Office of the Public Advocate

Status report on Supported Residential Services (SRSs) – Sept 2009

Introduction

What are SRSs?

Supported Residential Services (SRSs) are privately owned and run facilities that fall under the regulatory umbrella of the *Health Services Act 1988* and associated SRS regulations. In section 3 of the Act, they are defined as 'premises where accommodation and special or personal care are provided or offered for persons [other than family members of the proprietor] for fee or reward', not including Commonwealth or State funded residential care services. Supporting the Act is the *Health Services (Supported Residential Services) Regulations 2001*, which prescribes 'minimum standards for the care and wellbeing of residents' alongside registration and administrative procedures.[1] The Department of Human Services has responsibility for regulating SRSs.

As long as they meet their regulatory requirements, SRS proprietors are free to make decisions about their business model, including fees and range of services, and to whom they provide accommodation. This has meant that over time, and in response to changing economic and policy drivers, SRSs have employed a range of business models. Despite this diversity, facilities are often categorised into two broad groups: pension-level facilities and the rest.

The department defines an establishment as pension-level if 80 per cent or more of its residents are paying fees less than or equal to the maximum Age Pension ($569.80 per fortnight or $40.70 per day)[2]. And while pension-level facilities are defined by the fees charged, their age and disability profiles are very different to those of above-pension facilities; for example, pension-level residents are generally younger and more likely to have a mental illness or intellectual disability than above-pension residents. The Community Visitors Program[3], which works to safeguard the interests of people with disabilities in accommodation and support services (and mental health treatment facilities), decided to target its efforts in the SRS sector towards pension-level facilities to better address the concerns arising in those facilities. Hence, it visits all pension-level facilities monthly and other facilities quarterly. Community Visitors also visit in response to resident or third party complaints about facilities or their work practices.

The types of personal assistance provided by SRS staff include help with tasks of daily living, general supervision and administration of medication.

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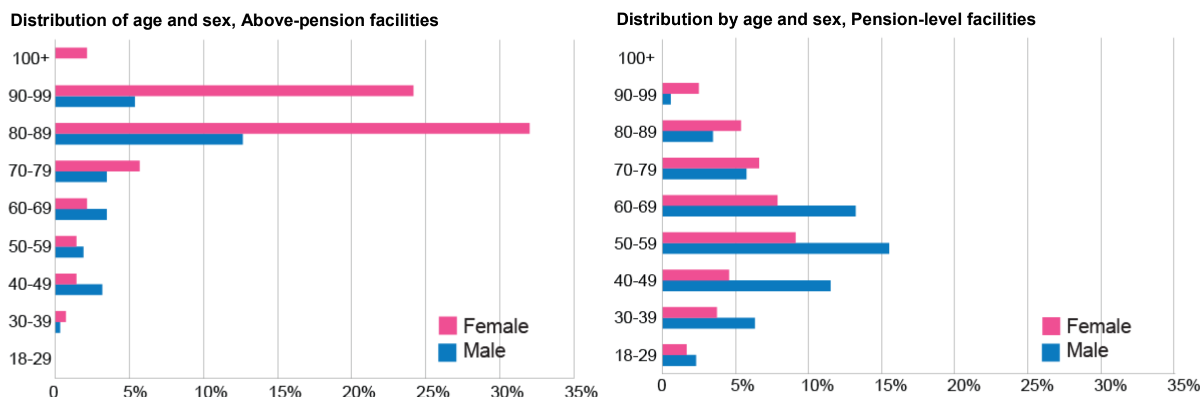
[1] The government has a review of the regulation of Supported Residential Services in Victoria underway, that will recommend changes to the Act and the regulations.
[2] Single age pension rate as at 1 July 2009, accessed on 25 August 2009 from http://www.centrelink.gov.au/internet/internet.nsf/payments/age_rates.htm.
[3] The program is managed by the Office of the Public Advocate.

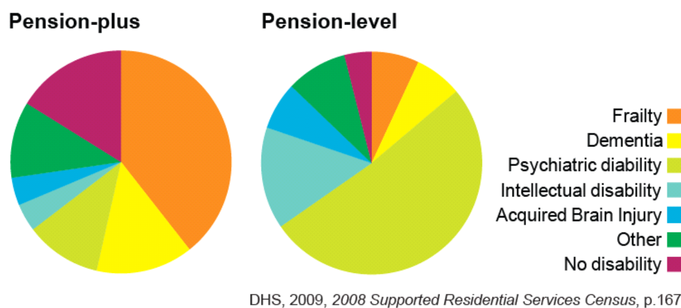
Who lives in SRSs?

