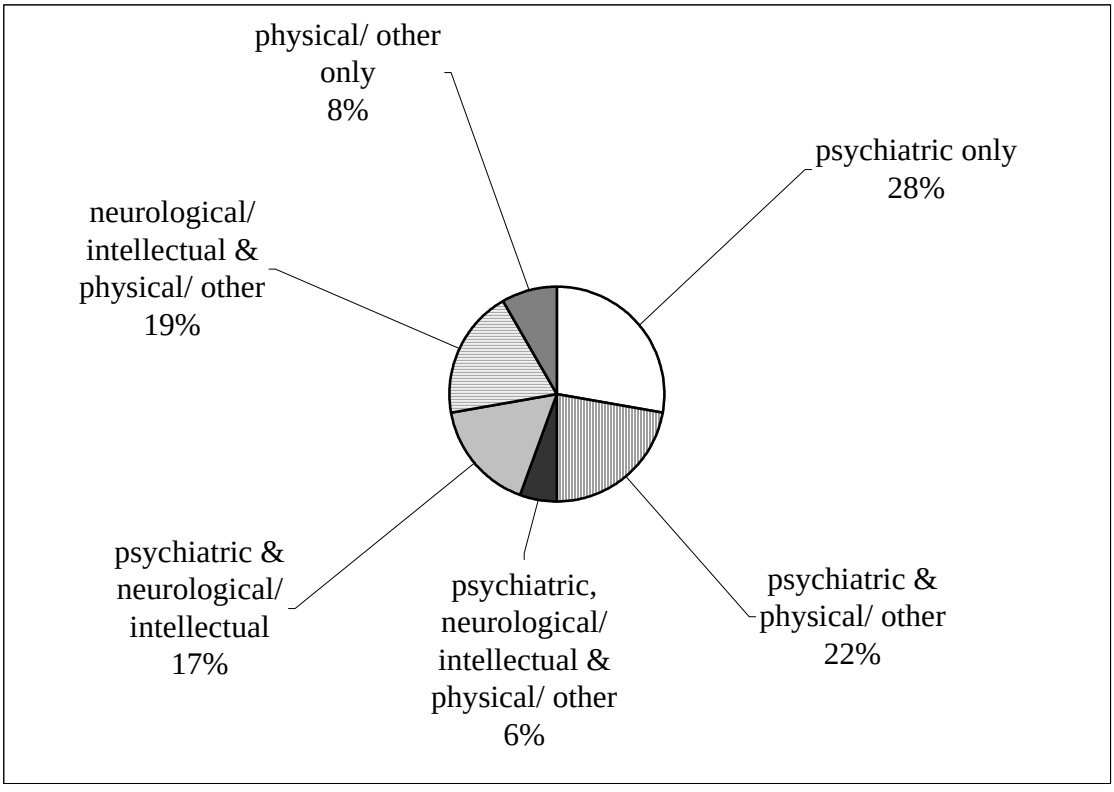
Table 2.2: Recruitment in the Longitudinal Cohort

First wave (February 2004)	Second wave (June 2004)	Third wave (October 2004)
Recruited and interviewed: 32 residents	Re-interviewed: 26 residents	Re-interviewed: 24 residents
	Not interviewed: 6 residents (one deceased, one voluntary withdrawal from study, one seriously ill, one left Queensland, two unable to be located)	Not interviewed: 2 residents (unable to be contacted because one in aged care facility and one left the area)
	Additional participants recruited and interviewed: 4 residents	Re-interviewed: 4 residents

The longitudinal study provided detailed information about the various impairment characteristics and disability experiences of participants. Mainly these were people experiencing psychiatric disability and multiple disability:

- people with a psychiatric disability comprise 73 per cent of the cohort;
- 55 per cent of the cohort experienced a physical disability;
- neurological and intellectual disability affects 42 per cent of the cohort;
- multiple disability affects 64 per cent of the cohort (Figure 2.3).

Figure 2.3: Relative Prevalence of Disability Type among Resident Cohort



Note: For the purpose of this figure, impairment types of people in the resident cohort are reduced to three groups: 1. Psychiatric 2. Neurological or intellectual and 3. Physical and other.

2.2 Service Profile

The second way of describing the program is the number of services provided. Service output data were recorded differently in the CSTDA NMDS and the HACC MDSs. The HACC MDS data records the hours of services received over the reporting period, with the exception of transport services, which were recorded as the number of one-way trips. In contrast, the available CSTDA data included the number of hours of service provision within a reference week and within a typical week. For this reason, a summary of the services provided is presented separately here by funder.

Over the twelve months, the largest service type probably CLP (estimated at 18,148 hours), compared with DSS (estimated at 14,482 hours) and KSW (6424 hours, plus 1969 transport trips, explained below).

Stakeholders contrasted waiting lists for some service types in some locations (eg. CLP in Brisbane), with low service take up in other regions (eg. DSS in Townsville).

Key Support Worker services

The total quantity of services provided in the reporting period was recorded for various categories of HACC services relating to the KSW service (Table 2.3). For each category except transport, the quantity was recorded as hours of services provided. Transport was recorded as the number of one-way trips. The total hours remained stable between quarters (1569-1634 hours per quarter). Within regions there was two notable changes: in the Gold Coast, more hours of service were reported in the first quarter than in the subsequent three quarters combined; and a large increase from a low base in services in Townsville.

Transport was a large responsibility in this service type (1969 trips compared to 6424 hours of other service).

Disability Support Service and Community Linkage Projects

Estimates of total DSS and CLP hours are shown by location, service type and quarter in Table 2.4. The method for estimating the hours is discussed in Appendix A. The appendix also notes these data were characterised by a high proportion of missing values. No estimates were made for Disability Support Services in Ipswich or Toowoomba (except for in the Jul-Sep 2004 quarter) due to missing data.

On average, people received slightly more hours of CLP than DSS (86.8 compared to 78.3 hours in the 12 months). The total average hours of RSP service per person increased slightly over the evaluation period, from 32.6 to 42.7 hours per quarter. This was due primarily to an increase in DSS average hours. Total hours provided increased from 7035 in the Oct-Dec 2003 quarter to at least 11,272 hours in the Jul-Oct 2004 quarter.

Table 2.3: Total HACC RSP Service Hours and One-way Trips by Quarter, Service Type and Location, October 2003-September 2004

	Brisbane	Gold Coast	Ipswich	Toowoomba	Townsville	All
Oct-Dec 2003						
Assessment	136	93	11	14	2	256
Case management	245	116	41	144	17	563
Case planning	53	101	5	158	3	320
Counselling	62	74	2	113	41	292
Domestic assistance	0	0	14	0	0	14
Home maintenance	0	3	0	0	0	3
Social support	11	119	53	0	0	183
Oct-Dec hours excluding transport	507	506	126	429	63	1631
Transport (one way trips)	1	278	62	119	149	609
Jan-Mar 2004						
Assessment	248	19	18	48	13	346
Case management	291	16	34	148	22	511
Case planning	89	15	6	196	18	324
Counselling	92	76	12	105	31	316
Domestic assistance	0	0	12	0	0	12
Home maintenance	0	0	0	0	0	0
Social support	12	0	48	0	0	60
Jan-Mar hours excluding transport	732	126	130	497	84	1569
Transport (one way trips)	15	78	77	147	29	346
Apr-Jun 2004						
Assessment	216	12	7	22	20	20
Case management	307	54	35	151	40	40
Case planning	114	35	15	208	53	53
Counselling	93	20	18	87	33	33
Domestic assistance	2	0	13	0	0	0
Home maintenance	0	0	0	0	1	1
Social support	2	7	69	0	0	0
Apr-Jun hours excluding transport	734	128	157	468	147	1634
Transport (one way trips)	0	8	283	190	72	553
Jul-Sep 2004						
Assessment	213	28	8	11	16	276
Case management	262	85	22	180	57	606
Case planning	94	71	20	187	28	400
Counselling	46	35	4	80	39	204
Domestic assistance	1	0	10	0	0	11
Home maintenance	0	1	0	0	0	1
Social support	0	18	74	0	0	92
Jul-Oct hours excluding transport	616	238	138	458	140	1590
Transport (one way trips)	0	36	177	197	51	461
Oct 2003-Sep 2004						
Assessment	813	152	44	95	51	1155
Case management	1105	271	132	623	136	2267
Case planning	350	222	46	749	102	1469
Counselling	293	205	36	385	144	1063
Domestic assistance	3	0	49	0	0	52
Home maintenance	0	4	0	0	1	5
Social support	25	144	244	0	0	413
Total hours excluding transport	2589	998	551	1852	434	6424
Transport (one way trips)	16	400	599	653	301	1969

Table 2.4: CSTDA RSP Service Hours by Location, Service Type and Quarter, October 2003-September 2004

	Brisbane		Gold Coast		Ipswich		Toowoomba		Townsville		All locations	
	Per person	Total	Per person	Total	Per person	Total	Per person	Total	Per person	Total	Per person	Total
Oct-Dec 2003												
Community Linkage Projects	21.4	835	67.9	1629	29.4	647	25.6	972	54.4	652	37.9	4734
Disability Support Services	14.3	829	85.7	257	n/a	n/a	30.4	395	n/a	n/a	20.0	2301
Total DSQ	18.6	1664	72.6	1886	n/a	n/a	27.9	1367	n/a	n/a	32.6	7035
Jan-Mar 2004												
Community Linkage Projects	17.7	585	37.6	790	15.3	490	40.0	1599	37.0	593	29.9	4057
Disability Support Services	16	942	29.6	89	n/a	n/a	35.3	601	n/a	n/a	20.7	2065
Total DSQ	17.4	1527	38.2	879	n/a	n/a	39.2	2200	n/a	n/a	28.0	6122
Apr-Jun 2004												
Community Linkage Projects	25.6	793	51.5	1133	16.5	411	63.2	1896	33.3	833	39.2	5066
Disability Support Services	19.3	1040	23.2	256	n/a	n/a	35.3	670	n/a	n/a	23.4	3136
Total DSQ	22.6	1833	58.4	1389	n/a	n/a	56.1	2566	n/a	n/a	36.3	8202
*Jul-Sep 2004**												
Community Linkage Projects	70.4	2182	32.3	549	16.3	375	28.3	567	21.4	619	41.4	4291
Disability Support Services	20.1	863	45.6	501	n/a	n/a	74.0	1406	36.0	1474	37.7	6980
Total DSQ	43.8	3044	47.7	1050	n/a	n/a	55.9	1973	n/a	2093	42.7	11272
Total Oct 2003-Sep 2004												
Community Linkage Projects	74.5	4394	151.9	4101	44.7	1922	96.8	5034	93.0	2697	86.8	18148
Disability Support Services	54.8	3674	148.5	1103	n/a	n/a	128.0	3073	n/a	n/a	78.3	14482
Total DSQ	70.2	8068	185.9	5204	n/a	n/a	117.5	8106	n/a	n/a	93.2	32631

n/a: not available

* July-Sep 2004 numbers based on incomplete data

2.3 Financial Information and Provider Profile

The final part of the RSP profile relates to the financial commitment to the program and the resource profile of the providers by financial quarter.

Notes for tables

All costs quoted are GST exclusive.
'Number of RSP provider staff (EFT)' includes coordinator and direct service positions.
Notes for CLP and DSS:
Financial data may represent estimated budget and/or expenditure for the period of interest where service providers' Quarterly Statements of Income and Expenditure reported budget and expenditure for a period greater than reported combined budget and expenditure across service types.
'Service cost - non-labour' may include expenditure identified against operating, other or discretionary funding.
Brisbane – DSS 'Number of RSP units of service' includes personal care, assessment and case planning and coordination. Gold Coast - CLP and DSS 'Number of RSP units of service' includes community linking and case planning and coordination/personal care and case planning and coordination.
Notes for KSW:
MDS does not reflect 100% of collection as some service providers do not complete all data fields or clients do not allow their data to be entered.
Data sources - CLP and DSS:
Financial data - Grants Management System and service providers' Quarterly Statements of Income and Expenditure. Service data - service provider reports which are independent of the MDS
Data sources - KSW:
Recurrent Financial data - service providers' Quarterly Statements of Income and Expenditure. Capital & budget - Services Information Management System. Consumer data – MDS. Premises data – LCG reports. Staff - Area HACC Managers

Table 2.5: Finances in the Resident Support Program

RSP Totals	October to December 2003	January to March 2004	April to June 2004	July to September 2004
Total cost ($)	520,318	473,557	556,238	546,998
Service cost - labour	262,286	320,819	333,925	390,498
Service cost - non-labour	141,195	150,012	222,313	155,251
Capital cost (RSP provider) - establishment	116,837	2,726	0	1,249
Recurrent budget - period	478,552	472,541	481,703	560,441
Capital budget (RSP provider) - establishment	125,535	10,785	0	1,588
Total number of RSP premises-units	43	47	47	47
Total number of RSP providers	16	16	16	16
Number of RSP provider staff (EFT)	33	34	34	33

Table 2.6: Finance in the Resident Support Program by Service Type

	Community Linking Projects	Disability Support Services	Key Support Workers
October to December 2003			
Total cost ($)	124,061	144,187	252,070
Service cost – Labour	80,020	85,478	96,788
Service cost - non-labour	44,041	58,709	38,445
Capital cost (RSP provider) - establishment	0	0	116,837
Recurrent budget - period	107,369	221,033	150,150
Capital budget (RSP provider) - establishment	8,698	0	116,837
Number of RSP premises-units	31	25	41
Number of RSP providers	5	5	6
Number of RSP provider staff (EFT)	12	14	7
January to March 2004			
Total cost ($)	143,124	205,182	125,251
Service cost - Labour	88,374	142,285	90,160
Service cost - non-labour	54,205	62,897	32,910
Capital cost (RSP provider) - establishment	545	0	2,181
Recurrent budget - period	104,489	221,476	146,576
Capital budget (RSP provider) - establishment	8,604	0	2,181
Number of RSP premises-units	35	35	45
Number of RSP providers	5	5	6
Number of RSP provider staff (EFT)	14	13	7
April to June 2004			
Total cost ($)	233,280	214,193	108,764
Service cost - Labour	127,056	130,003	76,865
Service cost - non-labour	106,224	84,190	31,899
Capital cost (RSP provider) - establishment	0	0	0
Recurrent budget - period	127,495	207,633	146,575
Capital budget (RSP provider) - establishment	0	0	0
Number of RSP premises-units	35	34	45
Number of RSP providers	5	5	6
Number of RSP provider staff (EFT)	12	15	7
July to September 2004			
Total cost ($)	225,175	192,281	129,542
Service cost - Labour	153,716	149,733	87,049
Service cost - non-labour	71,459	42,548	41,244
Capital cost (RSP provider) - establishment	0	0	1,249
Recurrent budget - period	191,227	222,636	146,578
Capital budget (RSP provider) - establishment	0	339	1,249
Number of RSP premises-units	33	35	44
Number of RSP providers	5	5	6
Number of RSP provider staff (EFT)	10	16	7

