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Equity of access to HACC services for residents of licensed boarding houses: report for NSW DADHC

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Equity of Access to HACC Services for Residents of Licensed Boarding Houses

Final Report

Prepared for the NSW Department of Ageing, Disability and Home Care, Metro South West Region

by

The Disability Studies and Research Institute

August 2005
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## Abbreviations

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<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ALI</td>
<td>Active linking Initiative</td>
</tr>
<tr>
<td>BHRP</td>
<td>Boarding House Reform Program</td>
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<tr>
<td>BHT</td>
<td>Boarding House Team (more fully the Central Sydney Boarding House Team)</td>
</tr>
<tr>
<td>DSaRI</td>
<td>Disability Studies and Research Institute</td>
</tr>
<tr>
<td>DADHC</td>
<td>NSW Department of Ageing, Disability and Home Care</td>
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<tr>
<td>HACC</td>
<td>Home and Community Care</td>
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<tr>
<td>HACC DO</td>
<td>HACC Development Officer</td>
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<tr>
<td>JESI</td>
<td>Joint Enterprise Service Initiative</td>
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<tr>
<td>LGA</td>
<td>Local Government Area</td>
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<tr>
<td>LPA</td>
<td>Local Planning Area (HACC)</td>
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<td>LRC</td>
<td>Licensed Residential Centre</td>
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Executive summary

This paper reports on a research project which was funded under the HACC Program and commissioned by the NSW Department of Ageing, Disability and Home Care (DADHC) to examine the equity of access to Home and Community Care (HACC) services by residents living in licensed residential centres (LRCs) and identify measures to improve that access.

Barriers to the access of LRC residents to HACC services were identified through conduct of the research, which canvassed the views and experiences of LRC residents, HACC service providers, LRC licensees and stakeholders associated with the LRC sector.

A series of strategies to address the identified barriers were developed during the analysis of the project findings.

Training and Information Package

The primary output of the project is a training and information package designed to improve access to HACC service for LRC residents.

The package includes
- Training for HACC service providers
- Resources for HACC service providers
- An information resource for LRC residents
- An information resource for LRC licensees

Themes

The findings, barriers and strategies can be viewed through the five major themes which were developed during the project. These are detailed below.

1. Eligibility and Priority for HACC Services

Barriers for LRC resident’s accessing HACC services include:
- Understanding of LRC residents eligibility for HACC services by HACC service providers
- Understanding of the LRC environment by HACC providers

Strategies to address these barriers are:
- Increasing clarity of assessment processes
- Streamlining assessment processes
Ensuring the appropriateness of screening and assessment tools to this target group
- Considering targeted resources to ensure this group have equitable access to HACC services.

2. Information and Referral
Barriers in this area include:
- Level of knowledge of HACC services by LRC residents and licensees
- Level of knowledge of the LRC environment by HACC services.

Strategies to address these barriers are:
- Development of information about HACC services in formats accessible to LRC residents
- Development of information about HACC services targeted to LRC licensees
- Promotion of this information in a range of ways
- Development of information about LRCs for HACC service providers.

3. Service Provision
Barriers for LRC residents in receiving HACC services include:
- Level of expertise of HACC services in working with this group
- Resource limitations of HACC services
- Perceptions of the support needs of LRC residents
- Limitations of the physical environment of LRCs.

Strategies to address these barriers are:
- The development and implementation of a training workshop for HACC service providers to support them in working effectively with LRC residents
- Training HACC Development Officers or nominated representatives (eg HACC Training Officers) to conduct this training for other HACC workers
- Developing additional modes of education and awareness raising for HACC workers, such as coaching and mentoring.

4. Characteristics of Residents
Barriers to the provision of HACC services to residents in this area include:
- Lack of accessible information about HACC services for LRC residents
- Capacity of residents to identify their own need for HACC services
· Need for greater coordination for LRC residents with complex care needs.

Strategies to address these barriers are:
· Targeted use of HACC case management or strengthening of existing coordination strategies for those clients who require several HACC services.

5. Service Capacity and Systems Issues

Barriers in this area include:
· High demand for HACC services
· Access to LRCs by HACC services
· Communication between service systems
· Representation of LRC issues in HACC forums.

Strategies to address these barriers are:
· Using regular HACC forums to update others about initiatives and share information about LRCs
· Developing LRC specific forums to share information relevant to multiple stakeholders who work in the sector.
1. Introduction and Background

Introduction
This paper reports on a research project which was funded under the HACC Program and commissioned by the NSW Department of Ageing, Disability and Home Care (DADHC) to examine the equity of access to Home and Community Care (HACC) services by residents living in licensed residential centres (LRCs) and identify measures to improve that access.

The report summarises the findings of the research project, details the barriers to access identified in the research and discusses the strategies proposed to enable implementation of the barriers. The primary output of the project is a training and information package targeted to HACC service providers. The training module for HACC workers and accompanying information resources for LRC managers and residents form a significant attachment to the report.

Background
The overall aim of the research project was to examine equity of access to services of the HACC Program by residents of LRCs and to develop options to improve their access. The project focused on a metropolitan area (the Inner West Local Planning Area (LPA)) and a semi – rural area (the South West Sydney LPA), specifically the Wingecarribee Local Government Area. The project identified and articulated barriers to accessing HACC services for residents of LRCs. Following the identification of barriers, strategies have been developed which may overcome the barriers.