The Victorian Government identifies residents in the sector as 'amongst Victoria's most vulnerable and disadvantaged citizens' and recognises both the increasing proportion of residents with mental illness and the growth in the proportion of residents with complex support needs (DHS 2006, p. 1).

The *2008 Supported Residential Services Census* (DHS 2009b) provides the most up-to-date and comprehensive information available on SRS resident characteristics.



The differences in the age and sex distribution of residents by facility type are striking: more than one in two people in above-pension facilities are women over 80 years old, compared to less than one in ten pension-level residents. Pension-level residents are more evenly distributed by age and sex; notably there are fewer women than men and more than three quarters of residents are younger than 70 year old.



DHS, 2009, *2008 Supported Residential Services Census*, p.167

Reflecting these different age profiles, the majority of above-pension residents reportedly have either age related frailty or dementia as their main disability. Fewer pension-level residents suffer from these age related conditions: almost three in four residents have either a psychiatric (mental illness) or intellectual disability, or an acquired brain injury (ABI).

As the pie charts show, people who live in SRSs have a variety of disability types and associated care needs. However, in general, residents require some assistance with daily living – for example, they need monitoring to ensure they eat regularly and take their medication or need help with personal hygiene tasks – but who mainly have 'low-care' needs (that is, they are not bedridden and do not need nursing care).

Community Visitors and Advocate/Guardians have both identified poverty, social exclusion and a higher incidence of difficult behaviours among pension-level SRS residents. The census does not provide information on residents' income levels but does support reports of social exclusion and presence of 'behaviours of concern'. Only 45% of pension-level residents see family or friends more than once a month, and a quarter (26%) never see family or friends, compared to just 4% of residents in above-pension facilities. Pension-level residents are

significantly more likely to exhibit 'behaviours of concern' (49% compared to 31%); the most common behaviours reported are low motivation (29%) and verbal aggression (20%).

In 2001, the Department of Human Services identified some common functional characteristics of pension-level residents: poor to very limited living skills; likely to exhibit institutional behaviour through active psychosis and constant challenging/disturbed behaviour; needs that may be subject to rapid change; poor to severe memory problems and poor insight and decision-making skills; poor social skills and chronic health problems (p. 8). The Office of the Public Advocate continues to see these characteristics among this group of residents.

At 30 June 2008, approximately one third of all SRS beds were pension-level.

What role do SRSs play in the supported accommodation sector?

SRSs are just one form of supported accommodation: others include federally subsidised aged care hostels, nursing homes, retirement villages, government funded mental health services (including secure extended care units and community care units) and disability services (including congregate care, shared supported accommodation and respite beds).

The main thing that distinguishes SRSs from other supported-accommodation options is that SRSs are private businesses and are not government funded or subsidised – with the recent exception of pension-level facilities receiving 'cost-relief' funding from state government. This means that SRSs are heavily, if not solely, reliant on resident fees to meet their operating costs. This helps explain the striking differences in the demographic profiles of pension-level and above-pension facilities: younger people with lifelong disabilities are less likely than elderly people with age related disabilities to be able to pay higher fees and so end up in facilities with less to spend on facility maintenance and staff. Also, unlike the majority of the supported accommodation sector, SRSs do not cater for a specific client group (for example, people with an intellectual disability or of a specific age group).

In practice, pension-level SRSs meet the pressing need for supported accommodation from a group of people, with a range of disabilities, who cannot afford to finance their own care and who are either ineligible or on a waiting list for government subsidised supports. SRSs with fees substantially above pension-level provide accommodation and care to people who can afford to pay. There are also a group of above-pension level facilities, concentrated in the eastern suburbs, that charge fees not far above the pension rate. This section of the SRS sector in particular has experienced decreasing demand over time.