Table 2.7: Finances in the Resident Support Program by Region

	Brisbane	Ipswich	Gold Coast	Toowoomba	Townsville
October to December 2003					
Total cost	140,478	89,709	104,998	104,594	80,539
Service cost - Labour	69,658	32,593	58,557	51,423	50,055
Service cost - non-labour	48,375	33,964	24,966	22,631	11,259
Capital cost (RSP provider) - establishment	22,445	23,152	21,475	30,540	19,225
Recurrent budget - period	147,036	80,758	88,255	92,886	69,617
Capital budget (RSP provider) - establishment	22,445	31,850	21,475	30,540	19,225
Number of RSP premises-units	25	10	2	4	2
Number of RSP providers	4	3	3	3	3
Number of RSP provider staff (EFT)	8.2	6	7	4.5	7
January to March 2004					
Total cost	154,464	69,460	104,109	84,016	61,508
Service cost - Labour	111,704	31,719	66,610	62,370	48,416
Service cost - non-labour	42,760	37,741	36,954	21,646	10,911
Capital cost (RSP provider) - establishment	0	0	545	0	2,181
Recurrent budget - period	149,707	79,582	86,790	88,901	67,561
Capital budget (RSP provider) - establishment	0	8,604	0	0	2,181
Number of RSP premises-units	25	10	3	6	3
Number of RSP providers	4	3	3	3	3
Number of RSP provider staff (EFT)	10.9	6	7	4.7	5
April to June 2004					
Total cost	176,116	93,349	136,196	89,048	61,529
Service cost - Labour	130,062	35,522	55,938	62,849	49,553
Service cost - non-labour	46,054	57,826	80,258	26,199	11,976
Capital cost (RSP provider) - establishment	0	0	0	0	0
Recurrent budget - period	159,291	79,224	86,789	88,901	67,498
Capital budget (RSP provider) - establishment	0	0	0	0	0
Number of RSP premises-units	25	10	3	6	3
Number of RSP providers	4	3	3	3	3
Number of RSP provider staff (EFT)	10.8	4.9	7	5.7	6
July to September 2004					
Total cost	198,897	102,445	89,257	85,636	70,762
Service cost - Labour	136,251	65,560	65,971	64,418	58,297
Service cost - non-labour	62,646	36,885	23,286	19,969	12,465
Capital cost (RSP provider) - establishment	0	0	0	1,249	0
Recurrent budget - period	201,684	109,244	89,181	91,195	69,137
Capital budget (RSP provider) - establishment	0	0	0	1,588	0
Number of RSP premises-units	25	10	3	6	3
Number of RSP providers	4	3	3	3	3
Number of RSP provider staff (EFT)	11.2	5.2	7	5.7	4

Table 2.8: Finances in the Resident Support Program by Region and Service Type

October to December 2003	Brisbane	Ipswich	Gold Coast	Toowoomba	Townsville
Community Linking Projects					
Number of RSP premises-units	13	10	2	4	2
Number of RSP provider staff (EFT)	2	2	3	2.5	2
Number of RSP assessments	7	0	2	14	0
Disability Support Services					
Number of RSP premises-units	11	6	2	4	2
Number of RSP provider staff (EFT)	3.2	3	3	1	4
Number of RSP assessments	0	9	2	0	23
Key Support Workers					
Number of RSP premises-units	25	8	2	4	2
Number of RSP provider staff (EFT)	3	1	1	1	1
Number of RSP assessments	41	8	28	8	2
January to March 2004					
Community Linking Projects					
Number of RSP premises-units	15	10	3	4	3
Number of RSP provider staff (EFT)	3	2	3	2.5	3
Number of RSP assessments	0	0	0	0	0
Disability Support Services					
Number of RSP premises-units	18	7	3	4	3
Number of RSP provider staff (EFT)	4.9	3	3	1.2	1
Number of RSP assessments	19	4	0	0	3
Key Support Workers					
Number of RSP premises-units	25	8	3	6	3
Number of RSP provider staff (EFT)	3	1	1	1	1
Number of RSP assessments	60	14	10	31	13
April to June 2004					
Community Linking Projects					
Number of RSP premises-units	15	10	3	4	3
Number of RSP provider staff (EFT)	3.6	1.5	3	1.2	3
Number of RSP assessments	0	16	0	0	0
Disability Support Services					
Number of RSP premises-units	17	7	3	4	3
Number of RSP provider staff (EFT)	4.2	2.4	3	3.5	2
Number of RSP assessments	5	31	0	0	19
Key Support Workers					
Number of RSP premises-units	25	8	3	6	3
Number of RSP provider staff (EFT)	3	1	1	1	1
Number of RSP assessments	66	6	8	13	20
July to September 2004					
Community Linking Projects					
Number of RSP premises-units	13	10	3	4	3
Number of RSP provider staff (EFT)	3	1.5	3	1.2	1.5
Number of RSP assessments	0	18	0	0	0
Disability Support Services					
Number of RSP premises-units	18	7	3	4	3
Number of RSP provider staff (EFT)	5.2	2.7	3	3.5	1.5
Number of RSP assessments	19	33	0	0	0
Key Support Workers					
Number of RSP premises-units	25	8	2	6	3
Number of RSP provider staff (EFT)	3	1	1	1	1
Number of RSP assessments	74	7	17	5	16

3 Implementation of RSP

This section presents findings on the implementation of the RSP. These first describe the implementation of the service types and program approaches. The experience of residents in the program follows. Program delivery, structure and administration are then discussed, ending with links to other services and contextual matters that inhibit the program.

3.1 Service Types

The evaluation found that the three service types, DSS, CLP and KSW were implemented to the satisfaction of residents and other stakeholders, with further room for refinement. Section 4 presents the findings of resident benefits in relation to the service types. This section describes some of the implementation difficulties that arose.

Disability Support Service

DSS assistance was mainly assistance with grooming and showering. What constituted DSS activities changed over time with the inclusion of shopping for toiletries and disability specific products (eg. low-caffeine, low-sugar products and non-prescription medications) and assistance with room cleaning and laundry. Residents expressed satisfaction with DSS and increased their take up of assistance.

The definition of disability support was contested within the framework of the RSP. It was the service type that facilitated KSW and CLP goals and so relied on cooperation between providers. In some regions, inflexibility in the way DSS was operationalised was the cause of conflict.

The goal of DSS was the service provision would have a developmental focus towards independent care. Instead, it was apparent that some services were delivered within an ongoing care model.

Some providers and DSQ and HACC regional management suggested DSS faced these difficulties because the program was designed on the assumption that there would be more people with intellectual disability, who would require developmental assistance with cleanliness and hygiene.

Community Linking Program

The second service type, CLP provided help with social and community participation. It provided assistance such as contact with friends and family, attending social events, integrating into mainstream leisure options, education, training and employment assistance. Again, the program was designed to have an individual needs-based, developmental approach that was not always evident in the evaluation findings.

Goals were to increase family and social networks and community and economic participation with an individual focus. Some providers reported they use group activities as a ‘waiting room’ for individual linking assistance.

While resident satisfaction with community and social participation increased, contextual constraints such as physical access, low income and negative experiences with other people in mainstream activities undermined the success of CLP activities.

Some RSP support staff expressed concern that without continuing support, community linking activities could fail. This raises the question of the sustainability of CLP goals and whether it enabled independent social participation for residents.

Key Support Workers

The KSW role was clear for RSP providers and there were few problems defining the KSW concepts. However, it seemed that the interpretation of 'health and wellbeing' was often interpreted narrowly to focus of physical and mental health, rather than life support needs and participation.

Despite the difficulties inherent in promoting good health and access to health services to residents, the take up of KSW assistance was high. Resident self-identified health and wellbeing improved and their access to health and allied services and their satisfaction with service providers increased due to KSW activities. Central to the KSW role was the provision of supported transport and attendance at appointments. KSW was limited by the availability of free and accessible human services (Section 3.6).

Implementation of the needs assessment aspect of KSW in relation to DSS and CLP activities was inconsistent. In most regions this worked well, but where there were strained relationships between agencies, the coordination role of KSW failed and the complementarity of service types were compromised.

Summary

Within the constraints of defined service types, the services seemed to be reasonably well implemented and met their goals. Limitations for most residents included service gaps between the service types, such as suitable housing goals; an inconsistent approach to disability service principles; and limited flexibility and coordination problems between the service types to respond to resident need. Staff also identified resource constraints on providing the assistance required by residents.

3.2 Program Approaches

The program was implemented in regions with premises or individual approaches. The regions with a premises approach had the greatest implementation disruptions because of the reliance on continuity of the selected premises. The experiences in relation to each approach are summarised below.

Premises approach

Efficiency advantages of the approach were the economies of scale from having more residents in the one location; providing more opportunities for observation of the living circumstances of the residents; collateral benefits for all residents in the premises and more resident contact through the visibility of the RSP workers. Residents became aware of RSP staff when they were there to assist other residents, providing an opportunity for self-referral.

There were fewer relationships between operators and providers, with a smaller number of premises. This was interrupted however, when premises closed or relocated. Some of these advantages of the premises would be more difficult to achieve in the individual approach as it was configured in the pilot.

There was some evidence that residents had greater levels of satisfaction with their accommodation in this approach. This was consistent with premises having to meet additional standards in order to be selected for the program.

RSP providers liked the premises approach because of its relative ease and efficiency. Premises operators who had RSP liked it because of the privilege it gave their service. Presumably other facilities who missed out would not feel the same. A difficulty for DSQ and QH was the approach created the perception that it legitimised the premises.

Other disadvantages were that fewer residents were eligible for assistance. Residents who moved or for whom their facility closed were disadvantaged by this approach because their access to RSP was dependent on the particular facility. It was resource intensive for few residents, not necessarily targeting the most vulnerable residents and not offering any contact for residents in the most vulnerable facilities.

The administration of selecting a facility and coping with facility changes was a burden to DSQ, QH and the premises operators. RSP workers potentially also had to tolerate continued inappropriate behaviour in their relationships with some premises operators and staff because they were wholly dependent on the relationship to maintain access to the few premises they work in. The need to maintain the relationship possibly also compromised the workers' ability to act on suspicions of abuse, neglect and exploitation.

Individual approach

Strengths of the individual approach were that it allowed RSP workers to find, recruit and follow individual residents, irrespective of which private residential facility they were in and their mobility between them. In theory this could allow them to prioritise vulnerability, although whether that happened in practice was probably limited.

Benefits identified in the individual approach included a broader entitlement, with hostel, boarding house and aged care residents being eligible for assistance. Continuity of care was also enhanced, with residents retaining their eligibility if they moved between premises and into more independent housing options.

The disadvantages of the individual approach included that where premises were of a very poor standard, RSP involvement might create a perception that they were suitable places for people with disability to live. The tension between advocating for residents, and keeping access to these premises is a particular issue in these settings for RSP provider staff. RSP workers were probably exposed to greater occupational health and safety risks because of the greater range of facilities they visited.

Summary

Both the premises and individual approaches had advantages and disadvantages identified by stakeholders. In practice the main distinction between the approaches

was the number and quality of the premises in which the RSP operated in the region and the number of people assisted in each facility.

3.3 Resident Experiences of RSP

The third aspect of implementation was the experience of residents who used the program. A measure of the success of implementation of RSP was the satisfaction of residents. This section describes the results from the longitudinal research, which showed high and increasing satisfaction with the program, the workers and the opportunities it provided them. This is further reflected in the Section 4, resident outcomes.

The proportion of residents in the research cohort accessing each of the RSP service types increased over the first half of the year and decreased at the end of the evaluation, except for DSS (Table 3.1).

Table 3.1: Receiving RSP Service Types, per cent

	February 2004	June 2004	October 2004
Receiving DSS	31	40	54
Receiving CLP	72	80	71
Receiving KSW	69	80	79

Take up of DSS assistance increased across the 9 months from a third to over a half the cohort. DSS were personal services and require sensitivity in promoting them to residents and gaining their trust.

Use of CLP and KSW assistance increased between the first and second waves of the study, consistent with the sampling approach, which identified residents who had just started receiving RSP assistance. The drop in numbers towards the end of the evaluation in CLP mainly reflected the number of residents who left RSP eligible housing, losing their RSP entitlement.

Resident satisfaction with RSP providers and their services

The method for quantifying residents' levels of satisfaction within various life domains employed an adapted version of the Lifestyle Satisfaction Scale (Heal and Chadsey-Rusch, 1985) within the resident in-depth interviews (Appendix B). The analysis of changes in satisfaction among the cohort within this section draws on the 24 residents in the first wave who participated in discussions at the second and third waves. The scoring process delivers a score between –2 and +2. The nominal values are -2 (very negative), –1 (negative), 0 (indifferent), +1 (positive) and +2 (very positive).

Residents expressed a high level of satisfaction with RSP workers and their assistance (Table 3.2). Mean satisfaction ratings were between positive and very positive. Residents accessing CLP showed the most marked increases in satisfaction across the 9 months. However, the sample was too small to conduct significance testing between the service types, and so these results can only be conclusive in relation to recognising a high level of satisfaction with all service types, which probably stayed about the same or increased slightly.