This project was commissioned by DADHC and conducted by an independent research organisation in order to inform the Department in making implementation decisions in this area. Views expressed in the report are not necessarily those of the Department, and no commitment to implementing the strategies identified in the report has been made at this point.
2. Relevant Programs and Structures

*Home and Community Care Program (HACC)*

“The HACC Program is a joint Commonwealth, State and Territory initiative. It funds basic maintenance and support services to help frail older people and younger people with disabilities continue to live in the community.” (HACC 2002A)

“The aim of the Program is to assist these groups to live at home longer. Without HACC services they may be unable to manage at home and may need to go into long term residential care (such as a nursing home).” (HACC 2002a)

“People of any age may be eligible for HACC services. To be assisted through the HACC Program people must
- live in the community; and
- have difficulty performing every day tasks (eg dressing, preparing meals, house cleaning without help because of a disability; and
- may require admission into long term residential care without assistance from a HACC service.

The Program also assists the carers of this group of people.” (HACC 2002a)

“Some groups can have difficulty in finding suitable services due to cultural or other special needs. Special efforts are made to reach them. These groups are:
- people from culturally and linguistically diverse backgrounds;
- Aboriginal and Torres Strait Islanders;
- People with dementia;
- Financially disadvantaged people; and
- People living in remote or isolated areas”

(HACC 2002a)

“It is important to recognize that even though a person may fall within the categories of eligibility, HACC is not an entitlement program. There is no guarantee of receipt of HACC services, access to services is based on relative need. Service providers determine priority of access policies” (HACC 2002b).

The types of assistance which a person receives through the HACC Program (service types) include:
- Domestic assistance
- Social support
- Nursing care
- Allied health care
- Personal care
- Centre-based day care
- Meals
- Other food services
- Respite care
- Assessment
- Case management
- Case planning/review and co-ordination
- Home maintenance
- Home modification
- Transport

(HACC, May 1998)

Residents of Licensed Residential Centres:

- may be considered eligible for some HACC services subject to assessment processes and subject to the ‘NSW HACC Statement Clarifying Eligibility’ criteria on acute illness.
- situations apply to residents of LRCs where HACC services may be delivered to eligible clients where these services do not form part of the Conditions of License.
- may be considered to be part of the HACC special needs group of financially disadvantaged and as such service providers may make ‘special efforts to reach them’ (HACC 2002c).
- the service types for which their accommodation may make them ineligible would include:
  - Home modification
  - Home maintenance
  - Domestic assistance
  - Meals
- The service types for which their access to special programs may make them ineligible would include:
  - Centre-based day care (only available for frail aged people)
  - Social Support (peer support)

Case management services would only be available in exceptional circumstances where there is a need for multiple HACC services. HACC case management is not to be used as a substitute for mental health case management.
Licensed Residential Centres (LRCs)
Licensed Residential Centres (LRCs) are private-for-profit accommodation houses, sometimes referred to as “licensed boarding houses”, where two or more persons with a disability are accommodated. The LRCs are licensed under the Youth and Community Services (YACS) Act 1973. People who run these services are referred to in this report as ‘managers’ or ‘licensees’.

People with support needs who wish to become resident in an LRC are first be referred to the Aged Care Assessment Team (ACAT) in Metro South West Region, and undergo assessment for suitability using the Screening Tool for entry into Licensed Residential Centres. Residents pay up to 95% of their pension money for board and lodging at the LRCs (The Allen Consulting Group 2003). Under Conditions of Licence, LRC operators are obliged to provide meals, bedding and to ensure necessary health care and supervision.

Boarding House Reform Program (BHRP):
The BHRP refers to a strategy introduced by the NSW Government in 1998. Following a statewide assessment of residents in Licensed Residential Centres (LRCs), the Minister for Ageing and Disability announced three broad objectives under the BHRP in October 1998; namely:

- To improve the standard of accommodation and support to residents of LRCs;
- To relocate LRC residents whose needs could not be appropriately met in LRCs to other supported accommodation and to prevent inappropriate entry to LRCs; and
- For LRCs to remain viable options of accommodation and services where safety and affordability satisfy minimum benchmarks.

Capital funds were provided to establish alternative accommodation for relocated LRC residents. Funding was also provided to support the people relocated from LRCs to more appropriate supported accommodation and for services to people remaining in LRCs.

The key services provided to people under the BHRP remaining in LRCs are personal care, community integration activities comprising skills development, social and recreational activities, primary and secondary health care, and escorted medical and dental transport.

From 2004-05, the budget for personal care services in LRCs has been derived from the HACC program.
3. **Service Context**

This section describes findings about the service context derived from information gathered from DADHC, Steering Committee members, other stakeholders and national and international electronic searches.

Contextual matters have a considerable impact on the scope and effectiveness of the provision of supports to LRC residents. Six relevant issues are discussed briefly in the following section of the report: historic context, current LRC environment, services currently provided in LRCs, initiatives in other jurisdictions, availability of housing and human services, and community attitudes.

