

THE UNIVERSITY OF
NEW SOUTH WALES



*SERVICE NEEDS OF RESIDENTS IN PRIVATE
RESIDENTIAL SERVICES IN QUEENSLAND*

SUMMARY REPORT

SPRC Report 19/08

University of New South Wales Consortium
Social Policy Research Centre
Disability Studies and Research Centre
Griffith University
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Abbreviations and glossary

ABS	Australian Bureau of Statistics
Agency	Government, nongovernment and private
AIHW	Australian Institute of Health and Welfare
ATSI	Aboriginal and Torres Strait Islander
CALD	Culturally and linguistically diverse
Carer	Informal carer, usually family or friend
CSTDA	Commonwealth State and Territory Disability Agreement
DSRC	Disability Studies and Research Centre
DSQ	Disability Services Queensland
HACC	Home and Community Care
HIT	Hostel Industry Taskforce
Level	PRS are registered and accredited by the OFT to three levels depending on the services provided: Level 1: Accommodation only Level 2: Accommodation and food service Level 3: Accommodation, food and personal care
NGO	Nongovernment organisation
OFT	Office of Fair Trading
Owners and operators	People who own and operate private residential services
PRS	A private residential service, defined in <i>Residential Services (Accreditation) Act 2002 (Queensland)</i> , section 4 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, commonly referred to as hostels and boarding houses. It does not include DSQ accommodation providers or accommodation providers fully or partly funded by DSQ (or where residents receive individual funding packages), authorised mental health facilities, or services provided under SAAP.
Residents	People living in private residential services. For the purpose of the research, comparisons have been made to people with similar characteristics to residents, such as homeless people, explained further in Appendix A.
RSP	Resident Support Program
SAAP	Supported Accommodation Assistance Program
SAPA	Supported Accommodation Providers Association
SDAC	Survey of Disability and Carers, ABS 2003
Service providers	Agencies that provide support services
SPRC	Social Policy Research Centre
Support services	Services provided to people living in PRS to support their quality of life. The services include support provided by the PRS; mainstream services provided to any member of public, such as health, education, housing and employment services; and specialist services, depending on the person's particular needs, such as disability and mental health services.
UNSW	University of New South Wales

Executive Summary

The Queensland Premier established the Hostel Industry Taskforce (HIT) in 2000 to oversee the implementation of a reform package for the private residential services (PRS) sector. The aim of the reforms was to improve the quality of life of residents by improving residents' safety, residential amenity and services, residency rights and access to external support services.

Senior Executives of the Queensland Government Residential Services Reforms Committee recommended that research be undertaken to support service planning for the residents in PRS. The intent of the research is to determine the need for government and non-government support services among people living in PRS. The University of New South Wales Consortium was engaged to conduct this research.

Profile of People Living in Private Residential Services

The research aims to build a profile of people living in PRS. Since little direct information on PRS residents is currently collected, this profile is built for the most part from secondary sources, including data held by the Queensland Office of Fair Trading (OFT); census data and other and large scale quantitative data on homelessness, disability and other characteristics relevant to PRS residents. The following primary sources have also been used: a survey of operators of PRS specially conducted for this research project; information obtained from focus groups of officials from agencies that have contact with the residents, operators and staff in PRS; and interviews with other key informants.

The evidence suggests that a high proportion of PRS residents are likely to have high levels of disability and drug and alcohol dependence problems. They also face multiple disadvantages as a consequence of poverty and inability to rely on a family member or carer who can help them negotiate their needs. The evidence suggests that this complexity of needs requires flexible service delivery and outreach. However, the insecure nature of PRS makes service provision particularly difficult. The lack of privacy and the conditions of PRS means that this form of accommodation does not meet some people's needs and can present further challenges to service delivery to these people.

This profile shows that people living in PRS compared to other people are more likely to have support needs – for example levels of disability in this group could be overall between 1.5 and 2.5 times higher than among people who live in private households. They are moreover less likely to have informal carers or family members to support them. Their vulnerabilities and support needs are likely to be complex in two respects. First, many experience multiple vulnerabilities. Second, they are as a rule living in environments that add to their vulnerability in terms of the risk to safety from other people living in the facility.

Sections 3 and 4 examine the needs of PRS residents, and the extent to which those needs are met, according to the estimations from operators, expert professionals and modelled data from large scale datasets, and in comparison with people in private households.

Estimating Support Services Accessed and Needed

The research estimates the support services residents currently use and their unmet need with data from the operator survey, operators' comments, focus groups, interviews, literature and secondary data sources.

According to the operators, the support service types most often used are meals, support with basic living, community participation, mental health and allied health. Not all residents need support services. The proportions of residents who received support services was – with the exception of assistance with meals – less than 20 per cent for each support service type. The greatest unmet need is for allied health; support with transport, community participation and shopping; and mental health services. The support service needs identified from the research are as follows:

- Health-related services – physical and allied health services, such as quality general practitioner services, nursing care, dental, optical, therapies, support for ageing residents, health screening (eg. pap smears and breast screening) and counselling services (personal, responsive and goal oriented); mental health services; and drug and alcohol rehabilitation services;
- Support services to assist with daily living – needs included personal care such as bathing, showering, personal hygiene, toileting, dressing or eating; meals and nutrition; and physical assistance with moving eg. getting in and out of bed. They also included support to do activities outside the PRS such as assistance with shopping and transport. These findings are consistent with the high level of disability among people living in PRS;
- Support services for social and economic participation – support for social and economic participation, including education, employment and participation in community activities;
- Support in planning and decision making – case management, advocacy, assistance with decision making and financial management. A minority of residents have substitute decision makers. Others require such support but do not have access to it;
- Housing and accommodation support – according to respondents, residents of PRS have a lower priority of access to stable housing and accommodation support because they at least have a roof over their head; and
- Support from PRS – in addition to support services externally provided to people living in PRS, Level 2 and 3 PRS operators also provide support services themselves.

Estimating Service Need Using Secondary Disability Services Data

Support service need for people with disabilities is estimated using two large scale datasets, the ABS Survey of Disability and Carers (SDAC) (2003); Commonwealth and State/Territory Disability Agreement National Minimum Dataset (CSTDA-NMDS) for Queensland, 2004-05. Both datasets are useful for estimating need in relation to disability, but not other types of need discussed above. In both datasets, need and the extent to which that need is perceived to be met are compared across the homeless and boarding house populations on the one hand, and the population of people living in private households on the other.

While the data must be treated as tentative, they do nonetheless paint a fairly consistent picture of high levels of service need among people living in PRS and similar accommodation, and of unequal allocation of support services to homeless and near homeless people in comparison with people in private households. The modelling is also consistent with the more qualitative data described above, which showed higher levels of vulnerability, multiple vulnerability and poor access to services to address the support needs associated with these vulnerabilities.

Facilitators and Barriers to Accessing Support Services

The research draws implications for policy change to improve access to support for people living in PRS. The implications are about availability of suitable support services; information and referral; coordination between agencies; and improving access to support services through PRS facilitation.

Availability of suitable support services

The most difficult support service problem for people living in PRS is the shortage of suitable services. In some cases this is because of a general shortage in the community, such as affordable housing. In other cases it is because the way support services are provided is not suited to the additional needs of PRS residents. Many of the support service types most needed by people living in PRS are available to the general public, such as physical health services. Facilitators to improving access to these support services include:

- location of the support service, either outreach services going to or near the PRS; or supported transport to assist people to travel to the support service;
- consideration of people's complex vulnerabilities and insecurity of accommodation in the way support services are provided to people living in PRS, such as where services are provided, transport, cost, confidentiality, ongoing support and effective communication; and
- assistance to the resident to negotiate the service provided and to convey necessary information back to their place of residence with the person's permission (eg. medication changes or therapy exercises).

Other specialist services most needed by people living in PRS are specialist services relating to their vulnerabilities (such as, disability, mental health, home care, drug and alcohol services and housing). Facilitators to improving access to these support services include:

- review criteria for priority of access to these support services to improve the likelihood that people living in PRS are recognised as highly vulnerable, comparable to the needs of homeless people;
- recognition in the way that services are provided that support needs are likely to be prolonged, if not ongoing, because of the nature of the vulnerabilities experienced and historical service neglect of this group of people, which may have aggravated their vulnerabilities.

Information and referral

In addition to improving the supply and suitability of support services, the second facilitator to addressing support needs is effective information and referral. These processes are grouped in this section because from the perspective of the resident, they can have the same impact or shortcomings (Robinson et al, 2004). The implications for policy development relating to information and referral practices include:

- most information is shared through word of mouth from other residents, operators, service providers and other people who have contact with people who live in PRS. In addition, some people are unable to understand written materials. Therefore, any written information needs to be supplemented with opportunities to talk about the support services both within the PRS if that is possible, and also in places residents are likely to go outside the PRS; and
- referrals are most likely to be successful if they are made by someone who has developed a relationship with the resident. Agencies that provide support services therefore need to allocate sufficient time for contact with residents and to understand their particular needs and preferences and accompany them to new service opportunities.

In addition, implications about the supply of suitable support services are that information and referrals need to be prioritised about services that residents are likely to be able to access. This includes ensuring that the support services are available, accessible, affordable, recognise the additional needs of this group of people and are of sufficient quality and duration to address their needs.

Coordination between agencies

Information and referral is one example of coordination processes to enhance access to support services. In addition, effective coordination at the levels of referral, service delivery and policy (funding and planning) were identified as facilitators to effective use of support services. Coordination here is meant as between all agencies whether government, nongovernment or private. The implications of the coordination findings for policy development include the following:

- simple models of service support that minimise the number of organisations involved are more likely to effectively coordinate the complex support needs of people living in PRS. Similarly, simple models case management can be more responsive to the person's needs, such as coordination support that follows the person, rather than is located within a particular PRS;
- mental health services are central to the support needs of a significant proportion of residents in PRS. Mental health agencies are currently unable to meet the mental health service needs of people living in PRS. These agencies are struggling to manage competing demands from different groups of people in the community experiencing mental health problems. A review of the process to identify when case managers are unable to fulfil these needs and to trigger alternative support would help address the compromises that agencies are currently struggling to balance; and
- formal processes to encourage coordination to assist the multiple agencies to develop effective relationships for coordination. The processes need resources and regular review to check their continued application to current policy context.

Private Residential Services operators

PRS operators and focus group participants were asked what support they thought PRS operators need to help residents access support services. In addition to comments about the need for financial resources to support service improvements, operators commented on the limitation of availability of support services. Suggestions on how to increase access to support services for residents by improving support to PRS operators included:

- opportunities for training for management and staff, such as on-site, joint with other agencies, and formal training (eg. Certificate IV). The benefits include developing understanding about support needs and relationships with support agencies;
- support mechanisms to assist them to refer residents to the support they need, such as a single point of contact in a support agency to coordinate the requests for support;
- information about support services, such as an information manual, a point of contact;
- opportunities to build relationships of trust between support service providers and operators, such as joint training, information sessions and meetings, to improve the mutual understanding and respect about what each contribute; and
- better information from referring agencies when a person is referred to live in a PRS. They could then act to avoid some crises that are dependent on knowing the information and be more active in providing information to residents about relevant support services. Recommendations about confidentiality, duty of care and risk management in this situation were included in Robinson et al (2004), a review of referral processes to PRS.

Conclusion

The research aimed to develop a profile of people living in PRS including their characteristics and vulnerabilities. This profile has been applied to estimating their service use and unmet need. In general the profile data show that people living in PRS compared to other people are more likely to have support needs; less likely to access support services; if they do receive support services, they are likely to receive less services; and they are less likely to have informal carers or family members to support them. Their vulnerabilities and support needs are likely to be complex in two respects. First, they are likely to experience multiple vulnerabilities. Second, they are also living in an environment that adds to their vulnerability in terms of the risk to safety from other people living in the facility and poor access to generic and specialist support services.

The findings have implications for support services policy in three ways: availability of support services, information about services and coordination between services. Only the first, availability of services, has significant implications for additional resource allocation. Information and coordination may require policy change in the organisation of support services, particularly the way service agencies work with people living in PRS; and the way they work with owners, operators and staff in the PRS and with other service providers. These would entail policy changes to the information and coordination practices of government agencies responsible for policy, funding and planning; and those of government, nongovernment and private agencies responsible for service delivery.

1 Introduction

1.1 Background

The Queensland Premier established the Hostel Industry Taskforce (HIT) in 2000 to oversee the implementation of a reform package for the private residential services (PRS) sector. The aim of the reforms was to improve the quality of life of residents by improving residents' safety, residential amenity and services, residency rights and access to external support services.

Senior Executives of the Queensland Government Residential Services Reforms Committee recommended that research be undertaken to support service planning for the residents in PRS. The intent of the research is to determine the need for government and non-government support services among people living in PRS. The University of New South Wales Consortium was engaged to conduct this research.

This research focuses on the support service use and needs of people living in PRS and similar groups of people. Chamberlain's (1999) research suggests their needs are similar in a number of important respects to those of people who are homeless. A considerable number of people in PRS tend to cycle in and out of homelessness and temporary accommodation. For both groups, key vulnerabilities include mental illness, psychiatric disability, chronic illness and addiction (Decker et. al., 2006).

1.2 Private Residential Services Context

Research shows that around Australia, people living in PRS are 'increasingly people 'on the margins', both physically and socially, and that ill health, poverty, and disability...characterize the lives of many residents' (Anderson et al., 2003:1). This is not only an Australian phenomenon; it is occurring globally (Greenhalgh et al., 2004). A lack of significant relationships and support is often a catalyst for entry into this type of accommodation; such social isolation and loneliness is compounded by the nature of PRS living for many residents (Anderson et al.), and can mean absence of a vital link between the care they need and the service providers ability to meet these needs.

The complexity of need surrounding disability, health, poverty and social isolation means that needs fall within the remit of a wide range of service providers. It has been recognised at the national level that such needs are best met by a whole-of-government approach (AHURI, 2002). A minority of PRS residents with disabilities have significant support needs; it has been shown that some very vulnerable residents are not in contact with support services they need and to which they are entitled (Anderson et al., 2003:74). At the national level, efforts to provide coordinated and flexible delivery of housing and support services have been frustrated by the lack of a cohesive framework. Linkages between programs are mainly informal co-operative efforts that vary in their effectiveness, efficiency and equity (AHURI, 2002). Queensland recognised this when, in 2001, Disability Services Queensland (DSQ) introduced the Residential Support Program (RSP; Robinson, et al 2004). Queensland initiatives to reduce these problems are in the process of producing positive outcomes. However, many challenges still remain.