Table 3.2: Satisfaction with RSP Service Delivery by Service Type, mean

Program type	First contact	Second contact	Third contact	Change
DSS	+1.80	+1.88	+1.89	+0.09
CLP	+1.50	+1.85	+1.84	+0.34
KSW	+1.31	+1.28	+1.28	-0.03
All RSP	+0.96	+1.64	+1.57	+0.61

Few residents expressed decreasing satisfaction with RSP workers (Table 3.3). The small decline in satisfaction with KSW reflected staff changes in the role.

Table 3.3: Change in Satisfaction with RSP Delivery for Individual Residents, per cent

	Decreased	Increased	Same
Receiving DSS	0	0	100
Receiving CLP	0	28	72
Receiving KSW	9	27	64

Most RSP providers had arrangements for residents to express any dissatisfaction they have with their services. At least one agency did not. Most providers built these mechanisms into case reviews with clients and actively promote feedback. Some providers arranged independent evaluations of service satisfaction. However, the reported knowledge of complaints processes by residents was low.

Advocacy organisations and individual advocates acknowledged that RSP had some positive effects but it was 'a stopgap measure'. They reported that they had not been called on to advocate for residents in complaints with RSP service providers. Mainly their RSP related activities were in supporting residents in various difficulties with premises operators. They felt that the monitoring effects of the RSP process were positive in that more was known about what goes on in individual premises.

Nevertheless advocates had a general concern that RSP interventions were minimal in nature and not likely to result in long-term benefits. There are no benchmarks for the RSP - 'being better than homelessness is not a benchmark', is how one put it. One advocate maintained that residents have histories of being over-controlled by others and many don't want their situations 'intervened in'.

3.4 Program Delivery

The next aspect of implementation was how the RSP providers delivered the program.

RSP service delivery

RSP support workers adopted an informal approach to initial interviews with residents. Their focus was to gaining trust and learning about the needs, wishes and desires of residents. Paperwork might not be completed at a first or even second interview in many cases, and much of that was done away from the resident (particularly if the service plan involved getting secondary information from carers, family members, health services and premises operators). Residents might take some time to get used to the idea of receiving assistance, or simply did not respond to formal questionnaire-based interviewing. At some stage, the RSP worker presented a

service plan and checks each detail with the resident. The worker might also have to review the plan with premises operators and carers so that activities did not clash with other commitments of the resident.

There were service delivery process problems specific to individual service types. For DSS particularly, the process of engaging residents in what was usually a very personal domain could take time. CLP workers needed to address the fears of residents in travelling about the community, using public transport alone and engaging in individual community linking activities. Most CLP workers put forward the view that group activities were initially necessary for some people. KSW mentioned the particular problems associated with service planning with people who were transient. These residents' service arrangements (particularly with mental health providers) break down each time they moved areas.

Funding

Most providers found their funding was inadequate to meet demand. Providers adopted approaches to prioritise the needs of residents for available assistance or limit the number who received assistance at any one time. Nevertheless providers described themselves as financially viable. One provider was critical of the process by which needs were identified and built into the allocation of resources to regions and program types. Another was critical that organisations were not engaged in the process of identifying service gaps and how new moneys available to the program could be best used. Another was critical of 'a lack of discretionary funding to broker short-term assistance of various kinds' given that this was 'a big operational issue with the long waiting lists for services.'

Workforce

Staffing for RSP services did not appear overly problematic. Like other human services, RSP staff recruitment and turnover is determined by wages and conditions; quality of supervision, support, training and occupational health and safety conditions; and clarity in responsibilities. The most difficult positions to fill in relation to these criteria were the DSS positions because of the tension between simply providing personal care and a developmental approach that encourages and trained residents to take control of their personal care where they were able.

Most RSP workers felt that they had the active support of their management within their organisations. Processes for accounting to management were similar across the services and regions and extended beyond the reports required by the Departments (monthly activity reports and HACC-MDS and CSTDA-MDS data). They included written reports, file notes, supervision meetings and occasional debriefings. In some cases, managers review the documentation from resident registration, assessment and service planning. Some workers also had independent clinical supervision as required by their professional associations.

3.5 Program Structure

The next aspect of implementation was the structure to implement and support the program. The evaluation findings about program structure changed over the 9-month evaluation period. There were several possible explanations, primary being that the program was in a pilot phase, gradually improving its operation and policy; and it was

a formative evaluation, where the program responded to interim findings to improve the program. A new set of joint operational guidelines were developed during the second half of the evaluation, to be released in early 2005.

Government structures

The evaluation found that the program structure described in Section 1.1 was successful in terms of implementing a program and responding to suggestions for change. It still however remained an inefficient program structure.

The primary inefficiency was joint management between DSQ and QH. The agencies seemed to work in parallel rather than an integrated approach, which replicated or contradicted management processes for the various stakeholders. While there were reasons for this approach in a pilot, it would be hard to justify in a continuing program.

Second, responsibility was also divided between central offices and the regions, yet this regional structure was not the same between the two agencies. Distance between central decision makers and regional officers in terms of geography, frequency and quality of contact and time for response, resulted in inconsistent and poor program management for some providers. Financially, these inefficiencies no doubt drained the administrative resources of the program.

DSQ and HACC regional managers established working relationships and processes for managing the RSP in their regions. A concern raised by managers was the complexity of the RSP due to its multiple stakeholders. Other community programs they managed were described as being considerably more straightforward than RSP, involving contracts with single providers to deliver the various programs. These programs were described as easier to administer in terms of program standards, processes and outputs. The number of other programs and the size of the areas they administered put significant restraints on their capacity to manage the RSP.

Accountability of RSP providers was also a concern to regional departmental managers. The central management of KSW contracts by QH was seen as having distanced HACC managers from the developmental phase of the RSP. Later in the pilot, HACC State Office managers were communicating with HACC regional managers, requiring monthly qualitative reports on the RSP as well as the HACC-MDS data. This was seen by them to have enhance the contract management of KSW providers.

DSQ managers felt much more in control of contract management of their providers as this was one of their roles at the regional level and they thought they improved the levels of accountability within those contracts over time.

RSP providers were almost universally frustrated by the management structures of the RSP and the limited opportunities for refining the program. They wanted opportunities to discuss, and for the government to act on, implications from fundamental assumptions about the design of the program, such as the proportion of people likely to need access to mental health services and the flexibility and scope of service delivery.

Planning, policy and delivery issues were to be resolved locally between the many stakeholders through the Local Coordination Groups. Earlier reports referred to the shortcomings of the coordination structure. Most people supported the need for a coordination structure, but the administrative arrangements discussed in early evaluation reports were frustrating. It was not clear from the evaluation fieldwork whether the changes proposed by the RSP Working Party to the structure and function of LCGs were effectively implemented. The new 2005 operational guidelines attempt to address these concerns.

RSP providers and residential premises

The other set of program structure findings were about the variation between regions on the availability and viability of RSP providers. Government and non-government social services varied in the regions in terms of their history, culture, willingness to form partnerships and capacity for service delivery. Their relationships were underpinned by different approaches to resident rights and service delivery principles. These differences were particularly evident around issues such as: definitions of disability (e.g. whether people with a mental illness have a disability); approaches to service delivery (e.g. developmental approaches that involve skills training and aim for enhanced resident independence and sustained benefits); resident input to planning, delivery and evaluation of services; and interagency cooperation.

Many premises operators and owners cited initial problems in the implementation of the RSP: inadequate information, confusion over the roles and boundaries of various RSP functions, communication failures and inadequate services. In the main these had been resolved, and most premises operators and owners expressed a high regard for RSP providers and the processes of coordinating their activities with them. Many acknowledged the value of RSP providers' expertise, advice and contacts in the health and related services. A minority of providers reported persistent difficulties citing insufficient accountability, unreliable service delivery, disruption of resident households, a confrontational advocacy style and inadequate structures to mediate difficulties.

The management representatives of RSP service providers were largely positive about their relationships with residential premises. They appeared to take a pragmatic approach to the relationship in terms of accepting the residential context of the program, the business nature of the premises and the broader reform context. On a practical level they struck a balance between acting on the interests and rights of residents, while maintaining RSP access to the premises and operators, acknowledging their viability concerns.

The quality of day-to-day relationships between RSP provider staff and premises operators, however, varied significantly. Many RSP provider staff had mainly good relationships with all or most of the staff at the premises in which their clients live. They developed various ways to maintain constructive relationships without having to compromise their concerns for the rights of residents.

The problems at stake were mostly about perceptions of some operators' paternalistic and controlling attitudes to residents, rather than abuse, neglect and exploitation. For some RSP workers the process was difficult and they regularly found themselves having to compromise to keep the doors open to them. A few staff appeared to have

become fatalistic and stopped advocating for residents when necessary in order to keep their jobs. Others resigned their jobs in similar circumstances. Several ex-RSP workers gave accounts of such scenarios. Many staff suggested that there should be some kind of legal requirement on premises operators to give reasonable access of RSP workers to residents.

Another of their concerns was that RSP workers have borne the brunt of premises operators' reactions when allegations of resident abuse or neglect were made, even when RSP workers have not triggered complaints themselves.

Advocacy organisations identified this tension as one of the key design faults in the RSP. In their view, keeping good relationships with premises operators at the expense of residents' needs and rights is a fundamental conflict of interest for RSP provider organisations.

3.6 Links to Other Human Services

The next section on context will discuss the impact of the shortage of housing and human services. Within RSP, integration of the program with mental health services was a matter that was addressed during the pilot to improve residents' access to necessary mental health support. DSQ Regional Directors and QH Area HACC Managers reported that awareness of RSP was limited to some parts of the MHS and some other HACC programs. They reported that MHS case managers were referring residents to RSP as a means of justifying their discharge from acute inpatient units and over time, from their caseloads. Advocacy organisations and advocates also held this view, but in more strident terms. They claimed that MHS were using the RSP to prop up a failed mental health system. They were concerned that acute inpatients were being 'dumped' in boarding houses on discharge, with little actual case management, and Community Mental Health Team workers have large caseloads and rely on hospital admissions rather than delivering a recovery focussed community mental health service.

Some RSP service staff argued that at the policy level DSQ must respond to the needs of people with a psychiatric disability. They suggested that the MHS must become a central stakeholder in the program and guarantee services to RSP clients with a mental illness - staff were almost unanimous on this.

CLP staff were disappointed with disability and other employment assistance providers. TAFE, on the other hand, was seen to be keen to assist the integration of residents into the community through training. Volunteer agencies have cooperated with CLP staff in facilitating residents access to voluntary work.

KSW staff were attuned to the impact of health services on residents. All KSW staff expressed difficulty with not having funds to broker health services. Free or subsidised services in particular have long waiting lists. Even finding GPs who bulk bill is a challenge in some regions. GPs that do bulk bill often close their books for periods when they were at full capacity. KSW staff expressed concern about some premises having their own 'visiting GPs'. As one said: 'Residents don't get a choice of doctor, there is no surgery so discussions are held without privacy, and they are unlikely to do actual examinations or procedures'.

Free or bulk-billed psychological services were practically non-existent and the referral arrangements with MHS usually work the other way: 'them wanting to refer to you'. Many KSW staff had success in confronting these conditions and getting services for residents. Some talked about strategies in ‘bullying’ and 'guilt-tripping' providers and talking up the pain or distress that residents were experiencing in order to jump queues.

3.7 Context of RSP

The purpose of the evaluation did not include a review of the context, however, contextual matters had the effect of limiting the scope and effectiveness of the program. This discussion includes five relevant issues: historic context, residential services reform, availability of housing and human services, income and participation and community attitudes. Regional variations in these and other contextual issues discussed in the baseline report also affected the implementation of the RSP.

Historical context

Historical developments in the provision of supported low cost housing for people with a disability shaped the expectations of stakeholders with regard to the scope, purpose and outcomes of the RSP. The first of these is past deinstitutionalisation of people from large long-term acute care and other institutions for people with psychiatric and intellectual disabilities. While the principle of deinstitutionalisation was to be applauded, implementation without sufficient alternative accommodation resulted in many people being displaced into private residential facilities, without adequate support. This further aggravated the risk of abuse, neglect and exploitation, conditions under which they had lived in institutional care.

The contemporary commitment to further deinstitutionalisation without, as yet a complementary supporting budget threatens to continue this historic vulnerability of residents in this form of accommodation.

This historic context also affected the characteristics of these residents due to their experiences in unsuitable accommodation. Many of them had had negative experiences of or rejection from accommodation, which reduced their remaining accommodation options. Some of them, especially in the northern region, tended to be highly mobile due to factors such as itinerancy, seasonal ‘migration’ in tropical areas, boarding house closures.

Residential Services Reform

The pilot program operated in the midst of large-scale reform of the private residential sector to improve the quality of accommodation available to vulnerable residents. The sector is undergoing significant changes in response to the introduction of legislation requiring the registration and accreditation of residential facilities and monitoring their ongoing operation.

In several instances, the additional requirements imposed by the new legislation have prompted operators to close their business. It is anticipated that further closures will occur in the near future. The reduction of available places in these facilities compounds the existing shortage of accommodation for people with a disability. The closure of premises disrupted RSP in ways such as creating transition needs for residents, temporarily displacing the availability of the program in premises approach

regions and reducing the number of housing options, even if they were unsuitable. Similarly, within the premises in which residents lived, RSP providers reported negative effects of very poor standards of accommodation and vulnerability to abuse, neglect and exploitation on health and community linking.

Some premises operators confused RSP with the broader reforms. This context created a number of false expectations about RSP. Some premises operators thought that RSP was for the benefit of the industry rather than the residents. The concurrent reforms in residential services created suspicion among some premises operators about the role of RSP workers in at their premises. As a result, RSP providers had difficulty promoting the RSP and involving premises in the premises approach regions, as well as receiving hostility in entering some individual approach facilities.