3.1 **Historical context**

The process of deinstitutionalisation that occurred in NSW since the early 1980s is highly pertinent to the current service context. Large numbers of people with a disability were referred from government-run institutions, both psychiatric facilities and those specifically for people with an intellectual disability, to private residential facilities. Anecdotal information indicates that a significant proportion of those people are still residents in private residential facilities today. There is a considerable population of long term residents who have support needs that are inadequately met in the private residential environment.

3.2 **Current environment**

The primary diagnosis of LRC residents is mental illness (65.8%), with 21.1% having an intellectual disability, and 9.7% having alcohol related brain damage (The Allen Consulting Group 2003).

For a number of years the health of the LRC residents has been a major focus of concern and action by the professionals who have provided support within those environments. Health issues of LRC residents are rendered complex by the high incidence of mental illness amongst the population, the passive nature of many residents, and the collective environments in which they live, which can serve to render individual needs invisible. Several research reports comment on the pervasive impact of the reluctance and inability of many LRC residents to self monitor their health (Swan, 2001) and deficiencies in ongoing preventative and responsive health treatment (Carroll and Millard, 1999).
3.3 Current provision of services to LRC residents
In 1998 the Boarding House Reform Program (BHRP) was initiated by the NSW Government to improve conditions for those people living within LRCs. A large number of residents, identified as having “high high” needs were moved from the LRCs into alternative, supported accommodation. For those who remained living in the LRCs recurrent funding was committed to supports to residents, such as the Active Linking Initiative (ALI) support to assist residents to access leisure and other options outside of the LRCs; and the purchase of personal care support from the Home Care Service of NSW and to enable all residents remaining within the LRCs to have access to personal care as they require it. Funds were also allocated to provide health and allied health services to LRC residents, in particular podiatry and dental services. From 2004-5, personal care services are funded through the HACC Program.

The Central Sydney Area Health Service Boarding House Team, commonly known as The Boarding House Team (BHT) was established in 1995 to improve the standard of health and hygiene of LRC residents in the Inner West Sydney LPA (Swan 2001). The function of the BHT is broad, fulfilling the role of Mental Health case management, but also overseeing many of the primary and allied health needs of the residents. This involves negotiation with LRC licensees, and the coordination of various transport and other services to ensure residents have access to the services they require to address their health needs.

In the Wingecarribee area the position of LRC Case Worker was established in 2000. This is funded by DADHC using BHRP funds. The role of this worker is very similar to that of the BHT in the Inner West, delivery of primary and secondary health support to LRC residents. The role of the Mental Health Liaison Officer has recently been enhanced by the development of a regular mental health clinic within one of the large LRCs in the Wingecarribee, effectively providing a more targeted and regular management of mental health matters for LRC residents.

3.4 Other initiatives
Other initiatives that have targeted the health care of LRC residents have used a similar model to that used in both the Inner West and the Wingecarribee areas, namely a dedicated worker or team that has close association with, or is employed by, the local Area Health Service.
Other states are also grappling with these issues. The Resident Support Program in Queensland provides three linked service types to residents of privately operated hostels and boarding houses in five areas of the state. The first service type, Key Support, is a short term limited case management and referral model which is funded and monitored by Queensland Health. The second service type, Disability Support Services, offers personal care assistance to residents, and is funded and monitored by Disability Services Queensland (DSQ) and implemented by non government agencies. The third service type, Community Linking, offers social and community linking support to residents in order to encourage their inclusion in a range of activities and relationships in their communities. This element is funded and monitored by DSQ.

3.5 Availability of housing and human services
Unmet demand for accommodation and support arrangements to meet the needs of people with a disability is high across the State. The shortage of social housing across NSW has been described as a critical issue at several points in the review.

The shortage of suitable, low-cost social housing, mainstream human services (eg. health, mental health, allied health, community, welfare, employment and education), and disability specialist support services is a significant contextual issue which impacts on the demand for, access to and provision of HACC services to LRC residents.

3.6 Community attitudes
The final contextual limitation is community attitudes. Prejudice and discrimination in the general community will constrain any long-term strategies to integrate people with a disability living in the most marginal settings into the community at large.
4. Methodology
The research was developed and undertaken using a combination of research methods underpinned by a participatory action research methodology. An overview of the methods of data collection, their objectives and the target groups are described in this section.

The development and implementation of the methodology was overseen by an internal DADHC steering committee and advised by an expert reference group made up of representatives from the sector.

4.1 Literature review
Literature, document and information reviews were conducted, with particular emphasis on Australian and New South Wales literature and information, including historical information that provides context or informs the review. This material was gathered from DADHC, Steering Committee members, other stakeholders and national and international electronic searches. Any links to other Australian or similar jurisdictions were also investigated.

The current policies and practices used by HACC services to refer and provide HACC services to residents of LRCs were identified and scoped through document review and interviews as described in this document. This included description and review in terms of appropriateness, effectiveness and efficiency from the multiple perspectives of DADHC, people using HACC services and other stakeholders.

4.2 Collection of primary data
The aim of the data collection was to capture information on the equity of access to HACC services for people living in LRCs, identify barriers to this access, and develop strategies for overcoming those barriers. Through the use of qualitative and quantitative research methods, two main data collection methods were employed to meet the above objective – a written structured questionnaire, and face-to-face and telephone interviews for both individuals and groups.

4.2.1 Data Collection Methods

Structured Interviews
Themed interviews were conducted with the following stakeholders to identify barriers to access:
Table 1: Details of Interviewees.

