

**Advice to the  
Department of Human Services  
On  
Supported Residential Services**

(Green Report August 2001, updated 2004)

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## **Part 1**

# **The Background And Context**

# Chapter 1: Project Requirements

On 9 December 1999 the Annual Report of Community Visitors appointed under the Health Services Act 1988 was laid on the table of the Legislative Assembly. That Report opens<sup>1</sup>:

*After nearly a decade of consistent visiting under the Health Services Act 1988, Community Visitors conclude it is time for a complete rethinking of the role Supported Residential Services (SRSs) play in the Victorian health care system. It is time to unpack the bundle of services provided by the SRSs and see how best to fulfil the various roles they perform.*

In arguing for a review of the industry, Community Visitors stressed that any reforms must result in better accommodation and community access. Community Visitors were also concerned to address the relative isolation of SRSs from the rest of the service system and the impact of the emergence of new models of supported accommodation.

Acknowledging that Community Visitors had produced a number of annual reports raising proposals that had remained largely unanswered, the Minister for Housing and Aged Care requested further advice on priorities for policy implementation and this project was commissioned by the Director Aged Community and Mental Health.

It was clear from the outset that what the Minister wanted was not another glossy document to sit on a shelf somewhere and gather dust, but a coordinated set of practical strategies that would address the needs of residents. Substance was to take precedence over form and reality over rhetoric.

The Project Outline, therefore, requires the presentation of policy options that will<sup>2</sup>:

1. improve the responsiveness of Departmental officers and programs, and funded services, to the needs of different client groups living in pension only SRSs;
2. encourage the enhancement of the skill levels of personal care workers in pension only SRSs;
3. ensure that residents of pension only SRSs aged over 65 years are assessed by an ACAT and, if eligible, are assisted to secure appropriate care options;
4. improve Departmental processes in relation to monitoring compliance with legislative requirements;
5. improve Departmental processes in relation to determining the suitability of prospective proprietors, the registration system and processes around approving new facilities; and
6. ensure the adequacy of alternative accommodation options available for residents of pension only SRSs, particularly those residents faced with dislocation from facility closure and those assessed as eligible for Commonwealth funded residential care.

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<sup>1</sup> Office of the Public Advocate (1999), *Annual Report of Community Visitors: Health Services Act 1988*, Melbourne, p. 1.

<sup>2</sup> Green, D. (October 2000), *Interim Report on Supported Residential Services to the Minister for Aged Care*, Department of Human Services, Melbourne.

Preparing viable policy proposals is a daunting task. It requires intense activity and coordination with other government decisions as well as consideration of the competing interests of those likely to be affected. The policy proposals, even then, are only the beginning of what can be a long process of checks and balances as the decision makers must weigh the 'expert advice' with input from both the stakeholder and bureaucratic arenas<sup>3</sup>.

This project represents one 'expert advice' component of the policy process in relation to the SRS industry in Victoria.

## Interim Report

An additional requirement of the Project was that advice be provided in October 2000 regarding any priority actions that could be taken by the Department of Human Services to improve the adequacy and effectiveness of its administrative and monitoring responsibilities.

Initial and immediate attention was given to this request and four proposals were briefly outlined for the consideration of the Department in an Interim Report. They were that the Department:

1. require all funded health and community service agencies to provide appropriate social and clinical assessments of their patients and clients referred to and placed in any SRS as a condition of their referral;
2. fund a selected number of appropriate, high quality, professional and clinical services to undertake a mentoring and support role to one or more SRSs in their region or catchment area;
3. consolidate the responsibilities involved in the administration of Part 4 of the *Health Services Act 1988* including those provisions that apply to SRSs; and
4. prepare or fund the development of contingency plans that can be activated on short notice in the event of a facility closure.

Whilst the interim recommendations were made with a number of qualifications (particularly in relation to the short time available for their preparation) and on the basis of several assumptions<sup>4</sup>, they have proven to be relatively robust in discussion with a range of industry stakeholders. They have, therefore, been included in the policy framework of this paper.

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<sup>3</sup> Bridgman, P. and Davis, G. (2000), *The Australian Policy Handbook, 2<sup>nd</sup> Edition*, Allen and Unwin, St Leonards, p. 1.

<sup>4</sup> *Op. Cit.* pp. 2 – 4.

## Chapter 2: Brief History of the Industry

The term ‘Special Accommodation House’ (SAH) was developed in the early 1970’s to distinguish those boarding houses that provided personal care services from those that did not. In **1973**, the then Liberal Government introduced the *Health (Special Accommodation Houses) Act* to Parliament to amend the *Health Act* and establish a code for the registration of those boarding houses that catered for older and handicapped residents. An SAH was then defined<sup>5</sup> as:

*a boarding house in which more than two of the persons exclusive of the family of the proprietor thereof who are lodged or boarded are persons –*

- (a) *who are 60 years or over; or*
- (b) *who are physically or mentally handicapped to the extent that their ability is significantly impaired-*

*but whose condition is not of such a kind as would require them to be lodged in a hospital or a nursing home.*

In **1980**, Parliament amended the Health Act again to correct a number of anomalies in the earlier legislation<sup>6</sup>. Those changes were supported by the making of new regulations for the SAH industry<sup>7</sup> in June of that year.

A **1983** Health Commission of Victoria Working Party identified further anomalies in the legislation and recommended that the distinction between boarding houses and SAHs should be based on the functional capacity of residents and not the age of the resident or the nature of their disability<sup>8</sup>. Following on from that work, the *Health Act* was further amended by Parliament in December **1985** and included the new SAH definition<sup>9</sup> of:

- (a) *a place which provides or offers to provide accommodation to persons (other than members of the family of the proprietor) and which provides or offers to provide special or personal care to the residents; or*
- (b) *a place that is registered under this Division –*  
*but does not include a place that under the regulations is exempt from this Division.*

Special or personal care was also defined as meaning one or more of the following:

- (a) *Assistance with feeding or dressing.*
- (b) *Assistance with the taking of medication.*
- (c) *Assistance with maintaining personal hygiene.*

In October 1985 the Minister for Health, the Hon David White MLC, initiated a major review of health legislation in Victoria, including those provisions relating to the SAH industry. In

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<sup>5</sup> *Health (Special Accommodation Houses) Act 1973, No. 8501, Section 2.*

<sup>6</sup> *Health (Special Accommodation Houses) Act 1980, No. 9374.*

<sup>7</sup> *Health (Special Accommodation Houses) Regulations 1980, SR No.207.*

<sup>8</sup> Health Commission of Victoria (December 1983), *Review of the Application of the Health (Special Accommodation Houses) Act to Boarding Houses and Other Lodging Places*, Melbourne, pp. 11 – 12.

<sup>9</sup> *Health (Amendment) Act 1985, No. 10262, Section 2.*

November that year he also established a Ministerial Review of Special Accommodation Houses. The Report of that Review (the Sandon Report) was presented to Minister White in March **1987**.

The Sandon Report identified a number of concerns about the standards of care and support for residents, particularly in the areas of<sup>10</sup>:

- (a) physical care and neglect;
- (b) quality and quantity of meals;
- (c) lack of disposable income;
- (d) lack of individualised care and rehabilitation; and
- (e) lack of privacy and personal space.

The Review also raised concerns about the ongoing financial viability of facilities that cater to the pensioner market<sup>11</sup> and recommended the implementation of a strategy with four key elements<sup>12</sup>:

- (1) the provision of community support services to residents in SAHs;
- (2) the continued expansion of community based accommodation options for older people and people with a disability;
- (3) legislation to protect residents' financial and legal rights; and
- (4) *the establishment of a Supported Accommodation Program in the Health Department.*

It was also noted that<sup>13</sup>:

*It is a sad comment that similar issues to those ... in the late 70's and early 80's are still being considered by this Review Committee, and that the intent of the 1980 legislation has not been achieved. SAH residents represent one of the most vulnerable and disadvantaged groups in our community. The guarantee of a reasonable quality of life and the protection of vulnerable residents is an integrally important component of the Government's policy on services for older and disabled people.*

The term Special Accommodation House was formally replaced with Supported Residential Service (SRS) with the passing of the *Health Services Act* in **1988**. An SRS was defined<sup>14</sup> as meaning a premises where:

- (a) *accommodation; and*
- (b) *special or personal care –*  
*are provided or offered for persons (other than members of the family of the proprietor of the premises) for profit but does not include a hostel.*

The previous definition of special or personal care was also significantly changed to mean:

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<sup>10</sup> Health Department of Victoria (1987), *Final Report: Ministerial Review of Special Accommodation Houses*, Melbourne, pp. 45 – 51.

<sup>11</sup> *Ibid.* pp. 85 – 111.

<sup>12</sup> *Ibid.* executive summary.

<sup>13</sup> *Ibid.* p. 1.

<sup>14</sup> *Health Services Act 1988, No. 49 of 1988, Section 3.*

- (a) *assistance with one or more of the following:*
  - (i) *Bathing, showering or personal hygiene;*
  - (ii) *Toileting;*
  - (iii) *Dressing or undressing;*
  - (iv) *Meals; or*
- (b) *physical assistance for persons with mobility problems; or*
- (c) *assistance for persons who are mobile but require some form of supervision or assistance; or*
- (d) *assistance or supervision in dispensing medicine; or*
- (e) *the provision of substantial emotional support.*

The minimum standards of safety and care of residents, and certain other matters authorised or required by the Act, were prescribed in the *Health Services (Residential Care Regulations)* that came into effect in **1991**.

The Act and Regulations put in place a more significant approvals and registration process for SRSs, established the roles of Authorised Officers and Community Visitors, and stipulated new minimum standards of safety and care for residents.

Whilst the definition of special or personal care has remained unaltered since 1991, the definition of an SRS has been amended twice to change the emphasis from service provision ‘for profit’ to ‘for fee or reward’<sup>15</sup> and to reflect changes in the funded residential care industry<sup>16</sup>. Additional amendments were made to the Act and Regulations in **1997** to strengthen the safety and care provisions and to allow for more substantial penalties in the event that breaches of those provisions are proven.

The SRS industry has been, and will continue to be, subject to legislated and policy changes that impact on the cost and revenue profiles of facilities. These changes have generally been applied as standards immediately applicable to new facilities and progressively applicable to existing facilities.

It has been argued that each of the changes mentioned below have disproportionately impacted on the viability of pension-level facilities, contributed to the continued pattern of closures in that sector of the industry, and further reduced the likelihood of there being new pension-level applicants for registration.

In response to ongoing concerns with resident safety and privacy the Department of Human Services introduced new Bed Number Guidelines in **1998**. The Guidelines were designed to remove ‘non-existent’<sup>17</sup> beds from facility registrations and to progressively reduce overcrowding and improve privacy in existing SRSs<sup>18</sup>.

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<sup>15</sup> *Health Services (Further Amendment) Act 1990, No. 53 of 1990, Section 2.*

<sup>16</sup> *Health Services (Further Amendment) Act 1997, No. 73 of 1997, Section 2.*

<sup>17</sup> Aged Community and Mental Health Division (June 1998), *Supported Residential Services Bed Number Guidelines*, Department of Human Services, Melbourne, 4.1.8.

<sup>18</sup> Aged Community and Mental Health Division (June 1998), *Supported Residential Services Bed Number Guidelines*, Department of Human Services, Melbourne, 4.1.1 – 7.

Since 31 March **1999**, all premises where food is prepared for ‘vulnerable people’<sup>19</sup>, including SRSs, have been subject to new food handling and storage procedures that have often included planning, process and physical design changes in line with the requirements of the *Food Act 1984*.

On 1 January **2001**, new minimum qualification and employment requirements came into effect for Personal Care Coordinators in SRSs<sup>20</sup>.

By 1 August **2002**, all existing SRSs are required to be sprinklered in accordance with new fire safety regulations. All facilities constructed since the mid-90’s are already sprinklered.

In terms of both numbers of registered facilities and numbers of registered beds, the SAH-SRS industry was at its peak in the early 90’s.

SRS REGISTRATIONS- SELECTED YEARS, 1980 – 2001.

Year	Registered Facilities	Registered Beds
1980	190	4,900
1983	240	6,100
1986	280	7,100
1989	305	8,400
1992	315	9,100
1995	280	8,300
1998	250	7,700
2001	240	7,100

Source: Department of Human Services registration records.

Note: Figures have been approximated as the number of registered facilities and beds vary across any given year.

In terms of providing care to financially disadvantaged people, the SAH-SRS industry is in long-term decline. There is a general consensus, though little data to support it, that the early industry was overwhelmingly dominated by the provision of accommodation and low level supervision and care to frail, elderly, pensioner residents with less complicating disabilities.

A 1986 survey conducted during the preparation of the Sardon Report indicated that about 74 per cent of registered facilities at that time were either entirely or primarily dependent upon pensioner residents<sup>21</sup>. With an industry capacity of approximately 7,100, that implies a pension only capacity of something in excess of 5,000 beds.

We again have an industry capacity of approximately 7,100 in 2001, but recent estimates of the pension only capacity are around 2,000<sup>22</sup>. Most of those pensioner residents are now younger people, that is 73% are under 70 years and only 9% are over 80 years, with a psychiatric or intellectual disability, or, where they are age pensioners, have complicating disabilities in addition to age related frailty.

<sup>19</sup> Food Safety Victoria, Public Health and Development Division (1999), *Guidelines for Safe Food Preparation in Health Care Facilities*, Department of Human Services, Melbourne, p. 10.

<sup>20</sup> *Health Services (Residential Care) (Personal care Coordinator) Regulations 1999, SR No. 95*.

<sup>21</sup> Sach and Associates (1987), *Viability of Special Accommodation: A Report to the Ministerial Advisory Committee of Special Accommodation Houses*, Ministerial review Committee of Special Accommodation Houses, Melbourne, p. vii.

<sup>22</sup> See, for example, Aged Community and Mental Health Division, (2000), *Supported Residential Services Census: May 1998*, Department of Human Services, Melbourne, p. 7.

A considerable number of reports on SRS have been released in the past 5 – 10 years, particularly since the gradual commencement of HACC funding and projects in the past decade. On the basis of a very extensive use of these local reports, relevant Government reports and enquiries, and the growing literature in support housing. This analysis of the industry and possible solutions to the problems have been made. The bibliography documents, the 190 references used for this report.

As the Report demonstrates, there have been substantial changes that have major implications for the policy and legislative frameworks in which the industry operates. These changes, and their significance, are consolidated for the first time in this paper.

Finally it should be noted that like Licensed Residential Centres in NSW, SRS are private for profit businesses that do not receive any Commonwealth or State Subsidy for supported accommodation and support for people with disabilities.

## Chapter 3: The Changes Since 1987

As noted in the previous Chapter, the Sandon Report was delivered in March 1987 after 18 months of intensive and extensive research, analysis, commissioned reports and consultation with many stakeholders and experts relevant to the then SAH industry and its role in the Victorian service system.

It presented a comprehensive package of measures directed towards both establishing the role of the industry in the Victorian health and community services system and addressing questions of industry stability, standards and performance.

The Review rejected the introduction of planning guidelines, the control of resident admissions and the subsidy of facilities as either ineffectual or counterproductive interventions in the supported accommodation market.

A full discussion of the recommendations and their implementation is not warranted in the context of the current review. Two or three matters are important, however, and I shall address these both here and in other sections of the Report.

