Resident Support Program Evaluation Interim Report Summary

Background

The Resident Support Program (RSP) is jointly funded by Disability Services Queensland (DSQ) and Queensland Health (QH). The departments contract non-government organisations to provide a range of external support services to people with disability living in private hostels, boarding houses and aged rental accommodation facilities. RSP services include: Community Linking Projects (CLP) which support residents in mainstream community and leisure activities; Disability Support Services (DSS) for support with basic self care and presentation; and Key Support Workers (KSW) providing support with health and wellbeing. The program is being trialled in five locations – Brisbane, Ipswich, Toowoomba, Gold Coast and Townsville.

DSQ engaged a University of New South Wales Consortium to evaluate the RSP throughout 2004. The researchers are from the Social Policy Research Centre UNSW, the Disability Studies and Research Institute Sydney, and the University of Queensland.

The baseline evaluation report (July 2004) focussed on the characteristics, service use and experiences of residents; and the impact of the implementation and management of the program for other stakeholders.

This is a summary of the first interim report of the evaluation. The interim report presents the findings from the second round of evaluation activities, including interviews with residents, with findings from longitudinal comparisons; interviews with boarding house and hostel owners and operators; and discussions with the managers of organisations providing RSP services.

Resident experiences

The longitudinal resident study has shown an overall marginal increase of satisfaction with housing and social and economic participation. Some of this is accounted for by improvements in the living conditions of people who have been able to move to other accommodation, either independent housing or a hostel with which they were more satisfied.

The RSP has not significantly changed residents' relationships with family or friends. While many people are getting out more with RSP assistance, the affects of physical disability and poverty are working against sustainable independent community participation for some residents.

Labour force participation, which was very low at first contact within the resident cohort, has fallen. Most residents are now out of the workforce. Several participants have stopped doing voluntary work and one participant who had gained employment with JobNetwork assistance became ill and could not continue with it. On the other hand, many people are participating in education, mainly in TAFE courses, with the support of the RSP.

Self-identified health and well-being of residents is largely unchanged, showing a slight overall decline. Their frequency of access to health and allied services has increased slightly. The key contribution of KSW has been to better operationalise the outcomes of medical appointments and treatments. Perhaps reflecting this, resident satisfaction with health providers has improved significantly between first and second contacts.

The number of people in the resident cohort accessing the three components of the RSP has increased between first and second contacts. This reflects the time taken in gaining the trust

of residents and their commitment to accepting assistance with these aspects of daily life. The range of activities has expanded, and participants are expressing increased levels of satisfaction with RSP workers and services. For people who had moved, continuity of access to RSP was an important constant in their lives. Time and consistency of support probably had an impact on the increased satisfaction with RSP.

Residential premises operators

Most residential premises operators had a positive view of the RSP. In the main, they had sorted out lines of communication with RSP providers, so that the program enhanced their facilities. Effective communication seemed to rely on relationships between operators and providers, which meant that when there were communication problems, there were insufficient structures to resolve them.

As one would expect of any such strategy the RSP, in some cases, got off to a rocky start as far as premises owners and operators were concerned. There were immediate effects on the relationships that operators had with their residents. Initial difficulties were short-lived, and the operators (those interviewed at least) were able to build valuable relationships with RSP providers.

Enhancement to the viability and quality of their facilities included relieving staff of some duties so that they could offer other support and meet some unmet needs for some residents. They experienced benefits in terms of staff time rather than cost relief. Additional responsibilities from RSP included extra administration and communication.

As they have developed, the interventions of RSP providers have lightened the load of operators and in some cases their staff. This has enabled all these operators to focus a little more on other aspects of their day-to-day work (such as spending a bit more time with residents, putting more energy into cleaning and cooking or putting in the many hours required to satisfy the accreditation process). Operators in regions with the premises model commented on the time spent in the registration process (to become eligible RSP premises).

There has been a marginal cost benefit for some operators in not having to transport residents to appointments or other activities or pay for taxis. KSW assistance has reduced the efforts required by operators to organise and transport residents to medical appointments and follow up with practitioners on treatments and so on. Some operators remarked on RSP workers' 'pull' in getting urgent appointments. DSS assistance in particular has substituted for and complemented many operators' time spent assisting residents with washing and grooming. There was no evidence of reduced cost to residents.

Operators were quick to identify the benefits for residents from RSP interventions in terms of their health, wellbeing and increased independence. Like the residents, the operators spoke highly of the ability of RSP to link residents with other services, such as health, education and community activities.

Not all relationships have been positive. Based on the evaluators' observations, premises offering lower standards of accommodation and care are not prioritised by RSP providers as the Program's guidelines identify supported accommodation as a priority. The level of unmet need in hostels is sufficient to fill RSP places, leaving little resource availability to support people living in boarding houses. It is important to note, therefore, that their views are under-represented in these data. As well there are incidents of significant conflict between specific operators and RSP providers. These call into question the accountability within provider organisations (their complaint and grievance resolution capacity) and the relationships between the RSP provider contract managers (DSQ and QH) and operators.

The operators canvassed in the evaluation are unanimous about one thing that substantiates the benefits of the RSP. They say that if it were to be withdrawn, residents would be severely affected and the quality of the accommodation and standards of care that they offer would be adversely affected. They were unanimous in their advocacy for continuation and expansion of the program.

RSP providers

RSP providers were 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.

Themes raised in the baseline report, about over-management and coordination between the two government agencies, state and regional level management, were reiterated. The RSP providers thought these problems had negative implications for reactive support from the government and inertia in the program to respond to design problems.