Peak disability and tenancy advocates asked fundamental questions about the wisdom of a ‘bandaid’ approach such as the RSP in propping up what is, in their view, a non-viable industry and inappropriate accommodation for people with disabilities who need support services. One issue of general concern for advocates consulted was that RSP is 'propping up a bad option', it is 'industry- rather than resident-focused' and 'doesn't constitute a real commitment to change'. Some suggested other options for the RSP in terms of other programs and projects that focus on a model to 'support the development of belonging in the community'.

Availability of housing and human services

Fundamental to the implementation of RSP was the next significant contextual issue of a shortage of suitable, low-cost social housing, mainstream human services (eg. health, mental health, allied health, community, welfare, employment and education), and disability specialist support services, including Lifestyle Support Packages.

Due to the historic context described above, people with disabilities and other support needs live inappropriately in private residential facilities. This need for suitable accommodation was not solved by RSP and nor could RSP workers successfully refer these residents to more appropriate accommodation because very little of it was available. Despite their historic disadvantage, these residents are not given priority for affordable housing, social housing with specialist support or DSQ Lifestyle Support Packages.

RSP was an attempt to ameliorate these unsuitable accommodation conditions. Yet it was a small program, built on the assumption that RSP referrals can access support from other mainstream and disability services. The findings discussed in this and earlier evaluation reports described how the shortage of these other human services is a severe limitation on the program.

KSW identified difficulties in accessing subsidised treatments and services, with long waiting lists (such as psychological counselling, rehabilitation, dentistry, physiotherapy); highly targeted programs that place higher priorities on other groups (homelessness programs, MHS case management, public psychiatry, crisis public housing lists, labour market programs); and changes in private medical practice (GPs who have stopped bulk-billing and increased pressure on those that have continued). The limitations of available accessible transport, supported transport and travel training services have also been significant.

The limitations around the use of the small amount of brokerage funds within the program have made it difficult to have resident needs met through direct purchasing or internal provision of services. Many of the factors affecting resident access to human services, were beyond the realm of influence of RSP providers.

Income and economic participation

RSP provider staff identified limitations of low income on the interventions they could make, such as implications for personal hygiene, independent travel, and community linking.

While the main contextual consideration for the program is residents' vulnerability due to their accommodation, a second changing consideration is the implications of expected welfare reforms at the federal level. The proposed changes to eligibility for income support and requirements of economic participation will heighten the vulnerability of this group of people with disabilities.

Already, the movement in FaCS funded open employment services to a case-based funding approach meant that some people most in need, with the greatest labour market barriers and the least social supports were not being accepted for assistance.

Community attitudes

The final contextual limitation is community attitudes. Prejudice and discrimination in the general community will constrain any long-term strategies to integrate people with disability living in the most marginal settings into the community at large. The idea of community was contested within the RSP stakeholder groups. For example, is a church-based drop-in centre catering to people with multiple disadvantages an integrated community setting or a congregate care setting? The same ambiguity confounds CLP policies in defining individual and group community linking activities. Existing community attitudes mitigate the achievability of the aim of the pilot project to provide support and then fade assistance as the links between residents and community grow.

CLP workers varied in their accounts as to how and how much mainstream cultural, leisure and entertainment providers, clubs and social groups were willing to accept the participation of residents in their activities. According to some CLP staff, residents confronted a general disinterest, within their communities. One CLP worker gave an account of a craft group that accepted residents because it was the 'right thing to do'. The effect was to disrupt the dynamics of the group and other members left. There were a few accounts of successful integration where this was underpinned by the use of enhancement funds, helping residents with the costs of participating, but the sustainability of such involvement is uncertain.

Overcoming resistant or exclusionary community attitudes to participation of people with disabilities relies on fieldworkers having community development skills, which was not explicitly acknowledged in the program design. Stakeholders argued that a community development approach would be a useful adjunct to individual linking activities.

3.8 Summary of Implementation

The many people involved in establishing and implementing the RSP pilot achieved a relatively stable, recognisable program in which residents were pleased to be involved. The managers and workers in policy and service delivery responded to suggestions for improvement, within the constraints of the pilot design. Even the difficult task of resolving relationships between participants with different service principles was approached constructively by most stakeholders.

Implementation in a pilot phase is always difficult because of its ground-breaking and potentially temporary nature. Added to this were a number of contextual constraints including barriers such as the historical accommodation context, the shortage of housing and human services, welfare reform and community attitudes. It was also in a time of rapid residential services sector reform.

Despite this, the program remained viable and within budget and appeared to have improved the lives of residents in all regions where it was piloted.

4 Impact on Residents

This section presents findings relating to the impact of the RSP on the longitudinal resident cohort. It begins with an examination of the changes for residents in their self-identified health and wellbeing, followed by residents' access and satisfaction with health providers and treatments, social and economic participation, accommodation and goals.

Most of the findings on resident benefits were from the residents themselves. These findings were also reflected in the comments of other stakeholders. RSP provider managers and workers and premises operators were unanimous in their comments that RSP assistance to residents was beneficial.

4.1 Health and Related Services

The first objective of the program was to improve resident health and wellbeing. Related to this was to improve their access to health related services.

Self-identified health and wellbeing

At the first contact, residents were asked four questions from the ABS National Health Survey addressing aspects of health and wellbeing (ABS 2001): their overall feelings about life, their self-identified health, health compared with a year earlier, and perceptions of over- or underweight. Full results are presented in Appendix C with analysis. In summary:

- feelings about life – there was a move towards population norms over the evaluation period;
- current health – the number of people reporting bad health reduced over the evaluation period approaching population norms, though they were still much less likely than the total population to identify their health as very good or excellent;
- health compared with a year ago - participants were much more likely than the overall population to describe themselves as much or a bit better – this was consistent with the qualitative evidence that many had had very negative experiences of during 2003 prior to their participation in the RSP; and
- perceptions of body weight – there was a movement over the evaluation period towards population norms. Qualitative evidence suggests that health interventions supported this move.

The most likely explanation for these changes relate to residents' increased access to health services across the 9 months and the additional benefits of having KSW assist them to attend appointments and follow treatment instructions.

Access to health support

Access to health professionals among the resident cohort was fairly constant across the 9 months, except for access to MHS case managers, which increased markedly by the middle of the evaluation and then declined towards the end of the evaluation (Table 4.1). This reflects the short-term nature of most MHS case manager interventions.

Table 4.1: Change in Resident Access to Health Professionals, per cent

	Per cent of resident cohort accessing:				
	GP	MHS case manager	Psychiatrist	Other medical specialist	Other health worker*
First wave	94	38	38	22	19
Second wave	93	47	37	17	10
Third wave	96	39	43	18	18
Change	+3	+2	+5	-4	-1

Note: * Includes various counsellors

The types of treatment and support used by these residents included (in order of decreasing frequency): taking anti-psychotic, anti-depressant, anti-epileptic or unidentified psychiatric medication; GP treating mental health; psychiatrist treating mental health; GP treating other conditions; regular contact with a MHS case manager; counselling (psychiatrist, psychologist or other: domestic violence, child sexual abuse, addiction); taking an analgesic or anti-inflammatory; specialist surgery for a physical condition; no treatments; having physiotherapy; taking a mood stabilising medication; taking sleeping medication; having electro-convulsive treatment; GP treats epilepsy; specialist cancer treatment; GP treats diabetes; GP treats blood pressure; heart specialist treatment; endocrinologist treatment; eye specialist treatment; blood tests for Clozapine toxicity; and HIV treatment. The types of treatments being accessed did not substantially change over the evaluation period.

Resident satisfaction with health providers

The method for establishing resident satisfaction was discussed in Section 3.3 and is explained fully at Appendix B. Residents' satisfaction with various health providers increased throughout the evaluation (Table 4.2), within the positive to very positive range.

Table 4.2: Resident Satisfaction with Health Providers

	Mean	Range	Median
First contact	+1.24	0 to +2	+1.17
Second contact	+1.45	0 to+2	+1.67
Third contact	+1.45	-2 to +2	+1.67
Change in satisfaction	+0.47		

Analysis of resident satisfaction with health professionals involved in their health care showed some improvements for GPs, psychiatrists and other specialists, and MHS mental health case managers (Table 4.3), with all ratings between positive and very positive.

Table 4.3: Resident Satisfaction with Specific Health Providers

	Mean satisfaction at first contact	second contact	third contact
Specialist medical practitioners (other than psychiatrists)	+1.5	+1.8	+1.8
GPs	+1.41	+1.64	+1.77
Mental health case manager	+1.4	+1.17	+1.5
Psychiatrists	+1.0	+1.2	+1.11

Analysis of the overall changes for people in the cohort show that most residents (96 per cent) report increased or similar levels of satisfaction across the evaluation (Table 4.4).

Table 4.4: Changes in Satisfaction with Health Providers for Individual Residents, per cent

	Decreased	Increased	Same
Per cent of cohort	4	43	52

Most members of the cohort increased their access to health care over the evaluation period (Table 4.1). The support of RSP workers in transporting residents and organising and supporting their appointments was critical to this. Supporting residents at appointments also improved the quality of care at and after appointments, with better liaison between medical practitioners and people who provide care and support to residents in their residential settings (eg. appropriateness of medication and other treatments).

Premises operators also identified improvements in residents' health through RSP intervention. Transport to and support at medical appointments were particularly valued, improving residents' experiences in their interactions with the health system and health professionals and improving the continuity of their medical treatments in their residences. They also identified a number of medical and allied services that residents were now receiving that they hadn't been able to access before: psychiatry, psychological services, mental health case management, podiatry, dentistry, physiotherapy, diversional therapy, and the beneficial effects of having someone with time taking a personal interest. Operators also commented on the RSP providers' capacity to act promptly and influence other service providers on behalf of the residents.

4.2 Social and Economic Participation

The level of satisfaction with social and economic participation showed marginal improvement (Table 4.5).

Table 4.5: Resident Satisfaction with Social and Economic Participation

	Mean	Range	Median
First contact	+0.42	-1.13 to +1.75	+0.5
Second contact	+0.66	-0.88 to +2.0	+0.57
Third contact	+0.90	-0.88 to +2.0	+0.88
Change in satisfaction	+0.48		

Table 4.6: Change in Satisfaction with Social and Economic Participation for Individual Residents, per cent

	Decreased	Increased	Same
Per cent of cohort	26	70	4

About three-quarters of the cohort reported an increased or similar level of satisfaction (Table 4.6). The factors underpinning increased satisfaction with social participation were similar to those associated with increased satisfaction with accommodation but included the effects of participating in community linking activity.

For the one quarter of residents expressing decreasing satisfaction the associated factors were: recent illness, degenerative physical conditions reducing mobility, loss of relationships and low income reducing social participation options.

Most premises operators observed participation benefits for residents who received RSP assistance. They described improvements in residents' ability to go out into the community and enjoy themselves. They referred to the benefits of someone else to talk to residents about their social difficulties, doing CLP activities that they enjoy and would otherwise be inaccessible, getting out as a group of residents away from their accommodation, mixing with others in the community, watching less television, spending less time sitting around becoming introverted, achieving in TAFE courses and holding down part-time voluntary work.

RSP providers reported residents' benefits related to increased confidence, improved socialising, acceptability to others, improved health and happiness. Some big achievements may appear small to the casual viewer - someone with schizophrenia and an intellectual disability successfully catching a bus on their own for the first time, after a year of travel training and support.

Social networks

Relationships between residents and their partners and children remained similar throughout the evaluation. Family disruptions and breakdowns figure commonly in the backgrounds of residents. About two-thirds of participants that have had families have little or no contact with their former partners or children. While CLP workers undertook to assist several residents in finding and reuniting with family members, most of these were unsuccessful, even when family members were found. Over half of the resident cohort had little or no ongoing contact with birth family members. Residents' isolation impacted on their capacity to benefit from RSP interventions.

Residents' friendships were commonly disrupted through moving accommodation, coupled with mobility restriction and being unable to afford travel or telephone calls. CLP activities in particular, and a more general involvement in community activities,

increased the friendship networks of some residents. It was also common for residents to increase the number of co-residents they saw as friends.

Resident satisfaction with their social participation improved across the 9 months. The factors limiting increased participation included declining physical mobility and low income. Some residents who had been unable to travel independently benefited significantly from travel training and support. Two thirds of the cohort were able to access public transport at the first contact (69 per cent), which was unchanged over the evaluation period. By the end of the evaluation period there was one resident who owned a car. People who were able to independently access a major retail centre comprised 69 per cent of the cohort at first contact, but this dropped to 61 per cent by the end of the year.

Employment

Labour market participation started and remained slight within the cohort. In February, 9 per cent of the cohort was doing some paid work, reducing to 7 per cent at the end of the evaluation. While a further 9 per cent were actively looking for work at the beginning of the evaluation, this declined to 3 per cent. Eighteen percent of residents were doing some voluntary work at the first contact, reducing to 14 per cent.

No one in the cohort accessed Commonwealth-funded Disability Employment Assistance (either open employment or business service assistance). One participant received the assistance of a Job Network Intensive Assistance provider but this resident's employment was disrupted by periods of illness.

As well as personal characteristics, this poor outcome in economic participation probably also reflected the shortage of support to enter the labour market, discussed in Section 3.6.

Education

Education was a significant activity within the cohort, with 30 per cent having done some study during the evaluation period. These were mainly initiated through CLP. Courses ranged from short interest-based courses in the arts and crafts to basic skills courses, some in vocational courses and one resident enrolled in an undergraduate degree.

4.3 Accommodation

Across the three contacts residents, overall, expressed an increased level of satisfaction with their accommodation (Table 4.7). The mean score for the sample rose from +0.64 at first interview to +0.97 at the third, approaching positive.

Table 4.7: Resident Satisfaction with Accommodation

	Mean	Range	Median
First contact	+0.64	-0.2 to +1.8	+0.71
Second contact	+0.87	+0.33 to +2.0	+0.86
Third contact	+0.97	0 to +2.0	+1.14
Change in satisfaction	+0.33		

Over two-thirds of the cohort expressed similar or increasing satisfaction during the evaluation (Table 4.8).