In particular, the Sandon Report very carefully examined the question of business viability and the range of policy options available in that regard. Specific research into the ongoing business viability of facilities operating at the low-cost, or pension only, end of the industry was commissioned<sup>23</sup> (Sach & Associates). It is clear that many of the difficulties identified in that research have persisted, and some of them have become even more significant.

At the time of writing, the Sandon Report was largely accepted by the government of the day. Yet as measures were being put into place to implement the recommendations dramatic changes were beginning to occur in the industry, some of which had profound impacts on the financial viability of SAHs and their ability to meet the standards required of them. The Report anticipated some of those changes, but could not have foreseen either their range or ultimate impact in the context of the Victorian health and community services system.

The world was changing, and before the ink was dry on the implementation plans complaints and concerns were being raised, particularly in relation to standards at the pension only end of the industry. Those complaints and concerns have been heard again and again over the last decade.

The nature of the changes that were occurring at the end of the 1980s, and their impact on the SRS industry, are generally well known, although in most discussions they are analysed from specific service sector viewpoints - mental health, intellectual disability, acquired brain injury, or particular age groups. However, the inter-sectoral effects of the changes and their impact on generic and accessible services like SRSs and rooming houses are extremely significant.

In addition, the creation of mega-departments from the 1990s within the State bureaucracy has not delivered any cross-sectoral insights or reforms of significance for a general service

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<sup>23</sup> Sach and Associates (1987), *Viability of Special Accommodation: A Report to the Ministerial Advisory Committee of Special Accommodation Houses*, Ministerial Review Committee of Special Accommodation Houses, Melbourne.

system such as SRSs. If anything, inter-program divides intensified as pressure on budgets increased, and the introduction of competition into public sector performance encouraged the identification of fault in other programs. SRS were seen as a regulatory responsibility only and no particular program area took on policy responsibility until some modest attempts to give the issues a profile commenced in 1993-4.

Since 1987, some significant market forces and policy changes have impacted on the SRS industry. These have favoured the development of pension plus services and changed the nature and function of low-cost, pension only services. The key changes since 1987 are briefly summarised below.

## Industry Divergence

While the data available to the Department does not allow for total confidence in regard to the current profile of the industry, there is sufficient evidence to suggest that pension only SRS and pension plus SRS are now two fairly different services types. The Community Visitors and Office of the Public Advocate support this view. They can be distinguished by the following factors:

- The age profile of their residents,
- The gender balance of their residents,
- The disability profile of their residents,
- The financial capacity of their residents to pay market fees,
- The standards of their infrastructure in terms of buildings, fittings and fixtures'
- The business acumen and skill base of industry participants,
- The probability of future stability and growth, and
- The appropriateness of their service to the requirements of their residents.

It needs to be said that the survey and census returns for the sector provided in 1987, 1993 and 1998 do not clearly show these changes. In fact the data is a little difficult to interpret as a result of different terms used at different stages. Take, for example, the following comparison of the disability or predominant condition in 1987 and 1998.

PREDOMINANT CONDITION/DISABILITY OF SRS RESIDENTS, 1987 AND 1998  
(% of total residents)

<b>Predominant disability</b>	<b>1987</b>	<b>1998</b>
Fit & healthy	15.3	Not recorded
Frail	21.3	46 (includes dementia)
Physical or sensory disability	Not recorded	6
Intellectually disability	9.2	4
Psychiatric disability (incl. dual disability)	16.2	25.6
ABI/Alcoholic related brain injury	21.5	4.5
Other disability (eg. aggressive)	Not recorded	4.4

Sources: Health Department of Victoria (1987), *Final Report: Ministerial Review of Special Accommodation Houses*, Melbourne, and Aged Community and Mental Health Division (2000), *Supported Residential Services Census: May 1998*, Department of Human Services, Melbourne.

Whilst these figures are not conclusive, it is important to note that the category ‘fit and healthy’ reported in 1987 would seem to indicate that a significant proportion of the residents at that time had relatively low dependency levels. There is sufficient anecdotal evidence to support the view that these people were, generally, aged pensioners in pension only facilities. By 1998 this type of aged pensioner resident was more-or-less unknown. They would either be living at home with support from HACC services or in subsidised hostels.

The census returns in 1988, 1993 and 1998 represent aggregate data for the entire industry but they are in some ways misleading and do not tell us all that is going on within the industry.

The proportion of residents with a psychiatric disability has increased, but what the consensus returns do not tell us is that this increase is almost all in pension only facilities. Up to 60 per cent of all residents in pension only SRSs now have a psychiatric disability or multiple disabilities including a psychiatric disability. This is, however, lower than for rooming houses in NSW. If, as indicated in the table above, the figure for the industry as a whole is about 25 per cent, the proportion of pension plus SRS residents with a mental illness must be very low.

With respect to gender, the profile of the total SRS population has been remarkably consistent since 1987.

GENDER OF SRS RESIDENTS, 1987, 1993 AND 1998  
(% of total residents)

Age category	1986		1993		1998	
	M	F	M	F	M	F
20-39	2	1	2	1	3	1
40-59	11	7	11	6	9	5
60-69	10	8	10	10	7	5
70-79	10	18	10	23	8	13
80+	7	27	6	22	12	37
TOTAL	39	61	38	62	39	61

Sources: Calculated from Health Department of Victoria (1987), *Final Report: Ministerial Review of Special Accommodation Houses*, Melbourne, Aged Care Division (1994?), *Supported Residential Services Resident Access Survey: General Report*, Department of Health and Community Services, Melbourne and Aged Community and Mental Health Division (2000), *Supported Residential Services Census: May 1998*, Department of Human Services, Melbourne.

Note: Columns may not total due to rounding error.

Again this picture is deceptive and important differences are revealed when the gender of residents is analysed within the two sectors of the industry.

As the pension plus industry sector consolidated into private aged care facilities, and their age profile increased, the proportion of women residents also increased. As the pension only industry sector moved to a younger (less than 70 years) resident profile, with more dual diagnosis and behaviourally disturbed residents, the proportion of their male residents increased. Thus, the industry-wide figures hide the growing difference between the two types of SRS.

Data supplied by ARBIAS in relation to five pension only facilities in the Southern Metropolitan Region (that participate in an ongoing recreation project) demonstrates

increased divergence in the industry and supports the proposition that these types of facilities should not be thought of aged care facilities, but as places where people with various disabilities live.

ARBIAS reports that across those five pension only SRSs: 81 per cent of residents are male; 92 per cent are aged less than 70; 48 per cent are known to have a primary psychiatric disability; 18 per cent a primary intellectual disability; and 25 per cent a primary acquired brain injury. Less than five per cent are reported as frail aged without a complicating disability.

A 1998 study of 614 SRS residents in the Northern Metropolitan Region compared the residents of pension plus and pension only facilities on a number of key indices. The data collected reveals the significance of the difference between the two types of SRS in that region at that time.

**REPORTED RESIDENT PROFILE: NORTHERN METROPOLITAN REGION**  
(% of total residents)

	<b>Pension Plus</b>	<b>Pension Only</b>
Gender	27 male, 73 female	64 male, 36 female
Age less than 70	5	73
Age more than 80	73	9
Frail aged	77	13
Psychiatric disability	21	66
Intellectual disability	21	71*
Physical or sensory disability	70	10
Acquired brain injury	24	53
Dementia	59	5
Community treatment order made	10	63
Case manager assigned	14	72

Source: Disability Resources Centre (August 1998), *Northern Metropolitan Region Supported Residential Services Home and Community Care Access Project*, Melbourne.

Note: \*This figure is suspect and may be an error.

Statewide industry figures are not so extreme, but do confirm that there is now a marked difference in the resident profile of the two sectors.

**REPORTED RESIDENT PROFILE: ALL REGIONS**  
(% of total residents)

	<b>Pension Plus</b>	<b>Pension Only</b>
Gender	27 male, 73 female	60 male, 40 female
Age less than 70	14	57
Age more than 80	64	22
Primary psychiatric disability	7	41
Primary intellectual disability	1	9
Physical or sensory disability	6	5
Primary acquired brain injury	2	8
Case manager assigned	11	26

Source: Calculated from Aged Community and Mental Health Division (2000), *Supported Residential Services Census: May 1998*, Department of Human Services, Melbourne and individual facility returns.

While it is true that some SRSs bridge the two industry sectors, the number of facilities with pension only and pension plus residents is declining as they move into either one sector of the industry or the other.

## **Aged Care Service Reforms**

There have been two distinct reform processes in aged care over the past 20 years. The first was introduced by the Hawke Government in 1985 and the second by the Howard Government in 1997.

Comprehensive analysis of the interactive effects of these two phases of reform is generally unavailable and it is far beyond the scope of this review to do that type of research. It is possible, however, to report on some of the general impacts that these major national policy programs have had on the Victorian SRS industry.

In 1985 the Hawke Government introduced their Aged Care Reform Package that favoured home care and low intensity residential care over traditional nursing homes. Aged care hostels as they were called and the Home and Community Care (HACC) Program had the effect of providing a subsidised option for many residents and potential residents of SRSs, particularly pensioners. There was a decline in demand from the traditional clientele of the SRS industry, particularly frail aged pensioners. As a result, the vacancy rate of SRSs increased over the following years. This created additional pressure on business viability for many SRSs and led to the opening of the SRS industry to other residents.

As indicated above, this impact has not been subject to empirical study but has been widely reported and commented on in numerous reports and studies over recent years.

Currently, Commonwealth Government policies in relation to the allocation of residential care places and equalisation of funding between States for HACC services are creating significant resourcing pressures for both health and aged care services in Victoria.

The supply of operational residential care places in Victoria is significantly below the Commonwealth's planning benchmark. While the Commonwealth have declined to provide the State with recent data on the number of operational places in Victoria, information available through the Productivity Commission, the Institute of Health and Welfare and analysis commissioned by the Department of Human Services estimate that Victoria has approximately 5,000 places less than required to meet the ageing population.

The Victorian Government Community Connection Program services use flexible care funds to provide proactive and immediate outreach support to people who are at risk of homelessness as a result of closure to their accommodation, particularly pension-level SRS.

In addition, the Housing Support for the Aged Program also has a flexible pool of funds to overcome crisis or immediate needs in the event these services are not readily available in the community.

The reports of the two census' of SRS residents conducted since 1987 do not convey a true picture of these changes with the two industry sectors. The following table shows changes in the industry overall, but not the different age profile between the two types of SRS.

AGE PROFILE OF SRS RESIDENTS 1987, 1993 AND 1998  
(% of total residents)

Age Cohort	Residents 1987	Residents 1993	Residents 1998
20 - 39	3	3	4
40 - 59	18	n.a.	14
40 - 64	n.a.	17	n.a.
60 - 69	18	n.a.	12
65 - 74	n.a.	20	n.a.
70 - 79	22	n.a.	21
75 - 84	n.a.	33	n.a.
80 +	33	n.a.	49
84 +	n.a.	27	n.a.

Sources: Calculated from Health Department of Victoria (1987), *Final Report: Ministerial Review of Special Accommodation Houses*, Melbourne, Aged Care Division (1994?), *Supported Residential Services Resident Access Survey: General Report*, Department of Health and Community Services, Melbourne and Aged Community and Mental Health Division (2000), *Supported Residential Services Census: May 1998*, Department of Human Services, Melbourne.

Note: Columns may not total due to rounding error.

The increase in the 80 plus age cohort between 1987 and 1998 is significant, and if the Northern Region figures discussed above are reasonably indicative, the majority of these residents are in pension plus facilities. Conversely almost all the residents under 60 years of age are living in pension only SRSs. The age profile of both types of SRS has changed significantly since 1987, in large part as a result of the aged care reforms.

At the same time as pension only SRSs lost their traditional clientele, it appears they gained (or retained) a small but significant part of that market - namely older people who are eligible for admission to Commonwealth funded hostels but whose level of dependency and, more particularly, ongoing behaviour management issues made them problematic in funded facilities. In effect, SRS lost lower dependency residents whilst retaining higher dependency residents with more complex needs.

Another consequence of the expansion of the funded residential care industry has been that a number of SRS proprietors have successfully applied for approved provider status and so their existing SRSs have been converted into hostels and nursing homes. The net effect of that type of business realignment is to reduce the size of the SRS industry and increase the size of the funded residential care industry by equal amounts. It improves the availability of supported accommodation for the aged at the expense of younger people with a disability. Increased Commonwealth expenditure in those circumstances has resulted in no additional service provision overall.

## Mental Health Service Reforms

Changes and reforms in Victoria over the past 30 years are widely recognised and understood, although it is significant that there has been little comprehensive assessment on their impact on either mainstream health and community services, or specialised services. It is difficult, therefore, to find sound data which analyses the impacts of these changes on the SRS industry.

The first phase of de-institutionalisation and mainstreaming occurred in the 1970's and was largely related to advances in medication and the early development of community based treatment programs. The period 1985 to 2000 represents the second wave of de-institutionalisation in Victoria and came about as the result of a mixed political agenda of individual rights and economic reform.

We know that many institutional beds have been closed over the past fifteen years in mental health, and we know something about the changed policies with respect to reducing length of stay in acute and other specialist treatment services, but we have less understanding of the impact of these changes on housing and accommodation support systems. Clearly, significant initiatives have been introduced to address the needs of people with mental illness in public housing programs, some subsidised supported accommodation programs, and community settings.

It is difficult to map the overall effect of these changes on the SRS industry in particular. There is no doubt, however, that significant numbers of adults with mental illness who were previously cared for in long term mental hospitals are now residents in SRSs. Some facilities were first registered during this period as a direct response to de-institutionalisation, and "dumping" did occur into new and existing SRSs (as well as rooming houses), particularly in the early 1990s.

What is important about this process is its impact on the distribution of people with a mental illness within the SRS industry itself. People with a mental illness now constitute the highest proportion of residents (in terms of disability or primary condition) in pension only SRSs. In 1987 few SRSs reported having a majority of their residents as referred by a mental health service and/or with a mental health illness. That has changed significantly.

As in so many other areas, the figures regarding the SRS industry overall do not provide the whole picture. After its most recent survey in 1998, DHS reported that the profile of residents in SRS overall had remained close to the 1987 and 1993 figures<sup>24</sup>. However, this obscures the fact that the mix of residents in pension only SRSs has changed considerably over this period of 15 years.

The impact of service system reform in mental health programs has been felt almost exclusively in the pension only sector. To restate, the study of 614 residents in the Northern Metropolitan Region<sup>25</sup> referred to earlier showed the following pattern:

- 66 per cent of residents in pension only facilities had a long term psychiatric disability, compared to 21 per cent in pension plus facilities
- 63 per cent of residents in pension only facilities were currently subject to a community treatment order as distinct from 10 per cent in pension plus facilities.
- 53 per cent of residents in pension only facilities had some form of acquired brain injury, including alcohol related brain injury, compared with 24 per cent in pension plus facilities.

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<sup>24</sup> Aged Community and Mental Health Division, (2000), *Supported Residential Services Census: May 1998*, Department of Human Services, Melbourne, pp. 20 – 26.

<sup>25</sup> Disability Resources Centre (August 1998), *Northern Metropolitan Region Supported Residential Services Home and Community Care Access Project*, Melbourne, p15.

- 72 per cent of pension only SRS residents had a case manager assigned to them, indicating moderate to high levels of disability or mental illness, compared to 14 per cent in pension plus facilities.