<table>
<thead>
<tr>
<th>Interviewees</th>
<th>Wingecarribee Area</th>
<th>Inner West Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRC Residents</td>
<td>12</td>
<td>18</td>
</tr>
<tr>
<td>LRC Licensees</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>ALI Providers</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Peak Body Reps</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Community Visitor</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

Community forums
Forums for service providers and other stakeholders were held in the Wingecarribee area and the Inner West of Sydney to identify barriers to access.

Table 2: Forum Attendees

<table>
<thead>
<tr>
<th>Forum Attendees</th>
<th>Wingecarribee Area</th>
<th>Inner West Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>HACC Service Providers</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>LRC Licensees</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>HACC DOs</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Peak Body Reps</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>ALI Providers</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Other Service Providers</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>LRC Caseworkers</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
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Consultation with Key Stakeholders
The second stage of the research project, development of strategies, included targeted interviews, based on the identified barriers, with 14 key stakeholders in the disability, HACC, LRC and peak organisation sectors.

Structured Questionnaire
A questionnaire was developed to be completed by HACC service providers to determine their levels of service provision within LRCs. 19 questionnaires were returned.

Other data collection
Telephone and individual interviews were also conducted with three other key stakeholders in order to follow up particular information. An unsolicited submission was received from one health provider.
4.3 Methods of analysis

Qualitative data obtained through interviews and consultation forums was manually themed and analysed to identify the emerging themes and critical issues. Data from written structured questionnaires was collated for descriptive analysis.
5. Findings of the research

The five primary themes which emerged during the data collection phase of the research are presented here. These themes are

1. Eligibility and Priority for HACC Services
2. Information and Referral
3. Service Provision
4. Characteristics of Residents
5. Service Capacity and Systems Issues

5.1 Eligibility and Priority

Eligibility for HACC services
A degree of uncertainty about the eligibility status of LRC residents for HACC services was identified amongst HACC services. Of the 18 responses to the HACC service provider questionnaire, 6, or 33%, indicated that they felt LRC residents were either ineligible for HACC services or they were unsure of their eligibility.

While HACC services are familiar with the HACC special needs groups, it is not clear that they recognise the position of LRC residents as potentially included as one of these special needs groups, financially disadvantaged people. This is in part due to a lack of knowledge of the LRC environment for some HACC service providers, leading to assumptions that care is already provided to people living in this environment, making them ineligible for HACC services. Another interpretation of HACC service providers which emerged in the research was that eligibility of LRC residents for HACC services may be called into question because LRCs are seen as institutions, and HACC services are delivered to people in the community in order to avoid institutionalisation.

LRC licensees did not demonstrate a sound understanding of the range of HACC services potentially available to residents, or an understanding of how to access those services. A poor level of knowledge of the way in which HACC services are organised was also a feature common to licensees.

Prioritisation of need
The research did not identify a single standardised system for prioritisation of need among HACC services. The overarching HACC policy for prioritising is ‘on the basis of relative need’ (HACC 2002c). A number of systems for determining priority of access to HACC
services were described by HACC service provider respondents to the questionnaire. These ranged from adherence to the Ongoing Needs Identification (ONI) tool, to allied health giving consideration purely to physical health, to a social support program which targeted men with high needs, as they were deemed to be at highest risk of social isolation. Although HACC policy requires service providers to prioritise, the range of prioritisation practices of particular services and the different weightings they use result in variation across services. This variation makes it more difficult to ensure LRC residents are prioritised for access to HACC services.

HACC service providers who did not provide targeted services to LRC residents indicated that they would not prioritise LRC residents, due to the support they perceive them to already receive through the LRC licensee. Stakeholders in the sector also reported a practice of failing to prioritise LRC residents by HACC services, because of the perception that they were already receiving adequate support through the LRC.

The issue of screening tools for LRC residents emerged at several points in the research. Two screening tools are in operation in the sector – the BHRP screening tool and the HACC Functional Screening and Assessment Tool.

The BHRP screening tool was explicitly developed to prevent inappropriate entry of people into LRCs. It is not a needs assessment tool. It is administered by the Aged Care Assessment Teams in Metro South West Region. It is not used by HACC service providers.

The HACC Functional Screening and Assessment Tool is used by many HACC services to provide an initial assessment of a person’s needs and to indicate when a more comprehensive assessment may be required.

Research indicated that some HACC service providers who are unfamiliar with the LRC environment and the BHRP screening tool may assume that the people screened for entry to LRCs may have low support needs and therefore be ineligible for HACC services. Stakeholders said that more training of HACC service providers would be required to ensure adequate understanding of the LRC environment and the function of the BHRP screening tool to prevent any disadvantage to LRC residents.
The capacity of the HACC entry and exit protocols to deal effectively with those who have episodic disability was raised several times in the research. The perception of both HACC workers and other stakeholders was that it is difficult for HACC services to meet the needs of people who had changing support needs, given the demands on HACC generally and the need to free up places to those who were in the most need.

5.2 Information and Referral

Residents were not aware of the HACC Program, although many could identify Home Care and Community Transport. Residents in both areas were unaware of how to access information about HACC services or how to get a service. Most residents indicated that they would approach the LRC Licensee to assist in a referral, although some residents were reticent about involving Licensees in referral, and chose instead to nominate alternative service providers or caseworkers as helping them with referral.