The SRS sector has been significantly affected by changes to state and federal government policies and programs. Deinstitutionalisation and growth in Home and Community Care (HACC) services and aged care hostels have altered the environment SRSs operate in, and the client group they see. In particular, HACC services have assisted a traditional SRS resident group of aged pensioners with relatively low dependency levels to remain at home or enter subsidised hostels (Green 2001, p. 13). Community Visitors also report that a significant number of people moved to an SRS post-deinstitutionalisation (OPA 1998), and Green's *Advice to the Department of Human Services on Supported Residential Services* (2001) noted that mental hospitals were 'dumping' long term patients into SRSs, particularly in the early 1990s (p. 17). People with a mental illness or ABI were more likely than people with an

intellectual disability to enter the SRS sector, as people with an intellectual disability often entered government funded group homes (Bostock, Gleeson, McPherson et al. 2001).

In 2001, Green wrote that 'the pension only SRSs have become last resort accommodation for some patients, clients or residents who are considered problematic by other professional, subsidised service systems' (p. 38). This group includes many people at risk of homelessness, including people with alcohol related acquired brain injuries and early onset dementia, and people with difficult behaviours. In part, this is because the funded supported accommodation system that developed in the wake of deinstitutionalisation caters to people with high support needs, has strict eligibility criteria and long waiting lists (Green 2001). People with lower but not insignificant support needs are shut out; and some of these people currently have no alternative but an SRS.

In the eight years since the Green Report, government policies have assisted a section of the population previously reliant on SRSs to access more tailored, community-based care. While these are positive developments for those people assisted, these developments have nevertheless placed additional pressure on the SRS sector.

Pension-level SRSs have no mandated entry criteria and so function as a catch-all for people who need support and accommodation but cannot find it elsewhere. Office of the Public Advocate Advocate/Guardians have observed that there are very few pathways out of pension-level SRSs for residents; the 2008 SRS Census supports this observation: average (mean) length of residency in a pension-level SRS is over three years (37 months) (DHS 2009a, p. 138).

What contact does the office have with SRS residents?

The Office of the Public Advocate has contact with SRS residents and their issues in three main ways. Where:

- Community Visitors visit SRSs and talk to residents to carry out their functions under the *Health Services Act 1988* (in 2007/08 Community Visitors undertook 1,313 visits to SRSs);
- the Public Advocate is appointed legal guardian of a person who lives in an SRS or the Public Advocate decides that it is in the best interests of the represented person (the person they are guardian for) to move into an SRS; or
- an SRS resident or someone concerned for an SRS resident uses the office's Advice Service.

The current situation

A struggling sector

The SRS sector has struggled with financial viability for many years (Sach 1987; Green 2001). This is particularly evident in the pension-level sector: between 1993 and 2001 they lost almost half of their 4,500 pension-level beds. The decline stabilised somewhat, likely assisted by the government's SRS Supported Accommodation for Vulnerable Victorians Initiative (SAVVI), which provides money to improve the financial viability of pension-level

facilities. In June 2008, there were approximately 2,200 pension-level beds in the sector (OPA 2008). Apart from the recent, time-limited funding from SAVVI, SRSs do not receive government subsidies.

SRS viability has suffered under cost increases linked to increased dependency and care needs of residents, increased rental costs, and increased regulatory compliance costs. Increases in running costs without a corresponding rise in the operating budget means residents are more likely to live in poor quality accommodation and be deprived of necessary supports (as maintenance and staffing budgets are squeezed). This in turn impinges on the capacity of facilities to fulfil resident rights to safety, privacy and security of tenure.

In 2001 Green stated that many pension-level facilities failed to meet community standards and legislative requirements 'at least some of the time and the majority of those are unlikely to be able to consistently reach the appropriate standards given the fundamental business weaknesses they exhibit' (p. 39). Subsequent Community Visitor reports suggest that many pension-level facilities still fail to meet community standards, as do some above-pension facilities. A review of Community Visitor Annual Reports from 2002/03 to 2006/07 showed multiple references to building maintenance and cleaning issues, further:

> The annual reports present examples of institutional practices in certain facilities: evening meals served at 5pm or earlier; residents locked out of their rooms during the day; residents not permitted to go out in the evening; residents having no say in the menu. Residents can have difficulty protecting their right to privacy because of facility design: many pension-level facilities have shared bedrooms and some have no space to make private phone calls. (OPA 2009, p. 28)

Linked to financial viability issues are the skill levels of proprietors and personal care staff: business budgets limit the salaries they can offer staff. Community Visitors have long been concerned that SRS staff do not always have the necessary skills to identify and meet residents' health and wellbeing needs; particularly those residents with multiple and complex needs. Data from the 2008 SRS Census suggests that one in three (33%) personal care workers in pension-level facilities have no qualifications, and just 13 per cent have a Certificate IV level qualification or higher (DHS 2009b, p. 88).[4] This staff skill profile could also be the result of the current regulations governing SRSs, which only require one SRS staff member to hold at least a Certificate III qualification in personal care.