Queensland legislation (*Residential Services (Accommodation) Act 2002*; *Residential Services (Accreditation) Act 2002*; Greenhalgh et al., 2004) shares similarities with

various Acts introduced to other states at the time, such as the *Supported Residential Facilities Act* introduced to South Australia in 1992. These initiatives separated the PRS sector into facilities that offer disability and psychiatric support services and those that offer accommodation only. 'It might be assumed therefore that people with disability and mental illness would not be prevalent in the boarding house sector today' (Anderson et al., 2003:14). However, studies show that the 'residential-only' boarding house sector still continues to accommodate some people with a level of disability or illness.' (Anderson et al., 2003:14). This is also the case in Queensland (Fisher et al, 2005).

As part of the reform of the PRS sector, all PRS are to become registered and then accredited, according to the level of services they provide, broadly Level 1: Accommodation only; Level 2: Accommodation and food service; and Level 3: Accommodation, food and personal care. Most PRS are Level 1 (77 per cent), followed by Level 3 (17 per cent) (Table 2.2).

This brief overview of the literature indicates the complexity of need within the PRS disability community and the challenges inherent in meeting them. It is the task of the current research to identify the extent and range of service needs for Queensland PRS residents. The analysis that follows brings together information from three principal sources: quantitative data from sources that are representative for all of Australia, or just for Queensland, including ABS surveys and state government administrative records; quantitative and qualitative data from a postal survey of operators of private residential services in Queensland; and information gathered from focus groups comprising service providers and government agencies.

1.3 Structure of the Report

Section 2 comprises a profile of people living in PRS derived from various research sources. Section 3 discusses support services used and needed by people living in PRS. Section 4 estimates support service need based on the profile of residents and information about what support services are used by residents and people similar to residents. Section 5 discusses factors that facilitate and impede access to support services, and implications for policy development. Section 6 draws conclusions from the research.

2 Profile of People Living in Private Residential Services

The purpose of this section is to build a profile of people living in PRS. Since little direct information on PRS residents is currently collected, this profile is built for the most part from secondary sources, including data held by the Queensland Office of Fair Trading (OFT); Census data and large scale quantitative data on disability and other characteristics relevant to PRS residents. The following primary sources have also been used: a survey of operators of PRS specially conducted for this research project; information obtained from focus groups of officials from agencies that have contact with the residents, operators and staff in PRS; and interviews with other key informants. Appendix A describes the data sources and methods in more detail.

Section 2.1 defines PRS, and looks at the overall number and geographical spread of PRS in Queensland. Section 2.2 describes some of the main social, economic and demographic characteristics of PRS residents, and Section 2.3 considers their vulnerabilities. Section 2.4 presents a brief summary.

2.1 Description of Private Residential Services

‘Private Residential Services’ (PRS) is an umbrella term that refers to for-profit services that provide boarding house or hostel type accommodation, mostly to people with low incomes. The Queensland *Residential Services (Accreditation) Act 2002* defines PRS as accommodation that has the following characteristics:

- there are at least four residents in one or more rooms;
- each resident has a right to occupy one or more rooms, but not the whole of the premises;
- rooms are not self-contained, and where residents share facilities such as a bathroom outside of their room.

A residential service may also provide a food and personal care services. PRS that provide only accommodation and no support services are designated Level 1 PRS. Level 2 PRS provide accommodation and food, while Level 3 PRS provide accommodation, food, and at least some level of personal care support.

PRS may be hostels established for particular purposes or to cater to specific vulnerable populations (such as mental health services) or boarding houses that provide a room and shared facilities. Such hostels and boarding houses are usually considered as ‘marginal housing’ in the sense that residency is often short-term (Chamberlain et al., 2007). People in marginal housing can be categorised as what Chamberlain et. al. (2007:14) define as,

Tertiary homelessness – people living permanently in single rooms in private boarding houses without their own bathroom or kitchen and without security of tenure. They are homeless because their accommodation does not have the characteristics identified in the minimum community standard.

Literature and data relating to the homeless population can provide important insights into the characteristics, vulnerabilities and needs of the PRS population, and these materials are drawn upon in this current study.

Numbers and geographical spread of PRS residents

There are two principal sources of data for the number and geographical distribution of PRS residents in Queensland: the 2001 Census, which records where people spent the night on Census Night in 2001 along with a limited number of their characteristics; and the Queensland Office of Fair Trading Public Register of Private Residential Services, which includes information of the location of all registered and accredited PRS in the state, and number of beds each PRS contains. While it is not entirely clear that the Census definition of a boarding house, developed by Chamberlain and MacKenzie (2003)¹ is identical to the definition of PRS covered by the OFT register,² there is nonetheless considerable overlap between the two, in that both include PRS where residents have no private space.

Table 2.1 compares data from these two sources. The OFT data, which do not include any information on actual PRS residents, show more beds than the Census data shows in terms of boarding house residents. However, the Census data suggest a smaller concentration of boarding house residents (and an even smaller concentration of all homeless people) in the greater Brisbane area than do the OFT data. The larger number of beds in the OFT data compared to the number of boarding house residents in the Census data is not surprising for three reasons. First, there are always likely to be more beds than residents to occupy them (one bed has a maximum of one resident; and on average, less than one resident, when accounting for periods of resident turnover). Second, the OFT data refer to 2007, while the Census data refer to 2001, and it is possible the PRS has expanded in the intervening years. Third, the OFT data may include some PRS that were not defined as boarding houses by Chamberlain and MacKenzie. On the other hand, the OFT data in Table 2.1 are not available for PRS with pending accreditation and registration applications (about 60 PRS with over 1100 bed spaces in February 2007). These additional PRS are not included in the other data collection.

Therefore, the discrepancies in overall numbers, and in the distribution of beds/residents between Brisbane and the rest of Queensland across the two sources underline the uncertainty of the size and distribution of the boarding house population at any given time. Table A.1 in the Appendix gives a more detailed breakdown of the geographical distribution of people in boarding houses and others defined by Chamberlain and MacKenzie (2003) as homeless on Census Night 2001.

¹ Boarding house or private hotel, excluding owners, staff members, backpackers whose usual address is overseas, people whose usual address is elsewhere in Australia, staff quarters or hotels, hotel/motel, staff quarters and other types of welfare accommodation (Chamberlain & Mackenzie, 2003: 21-2).

² *Residential Services (Accreditation) Act 2002 (Queensland)*, section 4, '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, commonly referred to as hostels and boarding houses.'

Table 2.1: Private Residential Services, Queensland: Region

	Office of Fair Trading 2007				Census 2001			
	Private Residential Services		Beds		Boarding house residents		All homeless persons	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Greater Brisbane*	222	68.9	4321	60.4	2345	45.6	5091	21.1
Other	100	31.1	2838	39.6	2792	54.4	19085	78.9
Total Queensland	322	100	7159	100	5137	100	24176	100

Source: Office of Fair Trading Public Register for DSQ 10 Regions, as at 16 February 2007; Chamberlain and McKenzie (2004)

Notes: * Greater Brisbane includes Brisbane city core, inner ring, outer ring and outer suburbs.

- Additional PRS with pending accreditation and registration applications are not available in the OFT data (about 60 PRS with over 1100 bed spaces in February 2007). These additional PRS are not included in the other data collection.

Table 2.2 shows the distribution of PRS into Level 1, Level 2 and Level 3 PRS according to OFT data. Over three quarters of all PRS and 60 per cent of beds are for Level 1 – accommodation only. A quarter of beds are for Level 3 PRS – accommodation, plus meals, plus some personal care services. Relatively few PRS provide accommodation and meals, but no personal services. Almost nine in ten PRS and three quarters of all beds in the Brisbane area are for Level 1 accommodation only.

Table 2.2: Level of Private Residential Services, Office of Fair Trading

Licensed PRS	PRS		Beds	
	Number	Per cent	Number	Per cent
Level 1 PRS	248	77.0	4470	62.4
Level 2 PRS	18	5.6	908	12.7
Level 3 PRS	56	17.4	1781	24.9
Total	322	100	7159	100

Source: Office of Fair Trading, Register for DSQ 10 Regions, as at 16 February 2007

Note: Excludes PRS pending accreditation, unavailable from OFT data.

Operator survey of PRS

As part of the present research project, a postal questionnaire was sent to all operators of PRS in Queensland who were identified in the OFT register. This survey is described in more detail in the Appendix. Of 322 questionnaires sent out, 76 (24 per cent) were received back by the research team. Table 2.3 shows that most respondents to the operator survey operate one or two PRS, but some operate as many as seven PRS. Respondents to the operator survey tend to run slightly larger establishments than the average. The average number of bed spaces that respondents to the survey manage is 28, while the OFT register suggests that the average number of bed spaces managed by all operators is 22. Respondents to the survey also report very high occupancy rates for their beds - an average of 25 out of 28, suggesting an occupancy rate of 88 per cent. It is not clear how representative this high occupancy rate is of all PRS in Queensland.

Table 2.3: Private Residential Services, Operator Survey

	Average (mean) number per respondent	Range per respondent	Total (absolute number)
PRS owned and/or operated	1.56	1-7	112
Beds available	27.72	4-172	2107
Beds currently filled	25.37	4-156	1856

Source: Operator Survey, 2007 (n=76)

Table 2.4 shows that the majority of respondents to the survey operate a Level 1 PRS. However, half the residents who live in PRS operated by the respondents, live in Level 3 PRS (50.32 per cent of residents). This is double the proportion of Level 3 beds among all PRS (Table 2.2). Results about Level 3 PRS are therefore overrepresented in the operator survey. The analysis of survey results that does not differentiate between the different levels of service may produce biased or non-representative results. Specifically, estimates of services accessed and needed (Section 3) does not differentiate between PRS levels in the operator survey results because the responses for some of the levels are too small and unrepresentative. Instead, the analysis draws on modelling from other secondary datasets (Appendix A; discussed further in Sections 3 and 4).

The majority of respondents operate PRS in Brisbane, which is consistent with overall OFT statistics (Table 2.1). Moreton and Darling Downs/South West Queensland also contain substantial numbers of PRS and bed spaces, but they both house less than 10 per cent each of the total number of residents.

Table 2.4: Level of Private Residential Services, Operator Survey

	Number of operators	Number of PRS	Number of residents*	Per cent of residents*
Level 1 PRS	45	69	732	39.44
Level 2 PRS	3	4	116	6.25
Level 3 PRS	24	39	934	50.32

Source: Operator Survey, 2007 (n=76)

Note: * Total beds currently filled, which differs from OFT data on total available beds Table 2.1

2.2 Resident Characteristics

In order to estimate service need among PRS residents, it is first necessary to describe their characteristics. In this section we use information from the operator survey, supplemented with quantitative data from secondary sources, to build a profile of PRS residents in Queensland.

The operator survey shows that across all service levels, most residents were male and of working age. Almost all PRS operators reported having male residents - 70 out of 76 respondents. Table 2.5 shows that most Level 1 PRS residents are men (87.7 per cent). Among Levels 2 and 3 the share of men in the total is somewhat less, at 79.5 per cent and 71.2 per cent, respectively. According to the operator survey, women comprise less than a quarter of all PRS residents. But in spite of the low overall share of women among PRS residents, the majority of operators (42 out of 76) reported having at least some female residents.

Table 2.5: Operators' Estimates of Resident Characteristics, Gender by PRS Level

	Level 1		Level 2		Level 3		All	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Male	629	87.7	101	79.5	685	71.2	1450	77.3
Female	88	12.3	26	20.5	277	28.8	426	22.7
Total	717	100	127	100	962	100	1876	100

Source: Operator Survey, 2007

Note: Data derived from responses of 76 operators

Table 2.6 classifies PRS residents by age, according to information provided by operators. Across all three levels of service about three quarters of residents are reported to be aged between 25 and 64, a fifth are aged 65 or over, and only a small proportion are aged under 25. As might be expected, Level 3 residents are on average older than Level 1 residents. For example, operators report that almost ten per cent of residents in the Level 1 PRS are aged 18-24, compared five per cent of residents of Level 3 PRS. The high proportion of people aged over 65 years has implications for needing aged care support.

Table 2.6: Operators' Estimates of Resident Characteristics, Age by PRS Level

	Level 1		Level 2		Level 3		All	
	Number	Per cent	Number	Per cent	Number	Per cent	Number	Per cent
Age 18-24	66	9.3	8	6.3	46	4.8	129	6.9
Age 25-64	532	75.3	84	66.1	709	73.7	1379	73.9
Age 65 +	108	15.2	35	27.6	207	21.5	357	19.1
Total	706*	100	127	100	962	100	1865*	100

Source: Operator Survey, 2007 (n=76)

Note: *11 responses missing

Table A. 3, Table A. 4, and Table A. 5 in Appendix A present information from the 2001 Census on the characteristics of the boarding house and homeless populations in Queensland and in Australia. The distribution of boarding house residents according to age and sex in the Census based tables is quite similar to the data presented above from the operator survey. Like the operator survey, for example, more than seven in ten boarding house residents were male according to the 2001 Census, and about seven in ten were of working age. The Appendix tables further show that two thirds of boarding house residents in Australia on Census Night 2001 were single men who lived alone, and a further 18 per cent were single women, with the remainder comprising couples, single parents, and children. Seven per cent of Australian boarding house residents on Census Night identified as Indigenous.

The Appendix A tables also reveal some important differences between the homeless and boarding house populations as reported in the Census. Notably, the homeless population includes a higher proportion of women than the boarding house population, and is also younger. Only 15 per cent of the homeless population were aged over 55 in 2001, compared with 25 per cent of the boarding house population. These differences are important to note, since some of the literature used in this analysis which concerns the wider homeless population may need careful interpretation in terms of implications for PRS residents.

2.3 Resident Vulnerabilities

For the purposes of estimating support service needs, the most important aspect of the profile of people living in PRS is their vulnerabilities. Little direct evidence is available about vulnerabilities among this group. Therefore, indirect evidence is taken from the operator survey, focus group and interview data, and secondary data. While a number of different types of vulnerabilities are discussed in this section, the most concrete evidence pertains to disabilities because of the datasets available to the researchers (CSTDA and SDAC). There is also considerable evidence in the literature on both psychiatric conditions and alcohol and drug problems among homeless people, and this is also likely to apply to people in PRS. First, estimations of vulnerabilities using available data are presented, and then implications are discussed.

Operator Survey

The operator survey shows that PRS operators report high numbers of residents as unemployed and/or having a mental illness or psychiatric disability, and/or an alcohol or drug problem (Table 2.7). When estimated as a proportion of the total number of current PRS residents (from the variable ‘currently filled beds’), 53 per cent of residents are described by the operators as being unemployed, 41.6 per cent have a mental illness or psychiatric disability and 24.4 per cent have an alcohol or drug problem. Operators reported smaller, but still significant, proportions of residents with a physical disability and/or an intellectual disability.