LRC Licensees showed a limited knowledge of the range of HACC services potentially available and how the HACC system hangs together. This varied across the regions, with Sydney based LRC licensees better aware of the range of services available. Awareness of HACC services by other stakeholders was quite high.

HACC service providers draw on a range of information resources to promote their services. None of these resources were targeted particularly to the needs and literacy levels of LRC residents. However, HACC service providers expressed unwillingness to actively promote services they were not able to deliver due to resource constraints. The need for accessible information about HACC services targeted at residents and at LRC licensees was commonly identified in the research.

The research indicated overall that LRC residents and LRC Licensees had little information about HACC services, what they offered and how to apply for them. Stakeholders suggested strategies of information provision and education, primarily to those service providers who currently do deliver support within the LRCs, as they are often in a good position to advise residents, and also to persuade LRC Licensees that the addition of HACC services within their premises is desirable. The need for LRC representatives to become more aware of ongoing HACC discussions, for example, at the HACC forums, was also discussed, as was the need for a forum
that looked at LRC service needs generally within the Inner West area.

The provision of information about HACC services was generally regarded as needing to be supplemented by visits from HACC services or representatives. This should occur on a regular basis, to provide an opportunity for LRC residents to engage with providers, and for LRC Licensees to become comfortable with the idea of new services.

HACC services were regarded by stakeholders in both regions as largely unaware of the needs of residents, unless they were already providing support within the LRCs. It was suggested that formal training be supplemented by closer collaboration amongst service providers, and the mentoring/coaching of HACC services by those HACC services, and other services, which already provide to LRCs.

### 5.3 Service provision

A range of HACC services were provided to residents by respondents, including personal care, transport and social support. Considerable variation between regions was found in the rate of HACC services provided to residents of LRCs. A range of issues were identified as barriers to the access of residents to HACC services.

**Physical issues**

HACC service providers nominated several issues which impacted on service provision to LRC residents. These included

- occupational health and safety issues (such as unsafe bathrooms)
- communication difficulties which resulted in clients not being ready or present to receive the service
- the control licensees have over residents and access to residents by HACC service providers
- mistrust and privacy concerns of residents which prevent them taking up HACC services, and
- resident characteristics such as challenging behaviour.

Several respondents gave examples of the cooperation of LRC managers in assisting residents to be ready for the service and in liaising about changing care and needs of residents.
There was little evidence of LRC residents using HACC services as other clients would, with some specific exceptions such as Community Transport and some meal services. This has implications for ensuring equity of access for residents to generic HACC services, rather than those provided through the targeted funding stream.

Systemic issues
HACC service providers in both areas spoke of the difficulty of meeting demands for service provision within existing resources. It was suggested by some that this pressure, coupled with a lack of knowledge of LRC residents and services provided within LRCs, may affect their judgement on the eligibility of LRC residents for LACC services.

LRC licensees were generally satisfied with the quality of the services that were being provided by outside agencies to the residents of their LRCs, although some were not satisfied with the quantity of those supports.

Several different views on ease of access into LRCs by HACC services were expressed in the course of the research. LRC licensees did not identify environmental issues within the LRCs as posing a barrier for residents to access HACC services. A significant number of other stakeholders in both interviews and forums reported that access of HACC services into LRCs is in places an issue of concern, as licensees determine which services and individuals are able to enter facilities and which do not. In the case of supportive licensees, access into facilities was facilitated by owners. A number of instances where access to LRCs was limited by licensees was reported by stakeholders. This finding points to a need for the development of working relationships between HACC service providers and LRC licensees.

Attitudinal issues
Many HACC service providers have not had a great deal of experience working with people who have a mental illness, and there are challenges in working well with mental health services. The existence of challenging behaviours amongst some LRC residents was also recognised, and it was felt that service providers who are supporting LRC residents should train their staff in dealing appropriately with challenging behaviours, as well as learning to understand and effectively support people with mental illness. Such training could be linked to the competency-based training that is already provided to HACC staff.
HACC service providers reported a concern that they are at times required to confront behavioural issues in LRCs, not only with the residents who were their clients, but also with those residents who were around the LRC at the time they were delivering support to others. It was seen that the risk assessments carried out routinely by HACC services are appropriate to these environments and could be usefully implemented. It was also suggested by HACC service providers that the safety of staff, in relation to other residents being present, could be addressed either by ensuring support is provided in the private, doctor’s area that each LRC is required to have, or through arrangements which ensure that other staff are available at the same time as the HACC service is being provided. One HACC service provider indicated, however, that the provision of two staff members, where normally one would suffice, was a solution that was implemented in other environments, and so would not be exclusive to the LRCs.

5.4 Characteristics of residents

The complexity of working to meet resident needs within the LRCs was raised by LRC caseworkers. LRC licensees also indicated that they felt the mental illness characteristic of so many of the residents may be problematic to some HACC services. This was perceived by LRC licenses to be mainly to do with the lethargy and apathy associated with conditions and the medications used to treat them. It was commonly reported across all stakeholder groups that there is inadequate ongoing monitoring of residents’ individual wellbeing.