Table 4.8: Change in Satisfaction with Accommodation for Individual Residents

	Decreased	Increased	Same
Per cent of cohort	30	57	13

The factors associated with decreasing satisfaction with accommodation included: periods of severe illness, changes in household composition, bereavement, sharing rooms with other people and disruption in the household by other residents.

The factors associated with increased satisfaction with accommodation included: moving to more independent living situations (these individuals showed the most marked increases in satisfaction with their accommodation); moving out of premises where resident had experienced abuse; feeling happier and experiencing less symptoms from mental illness.

RSP providers described some grand achievements, for example, helping someone who had spent their adolescence in a hostel to move into independent living and discover and express the depth and range of their talents and abilities.

4.4 Resident Short-term Goals

At each contact residents were asked about any immediate goals they had over the next three months. Living more independently or elsewhere continued to be a significant goal. People with concrete and manageable goals were more likely to have achieved them, such as doing another art course or passing exams at university. Some people who wanted to live elsewhere or more independently either achieved this goal, or had taken practical steps towards this. A significant number of residents at each contact said that they had no goals. This was often couched in a fatalistic tone, or even explicitly stated, such as ‘nothing will change’. Residents’ goals at the three contact points are detailed at Appendix D.

4.5 Summary

The lives of the residents who participated in the longitudinal resident survey at the first contact were characterised by: isolation within the community, estrangement from family, detachment from the labour market, poverty and reduced mobility and a fatalism about whether their situation could ever improve.

Residents with RSP assistance increased their access to health, welfare and community services. CLP played a major part in improved resident satisfaction with social participation, with most people benefiting from increased social contact and the development of broader interests. Low income and physical access issues continue to militate against the success of community integration attempts for many residents. RSP providers worked with limited resources (eg. diminishing numbers of bulk-billing doctors, long waiting lists for subsidised services, disability employment services which exclude clients without stable accommodation and social support, social and leisure groups which will not accept residents).

The most significant benefits to residents were increased access to and effectiveness of health services and treatments. Residents’ self-identified health and wellbeing improved substantially across the 9 months with many measures approaching

population norms. KSW supported residents to access services, attend appointments and follow treatment instructions. This contributed to increased resident satisfaction with health professionals and treatments. Many of the premises operators interviewed reinforced this view.

More residents were participating in education, training and voluntary activity, but not paid employment. Some residents moved to more suitable accommodation with the help of RSP workers.

5 Impact on Premises Operators

This section presents a summary of the findings relating to the impact of the RSP on premises operators.

Several operators commented on the lack of information available at the commencement of the RSP about the type and range of services available through the program. They increased referral to the KSW and DSS over time, as they learnt more about the program. However, they asked for clearer and more comprehensive information about what is available to residents under RSP.

Most operators reported a positive impact on workload. The RSP replaced or complemented some of the tasks that they or their staff had previously undertaken and this had freed up time to concentrate on other things such as the work associated with accreditation, or being able to pay more attention to premises operations. Providing assistance for residents with washing and transport was the biggest time saving. Several providers talked about the expertise of RSP workers around medical and disability issues as a resource to them in understanding and helping residents with complex disability support needs - particularly physical disability, mental illness, neurological disorders and ABI.

The RSP created some work in coordinating between premises staff, residents and RSP providers, though they mainly felt that this initial work was worth it in terms of both benefits to residents and in a consequent reduction in their own workload, particularly around providing personal care. There was additional work for operators in the regions where the premises model operates, specifically the time taken to go through the assessment process as suitable premises.

Premises operators were unanimous that they were not making much money from their businesses. The RSP impact on financial viability was marginal for most operators. Besides the free time that they were able to direct to other activities, the cost savings were small. For one provider, though, the arrival of the RSP helped make operations more viable - changing the business from a boarding house to a hostel, the provision of meals improved financial viability. The RSP referral process, along with the local mental health services, 'filled' rooms, replacing the need to advertise. On the other hand another operator claimed that aggressive relocation of residents to other premises by RSP workers reduced income by increasing vacancy rates. This operator estimates a further loss in unpaid rent of relocated residents who, with the support of RSP staff, had their liability waived by the Rental Tenancy Authority.

When asked about the future of the RSP the premises operators were unanimous that RSP should be continued beyond its trial phase, be expanded and be available to all those who might be entitled. They were concerned that residents who used the RSP pilot would be severely disadvantaged if the service were withdrawn. Many said that this would also impact negatively on the quality of accommodation that they offered as they would not have the extra time resources that the RSP delivered.

6 Cost Effectiveness

As discussed in the Evaluation Plan (Abello et al., 2004), cost effectiveness analysis provides information about the value added from RSP. Whereas cost-benefit analysis requires dollar figures to be placed on all components of the analysis (costs and benefits), cost effectiveness analysis allows the assessment of the benefits of the program in physical and social terms (e.g. quality of life gained) and is therefore more appropriate for the purposes of human service program evaluation (Schmaedick, 1993). The underlying principle of cost effectiveness is that for the given budget, DSQ wishes to maximise benefits conferred (or for a given goal DSQ wishes to minimise the cost of achieving it).

6.1 Program Costs and Outputs

The financial and service data in Sections 2.2 and 2.3 were used to derive a per person cost for the cost effectiveness analysis. Financial cost was calculated as the sum of average quarterly costs per person across the three quarters. This provides an estimate of average cost for people who participated in the program in each quarter, thereby corresponding with the outcomes data. Over the nine-month research period in 2004 this was $3986 (annualised $5315).

Over the same period is a calculation of the average use of services of people in the program. This was the sum of average quarterly hours/trips per person across the three quarters. This provides an estimate of average hours/trips per person who participated in the program in each quarter, thereby corresponding with the outcomes data. Over the nine-month period this was 76.1 hours and 3.4 trips per recipient.

6.2 Resident Outcomes

This section discusses the quantitative evaluation of outcomes. The results in this section should be treated with considerable caution for a number of reasons. In particular:

- The number of people who participated in both the initial and third interviews (24) is small. This sample is also too small to enable a comparison between sub-sets of the RSP.
- The main outcome measures (satisfaction with accommodation; satisfaction with social and economic participation; self-assessed health) are scales constructed from combinations of questions asked by the interviewers. But these are not validated scales (the justification for this is included in the instrument description at Appendix B).
- There was no comparison group included in the evaluation. Therefore, it is not certain whether any changes in outcomes observed for the sample of participants resulted from the program, or was due to other factors.
- The first interview was conducted shortly after the program had commenced. Thus there is no information from the participants prior to the intervention, and so the overall impact of the program may be underestimated. This may be problematic if the benefits of the program were immediate.

With these caveats in mind, the results are presented below for each of the outcome measures:

Satisfaction with accommodation

Five items collected in the interviews were combined within this domain of satisfaction:

- Do you like living here?
- Do you like the other people living here?
- Do you like the staff here?
- Do you like the food?
- Do you like that rule? (after the respondent mentioned a given rule)

The answers to these questions were scored by the researchers according to the following schema: –2 (extremely negative), -1 (negative), 0 (indifferent), +1 (positive) and +2 (enthusiastically positive). The sum of the five items resulted in a scale of satisfaction with accommodation ranging from –10 (extremely negative) to +10 (extremely positive). Across the 24 participants in the first and third interviews, the average score increased from 3.33 to 4.50. This increase was statistically significant (p=4 per cent).

Satisfaction with social and economic participation

Seven items collected in the interviews were combined in this domain of satisfaction:

- Are you satisfied with your friends?
- Do you like this neighbourhood?
- Do you feel you can get around as you'd like?
- Are you happy with your free time?
- Do you like the shops around here?
- Are you happy with working/not working?
- Are you happy with the education/training you had/are doing?

Items were scored in the same way as for the Satisfaction with Accommodation domain, thus resulting in a scale ranging from –14 to +14. Across the 24 participants in the first and third interviews, the average score increased from 3.17 to 6.29. This increase was statistically significant (p=1%).

Self-assessed health and wellbeing

A number of questions were asked related to self-assessed health and wellbeing. The first question required residents to identify their overall feeling about life on a slightly modified version of the seven point 'terrible-delighted' scale[2]. These responses were coded to a numeric scale 7 represents 'delighted' and 1 represents 'terrible'. Across the 24 participants in the first and third interviews, the average score increased from 4.83 to 4.96. This increase was not statistically significant.

[2] The next question is about how you feel overall. How do you feel about your life as a whole, taking into account what has happened in the last year, and what you expect to happen in the future?

The second question related to residents' health in general, prompting an answer on a five-point scale from excellent (5) to poor (1).[3] Across the 24 participants in the first and third interviews, the average score increased from 2.38 to 2.96, which was a statistically significant increase (p=2%).

Comparison of individual and premises approaches

Of the sample of 24 respondents interviewed in both waves 1 and 3, 16 participated in the 'individual model', and 8 in the 'premises model'. These small samples do not facilitate a rigorous quantitative evaluation of the relative success of the models. Indeed, the differences in outcomes associated with each model are not statistically significant in any of the domains examined. The qualitative analysis, reported in Section 3.2, is more informative in evaluating the relative performance of the two approaches.

However, the results in Table 6.1 can be used as a 'best-guess' quantitative comparison of the relative effectiveness of the two modes. With the exception of self-assessed wellbeing under the individual model, the results suggest some improvement in each outcome domain under both models. The average improvement in outcomes was higher for participants of the premises model approach than participants of the individual model across each of the four outcome domains considered. By these results it appears that, on average, the 'Premises approach' delivered a greater improvement in outcomes than the 'Individual approach'. This is consistent with that approach in that the smaller number of participating premises have had to meet additional criteria to be involved. The differences, though, more than likely reflect variations in the characteristics of residents and boarding house and hostel accommodation options between the regions. While every effort was made to ensure consistency between researchers in evaluating resident satisfaction, researcher bias cannot be ruled out. Once again, these differences are not statistically significant and the other limitations of the methods used were noted in earlier in this section.

Table 6.1: Comparison of Outcomes Associated with Individual and Premises Models

	Change in mean scores between Initial and Third Interview			
Mode	Satisfaction with accommodation	Satisfaction with social and economic participation	Self-assessed wellbeing	Self-assessed health
Individual (n=16)	+0.88 = +4.4% of scale	+2.50 = +8.9% of scale	-0.19 = -3.1% of scale	+0.50 = +12.5% of scale
Premises (n=8)	+1.75 = +8.8% of scale	+4.38 = +15.6% of scale	+0.75 = +12.5% of scale	+0.75 = +18.8% of scale

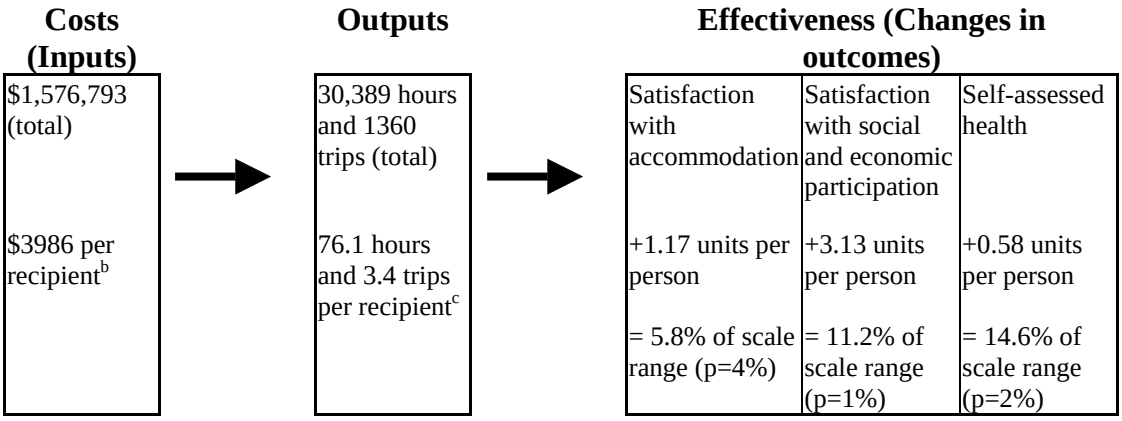
6.3 Cost-effectiveness Summary

By utilising financial data, MDS data and outcomes data, a cautious assessment of the inputs, outputs and outcomes of the RSP over a nine-month period (January-September 2004 for inputs and outputs and February-October 2004 for outcomes), can

[3] I would now like to ask you some questions about your own health. In general, would you say that your health is excellent, very good, good, fair or poor?

be made, recalling all of the caveats noted throughout this report. The results of this analysis are shown in Figure 6.1.

Figure 6.1: Summary of RSP Cost-effectiveness Analysis (Jan/Feb – Sep/Oct 2004) in the Production of Welfare Framework



Notes:

a. January-September 2004 for inputs and outputs and February-October 2004 for outcomes
b. Sum of average quarterly costs per person across the three quarters. This provides an estimate of average cost for persons who participated in the program in each quarter, thereby corresponding with the outcomes data (annualised $5315).
c. Sum of average quarterly hours/trips per person across the three quarters. This provides an estimate of average hours/trips per person who participated in the program in each quarter, thereby corresponding with the outcomes data (annualised 101 hours & 4.5 trips).

This analysis suggests that the program was successful in achieving statistically significant improvements in participant outcomes in a number of important aspects of their lives: satisfaction with accommodation, satisfaction with social and economic participation and self-assessed health, at an average cost of $3986 per participant over a nine-month period in 2004 (annualised $5315).

This method does not provide analysis to comment on the degree of change that could be expected with a different level of investment (Section 7.3).

7 Summary of the Evaluation Findings

The purpose of the evaluation was to research the process of implementation of RSP, the services provided to residents by the contracted support providers, residents' perceptions of the appropriateness of these services and impact on their quality of life, health and wellbeing, and the impact on residential facility operators and staff and other human services providers and Departments. The evaluation was also to review the cost effectiveness of the program to inform future resource allocation.

This report has presented the findings in relation to these evaluation purposes. This section summarises these findings, before moving on to discuss the implications for any future RSP-like programs in the last section of the report.