Residents without a future

Many pension-level SRS residents are referred to an SRS in a time of health or accommodation crisis by mental health services, family, hospitals and disability case managers. Once settled, contact with and support from the referring body is often lost. A DHS survey in the eastern metropolitan region in 2001 estimated follow-up from referring agencies to be less than fifty per cent (Hage 2001). Lack of follow-up and outside interest in these vulnerable residents, with the exception of Community Visitors, leaves residents without access to independent advocates. This is especially problematic for many pension-level

[4] These figures exclude 'other staff', hence the proportions capture the proportion of personal care staff with different levels of qualification.

residents who have irregular contact with family or friends, who can provide informal advocacy and support.

Although the principles stated in the *Health Services Act 1988* include that residents be provided with and encouraged to participate in 'physical and social rehabilitation', in practice this is not a focus of service monitoring and is not directly referred to in the supporting SRS regulations. Without a rehabilitation or skill-building focus,[5] SRSs are concerned with 'maintaining' residents' health and wellbeing. This lack of focus on people's futures increases the likelihood that residents will become disengaged from meaningful activity, leading to the 'worst outcomes of institutional care: aimless pacing, boredom, rocking, self-injury, sitting or standing around, wasted lives' (Clement & Bigby 2008, p. 2). Community Visitors frequently see these types of outcomes in SRS residents.

The office's Advocate/Guardians report that for their clients who are living in SRSs, there are very few pathways out – except moving to another SRS. This is because it is difficult to develop independent living skills in SRSs, to build up the cash reserves to meet the costs of private rental, to find alternative supported accommodation options for these clients, and to access public housing and Community Residential Units due to long waiting lists. Health care workers have reported that residents are de-skilled by the manner in which services are provided;[6] and Community Visitors have raised numerous concerns in recent years about poor care planning for residents. Some local and regional outreach initiatives[7] have identified pension-level SRS residents' vulnerable position and work to connect them to recreation opportunities or health services; however, these initiatives are not available in all areas.

That SRS residents are effectively stuck, until they become eligible for aged care services, is particularly concerning given research from 2003 that found that most boarding house residents would prefer to live in other, self-contained, accommodation (Anderson et al 2003, pp. 1-2).

Given the poor range of activities offered by many pension-level facilities[8] and that many residents have to rely on busy proprietors[9] to link them to other programs and services, residents are likely to become bored and de-skilled.

Conflicted regulators

The Department of Human Services (DHS) is responsible for supporting, regulating and monitoring SRSs, and prosecuting proprietors for breaches of the regulations. It is also responsible, alongside the federal government, for providing or funding the majority of the (already stretched) alternative supported accommodation options, and so would be directly impacted upon by an SRS closure. However, the department has successfully prosecuted a small number of SRSs in relation to breaches of regulations: 36 prosecutions in over 20 years. At the stage prior to prosecution, DHS Authorised Officers are responsible for auditing facility standards. The Office of the Public Advocate's Community Visitors are concerned that

[5] This issue is present in similar sectors interstate; research on the SRS equivalent sector in South Australia noted a lack of focus on building or learning skills among residents (Clark 2004).
[6] Residents are rarely involved in meal planning or preparation, and often cannot access laundry facilities.
[7] For example, EACH and Maroondah City Council
[8] Over half (58%) offer bingo, around a third offer music (39%), art (38%) or games (31%), and a fifth (22%) offer bus trips or outings (DHS 2009b, p. 223).
[9] Thirty-three per cent of pension-level residents have a case manager. (DHS 2009b, p. 213-16).

only 15 out of 56 of their concerns reported to the department's Authorised Officers have been substantiated by May 2009 in the financial year 2008/09 (DHS 2009, unpublished). It is, however, unclear whether this is because the regulations do not cover all areas of Community Visitors concern (who do not just report on whether facilities meet regulatory requirements but community standards) or because proprietors address the concerns raised by Community Visitors before the department investigates. Even when concerns are 'substantiated' by Authorised Officers they rarely prosecute, instead they prefer to support facilities to address the issues identified (often using an Action Plan).