## **Boarding and Rooming House Closures**

The loss of these traditional forms of low-cost accommodation in the metropolitan area, particularly in the inner urban area, has been well documented. Hundreds of these private housing services have closed and there is no doubt that this has had a sustained impact on a variety of other housing services and on the accommodation options available to adults and older adults dependent on pension or benefit.

The interaction between pension only SRS and the rooming house industry, however, is not immediately transparent. Despite the enormous loss of rooming houses the number of vacancies in pension only SRS remained consistently high until quite recently, particularly in certain areas, and the changing nature of pension only SRSs has meant that they may not be the kind of housing option desired by many former tenants of rooming houses.

## **Changing Practices in Acute Services**

Reduced length of stay in acute medical and psychiatric services has been a feature of practice in those services since the 1960s. However, the most significant reductions have occurred since the late 1980s. These changes were essentially technology and cost driven and have created pressure on a variety of service systems.

It is significant that there are increasing numbers of reports of SRSs or equivalent housing being used for post acute care. SRSs, particularly pension only SRSs, that take referrals from acute services are admitting residents at an earlier stage in their recovery and rehabilitation. The increased demand on proprietors for services associated with post acute care will have subsequent effects on the overall standards of the SRS and contribute to further viability pressures in these facilities.

## **Disability Service Reforms**

The role of SRS as providers of supported accommodation for people with dual disabilities, particularly psychiatric and intellectual co-disability and psychiatric and substance related co-disability, was noted in 1987 and has continued during fifteen years of intense service redevelopment in mental health. Notwithstanding the creation of specialised service programs, SRSs remain a major provider of accommodation for people with dual diagnoses.

While recent developments have seen an improvement in specialised services these usually focus on secondary consultation models. Funded, specialised supported accommodation services are not generally available in sufficient numbers for adults with a dual diagnosis, mental illness and intellectual co-disability, or a mental illness and an acquired brain injury, or mental illness and substance related co-disability.

## **Reform of Homeless Services**

In 1986 the Commonwealth and State Governments entered into an agreement under the Supported Accommodation Assistance Program to affect major redevelopment of the large night shelters which provided temporary accommodation for a significant number of Melbourne's homeless and itinerant adults. These services contributed to the overall provision of emergency supported housing in the state and although there was general agreement that their size and their structure and the model of service delivery were all problematic, the reduction in the overall number of overnight beds was another significant change impacting on Victoria's service system.

Whilst the provision of longer term supported accommodation is the primary business focus of SRS proprietors, the reduction in the quantum of crisis accommodation beds, and the increasing demand for those beds, has meant that SRSs are more frequently expected to provide short term, emergency accommodation.

When they are carrying vacancies, pension only SRS proprietors have little choice but to accept the inappropriate, crisis type referral in order to protect their relationship with the service agency and so ensure more appropriate, future referrals.

The provision of crisis accommodation within an SRS can create significant technical difficulties for the proprietor, particularly in relation to compliance with the provision of information, care planning and record keeping requirements of the legislative framework. There is also substantial anecdotal evidence that the procession of short term/crisis access has a significant negative impact on the wellbeing of the existing resident population.

## **Increased Cost Pressures**

Effectively the cost pressures identified by the 1987 review have escalated and constitute one of the most serious problems confronting this industry.

Again there is no systematic data with respect to this, but it is known that many SRSs are subject to high rental and leasing costs and that they constitute a significant proportion of the overall cost structure. Since 1987 rental costs in many of the areas where pension only SRSs have traditionally been located have increased substantially, and far in the excess of relative increases in the incomes of pensioners and other benefit recipients.

High and increasing rental costs are often directly associated with changes in relative land values. Another consequence of that appreciation has been the refusal by landlords in a number of cases to renew SRS leases as they come due in order that they may more effectively exploit windfall gains through property sales or redevelopment.

Compliance costs associated with regulatory and policy reform has also been a significant factor since 1987. The compliance cost issue has two aspects. Firstly, the increased cost imposition on existing SRSs adversely affects their financial viability, forcing them to either cut corners where they can and so lower the standards of care and accommodation, raise their fees and so price pensioner residents out of the facility, or exit the industry altogether. The second aspect is the increased disincentive to start new facilities to accommodate and care for

pensioners and other low-income residents. In an environment where it is almost as inexpensive to develop a relatively sound, pension plus business, why would any operator opt for a relatively precarious pension only development?

The short answer is that rational business operators would not choose the pension only option and it is telling that the overwhelming majority of new SRSs that have opened in the last few years operate predominantly in the pension plus sector.

During the last few years, SRS proprietors and developers have had increased capital and running costs imposed through a raft of regulatory and policy changes. At a State level these have included:

- strengthening of the privacy and dignity requirements in SRSs through the introduction of new Bed Number Guidelines in 1998 – the implementation of this policy has seen a reduction in registered bed numbers at many SRSs and has been cited by several proprietors as a key factor in their decision to close the facility<sup>26</sup>;
- more stringent food storage and handling requirements under the *Food Act 1984* which came into effect in SRSs in 1999 - these have included planning, process and physical design changes in many facilities;
- new minimum qualification and employment requirements for Personal Care Coordinators<sup>27</sup> that came into effect this year; and
- improved fire safety requirements which mean that smoke detectors must now be fitted in all SRSs and sprinkler systems must be installed by August next year – the sprinkler requirements in particular represent a significant, lump-sum capital cost on existing facilities and has also been cited by a number of proprietors as a key factor in their decision to exit the industry<sup>28</sup>.

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<sup>26</sup> DHS facility closure records.

<sup>27</sup> *Health Services (Residential Care) (Personal care Coordinator) Regulations 1999, SR No. 95.*

<sup>28</sup> DHS facility closure records.

# Chapter 4: Comparative Overview

## New South Wales

Licensed Residential Centres (LRCs), or Licensed Boarding Houses as they are also known, are private for-profit businesses that do not receive any State or Commonwealth subsidy for the provision of supported accommodation to people with disabilities. LRC revenue is derived from resident fees, with most residents paying between 85 and 100 per cent of the pension plus rental assistance. A relatively small proportion of residents pay above pension rates.

A survey of LRC residents conducted in February 1998<sup>29</sup> indicated that almost 30 per cent of residents were aged 65 years or older. More than four in ten were recorded as having multiple disability diagnoses and the largest individual disability diagnosis groups (in order of significance) were psychiatric disability, intellectual disability and alcohol related brain injury.

A prospective Licensee applies to the Boarding House Standards Unit (BHSU) of the Ageing and Disability Department for a licence to operate an LRC. Assessment of the application is made against criteria in the *Youth and Community Services Act 1973* and, if successful, a licence is granted stipulating the Licensee, Licensed Manager and the maximum number of residents permitted to be accommodated at the premises.

Licenses are reviewed and renewed annually and are not transferable.

Attached to each licence is a set of conditions that the Licensee and Licensed Manager have the responsibility to adhere to. Each set of conditions has ten standard areas that are covered, however, additional conditions can be added to specific premises if required. The ten standard licence conditions areas are:

- The Licence;
- Physical, Structural and General Requirements;
- Food Dining and Food Preparation Requirements;
- Record Keeping and Responsibilities of Licensee and Licensed Manager;
- Staffing Suitability;
- Resident's Rights and Welfare;
- Residents' Activities and Advocacy;
- Financial Affairs of Residents;
- Medication (Administration and Supervision) and Health;
- Service Entry Requirements.

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<sup>29</sup> Licensed Boarding House Reform Program (2001 - Unpublished Draft), *The Assessment of Residents of Licensed Boarding Houses. January – March 1998. Census Findings*, Ageing and Disability Department, Sydney.

Licensing Officers from the BHSU regularly monitor LRC compliance with licence conditions, usually every 1 to 2 months though they may be more frequent if there is a specific concern or complaint that needs to be investigated. Monitoring visits are usually unannounced.

In October 1998, the Minister for Disability Services introduced the Licensed Boarding House Reform Program in response to concerns about standards of care and industry viability. Major elements of the program included independent assessment of the care needs of all residents; relocation of high dependency residents to State or Commonwealth funded residential care; and external provision of personal care and community integration support for residents remaining in licensed boarding houses.

Total funding of \$66 million was allocated to the reform program<sup>3031</sup>. This included:

- \$14 million (capital) to build/purchase/lease properties for 310 high dependency clients relocated to State funded care (average capital cost \$45,000 per resident);
- \$37 million over three years (\$21.7 million in 2000-01) to support those 310 relocated high dependency residents (average annual cost \$70,000 per resident); and
- \$15 million over three years (\$5.7 million in 200-01) to support for the 1,400 residents remaining in boarding houses (average annual cost \$4,100 per resident).

It should be noted, however, that NSW does not have the extent of alternative supported housing models that exist in Victoria.

As part of the program, Aged Care Assessment Teams assessed 240 residents aged 65 years or older by April 1999. About one in four were assessed as eligible for placement in a Commonwealth funded residential aged care facility.

A standardised *Boarding House Entry Screening Tool* was introduced in 1999.

Persons seeking entry to an LRC must be referred to an ACAT for screening in order to prevent the inappropriate admission of people whose needs cannot be met in a boarding house. The referral would usually be made by a community agency seeking accommodation for the person (for example, on discharge from hospital), but could be also be made by the LRC staff or by prospective residents themselves.

In July 1999 there were 93 LRCs accommodating about 1,700 residents. As at February this year there are 77 LRCs with 1,382 licensed beds.

## Queensland

In Queensland, Supported Accommodations and Private Boarding Houses provide low-cost accommodation with varying degrees of support and personal care for residents. There is no

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<sup>30</sup> Ageing and Disability Department (December 1998), *What's New in Boarding Houses*, 1, p. 1.

<sup>31</sup> Ageing and Disability Department (July 1999), *What's New in Boarding Houses*, 2, p. 1.

single authority responsible for registration or monitoring the operation of facilities, these functions being carried out, where they are carried out at all, by Local Government.

The definition of accommodation types, minimum standards of care or physical infrastructure, and record keeping, varies significantly between Local Governments. In the Brisbane City Council area, for example, a dwelling that provides shared facilities such as bathrooms and kitchens, where the proprietor provides meals, is defined as a boarding house. This definition roughly equates to the supported accommodation sector in much of the rest of the state.

If the residents provide their own meals, however, Brisbane City Council defines the premises to be a tenement. This approximates what is commonly considered to be a boarding house in the rest of the state.

The situation is further confused by various legislated service definitions. These include:

- A hostel, defined in the *Health Act 1937* as *any house, apartment or other premises, other than a nursing home for which a licence is in force, which is used or intended to be used for the reception and care of persons who*
  - (a) *on account of age, infirmity or chronic ill health (whether physical or mental) require care and supervision or require assistance in coping with daily living; or*
  - (b) *on account of alcohol or drug abuse require rehabilitative care and supervision.*
- A nursing home, defined in the same Act as *any house, apartment or premises which is used or intended to be used for the reception, care and treatment of persons who on account of age, infirmity, chronic ill health or the effects of illness from which they are convalescent require nursing, care and supervision or care and supervision.*
- A health service, defined in the *Health Services Act 1991* as *a service for maintaining, improving or restoring people's health and wellbeing...*
- In the *Health Rights Commission Act 1991*, declared health services include *services provided in association with the use of a premises for the care, treatment or accommodation of persons who are aged or have a physical or mental illness.*
- The *Health Services Regulations 1992* definition of a residential care facility as *a nursing home, hostel or other facility operated by the State at which accommodation, and nursing or personal care, is provided to persons who, because of infirmity, illness, disease, incapacity or disability, have a continuing need for nursing or personal care...*

There are 25-30,000 boarding house and supported accommodation residents in Queensland, and the majority of residents are receiving a pension as their main or only source of income; about two fifths are 'aged'; and slightly more than half having an intellectual or psychiatric disability<sup>32</sup>.

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<sup>32</sup>Price Waterhouse Coopers Pty Ltd (October 1998), *Industry Economics and Financial Viability*, Hostel Industry Development Unit, Queensland Office of Fair Trading, Brisbane, p. 8.

In response to long held concerns with accommodation and service standards, the Queensland Government is moving to implement a legislative framework for supported accommodations, boarding houses and aged rental accommodation complexes<sup>33</sup>. The central features of the new framework will include:

- compulsory registration and accreditation of all operators;
- external monitoring of all operators;
- formal processes to recognise resident's rights and responsibilities;
- established minimum standards of care and accommodation; and
- appropriate sanctions for breaches of standards.

## South Australia

A prospective proprietor applies to the Local Government Authority, or its nominated licensing authority, for a licence to operate a Supported Residential Facility at a particular premises. Assessment of the application is made against criteria in the *Supported Residential Facilities Act 1992* and *Regulations 1994* and, if successful, a licence is granted for up to two years.

The Act and Regulations mention 3 different types of facilities: Supported Residential Facilities (SRFs), Nursing Homes (NHs), and Residential-only Premises (RPs).

An SRF is defined in section 3 of the Act as providing accommodation and personal care services. Those services may include occasional nursing care.

A NH is defined in the Regulations as an SRF where nursing care is offered on a continuing basis. The provision of care at a NH must be overseen by a registered nurse who has been approved by the licensing authority. Minimum nursing staff ratios are also prescribed.

RPs are defined in section 3 of the Act as premises used as boarding or lodging houses. They are not required to be licensed under the Act. The Act does, however, establish requirements for proprietors of RPs in regards rendering reasonable assistance for residents in obtaining care, allowing access to health service providers and certain other persons, and maintaining orderly conduct in the facility.

Detailed standards of care and fabric specifications are contained in the Regulations and supplementary information in the form of a *Guidelines and Standards Handbook* produced by the SRF Advisory Committee.

The Advisory Committee has 13 Members appointed by the Governor. They are:

- 2 nominated by the Minister with extensive industry management experience.
- 3 selected by the Minister from panels nominated by advocate organizations for people who are elderly, disabled or intellectually impaired.

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<sup>33</sup>Hostel Industry Development Unit (2000) "Government Decision on Legislation to Improve Conditions in Private Sector Accommodation for the Aged and People with a Disability" in *HIDU News Update* 1,1 p. 1.

- 1 selected by the Minister from panel nominated by the Trades and Labor Council.
- 4 nominated by the Local Government Association.
- 1 legally qualified medical practitioner nominated by the Minister.
- 1 nominated by the Minister after consultation with SA Health Commission.
- 1 nominated by an interested Commonwealth Department.

As well as preparing any operational guidelines it considers necessary, the Advisory Committee role includes advising licensing authorities in respect to granting of licenses and reporting to the Minister on any policy or legislative matter relating to the SRF industry or the provision of personal care services in the community<sup>34</sup>.

There is no central register of SRFs and licensing authority databases vary significantly in form and content. The SRF Association of South Australia (SRFA) estimates, however, that there are approximately 75 registered SRFs accommodating about 2,000 pensioner residents in South Australia.

A survey of SRFA members in February 2000 indicated that two thirds were aged 65 years or older and less than one in five were frail aged without a complicating disability. The major disability groups recorded (in order of significance) were psychiatric disability, intellectual disability, physical disability and dementia.

There is no requirement that prospective residents have their care needs assessed before being referred to, or moving into, an SRF although individual service plans are required to be prepared, implemented and reviewed, in consultation with the resident or resident's representative<sup>35</sup>.