Table 2.7: Operators’ Estimates of Resident Characteristics, Vulnerability

	Number of operators	Residents*	
		Number	Per cent
Mental illness, psychiatric disability	25	741	41.6
Alcohol/drug problem	16	434	24.4
Unemployed	26	944	53.0
Physical disability	20	145	8.1
Intellectual disability	24	334	18.7

Source: Operator Survey, 2007

Note: 19 of the 76 operators did not respond to this question

* per cent of total beds currently filled

- respondents identified multiple vulnerabilities for the same residents

Table 2.8 shows that Operators report mental illness and psychiatric disability as affecting a far larger proportion of Level 3 than Level 2 or Level 1 PRS residents: 66 per cent of Level 3 residents are reported as having a mental illness or psychiatric disorder, compared to 37 per cent of Level 2 residents and 7.4 per cent of Level 1 residents. High levels of unemployment are also reported across all three levels, which is consistent with data on people in boarding houses from the 2001 Census provided in Appendix Table A. 4. However, it is important to note that while these results make intuitive sense, the small absolute numbers of operator respondents from which these results are derived is small, particularly in the case of Level 2 and Level 3 residents. Results therefore may be subject to wide confidence intervals.

Table 2.8: Operators' Estimates of Resident Characteristics, Vulnerability by PRS Level

	Residents in Level 1		Residents in Level 2		Residents in Level 3	
	Number	Per cent	Number	Per cent	Number	Per cent
Mental illness, psychiatric disability	54	7.4	43	37.0	616	66.0
Alcohol/drug problem	157	21.4	41	35.3	230	24.6
Unemployed	287	39.2	106	91.3	531	56.9
Physical disability	16	2.2	12	10.3	113	12.1
Intellectual disability	43	5.9	10	8.6	278	29.8

Source: Operator Survey, 2007
Note: 19 of the 76 operators did not respond to this question. (n = 57)

It is also possible that PRS owner/operators (particularly those accommodating a large number of residents) have misleading impressions of the vulnerabilities of residents. For example, they may not be aware of disabilities related to vision or hearing impairment. The vulnerabilities identified in Table 2.7 and Table 2.8 suggest that operators may be useful conduits for outreach services related to characteristics such as mental illness and mobility limitations (which are visible and expressive disabilities), but that other means of delivering support services to the appropriate service users may be necessary for other conditions and disabilities.

Secondary data

Information in a number of secondary data sources were exploited to develop a picture of vulnerabilities among PRS residents to augment the data from the operator survey. In particular, two sources were used: the Australia-wide *Survey of Disabilities and Carers 2003* (SDAC), carried out by the Australian Bureau of Statistics, and the Commonwealth and State/Territory Disability Agreement National Minimum Data Set (CSTDA) for Queensland, based on detailed administrative returns from service providers for people with disability to the Australian Institute for Health and Welfare.

Survey of Disability and Carers

The SDAC is a nationally representative household survey conducted by the ABS every five years. The most recent survey (2003) included information on 41,233 people, and a limited dataset for the survey (a Confidentialised Unit Record File) has been available to researchers for analysis. In the survey, respondents were for the most part asked to self-identify as having a disability or long term health condition, although in some cases, other responsible people in the household were asked to identify household members with a disability. Adults who were identified as having a disability were personally interviewed, or another household member was interviewed on their behalf if for example their disability prevented them from easily communicating with the interviewer. While detailed information of a wide range of disabilities was collected in the survey, this analysis only uses highly summarized information on major classes of disability and health restrictions.

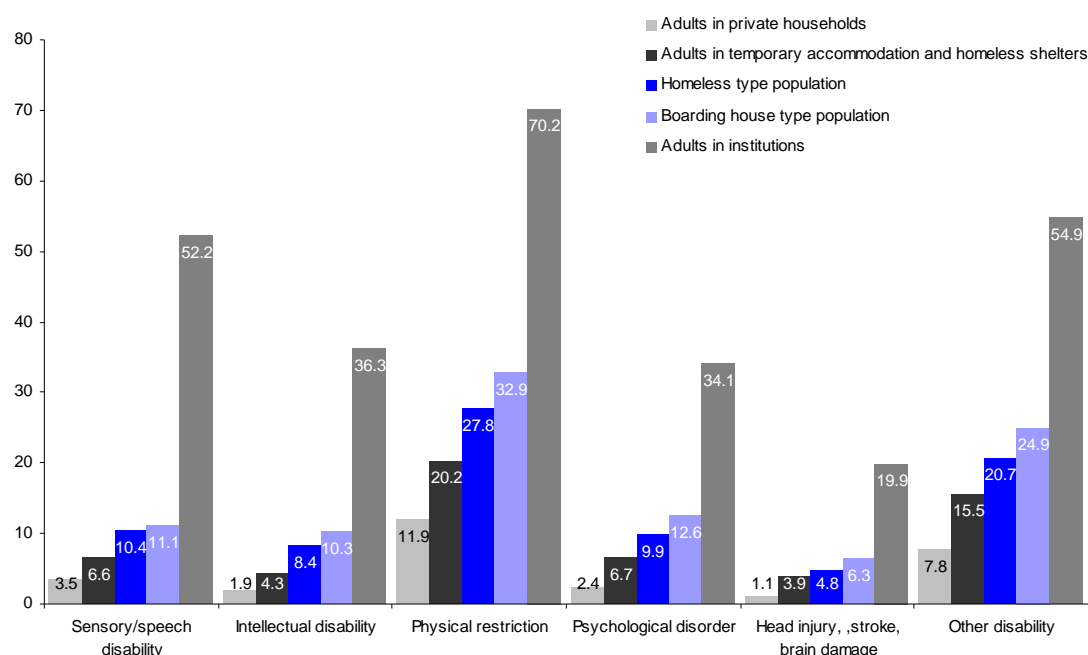
The SDAC is for the most part a household survey (of people who live in private households). However, the sample also included people with other living arrangements, including short-term caravan parks, non-private dwellings such as hotels, motels, boarding houses, and self-care components of retirement villages. A cared-accommodation component covered residents of hospitals, nursing homes, hostels and other homes. The boarding house and similar component in the total

survey is small (143 observations across all Australia), and therefore of questionable value on its own in terms of describing the vulnerabilities of people in PRS, particularly since it includes PRS staff who may live ‘on-site.’ Therefore, five different estimates of disability and need are derived from the SDAC:

1. ‘Adults in private households’: Respondents in private households – representative of all Australia
2. ‘Adults in temporary accommodation and homeless shelters’: Respondents who identify as homeless or near homeless, such as boarding house residents (but including boarding house staff who live on-site)
3. ‘Boarding house type population’: Respondents in private households, reweighted according to the age and family characteristics of boarding house residents in Australia
4. ‘Homeless type population’: Respondents in private households, reweighted according to the age and family characteristics of homeless people in Australia
5. ‘Adults in institutions’: Respondents in hospitals and institutions for the aged and people with disability.

Details of reweighting of the SDAC sample to ‘look more like’ the boarding house and homeless populations in Australia are outlined in the Appendix. Figure 2-1 shows percentages of SDAC respondents in each of the five groups who report having one or more of six broad classes of disability.

Figure 2.1: Disability by Housing Arrangements, 2003 (per cent)



Source: ABS Survey of Disability and Carers, 2003, authors’ calculations

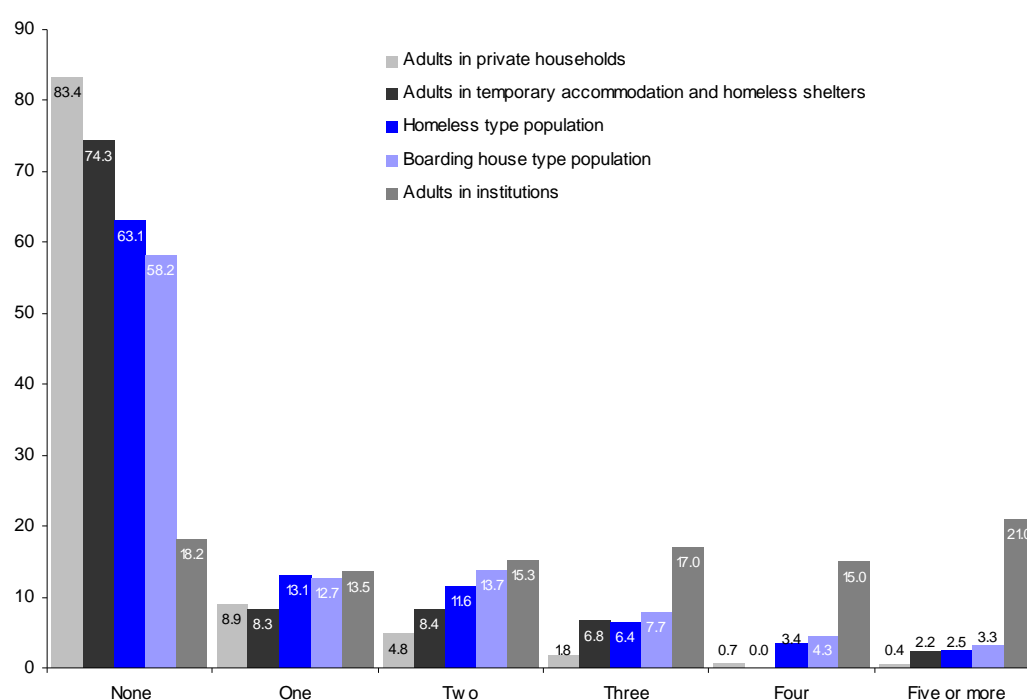
Note: The sample of people in temporary accommodation and homeless shelters (including boarding houses) is small (n=143), and its representativeness in terms of the homeless or boarding house population as a whole is uncertain.

Figure 2.1 shows that in every class of disability or restriction, incidence is lowest among adults in private households, followed by the small sample in the SDAC who

report themselves to be homeless. Levels of disability among the ‘homeless type population’ and among the ‘boarding house type population’ are notably higher, while disability levels among people who live in institutions are perhaps not surprisingly considerably higher than for all other groups. The data can be interpreted as follows: the private household population reports a rate of psychological disorder of 2.4 per cent.

This compares with a range of 6.7 to 12.6 per cent among respondents who are homeless, or have characteristics similar to people who are homeless or live in boarding houses. In other words, these data suggest that levels of psychological disorder among the homeless and boarding house populations in Australia are 3-5 times as high as they are among people who live in private households. If people who live in Level 3 PRS are assumed to have characteristics in common with people who live in institutions in the SDAC sample, then levels of disability in this group are potentially higher again. To some extent, the data on Figure 2.1 corroborate those from the operator survey presented above. However, they also suggest that operators appear to understate the extent of physical disability among PRS residents, perhaps because many of these disabilities may not be immediately apparent.

Figure 2.2 presents findings from the SDAC in a different way, and shows the proportion of each group who report any disability, and multiple disability. Overall patterns are similar to those in Figure 2.1, in that people in private households are most likely to report no disability at all, and people in institutions are most likely to report five or more different classes of disability. The first set of bars on the left of this Figure summarise overall vulnerability to disability among institutional, homeless and boarding house populations in comparison with people in private households. Over 80 per cent of adults in private households declare themselves to be disability free, compared with 74 per cent of the people who identify as homeless, 63 and 58 per cent, respectively, of the modelled homeless and boarding house populations, and only a fifth of people living in institutions. Put another way, this suggests that the probability of a person who is vulnerable to homelessness having a disability is 1.5 to 2.5 times greater than that for a person in the general private household population in Australia.

Figure 2.2: Number of Classes of Major Disability Types Experienced (per cent)

Source: ABS Survey of Disability and Carers, 2003, authors' calculations

Note: Classes of major disability types are (a) Sensory/speech disability; (b) Intellectual disability; (c) Physical restriction; (d) Psychological disorder; (e) Head injury, stroke, brain damage; (f) Other disability. For definition of population groups, see notes to Figure 2.1.

Documentation on the SDAC acknowledges that certain types of disability or restriction may be under-reported in the survey. In particular, it is noted that problems relating to drug and alcohol addiction are likely to be understated. Drug and alcohol addiction is a known problem among the homeless and boarding house populations. AIHW (2007) using Supported Accommodation Assistance Program (SAAP) administrative data, shows that in addition to the disabilities and restrictions reported above, almost a quarter (23.7 per cent) of 'support periods' provided to SAAP clients in 2004-5 were for drug and alcohol related problems. Among the men and women supported by SAAP for alcohol and drug related problems, additional mental illness issues were identified in about a fifth of 'support periods.' Therefore, a large proportion of people in homeless or near-homeless situations are likely to need support relating to alcohol and drug addiction, over and above the help that they may need for physical restrictions and psychological disorders, etc.

Commonwealth State and Territory Disability Agreement database

The CSTDA database contains annually updated administrative records on specialist support services for people with disability that are funded by Commonwealth and State/Territory governments. The data are collated centrally by the Australian Institute of Health and Welfare (AIHW), and include information provided by service providers on service users of each service they provide – their sex, age, Indigenous status, living arrangements (for example whether they live alone or with family members), residential setting (including if they live in boarding houses or hostels for homeless people), primary disability type, support needs, and actual support provided. At the time of undertaking this analysis, the most recent available data were for 2004-

05. In this analysis we use the CSTDA data for Queensland, which contains records for 11,694 adults aged 15 years and over. Of these, 113 are reported as living in boarding houses or other homeless type situations, 3,271 are reported as living in institutional settings, including hospitals, group homes, homes for the elderly, etc., and 8,310 are reported as living in private households. As with the SDAC therefore, the actual number in the database who can be directly identified as being in the population of interest is small. Moreover, information on family arrangements in the CSTDA is less comprehensive than in the SDAC, making it difficult to model a 'homeless type' or 'boarding house type' sample from this dataset.

Table 2.9 shows that almost half (45 per cent) of people in private homes in Queensland who receive disability related services are reported as having an intellectual disability as their primary disability, similar to the proportion of homeless and near homeless people. However, only 4 per cent of the 'homeless' observations are reported as having a physical restriction as their main disability, while over a quarter are reported as having a psychiatric disorder. What this Table shows therefore, in common with the data from the SDAC, is that people who are homeless or vulnerable to homelessness have a high risk of mental, psychological or psychiatric disorders. Unlike the SDAC however, but in common with the operator survey, it shows low levels of physical disability among the homeless/near homeless group. However, it is important to emphasize that CSTDA data capture only people who actually receive at least one disability-related service, a subset of all people with disability, and of people with service needs.