Stakeholders talked about the need for more individual assessments for residents, in order to address problems of them not identifying their own needs, and not having access to services or individuals who may be able to assist them to recognise issues and identify needs. Individual assessments could be updated as residents’ needs and circumstances change. The need for access to independent individual advocacy by residents was also raised, given that they are a group who have limited capacity to understand their own needs and to represent these to services which may be in a position to address them through support.

The need for case management and service coordination for residents with complex care needs was addressed by stakeholders. There are differences between types of case management:
HACC case management relates only to the coordination of HACC services for individuals with complex care needs. It is not likely that LRC residents will be found eligible for this service, as the range of care needs eligible clients usually have would preclude their living in an LRC environment.

Wholistic case management relates to the coordination of responses to needs over a range of domains.

Mental health case management relates to coordination of individual’s mental health support needs. This is currently being undertaken by the Boarding House Team in the Inner West area, and by the BHRP caseworker in the Wingecarribee area in conjunction with their respective Mental Health Teams.

Although not part of the HACC service system, some respondents favoured increasing the brief of the current Active Linking Initiative, to include wholistic case management for those who required it. Others felt it was more appropriate to involve HACC case management services in coordinating HACC service responses, even if this required specific, targeted funding initially to enable their caseloads to increase for this purpose.

### 5.5 Service capacity and service systems issues.

The interdependent nature of the supports provided to LRC residents by different service systems and bureaucracies was raised as an important issue by several stakeholders. These include Centrelink, HACC, BHRP and Health Programs. Each of these systems has their own constraints and limitations which add to the complexity of providing service to this group and have implications for the provision of HACC services in this environment.

The need was stressed to inform other services who are supporting LRC residents of any changes, especially reduction, in the level of service provision that is being delivered by any one agency, as the removal of one service may have implications for the delivery of another. A strategy that is already working well is the LRC-specific interagency in the Wingecarribee area, which spans all the service systems that currently provide support within the LRCs, and also includes the Licensees. The representation of LRC issues at regular HACC forums was also seen as a useful strategy by stakeholders. This has happened successfully in the past, and resumption of this strategy may be a useful information sharing tool.

Resource limitations are evident in HACC services in both of the areas included in the study. While these are caused by differing
factors, it can be assumed that all regions will be facing resource limitations in the amount of service they can provide to LRC residents. The research also shows an anticipated growth in numbers of LRC residents who are likely to require support due to ageing.

Some issues of HACC service capacity were raised by the research, in particular the ability of the HACC services within the Wingecarribee area to provide for the potential demand of LRC residents, given their significance as a proportion of the HACC Target Population. Stakeholders suggested that these figures should be informing the planning processes for the Wingecarribee area, and also that similar concentrations of LRCs, within particular LGAs in the Inner West area (for example, Marrickville), also be represented in planning forums.

The representation of LRC issues at regular HACC forums was also seen as an issue by stakeholders. This had happened prior to the BHRP, where a member of the Boarding House Team in the Inner West area had been effective in raising awareness of resident issues at forums, through describing the experiences of living within the LRC environments. It was, therefore, felt that a similarly effective mode of communication would be a useful component of the representation of LRC issues at HACC forums in the future.

5.6 Issues outside of the scope of the research

During the conduct of the research, several important issues were raised which are beyond the scope of the current project. It is important that they are recognised and fed into broader reform processes wherever possible. The issues considered to be beyond the scope of the current project centre on:

- Complexity of need of LRC residents (e.g. the need for wholistic case management; advocacy services to assist access to services and to accompany residents on appointments; increased social and recreational services)
- Better integration and communication between services: This relates to the complexity of need of some LRC residents and the need for wholistic case management.
6. **Barriers to access and strategies to improve access to HACC services for LRC residents**

This section of the report discusses the barriers for LRC residents in accessing HACC services which were identified from the findings of the research.

A series of strategies are offered in response to the identified barriers as practical actions which can improve access to HACC services for this group.

The barriers and strategies have been grouped into the five thematic areas used to describe the research findings in section 5 of this report. An overarching strategy has been developed in response to the barriers identified in the research. This primary response relates directly to the great bulk of individual barriers and strategies, and is detailed below.

**Primary Response to Research Findings: Training and Information Package**

The primary, overarching, strategy designed to improve access to HACC services for LRC residents is a training and information package. This package has been developed as part of the project, and includes:
- Training for HACC service providers
- Resources for HACC service providers
- An information resource for LRC residents
- An information resource for LRC licensees

This package can be found at attachment 1.

**Training module**

A training module was developed for HACC service providers to enable them to respond to the needs of clients within LRCS. As the research highlighted the need for a greater understanding of both the environment of LRCS, and the nature of the complex needs of residents, the training module was designed to assist HACC workers to examine and gain an understanding of:
- the needs of residents living within LRCS
- the nature of the relationship between residents and managers of LRCS
- the environment of the LRC and barriers to access for HACC services
• the attitudes and values which inhibit quality of service provision to residents
• the eligibility and prioritising principles which promote or prevent access to HACC services by residents

The training module was designed as a one day workshop, using recognised adult learning principles. It was developed into an experiential workshop, enabling participants to explore their attitudes and values in a safe learning environment. It includes presentation by facilitators who have personal experience of living with mental health issues and those who have experience working to provide HACC services within the LRC environment.