## Western Australia

There is no SRS equivalent industry in Western Australia. Individuals who are 'socially dependent because of mental illness'<sup>36</sup> may find supported accommodation in the 'private psychiatric hostel' (PPH) industry, but people who are aged and infirm, with an intellectual or other disability, or who have an ABI, have no systematic, regulated, non-government, supported accommodation option.

Prospective proprietors apply to the Private Sector Licensing Unit of the Department of Health for a licence to operate a PPH. Assessment is made against criteria described in the *Hospitals and Health Services Act 1927*.

Licences must be renewed annually and are not transferable.

There are currently less than 30 licensed PPHs with a total population of about 600 residents. PPH proprietors may receive a subsidy for the provision of personal care and 24 hour supervision. The average subsidy is \$7 per day per resident.

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<sup>34</sup> *Supported Residential Facilities Act 1992*, section 17.

<sup>35</sup> Supported Residential Facilities Advisory Committee (1997), *The Supported Residential Facilities Act 1992: Guidelines and Standards, Second Edition*, South Australian Health Commission, Adelaide, p. 41.

<sup>36</sup> *Hospitals and Health Services Act 1927*, section 26P.

There has been limited growth in the number of subsidised places, or in the rate of subsidy, over the last 15 years.

An unquantified number of people with support needs are accommodated in boarding and lodging houses. These facilities are licensed by local government, and there is no meaningful, centralised information system on the characteristics of residents, standards of infrastructure or quality of care (if any) that is provided.

The Office of the Public Advocate has indicated that work is being undertaken to introduce new fabric standards for boarding and lodging houses, though recognises that such moves may result in significant industry closures in an environment with few low-cost accommodation alternatives.

It is noted that the definition of a service contract contained in section 3 of the *Retirement Villages Act 1992* includes a range of services including 'hostel care' and 'any other services'. There may, therefore, be retirement villages in Western Australia with a similar resident profile to some of the above pension SRSs in Victoria. That is, self funded, frail aged retirees with personal care and support needs but few complicating disabilities.

## International

A number of examples of systematically regulated, non-government, supported accommodation service systems were described in the international literature. In the examples that were found, the industries were generally supported by government or quasi-government bodies to provide supported accommodation to the financially disadvantaged.

In Israel, for example, the National Insurance Institute (NII) and other government authorities fund the long-term care of seriously disabled and dependent elderly persons<sup>37</sup>. They assess eligibility for benefits, stipulate what personal care and other services are to be provided, and contract with particular facilities or agencies to provide those services. The payment for the services is made directly to the provider organization by the NII.

Services are purchased by the state.

In the United Kingdom, Residential Care Homes (RCHs) operate within the framework of the *Registered Homes Act* and *Residential Care Homes Regulations*. They are licensed and monitored by County Council licensing authorities, some of which prepare comprehensive guidelines for facility operation<sup>38</sup>. RCHs are licensed to provide supported accommodation for particular classes of residents (eg. the elderly, people with alcohol or drug dependency, people under/over 65 years of age with a mental illness, etc.). Whilst operators are required to make arrangements, where necessary, for residents to receive medical and dental services<sup>39</sup>, care provision is generally limited to personal care and support. It does not include clinical or nursing care.

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<sup>37</sup> Ajzenstadt, M. and Rosenhek, Z. (2000), "Privatisation and New Modes of State Intervention: The Long-Term Care Programme in Israel" in *Journal of Social Policy*, 29, 2, pp. 247 – 262.

<sup>38</sup> See, for example, Hampshire County Council (1998) *Quality Standards for Residential Care Homes*.

<sup>39</sup> Regulation 10(1)(p), *Residential Care Homes Regulations 1984*.

Private RCH operators may accept residents who have been referred by local social services for whom a set fee for service is paid. Client contribution to the set fee is means tested and, in addition, any top up fee required by the RCH operator must be met by the client (individuals who are willing to pay the full cost of residential care may be admitted to a RCH without referral by social services).

Service provision is regulated and directly subsidised by the state.

In California, the Department of Social Services, Community Care Licensing Division, issues licenses for residential facilities which provide 24 hour, non-medical care and supervision for children, adults and the elderly. The two most relevant facility classifications are Adult Residential Facilities (ARFs) and Residential Care Facilities for the Elderly (RCFEs).

ARFs provide care for adults aged 18 to 59 years who are unable to provide for their own daily needs. RCFEs provide personal care to persons aged 60 years or older, but may also provide care for younger persons with compatible needs<sup>40</sup>. Pre-admission assessment of a resident's medical, psychological and social needs, as well as functional capabilities, must be conducted before that resident is admitted to a facility, and then only to a facility that is able to meet the resident's assessed needs.

Financially disadvantaged residents who are aged or disabled may be eligible to receive additional income support from the Federal-State SSI/SSP program. Basic services (defined as including safe and healthful living conditions, nutritionally well balanced meals, personal assistance and care, arrangements to meet health care needs and planned activity programs) must be provided to SSI/SSP recipient residents at a set rate with no additional charge to residents.<sup>41</sup>

Service provision is regulated and indirectly subsidised by the state.

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<sup>40</sup> *California Code of Regulations, Title 22, Division 6, Chapters 6 and 8* respectively.

<sup>41</sup> *Ibid.* Regulations 85060 and 87590.

## Chapter 5: Consultation

The Project Outline required that I *review the available literature, reports and recommendations* in the development of an improved policy framework for the SRS industry. As such, the initial intent was that the review would be undertaken as a literature based exercise. It was both desirable and necessary to seek additional input from some key stakeholders.

A number of meetings were subsequently held with representatives of the Association of Supportive Care Homes and the Community Visitors Program, as the principle industry representative and non-regulatory observer groups respectively, and with various program and operational units of the Department.

The Association of Supportive Care Homes and the Community Visitors Program also made written submissions to this project.

A meeting was also held with the Members of the Independent Review Panel that was convened as part of the bed number review process. That Panel had conducted site visits and interviewed proprietors at 149 SRSs across the State during the last few years. They recorded observations about what they saw as the problems in the industry and made recommendations for possible solutions in a Report to the Minister for Housing and Aged Care.

Other discussions with individual industry stakeholders were conducted as the opportunity arose. At different times, discussions were held with a number of proprietors and developers, service agency staff, Departmental officers and non-government organization representatives. Whilst not separately catalogued here, the views of each of those individuals were carefully considered in the development of the proposed policy framework.

The views described in this Chapter are those presented to the review and are not necessarily endorsed. They are simply the views that were put as I understand them.

### **The Community Visitors Program Position**

Community Visitor concerns in relation to the SRS industry relate to the:

1. Ineffectiveness of the Department in carrying out its responsibilities in relation to licensing proprietors and facilities, and in enforcing minimum standards;
2. Poor quality of physical infrastructure in many pension only SRSs;
3. Lack of appropriate, alternative supported accommodation leaving residents with no option but to remain in SRSs;
4. Inappropriate referral practices and lack of ongoing resident support by State funded health and welfare agencies;
5. Continuation of the practice of accepting and maintaining people with high and/or multiple care needs in SRSs; and
6. Low levels of financial viability in the pension only industry sector leading to inadequate care and support being provided to residents.

During each meeting with the Community Visitors, considerable time was devoted to discussing the problems associated with an apparent under-resourcing of the operational areas of the Department, particularly in relation to monitoring and enforcing compliance with the requirements of the Health Services Act and Regulations.

Community Visitors believe that many SRS Advisors are presently overstretched in terms of the number of facilities that they are expected to individually monitor and the range of functions that they are expected to perform. It was suggested that the roles of regulation, registration, education and advice be separated and that resources available for those functions be significantly increased.

Perceived lack of compliance with privacy, care and cleanliness provisions was cited as a concern in a number of facilities, with little or no effective action being taken by the Department to address the problems, has been a long standing concern of Community Visitors.

Continued reliance on placing conditions on facility registration in such cases is seen as unsatisfactory: either there has been no ongoing breach, and then there would be no need to place a condition on the registration, or there has been an ongoing breach that should be prosecuted. The Community Visitor noted a significant minority of facilities that appear to be consistently dirty and unhygienic, serve inadequate and inappropriate food, and provide inadequate care and support, that have been counselled and warned regularly, but whose standards do not change over time. At the very least, it was argued, these facilities should be clean and hygienic and provide adequate and nutritious meals in accordance with the requirements of the Act and Regulations, or be closed.

Other methods of encouraging proprietors to comply with the requirements of the Act and Regulations should also be supported. These may include:

- Making annual facility inspection reports publicly available, as happens in other jurisdictions; and
- The introduction of a system of on the spot fines for minor breaches, as allowed for by section 155 of the Act.

Better resourcing of the registration functions is also required to ensure that only appropriate persons with the necessary business skills, financial capacity and expertise in the care of vulnerable people should be licensed. Community Visitors recognise that the proprietor seminars currently conducted by the Department and the recently instituted minimum qualifications for personal care coordinators, are steps in the right direction. There is, however, ongoing concern that registrations continue to be granted, and renewed, to proprietors who may not meet the criteria outlined in the Act.

Community Visitors believe that the diverse nature of the resident population, particularly in pension only facilities, and the immediacy of their needs requires that a wide range of fabric and service responses be put in place as a matter of some urgency. Those responses are outlined more fully in the attached submission, but generally include the:

- Provision of direct subsidies to targeted pension only SRSs;
- Expansion of appropriate, alternative supported accommodation options;

- Expansion of the use of publicly owned land and facilities for SRS-like developments;
- Consolidation and expansion of targeted resident support programs; and
- Regulating for a minimum proportion of places in all SRSs, including pension plus facilities, to be reserved for financially disadvantaged residents.

## **The Association of Supportive Care Homes Position**

The Association presented the view that there are a number of fundamental weaknesses in the way that government has traditionally related to the SRS industry. Those weaknesses include:

1. A lack of recognition that SRSs are first and foremost the homes of the residents, and as such are no different from any other private rental arrangement;
2. A lack of recognition of the recurrent cost-savings to government where frail aged and younger residents with psychiatric, intellectual and other disabilities privately fund their own personal care, support and accommodation;
3. A lack of recognition that individuals other than the proprietor have a role to play in ensuring adequate and appropriate care and living conditions are provided for SRS residents;
4. The institutionalised conflict of interest in the Department being responsible for policy and legislative development as well as licensing, standards monitoring and enforcement in the SRS industry, whilst simultaneously funding and providing services in direct competition with the industry; and
5. The institutionalised confusion of the role of the SRS Advisor as all things to everyone in the industry: regulator, prosecutor, educator, registrar, statistician and confidant.

Under these circumstances, and in an economic environment where they believe there is a budget excess, the Association argues that the State Government has the moral obligation and financial capacity to address each of these issues.

Recognition of the status of SRSs as places where people live, and the very significant cost to government at both State and Commonwealth level should SRSs no longer be available, should logically result in better access for residents to funded community based services. The ASCH say financially disadvantaged SRS residents require access to personal care services provided through the Home and Community Care and other State, Commonwealth and jointly funded programs in addition to access to health and allied services.

The Association also believes that the industry would benefit from a degree of role demarcation within and between the program and operational units of the Department. In particular, the Association proposes the development of an independent Registration Board to licence service proprietors. The proposed Registration Board could operate along similar lines to the Pharmacy Board of Victoria, the Pathology Services Accreditation Board or the Victorian Nursing Council.

The Association is of the view that it is extremely difficult for SRS proprietors to provide both acceptable accommodation and appropriate personal care for an increasingly complex client base at \$34 a day (approximately the amount of the full pension plus rental assistance).

Without significant, direct and immediate support, SRS supply in the pension only market segment will completely collapse in the foreseeable future.

Three alternative methods of support were suggested. Firstly, provide financially disadvantaged residents with a form of income support to allow them to purchase services to meet their needs from their preferred providers. Such purchasing may take the form of paying higher fees in a pension plus facility or paying for additional, private services to be delivered into the SRS where the resident currently lives.

The Association argues that this approach would be consistent with the general framework outlined in the document 'Ageing Well' produced by the Department in 1999.

Secondly, alleviate the financial burden on eligible residents by funding proprietors directly on a per diem basis relative to the assessed needs of those residents.

The Association argues that the Department receives subsidy of this type from the Commonwealth in relation to the residential aged care places that it provides.

The third alternative presented is that the State fund an external agency to provide a range of core services into appropriately designated facilities over and above those support programs already funded. Those services would include, at least, meals and personal care. Funding for such externally provided services should go only to those agencies that can clearly demonstrate a commitment to the target population and a good working knowledge of the SRS industry generally and the problems faced in the pension only sector specifically.

## **The Former Independent Review Panel**

The previous government appointed a Panel to review Bed Number Guidelines. Reports on bed numbers were completed on a facility by facility basis.

Having inspected the facilities and interviewed the proprietors of 149 SRSs across all nine regions, including almost all the pension only SRSs in the State, those former Panel Members may have a unique understanding of the problems and challenges that cut across the whole industry. As such, they were keen to contribute to this review and for it to result in improved outcomes for residents and proprietors.

One significant issue for these members was the degree of mistrust and hostility held for the Department by many proprietors.

This mistrust seems to be derived from a number of factors, including, but not necessarily limited to:

- The lack of financial contribution by the Department to facilities whilst still exercising considerable control over them;
- SRS Advisors acting as inspectors rather than being a source of practical assistance;
- A lack of sympathy by some SRS Advisors in their dealings with proprietors;
- The inconsistent application of sanctions between regions;

- The inconsistent interpretations of regulations and guidelines; and
- The lack of understanding of the different roles that Departmental Officers undertake.

Former Panel Members also pointed to the inadequate skill levels exhibited by some proprietors and other staff in SRSs. They argued for enhancement of generic business management skills as well as personal care skills, particularly in relation to caring for residents with ongoing mental health issues.

The relationship between proprietors and freeholders was also identified as being problematic with, in many instances, freeholders making no contribution to the maintenance or upgrade of facilities even when those upgrades are required by changing regulation. The former members argued that the current practice of registering the facility and operator together is the cause of this problem.

The former members also noted that the most frequently observed problem with the fabric standards in SRSs was the lack of privacy provisions in shared rooms. They cited this as an issue in 102 of the 149 facilities that they inspected.

The Panel had recommended a number of actions to address these and other issues, those recommendations included:

1. The establishment of an independent body, answerable directly to the Minister, to be responsible for registration, standards setting and monitoring in the SRS industry;
2. That intellectually and psychiatrically disabled SRS residents receive an income subsidy of \$10 per day to purchase additional personal care services;
3. That SRS proprietors undertake mandatory and ongoing training;
4. That all SRS staff involved in personal care have achieved appropriate minimum standards of training from a recognised and accredited training provider;
5. That the Department review the selection criteria and processes, and initiate human relationship management training, for all Departmental Officers who deal with SRS proprietors.
6. That annual facility and performance evaluations be followed up within two months; and
7. That the Department explore the options of making available cheap leasehold land and suitable Office of Housing stock to be developed and operated for use as pension only SRSs.

The Panel was firmly of the view that pension only SRSs perform a valuable function and that they should, if at all possible, be maintained in the wider service system.

## **Part 2**

# **The Options For Change**

# Chapter 6: Key Issues

## Viability

In a 1987 report on the viability of SAHs, the consultants concluded that it would *appear to be highly unlikely for most proprietors purchasing the business and accommodating a pension only clientele to be able to return a reasonable operating profit*<sup>42</sup>. They showed that the low-cost end of the industry was dominated by facilities operating in leasehold premises, with fewer than 25 residents, who were mostly pensioners with high dependency levels. *This combination of factors is a recipe for lower profitability*<sup>43</sup>.