Table 2.9: Primary Disability Type Among Adult Disability Support Service Users, by Housing Arrangements, Queensland 2004-5 (per cent)

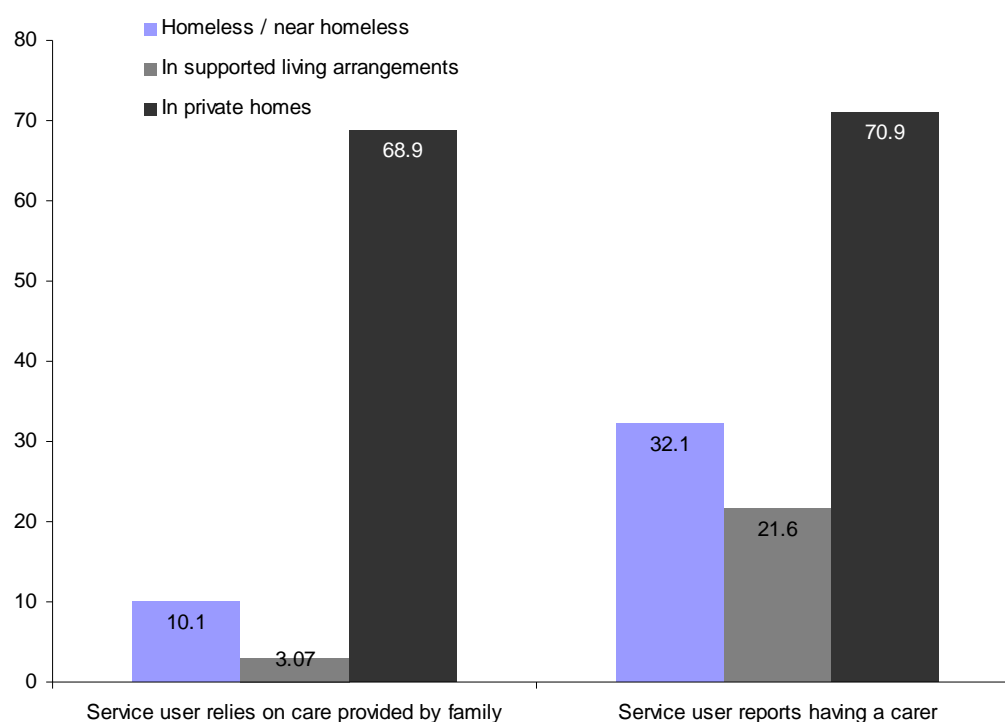
	Intellectual	Physical	Psychiatric	Other	Total	Number
Homeless / near homeless	41.6	4.4	29.2	24.8	100.0	113
In supported living arrangements	67.4	6.9	12.3	13.5	100.0	3271
In private homes	42.7	19.4	14.0	23.9	100.0	8310

Source: Commonwealth and State/Territory Disability Agreement National Minimum Dataset (CSTDA-NMDS) for Queensland, 2004-05.

Note: Adults are aged 15 and over. People who are homeless/near homeless include service users who are reported as living (a) in a boarding house or private hotel; (b) in a short term crisis, emergency or transitional shelter, or (c) in a public place or temporary shelter. The sample of people classified as living in supported arrangements includes (a) residence within an ASTI community, (b) domestic scale supported living facility, (c) supported accommodation facility (d) independent living unit within a retirement village, (e) residential aged care facility, (f) hospitals and psychiatric/mental health community care facilities. The 'Other' category of primary disability type includes acquired brain injury, neurological, autism, deaf-blind, hearing, vision, specific learning/ADD, speech and Not Stated.

Figure 2.3 provides information on a different type of vulnerability which people in PRS are likely to experience. While about seven in ten people in private homes can rely on support from an informal carer, usually a family member, this is true for only three in ten people in the homeless/near homeless sample. For people without a carer who they can rely on, disabilities and other difficulties may become even more difficult to deal with on a day to day basis.

Figure 2.3: Reliance on Carers and Family by Service Users, by Housing Arrangements, Queensland 2004-05 (per cent)



Source: Commonwealth and State/Territory Disability Agreement National Minimum Dataset (CSTDA-NMDS) for Queensland, 2004-05.

Notes: For definitions and discussion of housing arrangements, see notes to Table 2.9.

Focus group information

As part of the research for this project, six focus group meetings were held with a range of service provider and government agencies in Brisbane North, Brisbane South, Gold Coast, Townsville, Toowoomba, and Ipswich. A total of 70 people participated in the focus groups. The qualitative information gathered in the focus groups to a large extent corroborates the statistical data discussed above, and also gives insight to a wide range of other issues not covered by the statistical analyses. In summary, the focus group participants provided profile data about age, disability, socio-economic status and literacy, described below. This information is used to inform the analysis in the rest of this report.

According to focus group participants, a significant proportion of PRS residents are of retirement age. This is consistent with the Census data for people in boarding houses, which suggests that a quarter are aged 55 and over, compared with 15 per cent among the general homeless population (see Appendix Table A.5). Some focus group participants noted that people from culturally and linguistically diverse (CALD) backgrounds may also start to lose their English speaking ability as they age, increasing their vulnerability.

Focus group participants described residents with intellectual disability as the least likely to have connections to any other support services outside the facility. Focus group participants also indicated that they saw a higher proportion of people with mental illness and psychiatric disability in Level 1 and 2 PRS than they did in Level 3. This contradicts the information given by operators in the operator survey (Table 2.8),

which may be explained by the relatively small number of respondents to the operator survey. Another explanation for the contradiction could be the different perspectives of operators and professional staff, who each have contact with residents for different reasons. However, focus group participants did point out that many people with mental illness or psychiatric disability also have a dual diagnosis of alcohol or drug addiction or acquired brain injury, which according to operators affect one in five residents.

Focus group participants also highlighted the generally impoverished situation of PRS residents, that they often have poor financial management skills, and often cannot rely on assistance to manage their finances from an independent person or agency such as the Public Trustee. These residents are highly vulnerable to economic exploitation. One focus group participant described PRS residents as ‘financially incarcerated’, as they cannot afford to move out of their current arrangements.

According to the focus group participants, the majority of PRS residents live on very low incomes, mostly from a pension. They can pay up to 85 per cent of their income to operators, leaving them with very little money to cover other expenses. Some residents also make poor financial choices which result in them getting into debt, or going without food and other essentials. Access to identification and bank books may also be controlled by operators. Focus group participants provided an example of a facility in which all residents’ income goes into a ‘house account’ after their rent and board is taken out. From the house account, they can buy toiletries, cigarettes and sweets at the facility, at high prices.

Finally, focus group participants also highlighted literacy problems among PRS residents. They indicated that it is unlikely that residents will read and understand information brochures about support services, be able to understand and read tenancy agreements, or give informed consent to signing documents. This makes these residents less likely to know about and understand their rights, and less likely to know where and how to make a complaint.

Corroborating and complementary information

The literature on homelessness relating to both Australia and other countries provides a good deal of information that would tend to corroborate the above description of vulnerabilities among people in boarding houses and similar type accommodation. Mental illness has been found to be particularly common among PRS residents in both Melbourne (Greenhalgh et al., 2003) and Sydney. In Sydney, the Human Rights and Equal Opportunity Commission Inquiry into mental health reported that approximately 70-80 percent of residents in boarding houses in the central Sydney area experienced serious mental illness (Maher 1997, cited in Anderson et al., 2003:13). Anderson et al. (2003:3), in a study of boarding house accommodation in South Australia, found that high levels of disability, including psychiatric and addiction-related disorders, were found among residents. More generally, international research suggests a rate of mental illness among homeless people of about 30 per cent (Wright, 1988: 32). In relation to drug use, AIHW (2007) shows that almost a third of cases of men aged 25 to 64 who access the Supported Accommodation Assistance Program (many of whom are likely to spend some time in boarding houses) have drug and alcohol dependence issues, a proportion that fits well with the operators’ estimates of drug and alcohol addiction problems among residents in the PRS that they operate.

Literature shows that for people with psychiatric disabilities in ideal housing circumstances, other household members often provide instrumental communication assistance between people with disability and support services, alerting service providers when potential recipients cannot do this for themselves (O'Brien et al., 2002). Yet the lower proportion of PRS residents with stable and supportive family and friends who might be available for informal support, as suggested by Figure 2.3 means it is unlikely that people living in PRS have this experience.

Poverty experienced by boarding house residents has been found in the research literature to be a source of great anxiety. The lack of money 'limited choices and leisure options, especially where there were controls on spending money (i.e. those who received a daily allowance)' (Cleary et al., 1998:166). This again is consistent with the views of focus group participants cited above. A South Australian study on boarding house accommodation found that respondents were predominantly dependent on government income support, with almost a third receiving the Disability Support Pension (Anderson et al., 2003:3).

Perhaps not surprisingly, the PRS operators surveyed did not note any vulnerabilities associated with people formerly in corrective services. Indeed, a number of owner/operators noted in the survey that they would be unlikely to know this information, and focus group participants noted that operators are unlikely to be provided with information about former prisoners' support needs. The focus group participants noted they are most likely to live in Level 1 PRS. They also raised the problem of frequent victimisation of vulnerable residents by more violent or manipulative residents who have recently left corrective services. Willis (2004) out of 43,000 adults who leave the corrective services each year in Australia, homelessness is almost certainly a problem, although it is difficult using existing knowledge to gauge the extent of that problem. Willis's research also identifies a number of vulnerabilities that ex-prisoners are likely to face, over and above those faced by other homeless people. In particular they may need to re-learn many basic living skills after an extended period of institutionalisation; and they may face stigmatisation and discrimination that results in their exclusion from the private rental market.

More surprisingly, although Census data suggest that people from Aboriginal and/or Torres Strait Islander background made up about seven per cent of all people in boarding houses in Australia on Census night, there is little information in the wider literature on patterns of PRS use among this group, or among people from Culturally and Linguistically Diverse backgrounds. A small number of operators in the operator survey noted that they had residents in these groups, and as noted above, focus group participants articulated concerns that people from CALD background, as they grow older, may lose the ability to communicate in English, thus increasing their vulnerabilities.

Data about children and parents are difficult to interpret. Census data shows that most people who live in PRS or are homeless are unlikely to have children (Appendix Table A.4). However, between 2-6 per cent might have children, some of whom might also live in the PRS, at least for brief periods. Among the homeless population in general however, child and youth homelessness is recognised as a serious problem (Chamberlain, 2003), and Census estimates suggest that about a fifth of all homeless people are children aged under 15 (Appendix Table A.5). Government policy and homeless literature (Casey, 2002) support the expectation that people with

children are more likely to have priority to access assistance to find alternative accommodation outside of the PRS system.

Vulnerabilities due to living in PRS

Some vulnerabilities of people living in PRS are due to the shared residency rather than about the person themselves. These include lack of privacy, risk of abuse and isolation. In addition, the insecurity of tenancy adds to the vulnerability of people living in this form of housing. People with higher support needs living in Level 3 PRS were seen by focus group participants to be vulnerable due to the lack of control they have over their lives. In many cases, control over major parts of people's lives is vested in operators. People living in Level 2 and Level 1 PRS were seen as being at greater risk from other residents, in terms of physical safety and vulnerability to theft and coercion.

Privacy

People who live in PRS are surrounded by people and have listed the lack of privacy and disruption of other tenants as being particular disadvantages of this type of accommodation (Horan et al., 2001). Shared bathroom, kitchen and laundry facilities and the absence of self-containment (resulting in reduced privacy; Chamberlain, 1999) present particular challenges to service provision for tenants who require assistance with personal care and meal preparation.

One Australian study found that quality of life was greater for residents of boarding houses than for hostels: they reported higher general life satisfaction, higher satisfaction with their living situation, less victimization and more money to spend on themselves after rent (Horan et al., 2001). The difference between these two types of accommodation is noted as being historical: hostels were established to cater for psychiatric and mental illness, whereas boarding houses provided accommodation to seasonal workers and holiday makers. This means that boarding houses can offer more personal freedom, privacy, space and opportunities for self-determination (Burdekin 1993, cited in Cleary et al., 1998; Burdekin 1993, cited in Horan et al., 2001).

Abuse

Focus group participants observed that all residents of PRS are at risk of abuse, due to the nature of congregate living, particularly in situations where there is minimal supervision. People with disability, women, and young people were seen to be particularly vulnerable to abuses of all forms, including sexual, financial, emotional and physical abuse. The mix of residents in a facility may also increase the risk of abuse and assaults by other residents. Service provider and government agency representatives claimed this was particularly so in facilities that included residents formerly in corrective services.

An example was provided by a focus group participant of a facility in which each room had a door to the outside of the building, rather than a window. In order to get any ventilation, residents have to leave these doors open at night, leaving themselves vulnerable to anyone who might want to enter their room from outside.

Another facility had no bedroom doors, so residents were unable to have any privacy or to have reasonable security while sleeping. Violence and disruption from other

tenants is also common, adding to the risks already faced by this vulnerable population (Grigg et al., 2004; Horan et al., 2001).

Isolation

In rural areas, residents are geographically isolated, and often reliant on the operator to provide transport in order to leave the facility. Cost of transport and access to support services for people living in rural areas are both important issues. Many people living in PRS seldom leave the premises, and are very socially isolated, despite living in populous areas. According to focus group participants, they live institutionalised lives.

Case managers may place residents with little follow up. In some cases, these placements are out of area, due to a lack of available places locally. In this instance, residents are discharged by the case manager and often not allocated to a local case manager. They are also disengaged from their community and friendships by being moved to a different area.

One Australian study found that an advantage of communal living was that ‘the constant interaction among the residents provided some interpersonal contact’ (Cleary et al., 1998:168). However, this did not prevent social isolation from the wider community, something that focus group participants readily related.

Insecurity of housing

A central problem for residents living in PRS is the insecurity of the housing. Not all residents were reported to be aware of their right to a tenancy agreement;³ payment for accommodation is on a weekly or daily basis; and tenants are often not aware of their rights (Anderson et al., 2003). This kind of accommodation is the least preferred of people with mental illness and is found to be the least secure for younger residents (Browne & Courtney, 2004; O’Brien et al., 2002). Despite the illegality of their actions, there are reports of boarding house landlords locking out tenants and manipulating housing rules to ‘squeeze out’ disruptive, unreliable or difficult tenants. This has been found by a number of Melbourne studies to happen for tenants with psychiatric disabilities, because of their disability (Anderson et al., 2003). Paradoxically, disability has been found to be one of the antecedents of PRS accommodation over the private rental market: disability is highly associated with poverty, and few PRS residents are employed (Greenhalgh et al., 2004). Thus, housing vulnerability makes PRS one of the few housing options available to some people with disability (Anderson et al., 2003:69). All of these factors combine to make PRS a particularly insecure form of housing for people with disability and increase the likelihood of the desire or compulsion to ‘move on.’