The module is presented in a format that enables facilitators within HACC to implement the training for workers within their services. The layout outlines the objectives of each session, the methods for achieving those objectives, and the key points or information to support the content of the sessions. The training and information package can be found at attachment 1.

Pilot Training Workshop
A pilot of the workshop was conducted in the Inner West region and was promoted by HACC Development Officers through their networks. As the pilot was conducted prior to the deadline for this report, potential participants had little notice of the training, hence the number of attendees was disappointing, with only five participants.

HACC service providers were not well represented in the pilot. Stakeholders who provide a range of other services to LRC residents actively participated in the workshop. Due to the need for HACC service providers to manage their work load while attending training, it is recommended that a long lead in time is given to services prior to conducting a workshop in the future to support increased participation.

The expectations of participants, elicited at the training were to learn more about HACC and ALI services; to understand licensing responsibilities of LRC licensees; to learn strategies for improving the physical health of residents; to understand how services can better support people; and to learn about how to access boarding houses.
An evaluation was conducted at the completion of the training sessions. A summary of responses to the evaluation can be found at attachment 4.

Participants did not recommend any change to the training and felt that it fulfilled their needs and gave them insight into the LRC environment and a better understanding of the needs of residents.

It is recommended that the training be held over one full day of seven and a half hours instead of the piloted six hours. It is also recommended, to ensure sustainability of the project, that DADHC develop a strategy to induct HACC Development Officers into implementing the training across all NSW regions.

**Information Resources**

Information resources were developed to promote an understanding of HACC services to both LRC residents and managers. These resources are intended to complement the training module, providing practical resources for HACC workers to distribute when developing relationships with both LRC managers and residents.

A brochure was designed for LRC managers outlining the benefits of HACC services for residents and managers and providing information on contacting services.

A poster for residents was designed to give information in an accessible format about how to access HACC services and the services which may be available. It was also suggested that a creative use of the poster may be to laminate it and use it as a place mat under ashtrays in LRCs, to overcome the reluctance of residents to look at noticeboards.

The resources were focus tested with a small number of LRC residents and managers. Based on their feedback, adjustments were made to the content and style of both the brochure and poster. They are designed as a tool to enable longevity and sustainability of the project.

The information resources for LRC residents and licensees can be found at attachment 2.
6.1 Eligibility and Priority for HACC Services

Barrier 1.1: Understanding of eligibility for HACC services
Some HACC service providers continue to believe that LRC residents are ineligible for their services.

Barrier 1.2: Understanding of LRC environment by HACC services
LRC residents are likely to be prioritised lower in need than many in the community, because they live in accommodation where support and services are available, and their functional needs may be lower.

Barrier 1.3: Understanding of support needs by HACC services
Some HACC service providers have indicated that the complex support needs of many LRC residents makes it difficult for them to provide support.

Strategies:

**Strategy 1a)** The processes of referral and assessment of LRC residents to HACC services could be improved by HACC service providers, under the guidance of HACC Development Officers, ensuring clear information is available to residents and licensees; going through application processes in person with people; and developing personalised professional relationships between HACC workers and residents.

**Strategy 1b)** HACC Development Officers could form a working group to facilitate local initiatives amongst HACC services, to streamline referral and assessment processes, and ensure LRC residents understand where they can go when they need a HACC service.

**Strategy 1c)** Any assessment tools used by HACC services to prioritise the need of residents for HACC services should be reviewed to ensure that they accurately reflect the needs of LRC residents.
6.2: Information and Referral

Barrier 2.1: Knowledge of HACC services by LRC residents and licensees
Residents and licensees of LRCs have little knowledge of what types of HACC services exist, and the range of services available within their local area.

Barrier 2.2: Knowledge of the LRC environment by HACC services
HACC services which currently do not provide services within the LRCs have little knowledge about the needs of LRC residents, or about the environment in which they live.

Strategies:
Information about HACC services needs to be targeted at residents, at LRC licensees, and to other service providers who work with LRC residents.

Information to Residents

Strategy 2a) HACC Development Officers should be encouraged to develop a promotion plan for providing information in accessible ways to residents of LRCs in their regions. This could involve a mix of face to face meeting (eg, through attending a morning tea at an LRC), providing written material in easy English, and making the service known to residents through the LRC managers.

Strategy 2b) The poster being developed as part of this research which informs residents about HACC services and how they can access them should be printed and distributed to LRCs for posting on the LRC noticeboard.

Strategy 2c) Existing brochures should be written in an Easy-English format, with adequately sized font to ensure ease of reading and comprehension.

Information to LRC Licensees

Strategy 2d) The information brochure which is being developed as part of the training and resource package for this project should be printed and distributed widely by HACC service providers and Development Officers to LRC licensees.
**Strategy 2e)** Information about HACC services should be provided to LRC licensees when HACC Development Officers are providing information to residents as part of their promotion plan for residents.

**Strategy 2f)** The model of regular regional LRC Operator forums which currently operates in one region could be expanded to other LPAs. The presentation of information about HACC services to LRC licensees in such forums could be included by Development Officers in their promotion plan.

*Information to HACC Services*

**Strategy 2g)** Information about LRCs should be made available to HACC services, either electronically or on paper. Information should be available about:
- licensing and other conditions of the LRCs
- the BHRP services that go into LRCs, and the basis on which they are available to LRC residents
- the eligibility of LRC residents for HACC and other services, expressed through clarifying statements and other documents.