Later that year, the Sandon Committee reported that<sup>44</sup>:

*The financial viability of SAHs was identified as a critical issue early in the Review Committee's deliberations. Financial considerations were a common and recurring theme in submissions ... Financial concerns were often raised as issues in connection with the provision of adequate care, the availability of resident places, and appropriate assessment and referral procedures.*

In addition to the factors discussed above, the Sandon Committee identified occupancy rates and the business acumen of the proprietor as being key determinants of profitability, particularly at the pension only end of the industry<sup>45</sup>.

As discussed in a previous Chapter, a lot has changed in the environment of the SAH-SRS industry since the time of the Sandon Report. Not much has changed, however, in relation to the characteristics of pension only facilities when compared with the pension plus market sector. Pension only facilities still tend to be smaller than pension plus facilities (with a few notable exceptions), still generally operate in leasehold premises, cater for residents with a more diverse range of higher care needs and are more likely to be operated by proprietors without appropriate training or experience in business management, or the opportunity to access any company or network support.

The one thing that has improved is occupancy rates, though it may be that the more dependent resident profile means that the marginal cost of care for new residents is much closer to (or in some cases even exceeds) the marginal income received.

A useful way of elaborating this issue is to draw on the 1998 Price Waterhouse Coopers Report to the Queensland Hostel Industry Development Unit (previously referred to in this Report). In reporting on the supported accommodation industry overall, the consultants indicated that the key determinants of viability are<sup>46</sup>:

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<sup>42</sup> Sach and Associates (1987), *Viability of Special Accommodation: A Report to the Ministerial Advisory Committee of Special Accommodation Houses*, Ministerial Review Committee of Special Accommodation Houses, Melbourne, p. 74.

<sup>43</sup> *Ibid.*, p. 76.

<sup>44</sup> Health Department of Victoria (1987), *Final Report: Ministerial Review of Special Accommodation Houses*, Melbourne, p. 85.

<sup>45</sup> *Ibid.*, pp. 91 – 93.

<sup>46</sup> Price Waterhouse Coopers Pty Ltd (October 1998), *Industry Economics and Financial Viability*, Hostel Industry Development Unit, Queensland Office of Fair Trading, Brisbane, pp. 29 – 38.

- Ownership, or purchase, of the freehold;
- Economy of scale with a minimum sustainable size of 20 to 25 beds; and
- Manageable debt levels with maximum sustainable repayments not more than 25 per cent of revenue.

In the context of this advice (whilst recognising that it comes from another state and there may be other factors involved) and the pattern of pension only SRS closures in Victoria, it is fair to say that improved occupancy levels are, at best, marginal to the question of the viability of pension only SRS. Other factors, however, do inform the question of viability.

**It is confidently estimated that the number of aged residents with low dependency and low care needs in pension only SRS will continue to decline. Market logic and changes over the past fifteen years indicate that the original clientele of SAHs, namely low income older people with modest care needs, have moved and will continue to be housed elsewhere including the residential aged care sector.**

The most recent Report on Government Services released by the Productivity Commission earlier this year, indicates that whilst Victoria has the lowest number of Commonwealth funded, operational aged residential care beds per thousand persons aged over 70<sup>47</sup>, approximately 44 per cent of new residents into low-care beds (and approximately 48 per cent into all beds) are concessional residents<sup>48</sup>. Concessional residents are those who are in receipt of an income support payment and who have total assets of less than \$24,000.

What the Report on Government Services does not tell us is what happens to older people who are eligible for subsidised residential care services, but who find it difficult to gain admission because they do not conform to the character or style of the service and it's clientele. Reference to this issue is made in the discussion regarding the appropriateness of service models.

At the same time as pension only SRSs have lost most of their traditional lower cost clients to subsidised residential aged care, the recurrent cost implications of an increasingly complex resident profile in pension only facilities has been compounded by steadily increasing compliance costs that relate to, among other things, improved fabric standards, fire safety and food handling requirements. As discussed earlier, these changes have generated additional ongoing costs, and significant lump-sum imposts, that have impacted most significantly in the pension only sector.

It should be noted again that there has been a significant increase in the proportion of SRS charging fees above the pension (and significantly above the pension) since 1987. It is difficult to identify the direction of the causal relationship, if any, between the changing industry profile and the changing pensioner resident profile. It is clear, however, that these changes have been happening simultaneously.

Older people with above pension incomes are continuing to exercise their capacity to choose between the subsidised sector and the non-subsidised private sector namely pension plus SRS

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<sup>47</sup> Steering Committee for the Review of Commonwealth/State Service Provision (2001), *Report on Government Services, 2001*, Productivity Commission, Canberra, figure 12.7.

<sup>48</sup> *ibid.*, table 12.3.

or private hostels. The relative stability of the pension plus SRS sector indicates that the demand for their services is strong or at least steady.

In 1987 the Sandon Committee considered a range of industry interventions including direct subsidies, income support and regulatory admission and fee controls. However, it was realised at that stage that one sector of the industry was responding to changing circumstances quite positively and to intervene in those ways across the whole industry was potentially counterproductive, particularly in the pension only sector<sup>49</sup>.

The Committee also took the view that not only would subsidies at any normal level make little difference to financial viability in the pension only sector, they may be an incentive that attracts inappropriate participants leading to continued industry instability. Subsidies were also seen as bringing greater accountability requirements and leading to higher expectations that may not be able to be met.

It is now evident that market forces have prevailed and that that review's decision not to recommend subsidies of various types, or attempt to control the sector by regulating admissions and fees, could be said to have been vindicated.

A reasonably strong private residential aged care market has evolved supporting older people who are not poor and who are seeking alternatives to the subsidised sector. These services are increasingly differentiating themselves from pension only SRS and do not require subsidy or necessarily higher levels of regulation. Further reference to this matter will be made later.

To summarise on the matter of viability, the patterns noted and carefully analysed in 1987 have continued, and the viability of pension only SRS has been influenced by other changes which have occurred since that time.

If it was highly unlikely that they could generate a *reasonable* profit nearly 15 years ago, it is just as unlikely that most pension only facilities could generate reasonable profit today.

## **Business Capacity**

The pension plus sector of the SRS industry appears to be increasingly represented by more established businesses that are heavily invested in a range of aged care and accommodation services including retirement villages, serviced apartments, Commonwealth subsidised residential aged care as well as SRSs. Clearly, pension plus SRS in these categories have sophisticated infrastructure, well developed administrative, financial and professional supports and much easier access to specialist advice. They are entirely different with regard to those indices than most pension only SRSs.

In addition, an increasing number of pension plus SRSs are horizontally integrated in the corporation with similar services in different locations. Some are also vertically integrated with other forms of aged care including independent living either in retirement villages or serviced apartments at one level and subsidised high and low intensity residential care services at the other levels.

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<sup>49</sup> Health Department Victoria (1987), *op. cit.*, 95 –102.

As the pension plus SRS have become more closely aligned with the developments in the aged care industry overall, including more sophisticated accommodation and care models and more complex corporate structures, the pension only sector remains characterised as highly isolated, with very little infrastructure and lower levels of generic and specialist business skills.

Having said that, there are a number of proprietors of pension only SRSs who do an outstanding job caring for their residents and keeping the business operating under very difficult circumstances. The Department, the Association of Supportive Care Homes, and any other organization interested in maintaining SRS-like services as an accommodation option for financially disadvantaged persons should look to those proprietors as examples of good practice.

The Interim Report prepared for this project addressed the problem of the lack of business skills in the pension only sector, in part, by recommending the Department consider funding and encouraging mentoring relationship between appropriate service agencies and pension only SRS in order to improve their access to the skills and resources which they do not have within their own business. In the current climate, given the financial viability issues for these SRSs, there is no likelihood that they will be able to significantly change their skill base and improve their business competencies without deliberate, targeted assistance.

## **The Service Model**

Pension plus SRS have continued to provide a model of supported residential care for mostly older residents, which is consistent with the generally accepted requirements of a 'whole of life' in-house model of accommodation and support. It should be noted that some pension plus SRSs have been approved as private hostels, or part of their facility has been approved for the purposes of the Commonwealth guidelines. Some pension plus SRSs which have applied for accreditation have not been approved, but the overall pattern is that the pension plus SRS sector is providing a model of aged care which is consistent with the national program of residential aged care

While there are different views about the overall role of residential aged care in Australia's and Victoria's service system, pension plus SRS with their aged care focus are providing close to a main stream model of service.

At the other end of the spectrum of the industry, with its changing resident profile, the traditional SRS model without the addition of external support services, may be inappropriate for some of the people currently living in pension only facilities. Reference has been made to this issue in the other parts of the Report particularly in the context of the analysis of the changes that have occurred since 1987.

The resident profile is younger (under 70 years), with higher levels of long term intellectual or psychiatric disability, or other cognitive impairments, and often multiple disability diagnoses, which is similar to the profile in other States. Some large SRS are now providing residential care for such a diverse population that the facility can be unsuitable for certain categories of residents and may be counter to the care and rehabilitation needs of those residents. As indicated in the post 1987 analysis, the pension only SRS have become last resort

accommodation for some patients, clients or residents who are considered problematic in other professional, subsidised service systems.

Given that about two in every three pension only SRS residents have a diagnosed mental illness, many with multiple disability diagnoses including substance addiction, intellectual disability or acquired brain injury, it is relevant to give attention to the question of current research and writing on supported accommodation for people with long term mental illness.

The project has benefited from the findings of an extensive literature search and analysis undertaken by the Mental Health Branch of the Department in conjunction with the Homelessness Strategy Unit in the Office of Housing<sup>50</sup>. That review provides local, national and international evidence which supports the view that in-house, semi-skilled, whole of life services like pension only SRSs are unpopular for many people with a long term mental illness and can, in some cases, be counterproductive to their quality of life, independence and rehabilitation.

On the other hand the project identified that there are some people with a long term mental illness for whom this type of accommodation is preferred. The group also indicated a preference for residing in private for profit facilities. For these people, SRS type accommodation provides structure and a sense of community *in a non-institutional environment*.

The research indicates that *for many the* preferred accommodation type is generally independent housing, living with family or with a small group, with appropriate support services provided by relevant external agencies based in the community.

There is also a substantial national and international body of literature making similar arguments in relation to the needs of people with intellectual disabilities<sup>51</sup>.

One of the questions which is not answered by the literature review is what is an appropriate balance between in-house personal care and support services and externally provided services. One of the few intensive examinations of a current pension only SRS providing care exclusively for residents with long term mental illness<sup>52</sup> indicated a need for high levels of in-house service provision. This analysis did not address the question as to how many of the services currently provided by SRS staff could be provided by external agencies.

The implication was, however, that the personal care needs of the residents was relatively high and was driving up the overall cost structure of the SRS.

This issue of the appropriate service models, particularly for residents diverse care needs, is critical to discussion of the options available with respect to the future of the pension only SRS industry. Further discussion of the issue of the requirement to provide support services

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<sup>50</sup> Mental Health Branch (January 2001 – Unpublished Draft), *Housing and Support Program Literature Review*, Department of Human Services, Melbourne.

<sup>51</sup> See for example, Disability Support and Housing Alliance (February 1997), *Specific Housing Needs of Persons with Disabilities: Forum Notes*, Melbourne, Emerson, E. *et. al.* (2000), “The Quality and Costs of Community-Based Residential Supports and Residential Campuses for People with Severe and Complex Disabilities” in *Journal of Intellectual and Developmental Disability*, 25, 4, pp. 263 – 279, and Resolutions Group Pty Ltd (July 1998), *Review of Accommodation and Support Needs for People with Acquired Brain Injury (ABI) Stage 1: Project Report*, Victorian Coalition of ABI Service Providers, Melbourne.

<sup>52</sup> Ecumenical Housing Inc (March 2000), *Scottsdale SRS Review*, Melbourne.

in-house, or the capacity to provide them from outside the SRS, is continued in the options presented elsewhere in this report.

## **Compliance with Community Standards and Regulation**

Since the first Community Visitors Report in 1990-91, the issues raised have increasingly focussed on pension only SRSs, particularly over the past five years. While community visitors have identified issues in pension plus SRS and those facilities with a mix of pension only and pension plus residents, each of the reports since 1995-96 have specified that the issues raised apply almost exclusively to pension only SRS.

The focus on pension only facilities arises, in part, because of the fact that pension only SRS generally operate in older and less appropriate premises, seldom have more staff than the minimum required by their registration and are often subject to considerable cost pressure. This combination of factors can compromise the provision of care and support, the quality of meals and the capacity to adequately address changing resident needs.

Overcrowding in bedrooms in pension only SRS has also been a concern of Community Visitors in the past and was the impetus behind the former government's decision to review the bed guidelines and introduce a minimum standard with respect to a bedroom space and privacy for each resident.

Complaints from health and community service industry workers also are generally focussed on pension only SRS and these complaints have consistently identified the problems which were first discussed in the 1987 review and which have continued since that time.

Again it needs to be said that some pension only proprietors have worked with extremely limited resources to provide a humane and caring service to their residents. This outcome has generally been the result of the dedication, compassion and competency of the proprietor which in turn is usually linked to the fact that their leasing and debt costs are moderate and allow some flexibility with regard to the standard and maintenance of the accommodation; the quality of the meals; and attention to care and support services.

Some pension only SRSs with relatively mobile and independent residents who are able to maintain themselves in terms of health and hygiene, also function at reasonable standards.

Consequently, it cannot be said that all pension only SRS fail to meet community standards or the legislative requirements. It can be said, however, that many fail 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.

Since the Act was introduced in 1988, a wide range of formal sanctions have been applied to facilities in all sectors of the SRS industry. Those actions have included official warnings, conditional or short-term registration, refusal of applications for renewal of registration and prosecution for more serious breaches of the requirements of the Act or Regulations.

There have been at least 22 prosecutions in that period, and of 372 individual charges proven, 273 related to breaches in pension only facilities. More significantly, over 70 SRS have

closed since 1988, and most of those were pension only facilities unable to generate adequate returns and meet required standards.

## Market Demand

Notwithstanding the endemic problems of viability, buildings and service standards, business capacity and the appropriateness of the service model for some residents, the demand for pension only SRSs is high and likely to remain high. It is probable that pension only SRSs will experience a constant or increasing numbers of referrals from the wider service system into the foreseeable future, particularly for middle aged and aged adults with long term mental illness, acquired brain injury, multiple disability diagnoses and/or behavioural problems. This trend is similar in other States.

In addition, demand pressure can be expected to continue to increase on remaining pension only facilities as the result of the closure of other SRSs. This pattern is clearly evident already and the number of vacancies in the pension only sector has declined significantly over the past 18 months.

Also as discussed earlier, it appears that the demand for supported accommodation for people with a mental illness in particular will outstrip the capacity of the mental health program to address these needs. The Mental Health Branch estimates that an additional 3,400 people will be diagnosed with a mental illness each year, and 440 of these will need some form of support with respect to accommodation, personal care and rehabilitation.

People with ongoing mental health issues continue to be referred to pension only SRSs from acute settings and by community based mental health service providers. Given that there are many people with a mental illness living in SRSs now, and a significant number of others who are either homeless or living in rooming houses and boarding houses, the growth in need will ensure that there is a continuing demand for pension only SRS-like accommodation for people with a long term mental illness. It should be noted that Victoria, compared with other States, does have a greater range and number of accommodation options for people with mental illness.