The challenges of insecure housing are particularly apparent in light of the results of deinstitutionalisation and the ageing population. A study conducted by the Australian Housing and Urban Research Institute (AHURI, 2002) showed that managing a disability when residing in the community and as ageing progresses (compounding the

³ *Residential Services (Accommodation) Act 2002 (Qld)* s16 requires that tenancy agreements are in writing. In this context a ‘tenancy agreement’ is referred to as a ‘residential services agreement’.

challenges of disability) is possible ‘only if they have a secure home base into which support can be brought’ (AHURI, 2002:4).

2.4 Discussion of Resident Profile

The evidence from a number of sources presented above suggests that a high proportion of PRS residents are likely to have high levels of disability and drug and alcohol dependence problems. They also face multiple disadvantages as a consequence of poverty and inability to rely on informal support such as from family members or carers who can help them negotiate their needs. The evidence suggests that this complexity of needs requires flexible service delivery and outreach. However, the insecure nature of PRS makes service provision particularly difficult. The lack of privacy and the conditions of PRS means that this form of accommodation is not always appropriate to the needs of people who live there, thus presenting further challenges to service delivery to these people.

This profile indicates that people living in PRS compared to other people are more likely to have support needs – for example levels of disability in this group could be overall between 1.5 and 2.5 times higher than among people who live in private households. They are moreover less likely to have informal carers or family members to support them. Their vulnerabilities and support needs are likely to be complex in two respects. First, many experience multiple vulnerabilities. Second, they are as a rule living in environments that add to their vulnerability in terms of the risk to safety from other people living in the facility. Sections 3 and 4 examine the needs of PRS residents, and the extent to which those needs are met, according to the estimation of operators, expert professionals and modelled data from large scale datasets, and in comparison with people in private households.

3 Estimating Support Services Accessed and Needed

3.1 Introduction

This section applies the data about the profile of people living in PRS to information about the support services they currently use and need. It first presents the general data from the operator survey about all support service use and need (Table 3.1). The number of responses in the operator survey to the questions about service use and need was smaller than for the profile data analysed in Section 2. Additional data from the operators' comments, focus groups, interviews, literature and secondary data sources are discussed in the remainder of the section. Section 4 compares this analysis to modelling from other secondary data to estimate total levels of support service use and need for people living in PRS.

3.2 Operator Reported Support Service Use and Needs

According to the operators, the support service types most often used are meals, support with basic living, community participation, mental health and allied health (Table 3.1). The greatest unmet service needs are for allied health; support with transport, community participation and shopping; and mental health services.

The proportions of residents who received support services was less than 20 per cent for each support service type, with the exception of assistance with meals (Table 3.1). The proportion of residents reported as having an unmet need was greater than the proportion of residents reported as having received assistance for each service. Exceptions were mental health services, assistance with meals and assistance with basic living (such as personal care), where the proportion of residents receiving services was higher than the proportion of residents with unmet need.

This pattern of unmet need being higher than services received as a proportion of residents contrasts with the number of operators who reported services received by residents compared to the number of operators who reported unmet needs of residents (Table 3.1). For each support service type, a higher number of owner/operator respondents reported support services being received by some of the residents than the number of operators who reported unmet need of some of the residents, except physical assistance and rehabilitation. The operator estimates do not differentiate between PRS levels because the responses are too small and unrepresentative. Instead, the analysis by PRS level draws on modelling from other secondary datasets (Appendix A; discussed further in Section 4).

The remainder of the section discusses specific support service types, grouped according to the unmet support service needs of people living in PRS: health and related services; support in activities of daily living; social and economic participation; planning and decision making; housing and accommodation; and support provided by PRS operators.

Table 3.1: Operators' Estimates of Support Services Received and Unmet Need

Service type	Support services received			Unmet need		
	Number of operators ⁺	Residents Number	Per cent*	Number of operators ⁺	Residents Number	Per cent*
Allied health	21	296	16.0	20	651	35.0
Transport	20	246	13.3	15	529	28.5
Community participation	22	333	18.0	19	449	24.1
Shopping	25	188	10.1	14	380	20.5
Mental health	35	321	17.3	23	295	15.9
Other medical	15	174	9.4	9	237	12.8
Basic living	26	366	18.1	18	201	10.8
Drug and alcohol rehabilitation	11	17	1.0	18	199	10.7
Meals	28	543	29.3	5	183	9.9
Employment services	25	122	6.6	18	158	8.5
Nursing care	12	53	2.9	10	85	4.6
Physical assistance	3	7	0.4	4	45	2.4

Source: Operator Survey, 2007 (n=76)

Notes: 1. Descending order of unmet need

2. Number of responses is too small to reliably disaggregate by PRS Level or location. Level 3 PRS are overrepresented in the sample

+ Number of operators who indicated that they housed residents who received or needed each respective service.

*Number of residents who received/needed the service as a percentage of the total number of residents ('number of beds currently filled' = 1856)

3.3 Health-related Services

The research found unmet support service need for physical and allied health services, such as quality general practitioner services, nursing care, dental, optical, therapies, support for ageing residents, health screening (eg. pap smears and breast screening) and counselling services (personal, responsive and goal oriented); mental health services; and drug and alcohol rehabilitation services. The operator survey asked for numbers of residents receiving and needing (but not receiving) services for mental health, drug and alcohol rehabilitation, nursing care, allied health and other medical needs (Table 3.1).

Physical and allied health services

A major support service gap suggested by the operator survey data is addressing physical and allied health care needs. Operators reported 16 per cent of residents received allied health services (and 9.4 per cent received other health services), yet 35 per cent of residents were reported as still being in need of allied health care and 12.8 per cent need other medical care (Table 3.1). Health care was also seen by focus group participants to be of particular importance to residents, as it sets a foundation for their quality of life. They reported that several elements together result in a failure for many residents to have good quality medical and paramedical care in critical situations, for treatment of chronic conditions, and in the maintenance of aids and equipment. The high proportion of older people (Table 2.6) in some PRS indicates the likelihood of increased need for these services. Lack of access to the following resources was seen as being of great importance to residents:

- Quality general medical care (from GPs);
- Health care plans (for people with complex needs) or coordination of health care;

- Appropriate referral to specialists;
- Aids and equipment;
- Maintenance of aids and equipment;
- Dental treatment, for acute and chronic problems and regular maintenance;
- Therapies (eg, physiotherapy, speech therapy);
- Allied health care (such as podiatry); and
- Clinical mental health services.

For example, operators noted the lack of dental services as a main problem, with waiting lists years long, and residents alternatively going to the GP for antibiotics to numb their pain (SAPA meeting; Appendix A).⁴ One operator recommended that a dental van be established so that dental care is more easily accessible to residents.

The literature suggests that health care needs are, among this population, extensive. A Sydney study explored health service interactions of disadvantaged and homeless people that accessed a soup kitchen service (Trevena et al., 2003). While they were found to be of poor health, welfare-dependent (and thus materially deprived) and frequently attended a general practice, considerable barriers to accessing adequate health care were evident. Following prescribed treatment was impeded by affordability, not understanding instructions and not agreeing with advice, while follow-up consultations frequently did not occur due to long-held beliefs that problems would not be addressed, mistrust of health professionals and a lack of information about available support services. Knowledge of sexual health issues have been found to be poor, the outcomes of which are complicated by a reluctance to seek assistance or treatment and the potential for sexual violence that (particularly female) residents are aware of and fear (Gibson & Brew, 1999).

Some PRS residents maintain good contact with support services. However, research shows that without assertive outreach it is likely that some residents will 'slip through the net' (Anderson et al., 2003:74). Poor adherence to management regimes (including medication, physical therapy and maintenance of disability equipment such as wheelchairs) is common, and is one reason given for on-site programs (Layton et al., 1995). A service outreach program targeting unstably housed people, including PRS, has been found to be associated with increased use of regular medical care and improved perceived quality of care (Cunningham et al., 2005).

Mental health services

Nearly half (35) of the operators in the survey noted that mental health services had been received by residents in their facilities: 17.3 per cent of residents received these services (Table 3.1). Twenty-three operators reported that residents in the PRS they operate have unmet need for mental health services. In total, 15.9 per cent of residents across all PRS were reported as having an unmet need for these services.

⁴ Researchers attended a meeting of operators and owners organised by SAPA to contribute to the research (Appendix A).

PRS have been suggested as a possible source of housing for people with chronic mental conditions, provided they are managed effectively (Linhorst, 1991). The qualitative responses from the owner/operator survey suggest that the support services are insufficient to achieve this level of effectiveness. One reason for this is the lack of coordination and communication between services and PRS, discussed later in Section 5. One operator who houses a number of residents with psychiatric disabilities noted that when hospitals send patients home, they discharge patients to the PRS, but the discharge summary is sent to GPs, 'Operators are not informed to be able to provide continuity of support.'

Hospital discharge is one critical issue for PRS residents with mental health conditions. Recent research conducted on the Gold Coast found that people with schizophrenia who are discharged to boarding houses are significantly more likely to be readmitted to hospital than people who are discharged to their own home (Browne et al., 2004).

Drug and alcohol services

Operators reported that only one per cent of residents received drug and alcohol rehabilitation services, whereas unmet need was reported for 10.7 per cent (Table 3.1). More owner/operators recognised an unmet need for these support services than the number who reported these support services being received. This is consistent with the findings in Section 2 about the high incidence of drug and alcohol dependence.

3.4 Support Services to Assist with Daily Living

The second group of support services that some residents received but for which many residents had unmet need was support with daily living. The data sources all revealed unmet need for these support services. The needs included personal care such as bathing, showering, personal hygiene, toileting, dressing or eating; meals and nutrition; and physical assistance with moving eg. getting in and out of bed. They also included support to do activities outside the PRS such as assistance with shopping and transport. These findings are consistent with the high level of disability and an older age group among some people living in PRS discussed in Section 2.

The survey asked owner/operators to estimate the number of residents who received and needed support services to assist with physical assistance, transport, meals, shopping and basic living. Physical assistance was received by only seven residents, the smallest proportion of any service received (0.4 per cent). Only four operators noted physical assistance as being an unmet need, with a total of 2.4 per cent of residents across all PRS reported as having an unmet need for this service. As noted in Section 2, these operator estimates might not be accurate if they are only aware of the impact of physical rather than other disability.

Table 2.9, which presents CSTDA data, demonstrates the low rate of service support for people with physical disability and the comparatively higher level of support to people with psychiatric disability. The CSTDA data do not comment on the relative unmet need. The operator survey results also show higher support for people with psychiatric disability than physical disability (and higher unmet need for people with psychiatric disability; Table 3.1). Both these datasets relate to service users with these disabilities rather than commenting on rates of actual disability. The CSTDA data also suggest that support services for people who are homeless and private dwellers mainly address the needs of people with intellectual disability (Table 2.9).

Operators estimated that residents who received assistance with transport comprised 13.3 per cent of the total number of residents; however, an unmet need for transport was reported for 28.5 per cent of residents and was proportionally the second largest unmet need after allied health services. Focus group participants noted that some people do not or cannot use public transport or walk and they remain isolated in the facility. Operators agreed, stating that they spend considerable time assisting residents with transport, which can be both costly and time consuming, especially in rural areas (SAPA meeting). Operators reported that assistance with shopping was received by 10.1 per cent of residents; however, double that proportion (20.5 per cent) were still in need of that service. Focus group participants and operators raised the unmet need for supported transport because many PRS residents require support to complete the activity for which they need the transport.

Operators reported that the support received by the largest proportion of residents was meals (Table 3.1). Unlike most support service types, operators estimated that a greater proportion of residents received assistance with meals (29.3 per cent) and basic living (18.1 per cent) than people who needed it, but did not receive it (meals 9.9 per cent; basic living 10.8 per cent). Level 2 and 3 PRS include meal services. Additional qualitative data from the owner/operator surveys suggest that some of the daily living assistance is offered 'in-house' and informally. This may explain why assistance with meals and basic living is comparatively well provided: they do not necessarily involve resources such as money or equipment, and are home-based needs that could (to some degree) be provided by lay people.

Operators commented that residents in Level 1 PRS are 'disadvantaged because our accommodation is treated as though it is a service when in fact we only provide accommodation.' The impact is that they do not receive the necessary support services that they require. One operator sums up the urgent needs of the residents in the PRS,

They get almost none [support services] and need a lot of life skill support, rehab, travelling to Centrelink (10 miles away), anger management, education and job training! Mentally ill residents need daily support.

3.5 Support Services for Social and Economic Participation

The third service group relates to support for social and economic participation, including education, employment and participation in community activities. The operators reported employment services as received by 6.6 per cent of residents, with a further 8.5 per cent in need of them (Table 3.1). The resident profile in Section 2 showed operators observed that most people living in PRS are not employed. Operators estimated support services to assist with community participation were received by 18 per cent of residents, but remained an unmet need for another 24.1 per cent of residents. This was one of the largest proportions of unmet need reported. Focus group participants also emphasised the unmet need for social support and encouragement for people to join in with social and community activities.

Several operators commented on residents' social isolation and their need for opportunities to engage in the wider community. Several PRS operators suggested that support services to come into the PRS were needed to assist residents to socially interact inside and outside the PRS. Another operator of a Level 1 PRS said

that ‘some of these people really need to be encouraged to join in community activities. TV and pills from the doctor don’t help community spirits.’

This finding of high unmet need for participation support is consistent with a small qualitative study conducted in Sydney, where the majority of ‘social’ activities that boarding house residents undertook were individual activities, rather than group events based in the community (Cleary et al., 1998:167). The majority of residents in Cleary’s study did not have contact with, or receive visits from, the wider community outside the boarding house; however, people who did (such as participating in the outings of a local senior citizens’ center) gained tremendous benefit from doing so.

A recent Australian study demonstrated an association between social networks and self care and employment outcomes for people with psychosis (many of whom lived in PRS). People who had friends in their social networks were found to have better self care, yet the converse was found for employment outcomes: people with strong family links were more likely to be employed than people whose networks were dominated by friends (Harvey et al., 2002:xii). In addition, he found that people who live in PRS who are surrounded by people (staff and other residents) may be experiencing significant social isolation. What these findings suggest is that, regardless of the social and economic participatory profile of PRS residents, a need for support services in these areas is highly likely. No information on education services for children living in PRS was available to the research, although Section 2 noted that children are likely to remain in PRS for short periods only.

3.6 Support in Planning and Decision Making

Estimates of the profile of residents emphasised vulnerability due to intellectual disabilities, financial status and low literacy (Section 2). Their poor financial status in part was reported in focus groups and interviews as due to a prolonged lack of support over their lifetime to make decisions in their own interest, leading to debt and unsustainable financial arrangements with PRS operators. These residents are highly vulnerable to economic exploitation. One operator lamented, ‘We get criticised for being in control of the person’s whole life but who else is there to do these things? There are not enough supports or services.’