**6.3: Service Provision**

**Barrier 3.1: Expertise of HACC services in working with this group**
Lack of experience, training and support for HACC service providers to work with LRC residents may be a barrier to them taking up HACC clients who live in this environment.

**Barrier 3.2: Resource limitations of HACC services**
The inability of HACC service types to adequately address the needs of LRC residents may serve as a barrier to residents accessing some HACC services. For example, the need for transportation and the medical escort of residents to medical appointments, for the purpose of supporting residents and relaying important medical information.

**Barrier 3.3: Perceptions of support needs of LRC residents**
There is a perception that the provision of some HACC services to LRC residents (in-home, volunteer-based) can be more problematic than to clients in the general community, because of the personal
characteristics of the clients, particularly those people who have challenging behaviours.

**Barrier 3.4: Limitations of the physical environment of LRCs**
The congregate nature of the LRCs may pose OH&S barriers, such as dealing with privacy and confidentiality, lack of knowledge of the other residents who may be present, and environmental issues such as a smoky environment or inadequate bathroom safety equipment.

**Strategies:**

**Strategy 3a)** Training and development for HACC service providers is clearly needed. Training is required which addresses skills gaps for service providers in

- attitudes and values,
- understanding eligibility for services and the place of LRC residents as members of a HACC special needs group,
- addressing needs of LRC residents, and
- working with LRC managers and duty of care.

**Strategy 3b)** The training and resource package which is being developed as part of this project should be provided to HACC service providers and Development Officers.

**Strategy 3c)** HACC Development Officers or nominated representatives (e.g., HACC Training Officers) should receive a structured train the trainer course which provides them with the skills to implement the training package across all regions of NSW.

**Strategy 3d)** Access to training should be made available for new and existing staff. The training should be regularly scheduled to ensure new staff coming into the HACC program have the opportunity to participate as part of their orientation to the service.

**Strategy 3e)** An allocation of resources to ensure the availability of ongoing training for HACC staff in working with LRC residents and within LRC environments should be made to support the implementation of the package.

**Strategy 3f)** Where possible, the training module should be timed to be delivered in a suite with existing HACC training
projects in regions to minimise disruption to individual workers and to maximise the content of their training time.

**Strategy 3g)** Where possible, HACC workers should be drawn from a range of HACC services to attend training sessions. Their experiences and insights also provide learning opportunities for their peers from other regions or services.

**Strategy 3h)** Alternative modes of education and awareness raising should be considered, including coaching and mentoring. These are low cost strategies which could be useful enhancements to face to face training, and which involve learning in the LRC environment.

### 6.4: Characteristics of residents

**Barrier 4.1: Lack of accessible information about HACC services for residents**

Information about HACC services is currently not targeted directly at LRC residents.

**Barrier 4.2: Capacity to identify own need for HACC services**

In many instances residents do not have the capacity to understand and articulate their own needs, and so they do not identify their need for HACC services. A scarcity of independent individual advocacy or support to residents compounds this problem.

**Barrier 4.3: Need for case management or coordination for people with complex care needs**

**Strategies:**

The need for case management/case coordination is linked to the need for improved assessment and service delivery. As mentioned elsewhere in this report, wholistic case management, which is outside the scope of HACC services, was seen as one solution. The role of HACC case management services and better coordination of HACC services can also assist in addressing complex care needs of LRC residents.

**Strategy 4a)** HACC case management services might be used in certain instances to broker suitable supports to assist LRC residents.
**Strategy 4b)** HACC services, through such forums as case conferences, might achieve better coordination of service provision to LRC residents with complex care needs.

**6.5: Service Capacity and Service System Issues**

**Barrier 5.1: High demand for HACC services**
Concentrations of LRCs in particular LGAs result in high demand for a limited amount of HACC services.

- There is a perception in the Wingecarribee area that the allied health services there would not be able to cope with the influx of LRC residents should they access them as HACC clients.
- The ageing of a segment of the LRC population presents a significant challenge to all service systems, including the HACC service system, in relation to resources and the coordination of services, especially in the Wingecarribee area.

**Barrier 5.2: Access to LRCs by HACC services**
Access to the LRCs, and thus to the LRC residents, is still largely reliant upon the goodwill of LRC licensees. While many LRC operators are welcoming of support services, there were reports of some resistance in a few LRCs.

**Barrier 5.3: Communication between service systems**
Service provision by a range of different government and non-government agencies results in a complex milieu in LRCs. Communication of changes to service which may impact on other services and supports is at times unclear.

**Barrier 5.4: Representation of LRC issues in HACC forums**
LRC residents do not have a representative voice on the HACC forums, which meet regularly to discuss HACC service issues.

**Strategies**

**Strategy 5a)** Regular HACC Forums should be used to update services about issues and initiatives in LRCs. Such forums could include input from other service representatives (eg. Health), to enable a fuller understanding of the range of services provided, and provide opportunities to troubleshoot issues of service delivery and resources across service systems.
**Strategy 5b)** The LRC-specific services forum model successfully used in the Wingecarribee area should be replicated in other areas of the state which have a significant population of LRCs.
References


HACC (May 1998) Data Dictionary Version 1.0

HACC Program (2002a) A Summary of the National Program Guidelines for the Home and Community Care Program