7.1 Outcomes

The evaluation found measurable benefits to residents who use the program in relation to important aspects of their quality of life, including improved health and wellbeing, satisfaction with accommodation and social and economic participation. The cost effectiveness analysis showed that for people who participated in the program, measurable improvements were evident at a relatively low cost.

7.2 Process

Residents were satisfied with the organisation of the program. Benefits were evident from each of the program types. The two program approaches, individual and premises, each had advantages. The main difference between the two was the ability of the individual approach to reach a wider range of residents and flexibly respond to residents moving between premises.

Administrative arrangements associated with the pilot evolved over the evaluation period. In its pilot form, the program had a number of inefficiencies associated with management by two agencies, at a central and regional level, provided by a number of organisations in each region.

Implications from these process findings are discussed in the next section.

7.3 Limitations of the Evaluation

This type of evaluation cannot comment on comparison to outcomes of alternative programs or a different level of investment in the program. It measures change over time to make inferences compared to no program.

The pilot only operated on a small scale in five regions. Not all residents who were interested in these regions could access the program. The pilot prioritised residents in supported accommodation services over boarding houses.

The information from this type of evaluation is relevant to programs with similar goals and a similar level of investment per person. The analysis does not provide information to comment on the scale of benefit that could be expected from a higher level of investment for people living in such vulnerable situations.

8 Considerations for Future RSP-type Programs

This last section of the report discusses considerations and implications for future RSP-type programs, within the constraints of the policy context. These considerations are derived from the findings and analysis presented in the first part of this report.

The considerations discussed about the structure of a program, focusing on findings that would need to be addressed to better meet the support needs of residents. These include service principles, resident access, service types and program approaches, providers, premises, management, support and accountability, resources and links to other services. The section and report finish with a discussion on the summary of the implications for future programs and suggest a possible option to address the considerations.

8.1 Service Principles

While funding agreements were predicated on compliance with departmental philosophy and policies, this was not clearly or publicly articulated at any level in the program. Disability service principles did not seem to be operationalised in RSP structures and practice. These are principles such as those embodied in the Commonwealth and Queensland disability services legislation and the DSQ strategic plan.

The principles focus on an individual whole of life approach to service planning and delivery, including support and suitable accommodation; rights of individuals; a developmental approach to service provision; maximising independence; and decreasing vulnerability to abuse, neglect and exploitation. They promote a social model of disability that locates residents' individual whole of life support needs in relation to their participation in the community and the service sector.

Service principles could be more explicitly articulated in the goals of the program and incorporated in the operation of the program through contractual obligations and program and provider policies and procedures. This approach relies on the funding agency enforcing compliance.

The purpose would be to inform good practice in the interest of the resident. Some examples of this are:

- promoting a consistent representation of the purpose and goals of the program to all potential stakeholders
- establishing representative management structures, that incorporate resident representation;
- defining the program's consumer constituency;
- developing a person-focussed approach to maximise independence, assist people to live in unrestrictive accommodation and decrease vulnerability; and
- defining community participation and appropriate community linking activities.

8.2 Residents

A core consideration for the program is which residents can use the program. In the likely limited budget context, choices will be made to exclude some residents. Questions of access definitions, equity (between location, residents in one facility), resident mobility, amount of service and priority residents need to be answered in any continuation or extension of the program.

Responses could be to prioritise people referred or self-referred who are most vulnerable or in residential facilities where people are most likely to be vulnerable, referral or self-referral.

Another approach could be to limit to what needs can be met by type, hours or length of time in the program. This approach would depend on a service focus that prioritised referral to mainstream services (eg. HACC, ACAT) and disability-specialist services, with some mechanism such as brokerage to ensure access to using the service, rather than merely access to the waiting list (Section 8.10).

In the pilot, only residents who met disability or HACC criteria were eligible. An implication was inconsistency and inflexibility, such as an older person with a disability only being eligible for KSW. The research suggests that eligibility should be based on a person's support needs and continuity of care, rather than administrative boundaries of other programs.

8.3 Service Types

The pilot RSP had three service types: DSS, CLP and KSW. In some locations these types were interpreted flexibility to respond to resident needs, in others they were rigidly interpreted to the exclusion of some residents and their interests. The mere presence of a regular personal service provider was described as one of the greatest contributions of the program, irrespective of the service type.

The strength of DSS was its ability to address basic personal care needs, linking to the more ambitious CLP participation goal. However, it was not always implemented with a developmental approach. Where the limited capacity of the resident restricts the goals through this approach, it may be more appropriate to arrange HACC services.

CLP seemed to be effective in terms of social participation. This did not extend to economic participation and it was not possible to evaluate how sustainable the social participation is without continued CLP support, although several stakeholders indicated it was unlikely many residents could maintain their social activities without ongoing support. The quality of the service delivery in this service type also seemed to vary in the application of disability service principles.

In observable measures, the achievements of the KSW seemed to be the greatest through linking to other service providers and the other RSP service types. The process of needs assessment, referral and follow up were its strengths. Like the other service types, it was susceptible to the workers' understanding of social participation and developmental approach.

The implications of these findings were that the goals of all three strands address residents' needs and improve their quality of life. This is particularly so if the goals were applied flexibly in response to support needs, integrated with the other RSP service types and other services and were applied with a developmental approach.

In summary, the goals within an individual whole of life framework can be framed as: independent personal care; social and community participation and engagement; and referral to use of mainstream and specialist services and alternative suitable accommodation. In practice, the program also incorporated a fourth goal of supported transport, in terms of both social support and available, accessible transport.

Additionally, the research suggests that brokerage to overcome chronic human services shortages would also be necessary to effect these goals.

8.4 Program Approaches

The RSP pilot had two approaches by which residents can access the program, based on particular premises or an individual resident. Each region had only one approach.

Considerations for assessing the two approaches or alternatives include flexibility from the perspective of the resident, individualising care, access, equity, mobility of residents and transience of facilities and cost. A preferred model would incorporate the benefits of both approaches and address the disadvantages.

The research suggests that any future programs should take an individual approach, consistent with principles of service provision in other DSQ and HACC programs. This could be administratively organised to take advantage of the benefits from both pilot approaches, such as support staff being allocated a cluster of premises in a manageable sized location, to maximise their familiarity with the premises and the profile of the program to the residents in those premises.

8.5 RSP Providers

Criteria for future provider suitability should include experience and track record in disability, developmental training and a practical understanding of disability service principles. An understanding of community development techniques might be necessary to overcome the contextual limitation of community attitudes (Section 3.6).

Considerations for which providers and how many would depend on the range of available of existing providers in the local area, staff availability, training and support, staff skills and experience, record of interagency collaboration and the historical relationship with premises operators.

One option is to have one or fewer service providers per location. Potential advantages of this model would be efficiency, consistency of service and removing conflicts between providers. It would be more likely to facilitate flexibility, meaningful activity and responsiveness to whole of life needs of a resident.

In some areas, relationships between various elements of the RSP program were problematic. In other areas they were working well. However, even in areas where working relationships between organisations and individual staff were positive and

productive, significant amounts of time were spent in coordinating support arrangements and communicating program developments.

The role of the key support worker in assessing and referring residents to other organisations for the care and support they require is in many ways the cornerstone of meeting needs in a more holistic manner. A more streamlined approach to referral and accessing required resources would cut down on the time required to coordinate with other workers (including other RSP providers) considerably. This is discussed more fully at 8.12.

8.6 Private Residential Facilities

In the premises approach, facility operators chose to apply for suitability. In the individual approach, all individuals in all private residential services meeting disability or HACC were eligible. During the pilot period, supported accommodation facilities were prioritised.

From the perspective of residents, all private residential premises involved in the registration process should be included, irrespective of the condition of the facility Restricting premises to only the ones applying for accreditation, for example, could exclude the most vulnerable residents.

Communication to operators and their staff should include information about the purpose and scope of the program, method of referral and relationship to the residential services reform process. Regular separate communication about progress in the reforms would also help address the confusion between the two initiatives.

Consideration also needs to be given as to how the registration and accreditation processes could change the criteria for premises to be classified as suitable for RSP as the reforms progress over time.

8.7 Management

The pilot RSP management structure had a number of inefficiencies, discussed earlier in the implementation findings. A goal of improving efficiency is to increase the proportion of time and resources allocated to supporting people's needs rather than organising the program.

Alternatives to the joint management between DSQ and QH would be management by one agency entirely, or by one agency coordinating a whole of government approach to budget transfer or Memorandum of Understanding of available DSQ- and HACC-like funded services.

From the perspective of providers and regional managers, the program goals and contractual arrangements were similar to other DSQ and HACC programs. It could presumably gain efficiency by replicating the simpler management structure of other programs. The advantage of this model is integration of the program into other local support programs.

Alternatively, responsiveness could probably be improved by allocating responsibility to one central office person to whom all RSP providers report. The advantage of this

model is that person is more likely to be aware of other residential facility reform considerations.

The pilot structure included many people at the level of local service planning and delivery. This necessitated management through Local Coordination Groups. Elsewhere, the evaluation referred to the shortcomings of this coordination structure. It was amended during the program to separate the operational function from the stakeholder advisory function. The research cannot comment on the completion and effectiveness of the change, however, the intended new structure responded to the difficulties raised by local participants. A simplified local structure, similar to other DSQ or HACC programs, would not necessarily need a coordination mechanism.

8.8 Support and Accountability

The RSP pilot was a developing program, in the process of drafting operational structures. Finalised structures should reflect the disability service principles and focus on resident interests. They should be operationalised in supporting policies and procedures; coordination structures; processes to address abuse and neglect; grievance processes (complaints mechanisms, advocacy, Community Visitors, OFT and RSSR); assessment tool; practice manual; referral and follow up processes to other DSQ and QH funded programs, other services and community opportunities; and stakeholder relationship protocols.

Externally, the community visitors have begun visiting these facilities. This is an opportunity to observe outcomes for residents who are and are not using RSP support.

8.9 Resources

Decisions about RSP will also rely on resources available to the program from both or either agency in terms of funding, staff and infrastructure. Beyond the pilot, the cost of a statewide program will presumably require rationing, targeting and waiting lists.

Choices about how additional resources could be allocated would include: increase the number of residents using the services; increase the intensity of services available to each resident; prioritise the most vulnerable residents and residents in facilities where they are most likely to be vulnerable (Section 8.2); increase brokerage, crisis and alternative suitable accommodation funding; and increase the number of locations where RSP is provided.

If the number of locations was to be expanded, one consideration could be to prioritise areas with more premises on the grounds of efficiency of contact with the greatest number of vulnerable residents. Alternatively, the mechanism of regional roll out used for LAC, with metropolitan areas last would address the vulnerability of isolation and restricted alternative accommodation.

8.10 Links to Other Services

Links to other services are necessary in this type of program at two levels: individual referral to other services for residents using the program and policy links between agencies with similar goals.

Successful referral links rely on fieldworkers being aware of the whole life needs and rights of residents to access mainstream and specialist disability services, and their ability to facilitate access to the service rather than just the waiting list. This report has already discussed the likely need for brokerage funds to facilitate this (Section 8.2). The researchers observed few instances of significant activity to refer residents

to suitable accommodation or service support such as HACC services or Lifestyle Support Packages. In addition, below is a discussion of the need for whole of government policy commitment to address human service provision for these citizens.

Key government agencies with related policy goals include DSQ, Queensland Health HACC and Mental Health, and Housing. The latter two were not directly involved in the policy level at the beginning of the program. Mental Health became involved once it was clear so many residents had mental health needs and were unable to successfully access services. A new manual to facilitate better service provision was published (Queensland Health 2005) and Mental Health personnel are now involved in central and local implementation.

Housing did not become included in the pilot. RSP has the potential to address appropriate accommodation, the more fundamental question to improving quality of life, if agencies that contribute to housing policy were involved. Unmet demand for accommodation and support arrangements to meet the needs of people with a disability is high across the State, aggravated by the shortage of social housing.

A single agency responsible for program delivery is likely to improve program efficiency. There are also system advantages to a whole of government approach to the policy development that supports that program delivery. An agency responsible for the program has limited leverage to in commanding service support outside its budget responsibilities.

8.11 Summary of Implications

In summary, the findings from above indicate a preference for model options with one department primarily responsible; fewer or one provider in each region; an individual approach to prioritise and follow vulnerable residents; and services to include the range of goals currently covered by the three types, whether configured as one type or more.

One option to respond to the delivery problems indicated in the findings is to further develop the key worker model. Modifications could include using the key worker position as a gatekeeper to other support services through a whole of life needs assessment. The key worker would then have the flexible options of allocating responsibility for service types as needed within their own organisation, referral to DSQ, HACC or other services, or if necessary, brokerage to other services with discretionary funds.

Under this model, the pilot community linking and disability support service functions would be incorporated into one organisation's RSP team, coordinated by the key support worker. Individual support workers would undertake the tasks currently completed by the CLP and DSS agencies in a more seamless manner from the point of view of the resident (for example, assisting a person to shower before going to an appointment, travelling with them to and fro and supporting them during the appointment.) The advantages of this type of option is a single point of entry; with an individual plan; flexibility to respond to individual needs with meaningful activity; and access to brokerage funding as necessary to overcome human service shortages.

Programs similar to this model include the Community Aged Care Packages and Community Options programs (AIHW 2003).

Appendix A Data Considerations for Resident Support Program Profile

Data quality considerations that could affect the analysis in Section 2 include how the RSP service data was identified, missing data and linked records. Each of these considerations is described below.

In addition, the method of calculating an estimate of hours for DSS and CLP services is explained at the end of the appendix.

Identifying RSP service data

Health assured the researchers that the HACC MDS data provided contains RSP specific data exclusively.