Due to these vulnerabilities, the research found unmet need for case management, advocacy, assistance with decision making and financial management. A minority of residents have substitute decision makers. Others require such support but do not have access to it, such as when they are unwell. Focus group participants noted that many residents who have poor financial management skills do not have assistance to manage their finances from an independent person or agency such as the Public Trustee. Operators commented that inaccessibility of Centrelink poses a problem for people living in PRS. They noted that liaising with Centrelink was previously easier for both the resident and the operator because, ‘... they used to come to do home visits, but not any more.’ They said the consequence was that residents are vulnerable to losing their payments if they do not turn up for an interview. Some operators said they take responsibility of remembering residents’ appointments and getting them to the appointments on time (SAPA meeting).

Similarly, focus group participants noted a lack of access to independent decision making support and guardianship for people with impaired capacity who need an independent decision maker to support them. They also noted the shortage of

independent advocacy support, both for individuals and systemic change to improve service practice.

Operators raised problems they have experienced assisting residents to apply for a guardian at the Guardian and Administration Tribunal. They reported that their experience was that the process by which a guardian is granted is lengthy and time consuming, and because of the lack of support services, if the resident does not have anyone to assist them, it becomes the responsibility of the PRS operator. The operators insisted, 'We need more social workers in this area' (SAPA meeting).

A qualitative Australian study of boarding house residents suggested the difficulty and reluctance with which they foresaw their future and considered future options. A number of residents were fearful of the future and felt a lack of control over their lives; they were 'unable to articulate future goals' (Cleary et al., 1998:168). This suggests that assistance with planning and decision making – which often have future-oriented outcomes – may be beneficial to the population.

3.7 Housing and Accommodation Support

The fifth type of support service was housing and accommodation support. Focus group participants voiced their frustration that residents of PRS have a lower priority of access to stable housing and accommodation support because they at least have a roof over their head. They gave as an example the shortage of paths from PRS into other forms of housing, such as social housing. The majority of focus group participants were of the opinion that most PRS do not represent a minimum quality stable accommodation option for people with support needs. Robinson et al (2004) discussed barriers to people living in PRS needing to access housing more suitable for their support needs and drew implications for policy change to improve their quality of life.

3.8 Support from Private Residential Services

In addition to support services externally provided to people living in PRS, some PRS operators also provide support services themselves, particularly Level 2 and 3 PRS. Very little data were available to the research about Level 2 PRS, particularly from the operator survey. Level 1 PRS do not provide support services to residents. Owners do not usually live on site, and in some cases are rarely on site.

One operator noted that support from government services is not available to residents due to their remote location. Because of this, the PRS staff organises and provides various support, such as health and medical services, assistance with transport, shopping, and finance, and access to community activities. Another operator noted that her accommodation also provides various other support services free of charge. These include managing the finances for some residents, and transportation that is required for any shopping or appointments. They argued that providing such intensive care places strain on resources and is very time consuming, putting 'a large burden on the facility and will not be sustainable mid to long-term.'

Focus group participants consistently described an environment in which drug dealing and use, violence and criminal behaviour and prostitution are common. They described residents 'subletting' their rooms, often to young homeless people. They described Level 1 facilities as very unsafe places, especially for women.

Residents often have no control over the quality of the service which they pay for in Level 2 and Level 3 facilities. For example, they often do not have a say about menus, quality of food, amounts of food served. In some cases, residents provide part of the service, either for reduced rent or a small payment. Several focus group participants raised concerns about the capacity of PRS operators to adequately meet the complex needs of some residents. In the focus groups an example was given of a Level 2 facility that charged for and provided 2 meals per day, one of which consisted of two slices of bread. A focus group participant claimed that in another Level 2 facility, a friend of the operator was paid by residents for cleaning services, which were of very poor quality.

All types of residents were felt by focus group participants to be vulnerable due to the level of control that PRS operators have over their lives. In many cases, residents do not have family or other carers who support them. They are heavily reliant on operators to meet all their needs. If a PRS provides a poor or inappropriate level of service, it is extremely difficult for residents to complain, given their reliance on the operator. Additionally, the complaint forms which residents can use to make a formal complaint require good literacy skills or access to an independent advocate – which many residents do not have. Residents were reported by focus group participants as frequently being fearful of eviction, and reluctant to ‘rock the boat.’ Several examples were given by focus group participants of residents being moved on from facilities after making complaints.

According to focus group participants, the change of service models under the PRS reform has had both positive and negative effects. Mental health workers described the change from a facility based visiting model to a continuity model where they follow clients from one residence to another as they move. While they felt this has good outcomes for clients, they noted that it removes the possibility for them to raise issues of poor standards or practice with PRS operators on a general level. The only way to raise issues now is at an individual level, which makes the person vulnerable to repercussions from the complaint.

This section has discussed the findings about service use and unmet need. Section 4 estimates service need by combining this analysis with the profile and modelling from other secondary data.

4 Estimating Service Need Using Secondary Disability Services Data

4.1 Introduction

In addition to the data about service use and needs of all people living in PRS discussed in earlier sections, other secondary data are also available about the particular service use and needs of people with disability. In this section, service need for people with disabilities is estimated using two large scale datasets, the ABS Survey of Disability and Carers (SDAC) (2003); Commonwealth and State/Territory Disability Agreement National Minimum Dataset (CSTDA-NMDS) for Queensland, 2004-05. Both datasets are useful for estimating need in relation to disability, but not other types of need that are discussed in Section 3. In both datasets, need and the extent to which that need is perceived to be met are compared across the homeless and boarding house populations on the one hand, and the population of people living in private households on the other. The techniques used for estimating need among the homeless and boarding house populations is similar to that used to estimate the extent of need in Section 2. For the CSTDA administrative data which relate only to Queensland, it is estimated directly from the small number of observations in the dataset that are identified as living in boarding houses, hostels or homeless type accommodation. For the SDAC which are representative of all Australia, the boarding house type population is modelled from the sample of people living in private households using the reweighting technique discussed in Appendix A.

As is the case with the use of these datasets to estimate levels of need in Section 2, results should be treated with caution. In the case of the SDAC, this is because the analysis is based on modelling the boarding house population from a limited number of characteristics available in SDAC (employment status, family arrangements and age). Modelling was needed because SDAC does not specifically identify people living in PRS (Section 2.3 and Appendix A explain the modelling in more detail). The characteristics available in SDAC for modelling PRS residents do not capture many of the essential differences in the real population between people who are homeless or near homeless, and people who live securely in private housing. The absence of information in the SDAC about service needs due to drug and alcohol dependence is one example of how a problem affecting significant numbers of homeless and near homeless people are not well captured in this dataset. In the case of the CSTDA, the data only capture people who are already in receipt of at least some specialist disability services. People not in receipt of any disability related services are by definition excluded from the dataset, and it might be expected from other evidence presented in this report that homeless people and people in boarding houses are over-represented in this group.

4.2 Estimating Service Need Using the SDAC

The SDAC collects detailed information from respondents who report that they have disabilities on the kinds of assistance that they need, and the extent to which they believe those needs are partially or fully met. Information on needs in particular is collected in some detail. For example, with respect to needs related to cognition or emotion, respondents are asked whether they need assistance to manage their own behaviour because of disability; or to make decisions or think through problems; or to cope with feelings or emotions; or with relationships. In this analysis, needs arising from disability estimated from the SDAC are summarised into nine broad

groups. Table 4.1 shows self-reported perceptions of need and the extent to which people believe those needs are fully met, among the modelled 'boarding house type' population, among people in private households, and people who live in institutions such as aged care and disabled care facilities and hospitals.

Table 4.1: Self-perceived Needs and Meeting of Needs Among Adults with Disabilities, by Housing Arrangements, Australia 2003 (per cent)

	'Boarding house type' population		People in private households		People in institutions	
	Needs assistance	Needs fully met (of people with needs)	Needs assistance	Needs fully met (of people with needs)	Needs assistance	Needs fully met (of people with needs)
Help with transport	33.2	77.8	19.5	81.4	15.1	81.8
Help with cognitive/emotional tasks	22.7	66.2	8.7	66.6	56.3	60.3
Help with housework	18.5	72.9	12.9	77.5	10.7	89.8
Health care	17.8	78.1	12.0	82.7	71.3	91.4
Help with paperwork	13.6	78.8	5.4	83.8	50.6	91.8
Help with mobility	12.4	79.3	6.3	82.7	12.3	83.1
Help with self care	9.4	84.0	6.1	85.0	60.1	86.7
Help with meal preparation	8.4	82.1	4.3	88.3	3.0	91.4
Help with communication tasks	3.9	78.6	1.2	82.0	39.7	-

Source: ABS Survey of Disability and Carers, 2003, authors' calculations

Note: Descending order of need for working age people vulnerable to homelessness

Adults are defined here as aged 15 years and over. The 'Boarding house type' population is a reweighted SDAC subsample of non-working men and women living in private households, where age and family status weights are applied based on percentages of adults in each group estimated to be living in boarding houses, as reported in Appendix Table A.5.

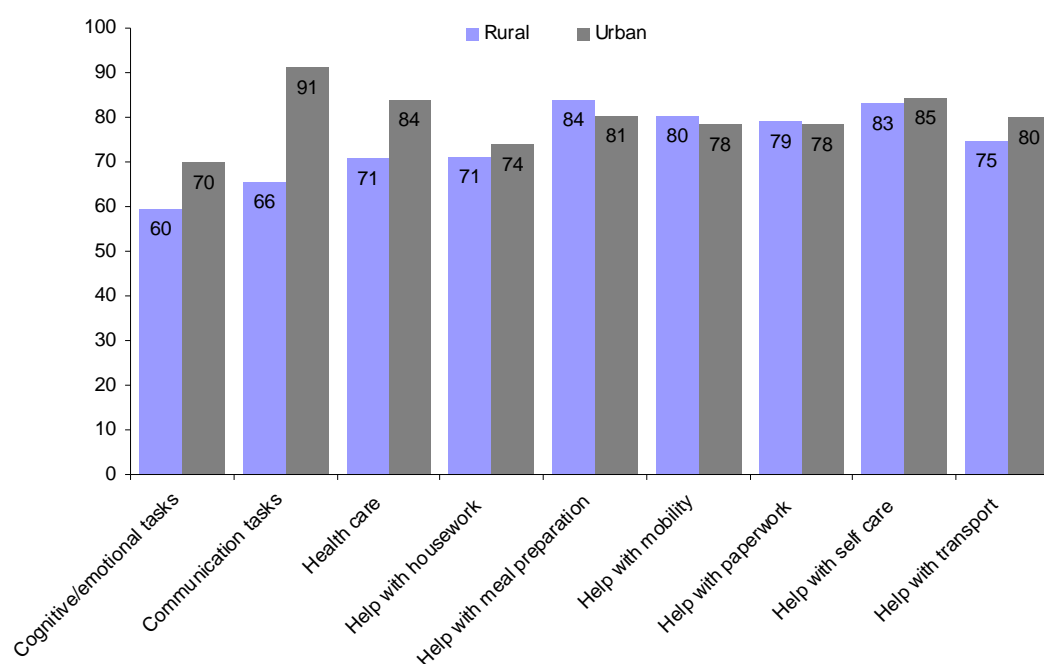
In Table 4.1, needs are only counted for SDAC respondents who state that they have a disability. Types of assistance needed are ranked according to reported level of need among the 'Boarding house type' population, which reports the highest level of need for help with transportation, and the least level of need for help with communication tasks. Across all categories, self-perceived needs are significantly higher among the 'Boarding house type' population than among people in private households. For example, almost a quarter in the former group report needing help with cognitive/emotional tasks, compared with less than a tenth in the latter group. The proportion of the 'Boarding house type' population who report needing help with mobility (12.4 per cent) is double the proportion in private households. Among people living in institutions, self-perceived levels of need are higher again across most categories, with the exception of those that might be less relevant in an institutional setting, such as help with housework and meal preparation.

Nonetheless, Table 4.1 also shows that respondents' perceptions of whether their needs across the different categories are fully met are uniform across the three types of housing arrangements. Respondents are least likely to perceive their needs in terms of emotion and cognition to be fully met, and most likely to perceive their needs in terms of support for self care to be fully met. Figure 4.1 however shows that there is some variation in disabled respondents' perceptions of whether their needs are fully met according to where they live. People who live in regional and rural areas are less

likely than people in large cities to report their needs for help with cognitive and emotional tasks, communication, and health care are fully met.

Using the modelling presented in Table 4.1 informs estimates about likely needs and unmet needs in Levels 1 and 3 PRS. The boarding house type population is most similar to Level 1 PRS, while people in institutions are most similar to people who live in Level 3 PRS.

Figure 4.1: Self-perceived Needs and Meeting of Needs Among Adults with Disabilities in Large Cities and Regional/rural Areas, ‘Boarding House Type’ Population, Australia 2003 (per cent)



Source: ABS Survey of Disability and Carers, 2003, authors' calculations

Note: Adults are defined as aged 15 years and over. The 'Boarding house type' population is a reweighted SDAC subsample of non-working men and women living in private households, where age and family status weights are applied based on percentages of adults in each group estimated to be living in boarding houses, as reported in Appendix Table A. 5.

4.3 Estimating Service Need Using the CSTDA database

Unlike the SDAC, the CSTDA database does not contain data on service need, but on actual service use among people who use disability related services. Table 4.2 shows provision to service users who are homeless or near homeless, in supported living arrangements, or in private households. It shows that among the homeless/near homeless who are service users, case management is the most common service type, with almost half in this category receiving it. On the other hand, only 18 per cent of the homeless/near homeless receive learning and life skills development services, compared with 30 per cent of people in private households. Less surprisingly, only 12 per cent of the homeless/near homeless benefit from respite care services, compared with 26 per cent of people in private households (and 5 per cent of people in supported living arrangements), since these service are aimed in particular at people who have a carer who looks after them. Figure 2.3 in Section 2 shows that fewer than

a third of the homeless/near homeless in the CSTDA have a carer, compared with 70 per cent of people who live in private households.

Table 4.2: Service Provision to Working Age People, by Housing Arrangements, Queensland 2004-5 (per cent)

	Homeless / near homeless	In supported living arrangements	In private households
Case management, local coordination and development	45.1	20.4	36.6
In-home accommodation support	24.8	16.4	23.4
Learning and life skills development	17.7	39.1	29.6
Respite care	12.4	5.0	26.3
Attendant care/personal care	4.4	7.4	1.9
Therapy support for individuals	2.7	16.8	7.4
Counselling (individual/family/group)	1.8	2.6	6.0
Behaviour/specialist intervention	1.8	14.2	1.9
Institutional care	0	50.6	0.6
Regional resource teams/other community support	0	1.7	2.4
all other support	31.0	23.6	15.1

Source: Commonwealth and State/Territory Disability Agreement National Minimum Dataset (CSTDA-NMDS) for Queensland, 2004-05.