Providers continue to focus on difficulties with the Local Co-ordination Group (LCG) structure and process. They seemed unclear about their purpose (decision making, feedback or information to other levels) and frustrated at the informal processes (minutes, meeting procedures, protocols and methods for resolving conflict).

Staffing for RSP services does not appear overly problematic. Like other human services, RSP staff recruitment and turnover appears to be 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 seem to be the DSS positions because of the tension between simply providing personal care and a developmental approach which encourages and trains residents to take control of their personal care where they are able.

All providers have developed complaints procedures and reported that they promote them formally and informally. They were pleased to see that residents had responded positively by initiating complaints and expressing opinions more often. However, the reported knowledge of complaints processes by residents was low.

Assessment processes vary between regions and seem to reflect the arrangements between the particular providers in each region. This does not seem to be a problem per se, but has implications of duplication where information is not shared or processes are repeated.

Relationships between residential premises operators and RSP providers were largely positive. The RSP providers seemed 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. They have had to strike a balance between acting on the interests and rights of residents, while maintaining RSP access to the premises and operators and acknowledging their viability.

Residents in the RSP seem to have benefited through greater integration into accessing mainstream and specialist services. Cost seems to be a significant barrier. A second barrier seems to be availability of services, particularly mental health support and even referral for assessment for eligibility for services, such as DSQ funded specialist disability services.

Conclusion

A number of themes about the implementation of the program were raised in the baseline report. This section summarises the perspectives of residents, operators and providers in this report through reference back to some of those themes.

Context of the program

- Regional variations in the demographic characteristics of residents continue to underscore some of the variations in approach that have been adopted by RSP providers.
- The instability of boarding house and hostel accommodation continues to affect the RSP, though this is not so critical an issue as it was earlier this year – regions operating the premises approach currently have a full complement of premises.
- There are a number of residents who are 'on their last boarding house' having been ejected from all others. These premises of 'last resort' offer poorer standards of accommodation and care and create tensions within the program. None were yet homeless.

Program structure

- Joint agency management (DSQ-QH) still has many critics among stakeholders in the RSP. Perceptions of long delays in policy and procedural refinement to the RSP continue, as well as a persistent sense of having limited input to these processes. The limited engagement of the RSP with the Department of Housing has restricted accommodation options for residents, and the capacity of the RSP to follow residents moving into public housing.
- There continue to be concerns among stakeholders about the commitment of and engagement by DSQ and QH's HACC regional management in some regions.
- LCG processes vary significantly from one region to the other in terms of their very purpose. Are they a forum for promoting RSP and gaining input of others or a mechanism for co-ordinating the overall management of the strategy? RSP providers have been critical of the efficiency and effectiveness of LCG processes and in some cases, the leadership provided by regional DSQ and HACC managers.

RSP providers

- Conflicts between RSP providers are still an issue in two regions. In one case an ongoing mediation of the parties has lead to a negotiated 'settlement' of the issues in dispute. In the other case parties remain unresolved and one of these agencies appears to be 'going it alone' in terms of attracting its own clients directly from premises. Otherwise relationships in regions are constructive and positive, with any issues being soluble within existing structures.
- Both RSP providers and premises operators seem to be committed to pragmatic and constructive relationships that will continue to enhance the successful implementation of the RSP and bring all the possible benefits to operators and their capacity to provide better standards of accommodation and care for residents.
- RSP providers are increasingly winning the respect of residents and their commitment to participate in the program and realise the possible benefits, particularly with DSS and KSW that are often very personal interventions.

Resident needs

- In the main, RSP providers are adopting flexible approaches responsive to residents' needs. Some degree of creativity in these have created economies of scale in operational

terms for RSP providers and premises operators. A minority of RSP providers continue to maintain fairly inflexible attitudes towards program design and client eligibility.

- Residents' access to health, welfare and community services is improving. Low income and physical access issues continue to militate against the success of social integration attempts for many residents. Poor availability of services, such as long waiting lists, and not accessing eligibility assessments affect the timeliness of RSP interventions and their success.
- Resident satisfaction with RSP providers remains high and has increased. The range of CLP, KSW and DSS assistance has grown and the number of residents accessing assistance (and particularly the co-ordinated assistance of two or three subprogram providers) continues to increase.
- Residents are now even less engaged with the labour market, but are more involved in training and educational opportunities.
- Resident perception of their health is not improving yet. Access to health services with the support of the RSP has increased resident satisfaction with these services and the number and range of those being used. Poorer standards of accommodation, for some in the cohort, undermine the health benefits stemming from improved primary health care and increased community participation.

Premises and Individual Approaches

- Premises approach operators were more likely to raise problems about administrative burden from the RSP in the earlier part of their participation in the RSP, though this was temporary.
- Relationships between operators and providers in regions implementing the premises approach are easier to manage, with a smaller number of premises, a higher visibility of RSP workers in premises and economies of scale in assisting more residents in each of the premises.
- Particular findings about the individual approach did not emerge in this round of fieldwork.

Further information

The plan for the evaluation and a summary of the evaluation's baseline report are now available at http://www.sprc.unsw.edu.au/reports/FinalEvaluationPlanSummary.pdf and http://www.sprc.unsw.edu.au/reports/baselinesummary.pdf, respectively. For further information about RSP please contact Carolyn Honeywill, Disability Services Queensland ph 07 3247 5112 or carolyn.honeywill@disability.qld.gov.au. For information about the evaluation please contact David Abelló ph 02 9385 7831 or email d.abello@unsw.edu.au.