A similar pattern of referral is exhibited in other sectors or program areas where clients *are* referred to pension only SRSs. Providers in intellectual disability and acquired brain injury service systems in particular have indicated that they often have no other option but to place clients in a SRS.

It is, therefore, important that provision is made for the better quality pension only SRSs to be included in the housing and support framework for residents with complex needs.

A great deal of work has been done by the Australian Institute of Health and Welfare on the definition, incidence and prevalence of various forms of disability in Australia<sup>53</sup>. That work clearly shows that population growth is a driver of increased demand for a wide range of

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<sup>53</sup> See, for example: Fortune, N, Wen, X. (1999), *The Definition, Incidence and Prevalence of Acquired Brain Injury in Australia*, Wen, X., Fortune, N. (1999), *The Definition and Prevalence of Physical Disability in Australia*, and Australian Institute of Health and Welfare (2000), *Disability and Ageing: Australian Population Patterns and Implications*, Canberra.

mental health, disability and acquired brain injury services, included supported accommodation services.

More significant, however, is the aging of the population. Incidence and prevalence of many disabilities are positively correlated to age, and as the absolute number of older people increases, so the quantity of demand for services, including supported accommodation service, will increase.

The only area in which pension only SRSs have experienced, and are likely to continue to experience, reduced demand is in the traditional market of low dependency, financially disadvantaged older people. The reduction in the numbers of frail aged in pension only SRSs is likely to continue as additional Commonwealth funded residential care services and home care options come on line in Victoria over the next two or three years.

It is also likely that in the context of population aging, and the increasing numbers of older people with independent income associated with superannuation, there is a continuing demand for pension plus SRS as an alternative to subsidised residential care. Pension plus SRS may be affected by the increase in allocation of residential care places in Victoria over the next few years, but it is probable that the overall impact of population ageing will mean that there is a continuing demand for private services. It is also likely that the market will adapt models of housing and care which suit older people with independent incomes and so it is probable that the pension plus part of the market will experience a period of continued growth.

Facilities operating with a mix of pension only and pension plus residents will either move out of business or increase the proportion of pension plus residents, as frail aged pension only residents find places in subsidised residential care or proprietors recognise the marginal cost – revenue implications of caring for pensioners.

## **Comparison of the Relative Business Positions of the Two Sectors of the Industry**

While the Department does not have reliable and systematic data regarding the financial viability and resilience of the industry, some observations about the key differences between the two industry sectors can be made based upon the factors discussed here. They are summarised in the table on the next page.

These factors represent key indicators of the future prospects for the industry in the absence of any immediate, direct and substantial intervention by Government. In most cases, the assessment of the mixed SRSs where there are pensioner and more affluent residents lies somewhere between the two extremes, usually at the lower end of the range unless those facilities are able to redefine themselves over time as pension plus facilities.

RELATIVE BUSINESS POSITIONS OF THE PENSION ONLY AND PENSION PLUS  
INDUSTRY SECTORS.

Indicator	Pension only sector	Pension plus sector
Financial viability	Variable, but generally low	Variable, but generally high
Business capacity	Low, with some exceptions	Variable, but generally high
Appropriateness of model	Generally low to medium for some <del>most</del> of the increasingly dependent resident profile	Generally medium to high for the relatively affluent, aged resident profile
Compliance with standards	Variable, but generally low to medium with less desirable fabric and limited economic resources	Medium to high with some variation across the sector
Demand for service	Medium to high, particularly for referrals from State <i>funded</i> programs	Medium to high, particularly in the area of accommodating self-funded retirees

Some will argue that this rating of the survival indicators is too positive with respect to the pension plus sector of the SRS industry. In particular, it could be argued that some pension plus facilities have experienced problems with financial viability, problems with compliance, and have demonstrated a lack of business skills or appropriate infrastructure.

However, from the information available, it appears that difficulties in pension plus facilities have largely occurred in those in the ‘middle market’.

# Chapter 7: Framing the Solutions

It is clear that the analysis of the industry and its role in the Victorian health and community services system poses some threshold questions which must be asked and answered before any robust and constructive policy framework can be discussed.

Those threshold questions are:

1. Can Victoria continue to lose the low-cost, supported accommodation provided by pension only SRSs?
2. If there is a continuing demand for pension only SRSs, but a number of facilities are increasingly inappropriate for some of their users, are the solutions found in different forms of in-home residential care or in supported housing services or in providing more support packages to residents in SRS with complex care needs?
3. If the viability of these services for adults and older adults on pensions or benefits is, and will remain, a problem, what are the preferred solutions?

This review finds that, not surprisingly, these three questions are interrelated.

Whilst they are examined here in turn, the conclusion derived is consistent with all three questions: Victoria requires an increase in the provision of low-cost housing for adults who, for a variety of reasons, require various forms of protection, care and support.

The solution is most likely to be found in diversifying the State's supported housing programs and the care and support of their residents through community based health, allied health, personal care, community integration, recreation and other specialist services. The poor performing pension only residential based care services should be phased out. In the interest of the residents, this should occur before these facilities are forced out of business by financial circumstances, relatively weak business positions, the additional costs necessary to meet the need to bring safety, accommodation and care standards up to acceptable community standards, and the inappropriate placement of 'difficult cases' by other services. The 'best practice' models of pension only SRS should be encouraged to continue providing accommodation and support for low income residents with complex care needs.

## Threshold Questions

- 1. Can Victoria continue to lose the low-cost, supported accommodation provided by pension only SRSs?**

This brief project has not included any new or detailed examination of current and future market demand for low-cost supported accommodation. Different service sectors, such as those specialising in mental health, intellectual disability, acquired brain injury and aged care, have different demand data sets, each with different levels of analysis and degrees of robustness. While there are strongly held views that the past and impending loss of SRSs is highly problematic, these concerns have not been subject to rigorous study, despite the costs to Government of re-housing people who have been displaced being significant, both capital

and recurrent. To a certain extent, therefore, this review has had to proceed on the basis of a number of assumptions.

It is argued that these assumptions have both face validity and are representative of a constructive position for planning for the future. For the purposes of this Report the following assumptions guide the conclusions:

1. Victoria's health and community services require and depend upon a wide variety of supported accommodation services and at this point there is a shortage of supported accommodation across a variety of different service sectors probably as a result of service redevelopment, reduced availability of low-cost housing and increase in the number of people requiring services. This Report assumes that the range and quantum of supported accommodation services will need to be increased rather than decreased.
2. This Report recognises that the physical location of low-cost and supported housing is important to residents, and potential residents, as well as to the services referring and using supported accommodation services. This assumption means that supported accommodation services, including SRSs or SRS-like services, are required in areas where land and housing costs may be relatively high.
3. This Report recognises that pension only SRSs as they are currently constituted will continue to be sought as accommodation for adults and older adults whose needs, behavior or disabilities *may* present difficulties for other service systems, including disability specific services, mental health services and residential aged care services.
4. A further assumption is that despite the expectation of continuing expansion of the Commonwealth funded residential aged care program and the State funded supported accommodation programs for various groups of people with a mental illness or other disabilities, publicly subsidised supported accommodation services will continue to be unable to meet the particular demand met by pension only SRSs into the foreseeable future.
5. As a result of a number of systemic and policy changes since 1987, the nature of the demand for pension only SRS accommodation has changed to a younger (under 70 years), less frail population with a greater range and level of disability. That change, which has not been fully recognized or acknowledged, will continue and must inform the State Government's response.

In brief, Victoria will continue to require low-cost housing options for adults and older adults with ongoing support needs, and their needs will not be met by the existing subsidised supported housing or residential care services or by the anticipated growth in aged residential care services funded by the Commonwealth..

- 2. If there is a continuing demand for pension only SRSs, but some SRSs are increasingly inappropriate for particular groups of users, are the solutions found in different forms of in-home residential care or in supported housing services or in providing support to SRS pension only residents in their SRS accommodation?**

This Report argues that Victoria will continue to need both supported housing services and residential care services for a significantly diverse population of largely middle aged and younger adults. It is estimated there are around 600 – 700 frail aged people, in pension only SRS, who should be assessed for residential care and given the option.

However, it is also clear that private SRSs, particularly those operating in high cost, leasehold facilities, cannot provide the required high level of care and support services at \$34 per bed-day.

These problems are significant, but by their very nature, point to possible solutions.

How can the pension only SRS industry continue to be a valuable part of the Victorian service system? The starting point is in their function as housing.

The Association of Supportive Care Homes has made the telling point that there is a widespread lack of acknowledgement of the role of the SRSs as, first and foremost, places where people live.

As long as SRSs are perceived as providing residential care, their residents will continue to be disadvantaged. There is generally only \$34 a day to pay for accommodation, utilities, meals, medications and other health needs, food, clothing, personal care and other incidentals, including discretionary expenditure on tobacco and alcohol products or recreational activities.

The validity of this observation can be most simply illustrated by example.

A person with a psychiatric or intellectual disability, in receipt of a disability pension and other appropriate benefits, may choose to live in a rented flat with the support of a community based service provider. That support may take the form of case management, assistance with tenancy management issues, social and clinical support and average up to 20 or 30 hours per week of direct contact with funded, professional workers. The client may choose to take advantage of the offered HACC delivered meals, for which s/he is fee exempt as a result of his financial disadvantage, occasionally supplemented by the free home delivery services provided by a range of local restaurants, for the bulk of her/his dietary requirements. S/he may also choose to pay for a cleaning service to come into his home a couple of hours every fortnight.

Making those choices means that somewhere between 80 and 90 per cent of her/his income is committed before it is received, but that in no way restricts her/his eligibility for, or access to the publicly funded services he receives.

Had s/he chosen to live in congregate environment of a boarding house rather than alone in a flat, s/he would still be eligible for, and have access to, the same range of publicly funded services. S/he may experience a reduction in her/his non-committed, disposable income, but is happy to trade that off against the social advantages of group living and the convenience of not having to pay separately for various utilities and other goods and services.

Had s/he chosen different congregate living arrangements, say a pension only SRS where the fees s/he has to pay even more of his total income, her/his eligibility to receive some of those services, particularly tenancy management, social support, would be limited. S/he may also find that while still technically eligible for the remaining services, s/he is given lower priority by the provider agencies and her/his access is either curtailed or cut-off altogether. In the eyes of the funding system and the provider agencies, there is always someone else more needy or more deserving.

This is a clear example of how publicly funded services can be rationed on the basis of accommodation type. It is also an example of how necessary services can become increasingly rationed as the ability of the individual to pay for them is diminished. It is, therefore, a significant breach of the funding and distribution principle of horizontal equity.

SRS residents have been treated differently by virtue of the private status of their housing and the perception that they live in 'residential care' style services. This perception, together with the consequent restriction of HACC services and the low priority given to SRS residents by other services, was a clear example of policy failure.

It should be noted however, that the current State Government has made provision of HACC services to SRS residents, a funding priority.

For example, in the last HACC funding round 9% of available HACC growth funds \$1.3m, was allocated to projects supporting people living in insecure housing or at risk of homelessness. 11 projects were targeted solely at people living in SRS. Examples of the projects funded in 2000/2001 include social support, planned activities for people living in SRS and a visual arts project, a literacy project, a visiting friends program and flexible support packages.

The importance of the recognition of SRSs as the home of residents is for Governments, Government Departments and funded agencies that SRS residents and those that care for them are beginning to be given some priority in HACC and related programs by Governments, Government Departments and funded agencies.

The aim of the jointly funded Home and Community Care Program, for example, is to provide services to assist people to be more independent at home and in the community<sup>54</sup>. Frail older people and younger people with a disability living in a home they own or rent, either privately or from the Office of Housing, are eligible for all HACC services. Boarding house residents are eligible for everything except property maintenance. SRS residents, on the other hand, are eligible for HACC services such as health care and support or social support, but not delivered meals, home care and property maintenance, personal care or home and community respite<sup>55</sup>.

However, while there is an implicit assumption there that SRSs are something other than a home – that they are long term residential care, even this is ambiguous. Long term residential care is defined in the HACC Act as including care provided in hospitals and other institutions, or through a residential care service within the meaning of the Aged Care Act 1997<sup>56</sup>.

The definition of residential care in the Aged Care Act includes personal care or nursing care, yet requires that there is appropriate staffing to meet the nursing and personal care needs<sup>57</sup>. SRSs do provide personal care, but generally do not provide nursing care and generally do not have appropriate staffing to meet any nursing care requirements that residents may have. Further, any facility that primarily provides care to people who are not frail and aged<sup>58</sup> are

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<sup>54</sup> Aged Care Branch (May 1998), *HACC Program Manual (Final Draft)*, Department of Human Services, Melbourne, p. 9.

<sup>55</sup> *Ibid.*, p. 11.

<sup>56</sup> *Home and Community Care Act 1985 (Commonwealth of Australia – as amended)*, s 4(1).

<sup>57</sup> *Aged Care Act 1997 (Commonwealth of Australia – as amended)*, s 41-3(1) and 41-3(1)(a)(i) respectively.

<sup>58</sup> *Ibid.*, s 41-3(2)(c).

specifically excluded from the definition of residential care, and many SRSs, particularly at the pension only end of the market, cater primarily to younger (under 70 years) people with one or more disabilities, not the frail aged.

The *Health Services Act 1988* makes it even clearer that SRSs are not to be considered as residential care services which are defined as meaning premises where personal and/or nursing care are provided to residents *in respect of whom a residential care subsidy or a flexible care subsidy is payable under an Act of the Commonwealth*<sup>59</sup>. No Commonwealth funding: not a residential care service.

Obviously, the legislation at both the Commonwealth and State level intended that SRSs not be considered as residential care services, yet that is the way that the HACC service system has treated them and other support services have perceived them.

There is also strong anecdotal evidence that SRS residents have greater difficulty accessing services from a range of funded programs, not just the HACC program. They include dental health services, mental health services, disability services and post-acute care.

Action is being taken by the State Government to increase access to these services for SRS residents in pension only facilities. There are for example two Dental Health programs at the Inner South Community Health Service and Western Region Health Service that are funded to provide outreach visits to SRS. Residents are exempted from copayments and given priority access. Oznam house is also funded for a full time dental service which treats homeless persons and residents of SRS. In 2000/2001 in addition to these services \$200,000 was provided for dental services to SRS residents.

So, SRSs are neither homes nor residential care, yet they are perceived as both by different parts of the service system at different times or in different contexts. Residents don't have the protections and benefits of residents in rental housing, nor the subsidised standards and levels of service available to people in similar circumstances.

Equally, the proprietors are confronted with the expectations of clients, their families and referring services that, in effect, demand all the benefits of supported housing and residential care. Despite this, industry reviews, including this review, have consistently recommended against public subsidy.

The view that SRSs are not homes, but residential care services is reinforced by the historic location of the legislative framework for their operation within the Health Act and, later, the Health Services Act. SRSs are substantially different from the other service types governed by the Act, namely hospitals (both public and private), community health centres and day procedure centres. They are all, first and foremost, providers of health services in the traditional sense and are designed to provide that care on the basis that the patient is either not admitted, or only admitted on a relatively short term basis. SRSs, on the other hand, are primarily in the business of providing accommodation for long-term residents.