Note: Support services listed in descending order of service use by people who are homeless or near homeless.

For definition of housing arrangements and umbers in each housing category, see notes to Table 2.9.

The 'all other support' category includes: Alternative family placement; Other accommodation support; Early childhood intervention; Recreation/holiday programs; and Other community access.

Table 4.3 shows the average typical hours of services provided per week for service users in the CSTDA with different types of housing arrangements. While these data need to be interpreted with caution since data on hours are not collected in the CSTDA for all types of service, the data do nonetheless give a rough picture of who benefits the most from service provision for people with disabilities. Overall, people who are homeless/near homeless receive fewer hours of service than people in private households. In a typical week, the former receive 16.5 hours, while the latter receive 22.8 hours. People in supported living arrangements receive on average 19.5 hours per week. If respite care, which is particularly aimed at people in private households, is excluded from the comparison, then there is greater equality among the three groups in terms of average hours of service received. However, the homeless/near homeless still receive fewer hours service on average than people in private households.

Table 4.2 and Table 4.3, based on CSTDA data, can be applied to estimating needs of people living in Levels 1 and 3 PRS. The modelling of services received by people in supported living arrangements is most similar to Level 3 PRS, while people who are homeless or near homeless are most similar to Level 1 PRS.

Table 4.3: Typical Hours Support Provided per Week by Housing Arrangements, Queensland 2004-05 (average hours)

	Total hours	Excluding respite care	Number
Homeless / near homeless	16.5	15.6	112
In supported living arrangements	19.5	18.1	3219
In private homes	22.8	17.2	8310
<i>Among service users with no family support</i>			
Homeless / near homeless	18.1	17.1	101
In supported living arrangements	19.7	18.5	3118
In private homes	33.4	31.1	2585
<i>Among service users with no carer</i>			
Homeless / near homeless	13.3	13.0	77
In supported living arrangements	17.0	16.0	2564
In private homes	25.1	23.7	2342

Source: Commonwealth and State/Territory Disability Agreement National Minimum Dataset (CSTDA-NMDS) for Queensland, 2004-05.

Notes: For definitions and discussion of housing arrangements, see notes to Table 2.9.

The contrast between people who are homeless/near homeless, and people who live in private households is sharpened if hours of service provision in a typical week are examined only for service users with no family or carer support – the majority in the case of the homeless (and people in supported living arrangements), but the minority in the case of people in private households. Among the homeless with no family support, average service provision is 18 hours per week, compared with 33 hours among people in private households. Where respite care is excluded, this gap remains almost as large. Among people with no carer, the average hours of service received per week by people in private homes is double that received by the homeless and near homeless.

4.4 Conclusion

While the data presented in this section must be treated as tentative for the reasons outlined above, they do nonetheless paint a fairly consistent picture of high levels of service need among people living in PRS and similar accommodation, and of unequal allocation of support services to homeless and near homeless people in comparison with people in private households. The data presented here are also consistent with the more qualitative data discussed in Sections 2 and 3, which showed higher levels of vulnerability, multiple vulnerability and poor access to services to address the support needs associated with the vulnerabilities.

5 Facilitators and Barriers to Accessing Support Services

The remainder of the report applies the profile of residents and estimate of support service need to information about good practice to facilitate access to support services. From this analysis, the section draw implications for policy change to improve access to support for people living in PRS.

5.1 Availability of Suitable Support Services

The most difficult problem for people living in PRS is the shortage of suitable support services. In some cases this is because of a general shortage in the community, such as affordable housing. In other cases it is because the way support services are provided is not suited to the additional needs of PRS residents. This section discusses the findings about facilitators and barriers to enhancing the supply of suitable support services. It concludes with some implications for policy development.

Supply of support services

Earlier sections of this report have discussed and estimated the extent of residents' unmet need for support services. While in some cases, the unmet need can be addressed through information and referral to support services, many of the findings revealed the shortage of human services to be the reason for the unmet need. A common response from focus group participants was that, 'Coordination of services is a great theory, but there's very little to coordinate!'

The shortage is evident in general support services that any member of the public would expect to access, such as physical and allied health services. In addition, it is particularly evident in the need for specialist services related to the vulnerabilities of people living in PRS. Section 3 highlighted unmet need for support service such as mental health case management and disability services accommodation support.

In the context of these shortages, both formal processes and discretionary decisions mitigate against residents accessing support services. According to focus group participants, access rules for some support services either prevent or do not prioritise PRS residents accessing support services. In addition, some professionals and agencies are reluctant to refer, or at times even provide information to residents about support services, because the waiting lists are so long that they are unlikely to be able to access support services. Focus group participants gave the example that case managers or others will tell someone if they are entitled to a service, but if there is a long waiting list or the service is not available, they are very disappointed.

The Resident Support Program (RSP) is specifically targeted at providing social support to people in PRS. However residents have limited access to the support in a number of ways. The program does not operate in all parts of the state and the service providers have a limited budget, which means that some people who need support miss out (Fisher et al, 2005). Focus group participants felt strongly that there was not enough RSP given its impact on direct service provision and service coordination (Section 5.3).

Suitability and quality of support services

In addition to the shortage of support services, the research found that the way services are delivered is sometimes unsuitable for the needs of residents. Some

support services are needed or under-utilised by residents, but are not being accessed, such as primary health services. This suggests residents perceive barriers to accessing support services. These can relate to accessibility; characteristics of the service; quality; and affordability.

Access. Accessibility relates to both processes to encourage use by people living in PRS; and physical location and place of the service. Focus group participants noted that in the experience of several RSP providers some mainstream support services and activity groups do not welcome PRS residents, and that residents are not comfortable using these support services. This related to both personal support services such as HACC; and community participation, such as sports clubs. They were of the view that inclusion in mainstream groups is not a realistic goal for some PRS residents.

Physical access is also a barrier for some residents. Staff from agencies noted that distance is a problem for residents of non-urban PRS because they cannot afford transport. Focus group participants noted the need for assistance with transport to support services and to participate in activities, such as getting to the doctor, sitting in on appointments, getting home, and assisting resident to give necessary information to operator. They observed this was particularly important for residents with disability. Further, the location of some services will have an influence on residents' ability to use them, such as government buildings. According to a government official in an interview, some people may feel unwelcome or intimidated to enter these facilities.

Characteristics of service provision. Focus group participants also noted that support services need be provided in a way that addresses the insecurities of residents due to both their vulnerabilities and their tenuous accommodation. They commented that effective support services give residents a sense of autonomy and control, choice, a feeling of belonging and connectedness. Importantly, they were seen by PRS residents as non-demanding (eg. offered a range of different ways to participate in the service, according to preference).

The way support services are provided also relates to restrictions on ongoing support. Given the chronic nature of some vulnerabilities, time limited support services are not realistic for some support needs. RSP providers have found over time that people require ongoing support to continue using support services, either due to the stable level of their need or due to the episodic nature of disability.

Quality. Focus group participants noted that some support services may not be good quality, but due to the lack of alternatives residents are encouraged to use the support services anyway. They reported that poor quality is aggravated trying to address complex needs with a limited supply and time-limited service provision. Limited funding impacts on the quality of service provided, the number of people served and on turnover of staff. An operator gave the example of personal care service staff, 'Some people have had five in the time they have been in the program. (It) takes them a long time to trust a person to bath them' (SAPA meeting, Appendix A).

The focus group comments about quality also related to the process of referral to some PRS themselves, particularly if an agency, such as hospital, mental health or corrective services, have pressure to discharge the person to alternative accommodation. They noted the lack of processes for mental health workers to assess the suitability of the placement. The mental health workers observed that this pressure was worse than 5 years ago because of the pressure on hospital services.

Affordability. As noted in Section 2, most people living in PRS have very limited discretionary income. Focus group participants noted they did not make referrals to support services unaffordable to residents. The shortage and extensive waiting lists for free services limits access to core support, such as dental services and affordable housing.

Implications for policy development

The findings on availability of suitable support services have two implications for policy development. Many of the support service types most needed by people living in PRS are available to the general public, such as physical health services. Facilitators to improving access to these support services include:

- location of the support service, either outreach services going to or near the PRS; or supported transport to assist people to travel to the support service;
- consideration of people's complex vulnerabilities and insecurity of accommodation in the way support services are provided to people living in PRS, such as where services are provided, transport, cost, confidentiality, ongoing support and effective communication; and
- assistance to the resident to negotiate the service provided and to convey necessary information back to their place of residence with the person's permission (eg. medication changes or therapy exercises).

Other specialist services most needed by people living in PRS are specialist services relating to their vulnerabilities (such as, disability, mental health, home care, drug and alcohol services and housing). Facilitators to improving access to these support services include:

- review criteria for priority of access to these support services to improve the likelihood that people living in PRS are recognised as highly vulnerable, comparable to the needs of homeless people;
- recognition in the way that services are provided that support needs are likely to be prolonged, if not ongoing, because of the nature of the vulnerabilities experienced and historical service neglect of this group of people, which may have aggravated their vulnerabilities.

5.2 Information and Referral

In addition to improving the supply and suitability of support services, the second facilitator to addressing support needs is effective information and referral. These processes are grouped in this section because from the perspective of the resident, they can have the same impact or shortcomings (Robinson et al, 2004).

According to focus group participants, people living in PRS become aware of available support services through:

- word of mouth from other residents and people they meet (particularly in Level 1 PRS). This source is restricted by the lack of meaningful social relationships for some residents;
- going to support services off the street (particularly from Level 1 and 2 PRS);

- promotion from some PRS operators – such as personal approaches and assistance to find support services in the best cases;
- written information – such as notice boards. However, this is limited, due to restricted literacy and lack of knowledge about how to use these information sources; and
- referral by other service providers, including case managers and people coming into the PRS to support other residents – discussed below.

Focus group participants also commented that service providers only become aware of residents who require support services through going to the person, rather than relying on people coming to an external point without support. They emphasised that information about support services need to be creatively promoted through personal contact. Agencies cannot rely on written brochures and information sheets. Examples given were to go to places residents spend time talking with them, getting to know them and personalising the service.

For some residents, particularly in Level 1 PRS, this requires going to places other than the PRS because of their tenuous accommodation arrangements. This approach is similar to that taken for engaging with people who are homeless. Some focus group participants noted that the PRS operators' attitudes to support services had a considerable impact on whether residents would use it or not. In cases where operators were not supportive of a service, service providers found it less likely that residents would take it up. They attributed this to suspicion from some operators, who view service use as threatening the likelihood that residents will continue to live in the PRS.

Referrals to support services are made by people who residents trust; some PRS operators; and other service providers. Personal referrals were reported as occurring if the resident has someone they trust, who can introduce them to the new service. The implication for service providers is that they have to allocate time to develop a relationship before they are likely to successfully make a referral to a support service. The focus group participants stressed the importance of personal connection and rapport in assisted and direct referral.

Referral pathways are complex for residents of PRS because of their multiple vulnerabilities, high mobility for some residents and the various pathways by which they come to be living in the PRS.

Focus group participants also emphasised that information and referral needs to be about appropriate support services. Similarly, they noted that information is only useful if it is relevant to the residents' self-perception of need for the support service. This means that people providing information must be aware of the particular characteristics of the service and the support needs and vulnerabilities of the residents. A focus group participant noted, 'It's a double bind, because you can't promote services that can't be taken up due to supply problems'.

Implications for policy development

The implications for policy development relating to information and referral practices include:

- most information is shared through word of mouth from other residents, operators, service providers and other people who have contact with people who live in PRS. In addition, some people are unable to understand written materials. Therefore, any written information needs to be supplemented with opportunities to talk about the support services both within the PRS if that is possible, and also in places residents are likely to go outside the PRS; and
- referrals are most likely to be successful if they are made by someone who has developed a relationship with the resident. Agencies that provide support services therefore need to allocate sufficient time for contact with residents and to understand their particular needs and preferences and accompany them to new service opportunities.

In addition, implications from the earlier section about the supply of suitable support services are that information and referrals need to be prioritised about services that residents are likely to be able to access. This includes ensuring that the support services are available, accessible, affordable, recognise the additional needs of this group of people and are of sufficient quality and duration to address their needs.

5.3 Coordination Between Agencies

Information and referral is one example of coordination processes to enhance access to support services. In addition, effective coordination at the levels of referral, service delivery and policy (funding and planning) were identified as facilitators to effective use of support services. Coordination here is meant as between all agencies whether government, nongovernment or private.

Coordinated referral

Referral processes across and within agencies were seen by focus group participants to have an impact on service use. Effective coordination of referral requires resolution about information sharing, confidentiality, knowledge about other support services and vacancy management. For this reason, agencies reported that the most effective referral coordination occurred in the simple models of service provision. These included co-locating several community services together; approaches to the RSP that involve two rather than three NGOs; and internal referral within agencies that run several support programs.

In addition, they pointed to the success of formalising referral processes such as the example of RSP. The RSP has referral forms and processes so that referrals can be made by telephone contact because residents do not have to repeat assessments and associated paperwork.

Coordinated service delivery

The second area of coordination is in the service delivery to residents who receive more than one service. Focus group participants were in most cases despondent about the lack of coordination. They reported that the impact is that some residents receive no support; and support of other residents is compromised. They attributed this to poor quality information sharing, case management and follow up. It is also aggravated by different professional approaches and priorities to service delivery, such as crisis management, skill development, rehabilitation, prevention, maintenance (Fisher et al, 2005).

Compromises to case management of people with mental health conditions was particularly highlighted. The agency staff reported difficulties from the point of

referral to PRS; inconsistent follow up once the person resides in PRS, because of priorities with other mental health consumers; poor information sharing with other agencies supporting the person; and poor access to mental health clinical support to supplement the social support from the other agencies. They called for acknowledgement of the gap between agency policy on principles of good mental health case management and practice because the case manager workload is unmanageable. Operators also voiced their concern in this area, stating that case management is poor and needs to be better organised, claiming that only one case manager is allocated for 135 people (SAPA meeting, Appendix A).

The need to address these problems has been recognised in some locations. A new initiative to coordinate between integrated mental health, police, RSP and owner/operators is underway in one part of the state. Agency staff had many suggestions about what they observed as facilitating good coordination in service delivery between all types of agencies. They observed that it relied on opportunities to develop good relationships between service providers through leadership, partnership approaches, management and worker meetings, joint case management and protocols balanced with discretion to solve problems.

Compromises to relationship development include staff turnover and competing time constraints. RSP was seen as positively identifying opportunities for coordination; addressing underlying problems; and developing relationships at grass roots levels between providers and residents and also between providers.

Policy

The third facilitator to effective coordination identified in the research is at the policy level of funding, planning and revising policy processes. As with service delivery, the respondents identified difficulties at the policy level from the compromises due to service shortages in one area having an impact on other support services. Examples mentioned above include the shortage of affordable housing and accommodation support; mental health clinical and community services; and personal and community support services. Section 3 discussed the impact of these shortages for PRS residents.