In the CSTDA NMDS data, however, services received are not classified directly by source of funding and so it is not possible to directly identify services provided through the RSP scheme. DSQ used the following criteria as the basis for inclusion of records in RSP data:

1. Broad agency/service provider data was included based on the Service IDs that received residential support program (RSP) funding from DSQ in 2003-04.
2. Service Type Outlet (STO) (ie. 'the unit of a funded agency that delivers a particular CSTDA service type at or from a discrete location') data was included based on the Service IDs identified in step 1 (above), then included or excluded using the following guidelines:

- STOs were included where:
    - the Service ID only received RSP funding from DSQ in 2003-04;
    - the Service ID received RSP funding and other types of funding from DSQ in 2003-04;
    - the STO identified 'RSP' in it's name (eg. x service – residential support program");
- STOs were excluded where:
    - the agency/Service ID clearly reports RSP funding/service separately through a different STO (eg. a different STO within the same agency/Service ID identifies 'RSP' in it's name);
    - the reported service type does not match the RSP service that DSQ funds that agency for.

3. Service User (SU) data (ie. person records) were included from the STOs identified for inclusion above, using the following guidelines:

- All SUs were included where:
    - the Service ID only received RSP funding from DSQ in 2003-04;
    - the STO identified 'RSP only' in it's name (eg. x service – residential support program");
- Some SUs were included where the Service ID received RSP funding and other types of funding from DSQ in 2003-04 and/or where the STO identified 'RSP'

and one or more other funding programs in its name (eg. x service – rsp, p300, gc):

- SUs were included where their residential setting was reported as either a boarding house, hostel or aged care rental facility (included in CSTDA NMDS residential settings '5', '4' and '7');
- SUs were excluded where their residential setting was not reported as either a boarding house, hostel or aged care rental facility.

Whilst this method may potentially overstate the quantity of RSP services provided, any bias is likely to be small. In any case, no alternative method is obvious.

Missing data

There are two types of missing data that may lead to an underestimation of the quantity of RSP residents and services. It is possible that data records were not entered for some RSP residents. But there is no way of assessing the extent of this type of error.

A second type of missing data is that of missing fields within records.[4] In particular, this affects the variables that record quantity of service provision. DSQ advised that people must have received some quantity of a given service type in order for a record to appear on the relevant data set. In the CSTDA NMDS, approximately 11.5 per cent of the records used in our analysis have missing 'hours of service in a typical week'. A further 12.1 had zero hours recorded for both 'hours of service in a typical week' and for 'typical weekly hours', thus implying that the person received no services in the quarter. The most likely explanation for the latter is missing data, and these records were treated as such. This represents a modification to the method used and reported in previous interim reports, where 'zero-zero' hourly data was treated at face value. Thus some of the data reported for earlier quarters in this report differs from earlier estimates.

This large proportion of missing service quantity data (23.6 per cent) presents a degree of uncertainty. The researchers have not treated these people as if they had received no services in the period. Instead, for the purposes of estimating overall hours of services provided, it was assumed that those with missing data received the same average quantity of service as other people receiving the service in the same quarter and service type (and location where sufficient non-missing data exist. Also, the missing values are concentrated in certain locations and service types. Specifically, this missing data is concentrated in the Ipswich and Townsville DSS records. This was taken into account in the comparisons that were made, as discussed in more detail in the relevant sections.

In comparison, it appears that only 1.5 per cent of HACC MDS records have no quantity of service recorded.

Linked records

Data from the two sources were linked by DSQ using a statistical linkage key (defined as the second, third and fifth letters of the person's surname). There is a possibility that some records were mistakenly matched on the basis of this method due to

[4] Records are unique for each combination of person, service type, location and quarter of service.

coincidence. Conversely, the records of some individuals appearing in both data sets may not be matched in the case of data entry spelling errors of the person's name in either data set.

Any such errors will have affected the number and profile of people receiving the service reported in this document. However, such errors will not affect the estimates of the quantity of services provided. There is no estimate of the extent to which this issue may impact the estimates of the number of residents.

Estimate of hours for DSS and CLP

Two data items are recorded in the NMDS regarding service usage. One of these refers to the number of hours of RSP service provision in a reference week. The other is the typical number of service hours in a week. The date of service commencement and the date of last service received are also recorded. On the basis of these data, one can infer estimates of the total service time provided over each period.

Two methods of estimating total hours were considered. One method was to use the 'typical weekly hours' data multiplied by the number of weeks in the period adjusted by date of commencement and date of last service.[5] The second method was to use the hours of service provision in the reference week multiplied by the number of weeks in the period. Under the assumption that the volume of services provided within the reference week is similar to that of an average week within each reporting period, these two methods should produce similar outcomes. But the reference week is always the last week in the reporting period. In the case of the October-December quarter, this is particularly significant as many services do not operate over the Christmas-New Year period and so the reference week method is not appropriate for the quarter. Excluding the first quarter, however, the two estimates provide estimates of total hours that differ by just four per cent. Thus for the sake of simplicity, only the results calculated on the basis of the 'typical hours' method are shown here.

Where data were available for each location, total hours across locations (the column on the far right) are simply the sum of totals for each location. Where data were missing for some locations, people with missing values were assumed to have received the same average quantity of service as people with non-missing hours within the same quarter and the same service type across all locations. The overall estimates of total hours across reporting periods are simply the sum of the quarterly estimates.

[5] For records with non-zero typical hours, the number of weeks of service receipt in the period was taken to equal (1+ (date of last service – max(date of commencement, first date of period))) / 7. Further, records where max(date of commencement, first date of period) < 7 were assumed to have received one week of service.

Appendix B The Resident Satisfaction Scale

The evaluators developed a scaling instrument to measure residents' satisfaction with various aspects of their accommodation and lifestyle, based on the Lifestyle Satisfaction Scale (LSS) (Heal and Chadsey-Rusch 1985). The LSS was developed to assess the satisfaction of people with intellectual disabilities, in the USA, with supported accommodation settings, associated services and community settings. The LSS employs 29 closed questions eliciting a yes or no answer. These are each scaled (from –2 to +2) by the interviewer to reflect the enthusiasm (or negativity) of the response. The questions are grouped into four domains:

- general satisfaction with one's community,
- satisfaction with friends and free time,
- satisfaction with services, and
- general satisfaction.

Responses are totaled within each domain and these are weighted to give a value range of between –20 and +20. Addition of these provides an overall satisfaction rating within the range –80 to +80. Acquiescence is also tested with inverted questions that garner levels of dissatisfaction in order to demonstrate whether the resident (or the interviewer) are more likely to give a positive answer. The LSS has been validated experimentally. It claims reliability, then, in comparing the level of satisfaction between varying cohorts and residential settings, even with small sample sizes. This was not a requirement for adaptation to the RSP evaluation as the evaluators only intended to measure changes in the level of satisfaction of individual residents over time, as illustrative of the factors influencing these changes, which were gathered in a qualitative fashion.

In adapting the LSS to the RSP significant other changes were made. Considerations included that the LSS was developed to measure the satisfaction levels of people with intellectual disability - there were few people with intellectual disability in the RSP longitudinal cohort and most of these have acquired brain impairment rather than developmental disability.

The LSS employs varying closed questions within each domain. In adapting the LSS for use in the RSP evaluation these same variations in question structure were retained, but they were used as open rather than closed questions, within the context of a narrative conversation. The same judgements were made by the evaluators in terms of scoring the positivity, negativity or indifference of participants to the various domains and aspects of domains, however the depth of the conversation provided a richer and more detailed understanding of the intentions of participants in addressing the questions and this allowed the evaluators to attach an average score for each domain, with considerably more confidence than one calculating a mean score from a small number of yes/no responses. The method also allowed the evaluators to be alert to, and challenge participant acquiescence.

The LSS was adapted to the Queensland context and to reflect the processes of the RSP. For example, satisfaction 'with your doctor' (from the LSS instrument) was disaggregated to specific medical and allied service providers. Satisfaction with aspects of the assistance received within the RSP have also been included.

The domains within the adapted satisfaction scale are:

- Satisfaction with RSP workers
- Satisfaction with residential context
- Satisfaction with social and economic participation
- Satisfaction with health care

The questions asked within each domain and the satisfaction scoring approaches are detailed below.

Domain	Aspect	Questions (key question in italics) †	Scoring
(S) Satisfaction with RSP workers	(S1) DSS	How is [DSS worker *name]* helping you? How did you first meet them? How often do you see them? *Do you like them?* *Are you happy with the help they give you?* Would you like to change what they are doing? Is there anything else you would like them to do that they are not doing now?	S1= -2 to +2
	(S2) CLP	How [CLP worker name] helping you? How did you first meet them? How often do you see them? *Do you like them?* *Are you happy with the help they give you?* Would you like to change what they are doing? Is there anything else you would like them to do that they are not doing now? Has [CLP worker name] helped you to see any doctor or other kind of health professional (e.g. HACC, doctor, specialist, allied health, podiatrist, dentist)? Would you like to change what they are doing?	S2= -2 to +2
	(S3) CLP	How is [KSW name] helping you? How did you first meet them? How often do you see them? *Do you like them?* *Are you happy with the help they give you?* Has [KSW name] helped you to see any doctor or other kind of health professional (e.g. HACC, doctor, specialist, allied health, podiatrist, dentist)? Would you like to change what they are doing? Is there anything else you would like them to do that they are not doing now?	S3= -2 to +2
	(S) Overall satisfaction with RSP providers		S = (S1+S2+S3) /3
(R)Satisfaction with residential context	(R1) How do you like living here?	How did you get to be in this housing? How long have you been here? Where were you living before? Did you like it better there or here? Is there somewhere else you would rather live, where would that be? *How do you like living here?* How much are you paying to live here? How do you pay that money? Do you think you get your money's worth? Do you like your room? Do you have privacy here? Do you have somewhere to be alone if you want? Is there anything about living here that you don't like? Is there anything about the place that you wish was different? What would make it better?	R1= -2 to +2
	(R2) Do you like living with the other people who live here?	*Do you like living with the other people who live here?* Are any of them your friends? Are there things about the people living here that you don't like?	R2= -2 to +2

† The questions followed conversational flow.

	(R3) How do you feel about the staff who work here?	How do you feel about the staff who work here? Do they do anything to help you? What do they do? Are you happy with that?	R3= -2 to +2
	(R4) Do you like the food here?	Do you like the food here? Would you like to have different food from what is served? Can you think of a place to live where the food would be better? Where would that be?	R4= -2 to +2
	(R5) Do you like the rules here?	Are there any rules here? Do you like that/these rules? If you wanted to complain about something that's going on here or about the place, how would you do that?	R5= -2 to +2
	(R) Overall satisfaction with residential context		R=(R1+R2+R3+R4+R5)/5
(P) Satisfaction with social and economic participation	(P1) Are you satisfied with your friends?	Who are your friends? Do you get to see them often enough? What sorts of things do you do together? Do you wish you had more friends? *Are you satisfied with your friends?* Can you think of a place to live where you would have more friends? Where would that be?	P1= -2 to +2
	(P2) Do you like this neighbourhood?	What do you do during your day? Do you do different things on the weekend than on weekdays? Is there anything you would rather do during your day? *Do you like this neighbourhood?* Would you prefer to live in a different neighbourhood? Where would that be?	P2= -2 to +2
	(P3) Do you feel that you are able to get around as much as you'd like?	How do you get around (means of transport)? [If uses public transport] What's the public transport like around here? Do you travel on your own? Does someone help you to get around? *Do you feel that you are able to get around as much as you'd like?*	P3= -2 to +2
	(P4) Are you happy with what you do in your free time?	Do you have any interests or hobbies, sports that you like to do? Do you get the opportunity to do them? Are you involved in any social activities, groups or clubs? What kind? What do you do together? Do you have friends there? Are there any social activities that you would like to get involved in? Do you get out and about on your own? *Are you happy with what you do in your free time?* Would you like to do more? Do you wish you could enjoy your time more?	P4= -2 to +2
	(P5) How do you like the shops and shopping centres around here?	*How do you like the shops and shopping centres around here?*	P5= -2 to +2