It is worth noting that there is a review of the regulations governing SRSs underway which may change the scope of current SRS regulations. This may provide more protections to residents, for example, in the area of tenancy rights.

The root(s) of the problem(s)

Invisible residents

Poverty, lack of support to enable their full participation in the public sphere, and community attitudes to people with a disability contribute to SRS residents' invisibility. Indeed, most Victorians have not heard of SRSs and know nothing of the challenges facing many of their residents. Hence, community pressure – and political impetus – for changes to the sector are weak to non-existent. There are no examples of organised self-advocacy or advocacy from resident family members, as seen among those involved with disability or mental health services.

There are community service organisations and advocacy organisations that are aware of the problems presented by the SRS sector, and a number are working together on a regional basis to coordinate services and individual advocacy for SRS residents. The Community Visitors Program has been monitoring SRS standards since its inception in 1986, and has provided regular feedback and recommendations to the department for improvement, including through the Community Visitors Annual Reports. While this feedback has contributed to positive policy and regulatory change, and Community Visitors have advocated for better outcomes for many individual residents, the office has struggled to raise the public profile of SRSs.

Strategies to empower residents to advocate for themselves, improve community awareness of the sector and promote social inclusion of residents, will all help address the invisibility problem. Real social inclusion is more than just going on a day trip. It is about developing relationships and participating in society – for example, involvement in sporting clubs or neighbourhood houses. Local councils, community and advocacy organisations are all well placed to work with SRS residents towards realising more independent and more community connected living.

While SRS residents are not defined as among the 'tertiary homeless' for the purposes of COAG's National Partnership Agreement on Homelessness, COAG goals nevertheless have the potential to improve the living situation of people currently living in SRSs as well as people who would otherwise end up in an SRS. Among other things, the agreement (COAG 2008) seeks to provide supports for people leaving correctional or health facilities to access and maintain secure housing, and it seeks to provide assistance for older people who are homeless or at risk of homelessness.

Dearth of supported accommodation options or a 'housing continuum'

The lack of available supported accommodation options for people with care needs in Victoria is well documented. Community Visitors annual reports over the last decade have noted bed shortages in mental health services and use of disability services respite beds for long-term placements. In 2008, the Victorian Auditor-General (2008) found that DHS Disability Services were unable to provide support to 30 per cent of the people who had requested support (1370 out of 4567 people). In addition, in 2006, it was estimated that in a given year 44 per cent of people with a severe mental illness did not receive services, which would include residential treatment services, and that over 340,000 people with a mild to moderate mental illness received no treatment (DHS 2008, p. 28).

This lack of alternatives, alongside tight eligibility criteria that exclude people who do not fit the 'criteria' of disability and/or mental illness within human services frameworks,[10] means that at least some people are living in SRSs because they have no other choice: not because they want to or because an SRS is best able to meet their care and rehabilitation needs. These individuals are being deprived of rights recognised in the 2006 UN Convention on the Rights of Persons with Disabilities (CRPD), including the right to choose where and with whom you live.

In 2001, the Green Report found that 'pension only SRS (sic) have become last resort accommodation for some patients, clients or residents who are considered problematic in other professional, subsidised service systems' (p. 38). The report also cited a literature review that found that service models similar to SRSs are not generally the first preference for people with a long-term mental illness and can be counterproductive to their quality of life. Many of this cohort preferred independent or small group housing with support from community-based agencies (p. 38). However, for some people the lack of alternate accommodation makes pension-level and low-fee SRSs their only alternative to homelessness.

There is supporting anecdotal evidence that many people entering pension-level SRSs have no other options available to them. Advocate/Guardians from the Office of the Public Advocate say they prefer not to place represented persons in SRSs, but do choose an SRS when it is the best of the accommodation options available to that person. Guardians cite long waiting lists and tight eligibility criteria for preferred options as key reasons for placing represented persons in SRSs.