Focus group participants particularly mentioned opportunities to review mechanisms to coordinate between government, nongovernment agencies and local government, such as brokering services. At the policy level they also noted that protocols between agencies need to be reviewed, with input from people providing the support services.

Implications for policy development

The implications of the coordination findings for policy development include the following:

- simple models of service support that minimise the number of organisations involved are more likely to effectively coordinate the complex support needs of people living in PRS. Similarly, simple models case management can be more responsive to the person's needs, such as coordination support that follows the person, rather than is located within a particular PRS;
- mental health services are central to the support needs of a significant proportion of residents in PRS. Mental health agencies are currently unable to meet the mental health service needs of people living in PRS. These agencies are struggling to manage competing demands from different groups of people in the community experiencing mental health problems. A review of the process to identify when

case managers are unable to fulfil these needs and to trigger alternative support would help address the compromises that agencies are currently struggling to balance; and

- formal processes to encourage coordination to assist the multiple agencies to develop effective relationships for coordination. The processes need resources and regular review to check their continued application to current policy context.

5.4 Private Residential Services Operators

PRS operators and focus group participants were asked what support they thought PRS operators need to help residents access support services. In addition to comments about the need for financial resources to support service improvements (Section 3), operators commented on the limitation of availability of support services (Section 5.1). Suggestions on how to increase access to support services for residents by improving support to PRS operators included:

- opportunities for training for management and staff, such as on-site, joint with other agencies, and formal training (eg. Certificate IV). The benefits include developing understanding about support needs and relationships with support agencies;
- support mechanisms to assist them to refer residents to the support they need, such as a single point of contact in a support agency to coordinate the requests for support;

A focus group participant commented that service providers need to recognise the amount of time it takes for owners to deal with multiple agencies, 'The number of agencies they need to deal with is very overwhelming – they're case managers without the skills, training and tools.'

- information about support services, such as an information manual and a point of contact;
- opportunities to build relationships of trust between support service providers and operators, such as joint training, information sessions and meetings, to improve the mutual understanding and respect about what each contribute. A focus group participant pointed to the success of RSP structures, 'Meetings with managers help build a closer relationship between workers and operators and really helps. People feel more comfortable and more able to raise issues on a non individual level.'; and
- better information from referring agencies when a person is referred to live in a PRS. They could then act to avoid some crises that are dependent on knowing the information and be more active in providing information to residents about relevant support services. Recommendations about confidentiality, duty of care and risk management in this situation were included in Robinson et al (2004), a review of referral processes to PRS.

6 Conclusion

The report has developed a profile of people living in PRS including their characteristics and vulnerabilities. This has been applied to estimating their service use and unmet need. In general the profile data show that people living in PRS compared to other people are more likely to have support needs; less likely to access support services; if they do receive support services, they are likely to receive less services; and they are less likely to have informal carers or family members to support them. Their vulnerabilities and support needs are likely to be complex in two respects. They are likely to experience multiple vulnerabilities. They are also living in an environment that adds to their vulnerability in terms of the risk to safety from other people living in the facility and poor access to generic and specialist support services.

The findings have implications for support services policy in three ways: availability of support services, information and coordination. Only the first, availability of services, has significant implications for additional resource allocation. Information and coordination may require policy change in the organisation of support services, particularly the way service agencies work with people living in PRS; and the way they work with owners, operators and staff in the PRS and with other service providers. These would entail policy changes to the information and coordination practices of government agencies responsible for policy, funding and planning; and those of government, nongovernment and private agencies responsible for service delivery.

Appendix A: Research Process

Focus groups, meetings and interviews

Eight focus groups and meetings were held with a range of service provider, government, nongovernment agencies and operators. Meetings were conducted in Brisbane North, Brisbane South, Gold Coast, Townsville, Toowoomba, and Ipswich. A small number of individual interviews were also undertaken. A total of 88 people participated in the focus groups and interviews, representing the following agencies:

- Resident Support Program (18)
- HACC programs (4)
- Mental Health (8)
- Department of Housing (9)
- Community Visitors (6)
- Advocacy and tenancy advice agencies, including systemic advocates (11)
- DSQ programs (7)
- Non government agencies (5)
- Homeless services (2)
- Private Residential Services (12)
- Other (service not noted) (6).

Targeted effort was made to supplement the focus groups by conducting individual and group interviews with key stakeholders who were either unrepresented or under-represented in the focus groups. This ensured that an adequate cross section of agencies representing a broad range of PRS residents had the opportunity to contribute to the research. In addition, researchers attended a meeting of operators and owners organised by SAPA to contribute to the research. Findings from the meeting are referred to as ‘SAPA meeting’ in the text.

Data on resident experiences was drawn from the focus groups and interviews with other interested people and research from previous projects in the residential services reform. Residents were not interviewed to avoid the risk of potential negative impact on this population arising from their participation.

Operator survey

A short questionnaire for all operators (322) was distributed to gather data on the profile of residents (number and vulnerabilities); and service need and use (service type). The questionnaire and follow up to operators was designed by the Consortium and DSQ. It was administered by DSQ with UNSW return envelopes. DSQ organised a supporting letter from SAPA. A remarkably high response rate (24%) was elicited, due in part to the persistence and support of DSQ and SAPA.

Survey data was obtained from 76 respondents. This sample is large enough to give meaningful information. Data quality is, for most sections of the survey, very good. ‘Part 3: Estimate of residents’ service use and need’ is more problematic. There are many more missing responses overall. There is also more missing data pertaining to need, where data pertaining to support received comprises fewer non-responses.

Many qualitative responses have been included, on nearly every survey ($n = 50$): in questions 5 and 6 where an 'other' option is included; question 7 'other comments'; and letters and reports attached to the survey. Some information relates to service need and provision, much relating to the issues facing owners/operators, also the unmet need of residents that respondents didn't feel the survey addressed. This useful information was used to supplement the focus group findings, particularly those concerning facilitators and barriers.

Literature review

A brief literature review was conducted for three purposes: to develop the research instruments; to compare to other states and countries; and to assist in critically informing analysis of the data. The review involved searches of recent research; electronic databases; published material; government and service provider reports; service organisations and academics.

Secondary data analysis

Data were available from the Office of Fair Trading Public Register of Residential Services, ABS Census, ABS Survey of Disability and Carers and the Commonwealth State and Territory Disability Agreement (CSTDA) National Minimum Dataset. The Consortium analysed these datasets for profile, service use and service needs in relation to people who live in boarding house-type accommodation or are homeless; people who live in long-term supported accommodation (institutional and community); and people in private households. Each dataset represents some aspect of the PRS population or contrast with them. The comparison between the groups provides the data for modelling service needs for people who live in PRS.

Published data from the Census data are only used for profiling some key socio-demographic characteristics of homeless people, and people living in boarding houses. Data from the SDAC and the CSTDA were used more directly to model need and service provision among people with disabilities in private households, in supported accommodation, and among the homeless and boarding house residents. Other published data were also used to estimate the profile, service use and service needs for other groups of people living in PRS.

In part because of limitations imposed by available data, and in part because of similarities between the two groups, the boarding house population and the homeless population have been merged into one group ('homeless/near homeless') in the analysis of CSTDA data. Chamberlain (Chamberlain et. al., 2007; Chamberlain and Mackenzie, 2003) argues that homeless people tend to cycle between different types of temporary accommodation that include shelters, as well as hostels and boarding houses, and that most homeless people spend at least some time in a boarding house. However, as noted in the text, and in Appendix Table A. 5, there are some important differences between the two groups: on average people in boarding houses are more likely to be male and single, and older than the general homeless population. Children, who make up a significant proportion of the homeless population, are less prevalent in the boarding house population.

The analysis of the SDAC in Section 2 attempts to account for these differences between boarding house and homeless populations by modelling levels of disability separately for each group, using demographic characteristic taken from the Census. For each group, a two stage reweighting process is applied (first age, then living

arrangements), to derive weighted samples that have similar age and living arrangements characteristics to people in the boarding house and homeless populations, as reported in the 2001 Census. Employed people are excluded from this reweighting exercise, as are children. As Table A.1 shows, the reweighting exercise involves giving lower weights to older people in the SDAC and higher weights to younger people; and considerably higher weights to single men who live alone in comparison with nearly all other population groups organised by living arrangements.

Table A.1: Reweighting factors used for the 2003 Survey of Disability and Carers to model boarding house and homeless populations.

	Age 15-34	Age 35-54	Age 55-64	Age 65+			
Boarding house	1.510	1.651	0.782	0.377			
homeless	2.032	1.428	0.572	0.201			
	Single man lives alone, not employed	Man in couple, no children, not employed	Man in couple, with children, employed	Single woman lives alone, not employed	Woman couple, no children, not employed	Woman in couple, with children, not employed	Single mother, not employed
Boarding house	5.51	0.17	0.22	1.05	0.14	0.10	0.31
Homeless	3.57	0.64	0.29	1.20	0.51	0.13	1.17

Source: Authors' calculations, derived from Census 2001 data as reported in Appendix Table A. 5.

Table A.2: Homeless and Near Homeless People in Queensland on Census Night, 2001 (absolute numbers)

	Boarding houses	SAAP	Friends and relatives	Improvised dwellings, etc.	Caravan dwellers	Total	(total excluding caravan dwellers)
BRISBANE AREA							
Brisbane City Core	1409	241	278	180	0	2108	2108
Brisbane Inner Ring	387	253	705	3	59	1407	1348
Brisbane Outer Ring	254	233	1111	37	821	2456	1635
Outer suburbs and growth corridors	295	312	1860	165	2039	4671	2632
<i>of which:</i>							
Gold Coast City Part A	14	86	144	13		257	257
Beau-Desert	13	0	81	15		109	109
Caboolture	38	60	328	39		465	465
Ipswich	156	68	236	14		474	474
Logan	0	65	441	17		523	523
Pine Rivers	3	10	216	16		245	245
Redcliffe	47	6	158	0		211	211
Redland	24	17	256	51		348	348
MORETON and DARLING DOWNS							
Gold Coast City Part B	421	150	1163	127	701	2562	1861
Sunshine Coast	56	101	835	33	506	1531	1025
Moreton SD Balance	78	3	539	425	557	1602	1045
Toowoomba	139	79	255	10	105	588	483
Darling Downs SD Balance	50	1	250	2	263	566	303
FAR WEST							
South West					59	252	193
Central West					40	290	250
North West					237	967	730
COASTAL QUEENSLAND							
Bundaberg	94	32	197	33	205	561	356
Wide Bay-Burnett SD Balance	154	68	711	545	441	1919	1478
Hervey Bay	30	16	255	67	293	661	368
Rockhampton	174	57	208	43	158	640	482
Gladstone	30	49	166	66	120	431	311
Fitzroy SD Balance	39	16	474	196	268	993	725
Mackay	87	18	220	23	186	534	348
Mackay SD Balance	132	7	856	266	512	1773	1261
Townsville	358	178	570	104	188	1398	1210
Northern SD Balance	423	0	296	115	190	1024	834
Cairns	365	163	708	33	533	1802	1269
Far North SD Balance	162	34	873	852	388	2309	1921
TOTAL	5137	2011	12530	3325	8869	33045	24176

Source: Chamberlain and McKenzie (2004)

Table A.3: Characteristics of People who are Homeless in Australia and Queensland on Census Night, 2001

	Australia		Queensland	
	N	per cent	N	per cent
All	99900		24569	
Rate of homelessness (per 10,000 population)		52.7		69.8
Boarding houses	22877	22.9	5346	21.8
SAAP accommodation	14251	14.3	2285	9.3
Friends and relatives	48614	48.7	13069	53.2
Improvised dwellings, sleeping out, etc.	14158	14.2	3869	15.7
Male	57942	58.0	14496	59.0
Female	41958	42.0	10073	41.0
Age under 12	9941	10.0	2328	9.5
Age 12-18	26060	26.1	6381	26.0
Age 19-24	10113	10.1	2264	9.2
Age 25-34	11567	11.6	3603	14.7
Age 35-44	12992	13.0	2985	12.1
Age 45-54	10349	10.4	2778	11.3
Age 55-64	7883	7.9	2549	10.4
Age 65+	5995	6.0	1681	6.8
Non-indigenous		91.5	1918	90.7
Indigenous		8.5	22487	9.3
Rate of non-indigenous homelessness (per 10,000 population)				66.0
Rate of indigenous homelessness (per 10,000 population)				164.0
Single	58116	58.2		
<i>of which:</i>				
<i>single adult males</i>	39056	67.2		
<i>single adult females</i>	19093	32.9		
Adults in couples	18840	18.9		
Single parents	3980	4.0		
Couples with dependent children	5531	5.5		
Children	13401	13.4		

Source: Chamberlain and MacKenzie (2003, 2004)

Table A.4: Characteristics of People in Boarding Houses in Australia on Census Night, 2001

	N	per cent
All	22877	100.0
Male		72.0
Female		28.0
Indigenous		7.1
Non-indigenous		92.9
Age 0-14	1298	5.7
Age 15-34	8416	36.8
Age 35-54	7337	32.1
Age 55+	5826	25.5
Capital city		67.0
Regional centre, remote location		33.0
Single adults	19178	83.8
<i>(of which: single adult males)</i>	15034	78.4
<i>(of which: single adult females)</i>	4144	21.6
Adults in couples	1284	5.6
Single parents	366	1.6
Couples with children	732	3.2
Children	1317	5.8
Employed		26.0
Unemployed/not in labour force		74.0
Personal income less than \$300 per week (aged 15+ only)		71.0
Personal income \$300-499 per week (aged 15+ only)		14.0
Personal income \$500 or more per week (aged 15+ only)		15.0

Source: Chamberlain and MacKenzie (2003)

Table A.5: Australia's Boarding House and Homeless Populations compared, Census Night 2001 (per cent)

	Boarding House	Homeless
<i>Age</i>		
Age 0-14	6	18
Age 15-34	37	43
Age 35-54	32	24
Age 55+	25	15
<i>Sex</i>		
Male	72	58
Female	28	42
<i>Indigenous status</i>		
Indigenous	7	9
Non-Indigenous	93	92
<i>Family status</i>		
<i>Adults</i>		
Single males	66	39
Single females	18	19
Couples without children	6	19
Couples with children	3	4
Single parents	2	6
Children	6	13

Source: Chamberlain and MacKenzie (2003)

Notes: percentages of homeless in age categories 0-14 and 15-34 and interpolated by the authors from different categorisations provided by Chamberlain and MacKenzie. Percentages in different family types are imputed by the authors. Percentages who are indigenous based on incomplete information: only about 80 per cent of homeless Census respondents appear to have reported their indigenous status.

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