It is a weakness in the existing legislative framework that such fundamentally dissimilar industries are governed by the same Act. It contributes to a lack of clarity of the role of SRSs in the wider service system, *and* creates unrealistic expectations on proprietors.

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<sup>59</sup> *Health Services Act 1988 (Victoria – as amended)*, s 3(1).

**3. If the viability of these services is, and will remain, a problem, what is the preferred solution: subsidise the service, subsidise the user of the service, or indirect subsidy through other service providers?**

The issue of financial viability has not been examined in any depth since 1987. Recent SRS closures, however, reinforce the fragile nature of the pension only industry sector.

A presumption of this project is that some pension only SRSs survived on marginal rates of return for very long periods of time. The fact that they have done so for so long has often been predicated on a willingness of individual proprietors to forego 'wages' in the anticipation of future capital gains on the sale of the business.

However, as a number of reports have pointed out, endorsed by a wide range of industry participants and observers, additional compliance costs arising from regulatory and policy reforms are soon to take effect and it is anticipated that these may have a major impact on those businesses that are borderline or operating with very marginal returns.

Recognising the precarious nature of viability at the pension end of the market, the 1987 Review examined very carefully the question of public subsidies. Their Report outlines the arguments for and against the application of subsidies and recommends against them for a range of reasons<sup>60</sup>.

To summarise, in 1987 it was concluded that the provision of a subsidy would not necessarily:

- Lead to an improvement in the standards of care;
- Ensure continued availability of the accommodation for financial disadvantaged persons; or
- Lead to an improvement in the viability of pension only facilities.

The Sandon Committee also found there was no industry-wide consensus in favour of subsidies and queried whether or not the introduction of subsidies would place undesirable limitations on the competitive strengths of the industry and limit the play of market forces.

There is no evidence to suggest that any of the arguments against subsidies are any less valid in 2001 than they were in 1987. In fact, other arguments have become apparent over the intervening period that support a case against subsidies. They include:

- The model of care provided in many pension only SRSs is now less appropriate for a number of their current residents, particularly in relation to their developmental and rehabilitation needs and the introduction of subsidies will not necessarily result in better care.
- The needs of residents with relatively low dependency levels, who choose or are placed in SRSs in order that they benefit from the general tenancy management and constant supervision provided by round the clock staffing, can also be met through the development of alternative services such as group living arrangements, supported rooming houses and other, less restrictive congregate accommodation types.

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<sup>60</sup> Health Department of Victoria (1987), *Final Report: Ministerial Review of Special Accommodation Houses*, Melbourne, pp. 94 – 100.

- A small number of residents with very complex clinical and care needs, who require very high levels of support are, and have always been, inappropriately housed in pension only SRSs with relatively poor infrastructure, low levels of expertise and lack of direct access to clinical services. These residents would not be appropriate for any housing and support model and should, in fact, be assessed for access to those subsidised services which were designed to meet their needs, including:
  - Funded residential aged care services;
  - Psycho-geriatric hostels;
  - Community Care and Community Rehabilitation Units provided through the mental health and disability service systems; and

all of which provide full time care with clinical services.

Finally, the significant last resort role for some pension only SRSs has consistently obscured recognition of the more developmental and less restrictive options now available for a number of their residents and the introduction of subsidies would support a service system which may limit the options available to significant numbers of adults with long term mental illness and disabilities of various types.

On this basis, the form of subsidy, which both supports the needs of the residents appropriately and reduces the cost structure of the facility is the enhanced provision of clinical, care and support services directly to the resident.

# Chapter 8: Strategies for Change

The recommendations arising from this project are outlined as three stages of intervention strategies. They have been constructed in this manner in order to address the terms of reference and the outcomes of the research, consultations and analysis undertaken.

The recommendations are based on the directions proposed in the previous Chapter but are modified by the reality of the demands on the SRS industry and associated services. As a consequence, the recommendations do not propose changes that pass on additional costs to SRS proprietors who may already be operating at marginal rates of return.

The recommendations propose a pathway to change the service model from quasi-residential care to supported housing that could be phased in without adding unnecessarily to the uncertainties currently faced by residents, proprietors and referring services.

The recommendations involve additional expenditure, largely in the form of increasing the provision of clinical care, personal care and other support services to SRS residents by community based providers.

The intervention strategies can be briefly described:

## **Stage 1 *Short Term*: Improving Procedures and Processes.**

Strategies to improve the rigour of the licensing and registration processes across the SRS industry; to expand the provision of information to proprietors, prospective residents and their families or referring services; and to strengthen Departmental planning processes, particularly contingency planning for SRS closures. These strategies do not require any changes to the legislative or regulatory environment, nor do they direct additional costs to proprietors.

## **Stage 2 *Short to Medium Term*: Strengthening Program Support.**

Strategies to address various functional and service needs through the provision of professional mentoring to SRSs; to improve resident access to clinical and personal support services; and, to provide discretionary assistance to proprietors to facilitate safety and fabric improvements. These strategies do not require any changes to the legislative or regulatory environment, nor do they direct additional costs to proprietors.

## **Stage 3 *Longer Term Options – Over 5 Years*: Achieving Appropriate Levels of Support.**

Strategies for longer term consideration include the possible introduction of new approaches to licensing and registration that specify the level of care and support services able to be provided by an SRS; this could require assessment of the dependency levels of prospective residents to avoid inappropriate accommodation in an SRS; and, assessment and, where appropriate, relocation of highly dependent residents to more appropriate care settings. These strategies would may result in changes to the legislative and regulatory environment but would not impose additional costs on proprietors.

### **Stage 3 *Longer Term Options: Moving from Residential Care to Supported Housing.***

Strategies for longer term consideration include managing a gradual phasing out of pension only SRSs and the phasing in of private supported rooming houses, privately managed rooming houses in publicly owned stock and other mixed models of accommodation and supportive care. They involve the structural redefinition of pension only supported accommodation services from residential care services within the framework of the Health Services Act to supported housing within the framework of the Residential Tenancies Act.

### **Stage 1 Short Term: Improving Procedures and Processes.**

#### **Relevant Terms of Reference**

The Project Outline for this review required that a range of specific policy, process and structural issues be investigated in the development of advice on a new policy framework. The specific issues addressed at this level of intervention are:

- Methods to improve the responsiveness of Departmental officers and programs, and publicly funded services, to the needs of different client groups living in pension only SRS;
- Strategies to ensure that residents of pension only SRS aged over 65 years are assessed by an Aged Care Assessment Service and, if eligible, are assisted to secure appropriate care options;
- Departmental processes in relation to monitoring compliance with legislative requirements, including the role of the SRS advisors; and
- Departmental processes in relation to determining the suitability of prospective proprietors, the licensing or registration system and processes around approving new facilities.

#### **Policy Objective**

**The policy objective of this intervention level is to define and strengthen the existing range of Departmental interactions with the SRS industry in order that it more effectively meets its legislated responsibilities and Government policy objectives.**

It is essentially a business systems strategy that recognises the practical and policy significance of the effective exercise of Departmental and funded sector agency responsibilities in relation to the information, care and support needs of residents, proprietors and other industry stakeholders.

These recommendations apply equally to pension plus SRSs as to pension only facilities.

#### **Recommendations 1.1: Licensing and Registration**

The Government is open to criticism that applications for approval in principle, registration and related actions are currently dealt with in a manner that is not rigorous, consistent nor timely. In circumstances where there is a potential investment of millions of dollars, where a vendor is awaiting completion of those processes to settle a business transfer, or where

residents are faced with the uncertainty of whether or not the facility they live in will continue to operate under the same management or undergo substantial change, unnecessary delay is inappropriate.

The Department must also develop an improved capacity to effectively meet the existing legislative requirements to consider financial viability and lease arrangements (where they exist) in deciding on applications for registration and renewal of registration. This will require that a more significant alignment of legal, financial and business acumen be brought to bear on those administrative processes in support of the current regulatory and policy expertise.

The current administrative arrangements where the registrar and regulator responsibilities are both aggregated together and decentralised to regions mitigates against the effectiveness of both roles.

In particular, the collection of annual fees from each and every facility and the processing of applications for renewal of registration for somewhere between a third and a half of all facilities every year, is time consuming and deflects SRS Advisors from the very important tasks of assisting and ensuring facility compliance with their obligations to residents.

Certainly, as has been argued, the compliance history of proprietors is critical in assessing applications for renewal of registration, but it is not the only consideration that must, according to the Act, be taken into account and is not sufficient reason to retain the entire process in a fragmented system. This is particularly so in a technological environment that allows for access to electronic records from multiple remote locations, the automated generation of routine reports and almost instant written communication.

There are, on the other hand, significant benefits that are derived from having the SRS Advisors located in Regional Offices. The most obvious advantage is that they are able to develop a clearer understanding of any local factors that may influence the standard of care in facilities. This allows them to work with proprietors on a more informed, and therefore probably more successful, basis than were the advisors managed centrally.

Another significant advantage of having regionally based SRS Advisors is that it puts them in closer touch with other Departmental Officers with intimate knowledge of the local service system across the full range of program areas managed by the Department. This gives Advisors relatively uninhibited access to expertise and resources and helps maintain the profile of the SRS industry with those programs. It is particularly important when a SRS closes and alternative supported accommodation arrangements must be found, sometimes at very short notice, for a significant number of residents.

Some senior Departmental officers argue that it is more appropriate, therefore, to place additional expert resources in Regional Offices in order that they may continue to provide the dual functions of registrar and regulator. If the necessary financial, legal and technical knowledge required for more rigorous scrutiny of applications can be delivered in the regions, then that argument should prevail. If not, the functions relevant to registration should be consolidated centrally.

It has been argued that the consolidation of the licensing functions is a more efficient use of resources, and one that will go some way to addressing the persistent criticism that rules and

guidelines are inconsistently applied. It could be seen as a positive step to addressing the matter of conflict of interest raised by the Association of Supportive Care Homes, the Community Visitors Program and the Independent Review Panel appointed as part of the Bed Number Review process.

Further, it would allow SRS Advisors to more effectively carry out the regulatory and advisory roles for which they were originally intended.

Providing that there is no diversion of current regional resources, consolidation of the registration and related tasks is an effective way for the Government to meet its policy commitment to provide adequate inspection services and effectively monitor compliance in the SRS industry.

**Recommendation 1.1:**

**That in order to undertake more intensive and rigorous screening of applications for registration and renewal of registration, the Department of Human Services consolidate into a single organisational unit, responsibility for the administrative processes currently described in Part 4 of the *Health Services Act 1988* as they relate to supported residential services.**

**Recommendation 1.2: Information for Proprietors.**

The Interim Report prepared as part of this review recommended that the Department require funded agencies to provide appropriate assessment information to SRSs as a condition of client referral to ensure appropriate care is provided upon placement.

Noting that informed consent is a necessary prerequisite to information transfer, this proposal has met with widespread support in discussion with industry stakeholders. It is seen as an important step in the care planning process.

Proprietors, however, need information on a wide range of subjects, not just resident assessments. The Department should develop broader and more accessible information resources for proprietors that include details of Government expectations not only in relation to the requirements of the Health Services Act and Regulations, but other areas including fire safety, food handling, environmental health, drugs and poisons, etc.

**Recommendation 1.2:**

**The Department of Human Services develop broader and more accessible information resources to assist proprietors of supported residential services.**

**Recommendation 1.3: Information for the Public.**

There appears to be a considerable amount of confusion in the community about what an SRS does, and does not, provide for residents. Often there are unrealistic expectations and

residents or their families may be surprised by what they find. The Department, therefore, needs to undertake a broader range of information activities with existing residents, referring agencies, health and support service providers and the wider community.

In addition to information about the industry generally, prospective residents would derive significant benefit from having independent information about specific SRSs that they are considering as accommodation options. Making information on the compliance history of those facilities available would not only be appropriate, but would seem to be a necessary to meet the objectives of the Act that health care agencies be accountable to the public and that users of services have sufficient information to make informed decisions about their care<sup>61</sup>.

**Recommendation 1.3:**

**The Department of Human Services develop broader and more accessible information resources for residents and prospective residents of supported residential services, including in particular, information on the care and support needs of prospective residents referred by funded agencies.**

**Recommendation 1.4: Contingency Planning.**

The Interim Report also recommended that the Department prepare contingency plans that can be activated on short notice in the event of a facility closure.

That proposal met with widespread support in discussion with industry stakeholders, though it was noted that the issue of planning needs to be extended beyond what to do if an SRS closes. Planning to help prevent closures by ensuring that an appropriate range of support services is available for residents is also of considerable importance.

**Recommendation 1.4:**

**That the Department develop more appropriate procedures to anticipate and respond to changes in the supported residential service industry, including in particular, contingency planning to deal with facility closures.**

**Expected Outcomes of these Recommendations**

These actions will reduce the potential risk to residents from inappropriate proprietor or facility registration and from placement or referral to inappropriate facilities. They will also allow existing Departmental Officers to more effectively carry out their monitoring and support roles, thereby meeting existing Government policy commitments, and engendering a more positive working relationship between the Department and the industry.

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<sup>61</sup> *Health Services Act 1988 (Victoria – as amended)*, s. 9(d) and (e) respectively.

They will not have a significant impact on the long-term viability of pension only SRSs operating in leasehold facilities, nor will they solve the problems arising from complex care demands experienced by SRSs accepting residents with very high care needs.

They will impact directly on the way that the Department goes about its business in relation to the SRS industry. The benefits to the industry will, therefore, be indirect and relatively minor, but will be felt in all industry sectors.

## **Stage 2 Short to Medium Term: Strengthening Program Support**

### **Relevant Terms of Reference**

The Project Outline for this review required that a range of specific policy, process and structural issues be investigated in the development of advice on a new policy framework. The specific issues addressed at this level of intervention are focused on the program, process and skill issues in the industry, including:

- Methods to improve the responsiveness of Departmental Officers and Programs, and funded services, to the needs of different client groups living in pension only SRS; and
- Actions that may be taken to encourage the enhancement of the skill levels of personal care workers in pension only SRS to improve outcomes for residents.

### **Policy Objective**

**The policy objective at this intervention level is to improve standards of care in pension only and above pension SRSs through non-regulatory program support changes.**

It is a strategy that recognises the increased cost drivers within the industry (such as increased level and diversity of resident dependency, legislated changes to fire safety and food handling requirements, etc.) and supports proprietors to meet their obligations to residents and other industry stakeholders.

Whilst these recommendations can also apply to pension plus SRSs, they should generally be targeted to pension only facilities.

### **Stage 2 Recommendation 2.1: Mentoring Agencies for SRSs.**

The State, through the Department, funds a wide range of professional and clinical agencies to provide services to the community. Many of these are 'large' organizations with strong expertise in the type of business management, care and ancillary services that are problematic in many pension only SRSs.

The Department should fund appropriate professional and clinical agencies to enter into contractual relationships with particular SRSs to provide a range of identified support services. The range of services provided will vary with individual circumstances.

Contractual or other arrangements will need to be developed that are flexible enough to allow for the provision of a wide range of support services including, but not limited to:

- Access to training programs;
- Financial and management advice;
- Secondary consultation;
- Liaison with service providers;
- Advice with dietetic and food services management; and
- Assistance with developing appropriate cleaning and maintenance schedules.

Residents will be advantaged through being cared for by more skilled staff and in a better managed home with a more secure long-term future.