The Office of the Public Advocate has regularly called for improvements to the accommodation options for people with complex needs, including through additional funding to public housing for people with a disability and new funded models of supported accommodation for residents whose needs are not currently met by SRSs.

While supporting people with complex needs to live independently is not easy, it is possible. Evaluation of a demonstration project in South Australia that aimed to 'enable people with complex needs to establish and maintain successful tenancies' (Slowinski & Rogers 2007, p. 1) by providing stable independent housing and person-centred and flexible support, found the participants experienced a range of positive changes.

Under-resourced support services and packages

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[10] For example, people with Huntington's Disease or a dual disability.

Some of the people currently living in SRSs may prefer to live in independent housing and access supports that allow them to maintain their independence, as is their right under the CRPD. Independent living may be possible for these residents as long as the right supports are available. However, as the numbers of people with unmet support needs seeking and requiring disability and mental health services testify, supported accommodation is not the only form of support in short supply.

Community Visitors have identified circumstances where SRS residents have inadequate support or opportunities to participate in social activities and where SRS residents have received inadequate health care. These conditions affect the health and wellbeing of residents: increasing the likelihood of emergency hospital admissions and residents suffering from boredom or depression.

As SRS regulations have not successfully addressed these issues, which have been repeatedly raised by Community Visitors over a long period, there is a clear need for additional support services targeting current SRS residents and for better links for residents to available services. Mental health services to prevent crises and rehabilitation to progress independent living goals would improve the wellbeing of many current residents. Outreach services that connect people with health care as well as opportunities for social participation are very valuable.

Reliance on the SRS band-aid

The State Government has been given much evidence that pension-level SRSs are not financially viable (Sach et al 1987; Green 2001) and are struggling to meet minimum regulatory standards (OPA 2007; OPA 2008). Unfortunately, government continues to depend on SRSs to fill a large gap in the supported accommodation market. While it has sought to address some of the problems using SRS regulatory reform, this has had little influence on the types of concerns expressed by community visitors and other stakeholders. More recently (2004-2009), the government has provided money ('cost-relief') to the pension-level SRS sector via SAVVI.

This tacit reliance on SRSs to meet the need for supported accommodation is not new. A poorly resourced deinstitutionalisation process across the 1990s has resulted in the accommodation of many people in SRSs who would otherwise have been in institutions.[11] While the Office of the Public Advocate supports deinstitutionalisation, the ideal of living in the community with supports has not been achieved for many in pension-level SRSs. Indeed, Community Visitors have labelled SRSs the 'new institutions' because of the rules and practices observed in some facilities (OPA 2007).

In order to ensure that SRSs only accommodate people who want to live in this type of setting and whose needs are met by the resources available, government needs to identify the client group whose needs are not met by the funded service systems and find other ways to fill these service gaps. To this end, OPA supports the current review of Supported Accommodation for Victorians with a Disability or Mental Illness. Government also needs to increase the

[11] Initially, the vast majority of people with an intellectual disability were housed in small group supported accommodation. Over time, the proportion of people with an intellectual disability has increased as funding for additional places has not kept pace with demand. People with a mental illness were most likely to have nowhere else to go when institutions closed.

availability of low cost accommodation in locations close to transport and services, and enhance support to maintain 'at-risk' tenancies.

Band-aiding SRSs

As private sector businesses, SRSs are subject to the ebbs and flows of demand for their services as well as changing profitability. For example, some businesses have been propping up their finances by taking in hospital patients on interim care arrangements because it is more profitable than housing another long-term resident; other businesses have become rooming houses or registered aged care facilities. For this reason, even without targeted government action, the SRS sector is likely to look quite different in ten years time.

In the meantime, government must do more (than SAVVI) to address the dire situation of many pension-level SRS residents. OPA sees many pension-level SRSs without the financial capacity or skilled staff to adequately care for their residents, however other accommodation options need to be developed before these residents can be moved. The section above proposes some options for addressing the root causes of the problems evident in the SRS sector. This section identifies some strategies for promoting the wellbeing of residents who currently have no other accommodation options.