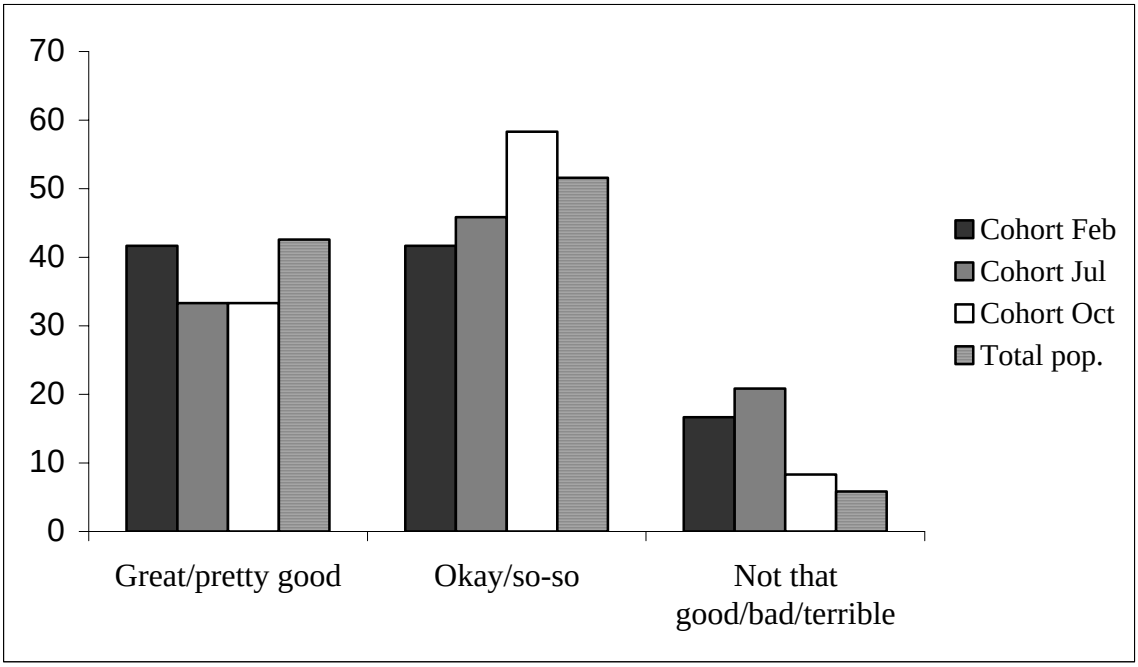
	(P6) Are you happy with your work [Happy not to be working]?	Are you doing any paid or voluntary work at the moment? In the past? Hope to in the future What work is that? Where do you work? How much do you get paid? How many hours do you work? How did you get that job? *Are you happy with your work [Happy not to be working]?* Workplace? Work colleagues? Does someone help you to do that job? (i.e. business service trainer, open employment support worker) [If not working] Do you wish you had a job? What kind of work would you like to do? Are you happy with your employment or unemployment situation?	P6= -2 to +2
	(P7) Are you satisfied with the education or training you have had?	Are you doing any courses or study? Have you done any in the past? What courses? What do/did you get out of the course? [If currently studying] Do you enjoy it? How are the teachers and fellow students? Are you planning to do any courses in the future? Are there any courses you would like to do? *Are you satisfied with education or training?* Did someone there help you to do the course? (e.g. TAFE Disability Support worker, TAFE counsellor)	P7= -2 to +2
	(P) Overall satisfaction with social and economic participation		P= (P1+P2+P3+ P4+P5+P6+ C7)/7
(H) Satisfaction with health care	(H1) Satisfaction with GP	Do you have a health care worker or doctor (eg GP, psychiatrist, specialist etc)? How often do you see them? About what? What kind of treatments are they providing you with?	H1= -2 to +2
	(H2) Satisfaction with psychiatrist	*Are you happy with them?* Do you like them?	H2= -2 to +2
	(H3) Satisfaction with specialist	Do you have a mental health care case manager?	H3= -2 to +2
	(H4) Satisfaction with mental health case manager	Do you attend a rehabilitation facility or vocational training facility? Are you having any treatment at the present time?	H4= -2 to +2
	(H5) Satisfaction with allied health provider	What sort of treatment are you having (medication, cognitive behavioural therapy, counselling)? Are you happy with your current treatment? Do you have a say in your treatment and care? Have you been in hospital in the last year? Are there any other people who are looking after your health (family member, guardian, partner, friend, advocate)? If you were becoming unwell, who would you call/ where would you go for help?	H5=-2 to +2
	(H)Overall satisfaction with health providers		H= (H1+H2+H3 +H4+H5)/5
Overall satisfaction (ST)			ST= (S+R+P+H)/ 4

Appendix C Self-identified Health and Wellbeing

This appendix summarises the findings of self-identified health and wellbeing of longitudinal resident cohort over the period of the evaluation.

The first ABS question required residents to identify their overall feeling about life on a slightly modified version of the seven point 'terrible-delighted' scale.[6] People in the cohort who had been interviewed at the three contacts (24 participants) were compared with the overall Australian population. In this illustration the seven categories were collapsed into three to improve readability. The data shows a move in the cohort towards the norm, with residents expressed wellbeing approaching those of the general population by the third contact.

Figure 8.1: Self-identified Wellbeing, Longitudinal Measures and Australian Population, per cent

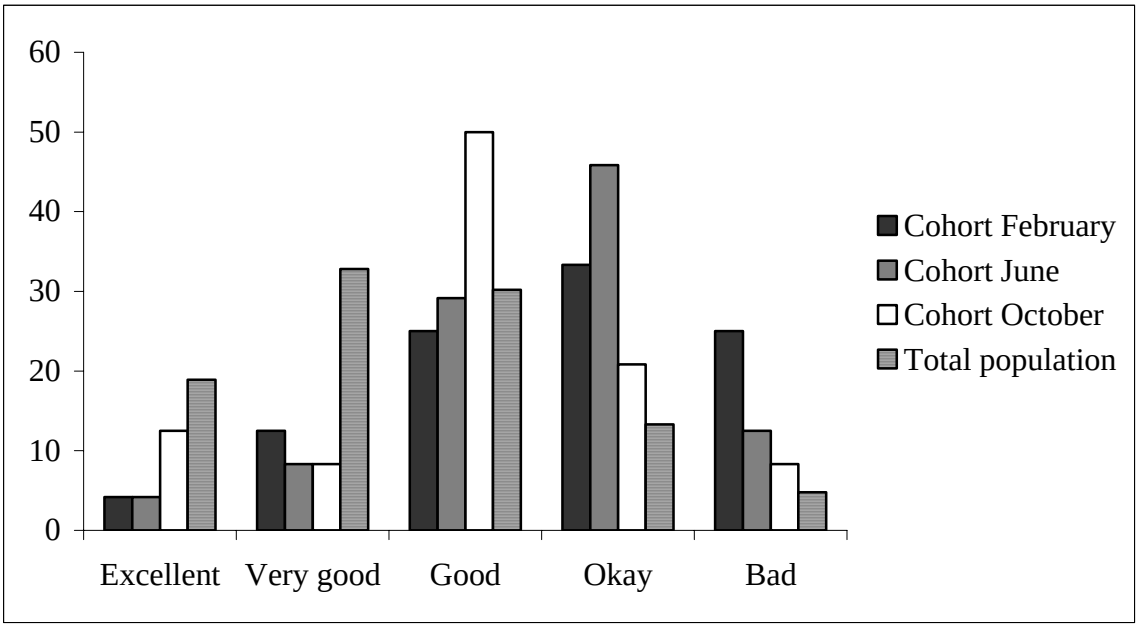


The second question related to residents' health in general, prompting an answer on a five-point scale from excellent to bad (Figure 8.2).[7]

[6] The next question is about how you feel overall. How do you feel about your life as a whole, taking into account what has happened in the last year, and what you expect to happen in the future?

[7] I would now like to ask you some questions about your own health. In general, would you say that your health is excellent, very good, good, fair or poor?

Figure 8.2: Self-identified Health, Longitudinal Measures and Australian Population, per cent



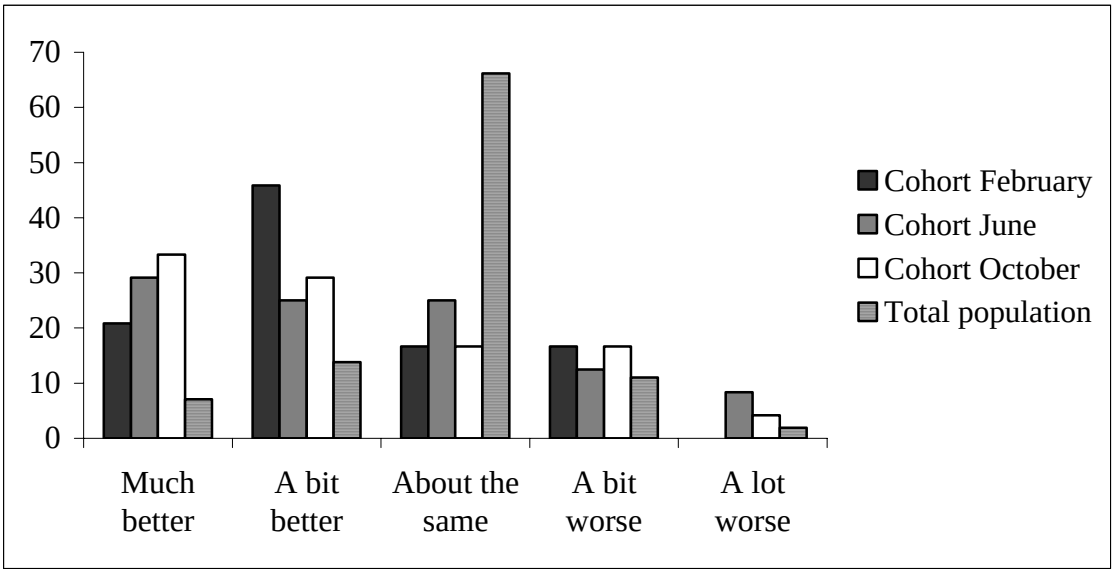
The data show a number of changes in the cohort. The level of people identifying as having had bad health reduced in the 9 months towards the overall population. There was also movement of people expressing bad and okay health towards good. The people in the cohort nevertheless were still much less likely than the total population to identify their health as very good or excellent, although there was a small increase in the number of people identifying this way.

The most likely explanation for these changes relate to the increasing access of residents to health services across the 9 months (Section 4.1) and the additional benefits of have KSW assisting them to attend appointments and follow treatment instructions.

The third ABS question was about residents' current health compared with a year ago (Figure 8.3).[8]

[8] Compared to one year ago, how would you rate your health in general now? Would you say it was much better, somewhat better, about the same, somewhat worse or much worse (than a year ago)?

Figure 8.3: Self-identified Health Compared with One Year Earlier, Longitudinal Measures and Australian Population, per cent

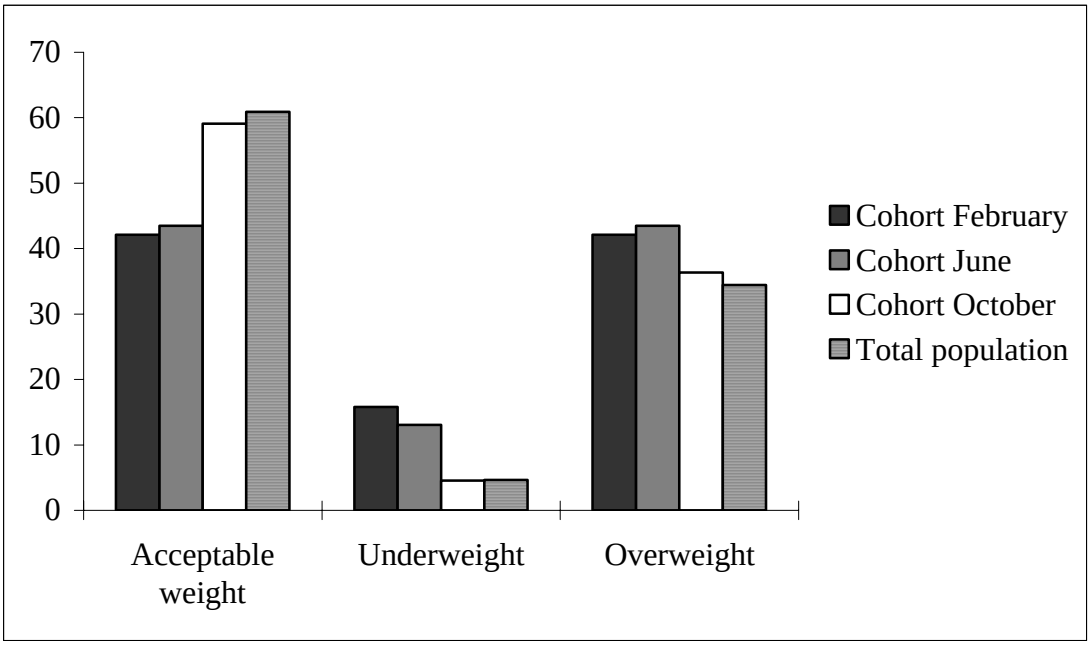


As the evaluation progressed, fewer residents identified as being a bit or a lot worse. Similarly, participants were much more likely than the overall population to describe themselves as much or a bit better. Consistent with the qualitative evidence, these improvements mainly relate to very negative experiences of residents during 2003 that had lead to their living in marginal accommodation. For some residents, these improvements in health relate directly to RSP interventions.

The final ABS National Health Survey question related to how residents considered their weight, prompting a score on a three-point scale from underweight to overweight (Figure 8.4).[9]

[9] Do you consider yourself to be acceptable weight (just right), underweight (too thin) or overweight?

Figure 8.4: Perception of Weight, Longitudinal Measures and Australian Population, per cent



The data show a movement across the 9 months towards population norms. Qualitative evidence supports the suggestion that health interventions have underpinned this movement. There continued to be a concern between the researchers that some people in the cohort appeared to be underweight, even when they felt they were an acceptable weight, though this could very well be a factor in the broader population as well.

Appendix D Resident Goals

	First contact (n=36)	Second contact (n=30)	Third contact (n=24)
Live more independently, live somewhere else	7	7	6
No goals ('No', 'Not really', 'I don't think so', 'Not likely')	12	6	7
Improve physical health and fitness ('I hope my legs are better', 'Get the 'all clear' from breast cancer', 'I'd like to put on some weight', 'Give up cigarettes'.)	6	4	0
Get some relief from symptoms of mental illness ('Get rid of the voices, paranoia, cutting up, suicidalness', 'My brain and the voices', 'keep working on mental attitude and anger management')	3	3	2
Improvements in current housing (e.g. 'Hope resident who assaulted me gets moved out', 'I'm still hoping the house gets better', 'Hope the person I share a room with who smokes in the room moves somewhere else', 'I'd like to be allowed to go out of the residence- I'd like to be allowed to go to church again', 'Hope that the resident who assaulted me moves out.')	4	2	1
Remain happy	1	2	2
Keep living in current accommodation	0	0	1
Keep doing a CLP activity ('Keep going to day activity centre', 'I'd like to go fishing again, I like fishing.')	0	2	1
'I hope to still be alive'.	0	1	0
'I would like to see my son', 'See kids for Xmas'.	0	1	2
'I wouldn't mind a girlfriend'	0	1	0
'I'd like to improve my expression.'	0	1	0
Get employment ('I hope to be working', 'Get a proper job that pays money'.)	3	1	0
Hoping everything stays the same	0	1	0
Spend more time with family members	2	1	1
Do more paintings	0	1	0
'I'd like a new lounge.'	0	1	0
Do more study ('Do more art lessons', 'Do a creative writing course', 'Learn ceramics')	2	1	0
Do well at uni, pass course	1	0	1
'I hope my wife survives and her cancer goes into remission.'	1	0	0
'I'd like some new clothes.'	1	0	0
'I'd like to get off the Public Trustee.'	1	0	0
'I want a carer.'	1	0	0
'I hope to win Lotto.'	1	0	0

a. Some residents had more than one goal
b. All residents in the longitudinal study are included.

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