Proprietors will be advantaged through being able to access advice and support in those areas that they themselves identify as needing assistance with. That support may help them, for example, to improve their financial management, reduce expenditure without compromising service delivery in regards meals and cleaning, or enable them to demonstrate that they have taken the reasonable steps necessary to provide appropriate care for their residents.

It will enhance both the financial viability and compliance capacity of pension only SRSs in an appropriately targeted fashion and so enhance the returns that proprietors receive from the operation of much needed businesses.

Major health and welfare agencies should be supportive of this program because they recognise that they have a vested interest in the maintenance of quality pension only SRSs as local supported accommodation for their clients or patients. Without a network of housing options many facilities, especially acute facilities, will continue to experience significant ‘bed blockages’ or other systemic bottlenecks and people will remain inappropriately housed in hospitals. Pension only SRSs are an important part of that network of accommodation.

Further, the provision of better care in more appropriate and robust home environments should lead to a reduction in the number of emergency and acute presentations for avoidable or manageable conditions by pension only SRS residents.

**Recommendation 2.1:**

**That the Department of Human Services develop and implement a program of professional mentoring agencies to enhance the business capacity and care skills in pension only supported residential services.**

**Recommendation 2.2: Priorities within Support Programs.**

Whilst the industry redefinition strategy recommends that there be changes to the general eligibility and priority criteria of funded programs, this recommendation recognises that changing practices to adapt to the new criteria will take time and that there is an immediate need to target resources to pension only SRS residents.

This means making SRS residents an identified priority target group in existing and new community based support programs and actively promoting to those programs their ongoing responsibility to SRS residents.

It also means providing additional resources to those programs. Many funded support services, however, actively participate in service rationing because the demand for their services is greater than their supply capacity. Under such circumstances, the effect of providing additional resources will be effectively diluted by the current non-SRS excess demand. It must be recognised, therefore, that additional resources need to be found for those programs, and that those resources be dedicated to supporting SRS residents.

This recommendation is about ensuring that funded service agencies more equitably apply needs based eligibility criteria and while it would apply to all sectors of the industry, it would impact most significantly on services available to residents of pension only SRSs.

**Recommendation 2.2:**

**Continue to improve the focus of funded support programs (particularly in the HACC, disability and mental health program areas) on supported residential service residents.**

**Recommendation 2.3: Discretionary Financial Support.**

As discussed in earlier Chapters, a number of pension only SRS proprietors are unable to meet the lump sum capital cost, and ongoing revenue impacts, of meeting new fire safety, food handling and privacy requirements. Deliberate action is required to assist those proprietors who otherwise provide an appropriate, caring and compliant service for their residents.

The Department must develop a capacity to provide favourable loans, non-recurrent grants or other financial support to assist or maintain valuable services on a case-by-case basis. As well as helping appropriate proprietors to meet the capital costs associated with legislative or policy driven changes, it will provide an opportunity for the Department to assist some proprietors negotiate more reasonable lease arrangements and so effectively reduce the ongoing fixed costs in particular facilities.

It should be noted that there is a loose, local precedent for this type of activity in the form of the SRS Sprinkler Initiative which last year provided six grants of \$15,000 each to SRSs that installed sprinklers before the due date.

**Recommendation 2.3:**

**The Department of Human Services consider developing a capacity for discretionary financial support to selected pension only SRS for safety and fabric changes resulting from changes in legislative requirements or Departmental policy.**

## **Expected Outcomes of these Recommendations**

These actions will improve the quality of service delivery and safety of residents in pension only SRSs and will increase the operational capacity of proprietors to meet their legislated responsibilities to residents. They may also preserve a number of valuable service providers in the industry.

These actions will require ongoing monitoring effort.

They will impact directly on the way that the Department supports residents and business operators in the SRS industry. They are targeted actions, the effects of which will be mostly felt in the pension only sector of the industry.

## **Stage 3 *Longer Term Options – over 5 years:* Achieving Appropriate Levels of Support**

### **Relevant Terms of Reference**

The Project Outline for this review required that a range of specific policy, process and structural issues be investigated in the development of advice on a new policy framework. The specific issues addressed at this level of intervention are:

- Actions that may be taken to encourage the enhancement of the skill levels of personal care workers in pension only SRS to improve outcomes for residents;
- Strategies to ensure that residents of pension only SRS aged over 65 years are assessed by an Aged Care Assessment Service and, if eligible, are assisted to secure appropriate care options;
- Departmental processes in relation to determining the suitability of prospective proprietors, the registration system and processes around approving new facilities; and
- The adequacy of alternative accommodation options available to residents of pension only SRS, particularly those residents faced with dislocation from facility closure and those assessed as eligible for Commonwealth funded residential care.

### **Policy Objective**

**The policy objectives, which underpin this intervention level, are:**

- (i) to retain the existing SRS model and improve standards of care and service viability by decreasing the level and diversity of resident dependency in SRSs through the changing of admission practices and dependency levels;**

**OR**

- (ii) to change the model to reduce the current reliance on the pension only SRS sector as ‘accommodation of last resort’ for financially disadvantaged people with ongoing care and support needs and, at the same time, to retain private expertise and privately owned fabric in the wider supported accommodation system through a range of supported housing programs.**

This strategy recognises that if, in the longer term, with the provision of support for residents and proprietors outlined above, it is not possible for some private providers to cover the cost of accommodation and personal care services, to a community acceptable standard, and maintain fees at a level available to people dependent on Centrelink pensions and payments as their sole source of income, other alternatives will need to be considered.

This strategy does not apply to the pension plus sector of the industry.

This approach represents a significant level of industry intervention similar to that currently in use in New South Wales and under development in Queensland and is likely to enhance reasonable standards of service in surviving businesses.

**Recommendation 3.1:**

**That the Department of Human Services further research and develop strategies for longer term intervention around the following possible options.**

*Option (i)*

The recommendation of the Interim Report that funded agencies be required to provide proprietors with assessment information as a condition of referral of a prospective resident has been generally supported by industry stakeholders and there is a recognition that it should be enhanced by expanding it to include assessment of all potential residents. That is, that all prospective residents have an appropriate, professional assessment of their care and support needs before they can be admitted to a registered SRS that can meet those needs. The earlier Chapter on comparable supported accommodation systems describes similar systems in operation in new South Wales and overseas, and currently under development in Queensland.

This would require that the Department identify and fund appropriate, professional assessment agencies and develop administrative processes that allow for registration of SRSs to include certification of the types, levels and mix of care and support services that may be provided to residents. It would also require that the Department develop administrative processes that require and facilitate the ongoing assessment of residents after admission to an SRS to ensure that they continue to be accommodated in an appropriate setting.

This strategy represents a significant new level of intervention into the industry. In 1987, the Sandon Committee rejected any intervention to control admissions or specify levels of care in particular facilities. The changing role of pension only SRSs, and the demands placed on them by other services, however, requires that these actions be considered. It is significant that New South Wales has such a system in place and that Queensland is looking at the options. It should be noted, however, that compared with NSW and Queensland, Victoria has a greater range and number of alternative accommodation options already in place.

Proprietors would benefit from a more consistent referral process and assistance with ongoing care planning as well as there being more realistic expectations of the service that they can deliver. There are also potential benefits from the identification of market opportunities in particular types of care and specialisation to exploit those opportunities.

This also represents an opportunity for the Department to gather information on the care needs of residents assist in planning and resourcing appropriate service responses. The lack of any comprehensive or reliable information of this type has been discussed earlier as an impediment to the preparation of this Report. There is no doubt that it has also been a significant contributory factor to the adequacy of the Department's response to the ongoing needs of residents and the crisis response nature of the limited planning that has gone on over many years.

- **That consideration is given to requiring better assessment of prospective residents' dependency levels by appropriate professional agencies before admission to a supported residential service and that residents only be referred to SRS, if appropriate to the resident's need.**
- **That facility and proprietor registration include recognition of their appropriateness to provide supported accommodation for people with different care and support needs.**

The observation has been made that there are some people living in SRSs that are inappropriate to their care needs because of their very high levels of dependency and their need for greater levels of support. As discussed earlier, this has serious repercussions for the physical and mental health of those residents and can lead to otherwise avoidable acute and emergency admissions to hospitals and other health services.

Such inappropriate placements can also have an adverse effect on the health and wellbeing of other residents, and drive costs up across the whole facility.

It is of concern that many of these inappropriately accommodated residents are living in pension only SRSs because they are considered too difficult to care for in State or Commonwealth funded services or because the residents do not want to live in Government funded services.

If, as a result of the gate-keeping measures above, these very high need residents cannot live in SRSs, they have to be provided with alternative accommodation and support. The State and Commonwealth must, therefore, fund some additional capacity in alternative care settings across a range of program areas, and in mental health and disability services particularly for these very high needs residents who need greater levels of support. There are a range of Government funded accommodation options available in Victoria. Some increases to these options targeted at very high needs residents in SRS who need and want to move are recommended.

Current pension only SRS residents will require priority access to those alternative care settings, including Commonwealth subsidised residential aged care services.

- **That consideration be given to relocating very high dependency residents to more appropriate care settings.**

## **Expected Outcomes of these Recommendations**

These actions will improve the standards and appropriateness of care for residents in surviving SRSs through better matching of care provider and receiver. They should also deliver improved viability for surviving businesses by decreasing costs associated with high levels and diversity of resident care needs.

These actions may be seen as an unwarranted restriction on the capacity of individual businesses to affect their customer base.

They will fundamentally change the way that the Department considers applications for registration and renewal of registration. It will also fundamentally change the way that prospective SRS residents access accommodation by ensuring that they can access appropriate services. Changes to referral and registration practices will apply to all sectors of the industry. The impact of those changes, however, will be greatest in the pension only sector where there are more likely to be inadequate fabric or residents with care needs and expectations beyond which the proprietor can reasonably manage with additional support.

### ***Option (ii)***

It is apparent that some pension only SRS currently have an uncertain future in their current form and all the recommendations are about taking positive, considered steps to ensure that there are sufficient supported accommodation options available for people who need them.

They are also about more effectively using under-utilized publicly owned infrastructure and working with appropriate public and private sector service providers to meet the needs of some of the most disadvantaged and vulnerable members of the community.

The type of actions that have been proposed at one time or another, and should be supported, include:

- Involving local government and community agencies in the development of new models of supported accommodation for financially disadvantaged people;
- Involving reputable service providers, including not-for-profit specialist agencies and appropriate SRS proprietors, in the provision of hotel and personal care services in those models;
- Enhancing existing housing and support programs to provide for clustering of support services in discrete locations, thereby enhancing the capacity of a range of housing options to meet the needs of people with support needs;
- Turning over nomination rights to hard-to-let Office of Housing stock to reputable service providers to operate as supported accommodation;
- Making Crown land available for development as supported accommodation, possibly under favourable long-term lease arrangements, in return for a contractual obligation to provision of care for an agreed number or proportion of financially disadvantaged persons.

In order to give coherence and direction to these proposals, DHS should consider strengthening the supported housing program with stronger linkages to the various disability specific programs, such as mental health, disability, drug and alcohol, etc.

- **That consideration be given to increasing the range and availability of publicly owned fabric for housing financially disadvantaged people with ongoing care and support needs.**
- **The Department consider development of a supported rooming house program in cooperation with local government and appropriate service providers.**

The current programs do not encourage skilled and committed private providers such as experienced SRS proprietors to shift from residential care to supported housing. This change has benefits for many stakeholders, but would require additional funded support programs.

Including SRS in the housing and support framework and supporting residents *and* proprietors to improve quality of accommodation and care and taking the actions described above will allow the Department to cease to approve applications for new SRSs where the financial capacity is not robust. Where appropriate, proprietors may be encouraged to register as rooming houses where support services will be available to residents from a variety of funded community based programs.

It is important to consider that SRS are an accommodation type preferred for some groups who do not want to be in Government accommodation.

- **Encourage some pension only SRSs to become supported housing rather than residential care, with appropriate support provided for residents by independent, external agencies.**

### **Expected Outcomes of these Recommendations**

These actions will remove the existing systemic reliance on the pension only SRS sector and provide an opportunity for the Government to be proactive in areas of concern identified in the Victorian Homelessness Strategy. Conversion of pension only SRSs into rooming houses with externally provided support has additional benefits in reducing the number of registered SRSs, and therefore the regulatory and monitoring effort required, whilst simultaneously opening them up to wider scrutiny and automatically extending the protection of the Residential Tenancies Act to residents in line with existing Government policy commitments.

These actions will not adversely affect the viability of above pension facilities, and may produce a long-term goodwill benefit from reduced negative industry exposure.

They are about making fundamental changes to the pension only SRS industry sector and should be seen as longer term recommendations for consideration by Government and the industry.

# RECOMMENDATIONS

## SHORT TERM RECOMMENDATIONS

**Recommendation 1.1:**

That in order to undertake more intensive and rigorous screening of applications for registration and renewal of registration, the Department of Human Services consolidate into a single organisational unit, responsibility for the administrative processes currently described in Part 4 of the *Health Services Act 1988* as they relate to supported residential services.

**Recommendation 1.2:**

The Department of Human Services develop broader and more accessible information resources to assist proprietors of supported residential services.

**Recommendation 1.3:**

The Department of Human Services develop broader and more accessible information resources for residents and prospective residents of supported residential services, including in particular, information on the care and support needs of prospective residents referred by funded agencies.

**Recommendation 1.4:**

That the Department develop more appropriate procedures to anticipate and respond to changes in the supported residential service industry, including in particular, contingency planning to deal with facility closures.

## SHORT TO MEDIUM TERM RECOMMENDATIONS

**Recommendation 2.1:**

That the Department of Human Services develop and implement a program of professional mentoring agencies to enhance the business capacity and care skills in pension only supported residential services.

**Recommendation 2.2:**

Continue to improve the capacity of funded support programs (particularly in the HACC, disability and mental health program areas) to focus on supported residential service residents.

**Recommendation 2.3:**

The Department of Human Services consider developing a capacity for discretionary financial support *to selected pension only SRS* for safety and fabric changes resulting from changes in legislative requirements or Departmental policy.

***LONGER TERM RECOMMENDATIONS – OVER 5 YEARS***

**Recommendation 3.1:** That the Department of Human Services further research and develop strategies for longer term intervention around the following possible options.

**Option (i):**

- That consideration is given to requiring better assessment of prospective residents' dependency levels by appropriate professional agencies before admission to a supported residential service and that residents only be referred to SRS, if appropriate to the resident's need.
- That facility and proprietor registration include recognition of their appropriateness to provide supported accommodation for people with different care and support needs.
- That consideration be given to relocating very high dependency residents to more appropriate care settings.

**Option (ii):**

- That consideration be given to increasing the range and availability of publicly owned fabric to house financially disadvantaged people with ongoing care and support needs.
- The Department consider development of a supported rooming house program in cooperation with local government and appropriate service providers.
- Encourage some pension only SRS to become supported housing, rather than residential care, with appropriate support provided for residents by independent, external agencies.

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187. *Retirement Villages Act 1992 (Western Australia – as amended)*.

188. *State Environmental Planning Policy No 10, Retention of Low-Cost Accommodation (New South Wales – as amended).*
189. *Supported Residential Facilities Act 1992 (South Australia – as amended).*
190. *Supported Residential Facilities Regulations 1994 (South Australia – as amended).*
191. *Youth and Community Services Act 1973 (New South Wales – as amended).*
192. *Youth and Community Services Regulations 1995 (New South Wales – as amended).*