Connecting with residents with mental health issues

The DHS 2008 Census reports that 62 per cent of pension-level SRS residents have a psychiatric disability (as identified by the facility manager/proprietor) (2009b, p. 168). The census reports that the majority of these residents receive psychiatric care from a GP (61 per cent) and 41 per cent have a mental health case manager (p. 186).[12] The census also reports that the vast majority of residents with a psychiatric illness only receive care from one health provider (p. 186).[13]

The census does not look at the effectiveness of the psychiatric care provided, but having so many residents (between 43% and 59%) treated solely by their GP raises questions. While, GPs do play a very important role in mental health care, and provide ongoing care for many people with a mental illness, is this level of care sufficient for patients with the complex needs presented by this resident group?

State and local government need to work together to ensure the mental health care needs of pension-level SRS residents are met. Realising the prevalence of mental health issues in pension-level facilities, and the vulnerable nature of the residents, governments need to further promote resident access to mental health services, in particular pro-active outreach services.

Addressing social exclusion – targeting SRSs

The majority of pension-level SRS residents suffer from multiple disadvantages: low-income, disability and insecure tenure. These factors put residents at substantial risk of social exclusion. In addition, one in two residents sees family or friends from outside their SRS less than once a month (DHS 2009b, p. 246). Because of residents' low incomes, they are often

[12] note: multiple responses were accepted, hence totals add to more than 100 per cent.
[13] Responses add to 118%.

reliant on organised activities to get them out of the SRS on a regular basis. In 2008, the SRS Census found that 34 per cent of pension-level residents attended a social or recreational program, 29 per cent participated in a community-based group and 21 per cent attended an organised disability program once a week or more (DHS 2009b, p. 241). Given that some residents may be involved in more than one form of activity, it is unclear from the data how many pension-level residents were not involved in any activities outside their SRS at least once a week. Experiences of the Community Visitors Program suggest that the likely number would be low.

To promote social inclusion of SRS residents the Maroondah City Council runs a Supported Residential Services Project. The project employs a Community Development Worker to provide support to residents in pension-level facilities and enhance their participation in the community. The worker promotes awareness in the community and in government of SRSs.[14] The council also has some funds for transport and activities arranged by the worker. This project enabled the development of collaborative programs for SRS residents with Eastern Access Community Health (EACH). The regional focus of the project has allowed the worker to build relationships with local service providers and work collaboratively to benefit residents. The worker helps overcome common barriers to service access by providing transport and even assisting residents to get ready to go out where necessary.

This is just one example of regional health and community services working collaboratively to support SRS residents. OPA recommends that state and local governments look at ways of learning from and further supporting these efforts, including prioritising pension-level SRS residents in programs and activities designed to reduce social exclusion and improving access to preventative health services.

Going some way towards addressing social exclusion in SRSs, the Victorian Government's *Community Connections* program (part of SAVVI) began operating in 2009: program goals include improving resident social participation and access to services, and enhancing SRS viability by building staff capacity.[15]

Case management for all SRS residents

While 33 per cent of residents in pension-level facilities have a case manager, the majority do not (DHS 2009b, p. 213). Further, Community Visitors note that proprietors have complained that case managers of their residents can be hard to contact.

The main role of a case manager is to assist their client to access the services and supports they need and apply for relevant funding to support their client's goals. In some cases, family members fulfil part of this role. In other cases, community advocacy organisations are involved.

However, two out of three residents in pension-level facilities have no case manager and less than half of residents see a friend or relative at least once a month. Without a case manager, advocate or active family member, pension-level residents have no one to support them to access the services and programs they need. The high incidence of disadvantage and social exclusion faced by residents, and the high number of residents who have no case manager and

[14] http://www.maroondah.vic.gov.au/SupportedResidentialServices.aspx accessed 24 June 2009.
[15] http://www.health.vic.gov.au/agedcare/services/lowcost/savvi.htm accessed 24 June 2009.

little family support, strongly suggest the need for pro-active outreach with case management services offered to pension-level residents.

These services are available in at least some regions, for example Doutta Galla's Community Connections program in the inner west, however high levels of social isolation and resident boredom seen by Community Visitors suggest that these types of programs need more resourcing.

Key services

In the absence of a case manager or other advocate to promote resident access to appropriate services, it is important that pension-level SRS residents be reviewed by ACAS on a regular basis. The White paper on homelessness identifies the elderly homeless as a 'special needs' group and Wintringham believes that this will help elderly people who are homeless access aged care services (Lipmann 2009). As many SRS residents are at risk of homelessness, this shift may support a proactive approach by ACAS.

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