RESPONSE TO DADHC DISCUSSION PAPER ON 'MODELS OF SUPPORTED ACCOMMODATION FOR PEOPLE WITH A DISABILITY'

INTRODUCTION

This paper is submitted on behalf of the Metro North Disability Support Group, in response to the DADHC Discussion Paper "Models of Supported Accommodation for People with a Disability".

The Metro North Disability Support Group represents people who live in the Metro North Region and/or have a child/adult with a disability living in the region. Current membership is approximately 150 people, and includes:

- people with a family member with a disability currently living in a DADHC group home,
- people with a family member with a disability currently living in a Non-Government Agency group home,
- people with a family member with a disability currently living in a large institution,
- people with a child/adult with a disability currently living at home, urgently seeking permanent accommodation now, or in the near future.

The Metro North Disability Support Group is not Government funded. It relies on volunteers who give of their time, donations towards mailing expenses, and the Baptist Community Services, Chatswood, who kindly permit meetings to be held in their hall, at no cost.

Our approach in formulating this Submission has been to circulate information on the Discussion Paper and hold several day and evening open forum meetings to discuss its contents and the models presented. The open forums have also created opportunities for participants to tell their stories of "real-life" experiences in group homes, large residentials and the lack of permanent accommodation for those currently living at home. A small focus group was formed to incorporate information gathered. The final submission was presented to the group for approval.

For the purpose of this submission, we have focused on models suitable for the target group identified in the Discussion Paper "People with high support needs/complex health issues and challenging behaviours". There was general agreement that there needs to be a choice of models.

Our proposal is to make available to people with disabilities:

(a) The "Cottage/Villa Cluster" Model; and
(b) The "Village" Model,

as further described below.

The suggested models are not in place of the Group Home Model, but in addition to it. The aim is to offer people with disabilities choices in accommodation that best meets their needs.

1. ANALYSIS OF MODELS IN DISCUSSION PAPER

The models outlined in the Discussion Paper were analysed at an open forum meeting. Annexure A of this submission sets out our analysis of the Models presented by DADHC showing Strengths, Weaknesses and Comments/Suggestions for Improvement of each model.

2. REAL-LIFE EXPERIENCES

Our research, based on open forums and follow-on telephone conversations and email correspondence, has provided us with a number of stories from parents who have first hand knowledge and experience of problems associated with some current accommodation models. These stories have been documented and are available on request.

The open forums identified common concerns, the most significant being adequate levels of trained permanent staff to meet clients' needs.

Other comments which contributed to the formulation of the Models set out in the submission were:

- Inexperienced and casual carers have little support or supervision.
- Last recruitment process and appointment of staff took some six months, and some houses had only 1 or two permanent staff of a total of 6.
- Casual and agency staff employed to replace staff on annual leave, training, attending to clients in hospital, staff on workers compensation, long service leave, or just call in sick at short notice. On some occasions both staff on shift are casual/agency staff.
- There is little back up or support network in place for staff.
- Excessive use of agency staff.
- The lack of support on hand causes high staff turnover and early burn out of staff
- Residents with high support needs/complex medical issues/challenging behaviours are seriously affected by lack of long term trained permanent staff and high turnover, particularly if close observation is needed to monitor affects of medication, manage seizures, and record changes over time.

- Some current models create isolation, particularly for people with high support needs who cannot access community independently, and limited number of visitors to home. Short visits or outings to other group homes involves greater effort for people in wheelchairs. Due to level of disability, they do not form friendships or socially interact with neighbours and general community.

- Incompatibility of residents. A cluster facilitates short breaks with others in cluster, or visits within cluster, with in wheelchair access.

- The medical/health needs of one client in a home may dictate and limit the activities of others. A cluster would facilitate easier networking within cluster. A trained nurse on shift would benefit more residents within cluster/villa.

- OH&S regulations require two staff for hoist transfers from wheelchair for toileting/bathing/changing/to and from bed/repositioning to prevent pressure sores etc. These essential tasks cannot be performed if second staff on duty is on the bus run, or accompanying another resident to medical, dental, podiatry appointments etc. On occasions when one client is hospitalised, staff are required to attend hospital, leaving one staff on shift in home with no support.

Some of these disadvantages have been identified in a recent publication by Roger J. Stancliffe and K. Carlie Lakin entitled "Costs and Outcomes of Community Services for People with Intellectual Disabilities", refer p.130. (Paul H. Brookes Publishing Co, 2005)

3. KEY REQUIREMENTS OF ALL MODELS

We have sought to identify Key Requirements that will provide long-term secure accommodation for people with high support needs, complex health issues and challenging behaviours. The requirements may be modified to meet the needs of other people with disabilities. Properties should be DADHC owned to provide a level of permanency and long tenure for life-time care. However, they provide a guide for future models.

Purpose built accommodation to include:

- Accommodation to be wheelchair accessible, within and without the premises
- Some bathrooms to be fitted with hoists and other equipment suitable for moving non-mobile clients
- Ducted reverse/cycle air-conditioning
- Shaded outdoor space
- Communal indoor and outdoor space
- Appropriate transport
- Undercover access from building
- Maintenance services to maintain equipment/buildings/grounds
- Close to transport or walking/wheelchair distance to local village of shops
- On-site Manager responsible for administration and staffing

- Staffing levels appropriate to client individual needs
- Emergency response system with "hands on" support. This need may be met by a nurse if medical care needs of residents are required, or in the case of people with challenging behaviour, a specialist in that field.
- Regular visits by specialist health professionals i.e. doctors/physiotherapists/occupational therapists/recreation officers/dieticians/speech pathologists.
- Support to assist in improving independent living skills
- Carers to facilitate community interaction to minimise social isolation
- Full compliance with Occupational Health and Safety requirements, fire regulations and any other relevant legislation.

4. PROPOSED MODELS

From the above list of Key Requirements, we have developed two Models which we have named:

(a) "Cottage/Villa Clusters", and

(b) The "Village" Model.

We outline below the key indicia of each of these Models.

(a) Cottage/Villa Clusters

We propose a "Cluster" model of 3 or 4 villas, each with three or four bedrooms, purpose-built and single storey on the same site, with Manager located on site and/or nursing care.

This model conforms with cluster models already in the community for the general population seeking medium density housing with minimal maintenance, security, independent living and cost effective accommodation. This model also provides companionship, support on hand and flexibility, whilst maintaining individual independence.

Each Cluster to comprise:

- Three or four x 4-bedroom villa homes, custom built on a level block
- The Network Manager's Office to be on site and act as an emergency response system for each cluster with 24-hour hands-on support in case of emergency. Network Manager responsible for administration and allocation of staff. Office to include computer/fax/photocopier.
- Common recreational space, partially covered.
- Shed for lock up storage of lawn mower/gardening and household tools/ladders etc. items used for general maintenance.

Each Villa to incorporate:

- 3 or 4 large bedrooms
- Lounge/Dining
- Office space for individual records etc.

- Eat in Kitchen
- Bathroom with toilet
- Separate Toilet
- Laundry
- Double Garage for staff vehicles, plus covered space for bus, with covered entry to cottage.
- Each resident to have own bedroom. Bedroom large enough to accommodate orthopaedic bed, personal furniture and designed to facilitate ease of movement with wheelchairs, hoists, access to bed for repositioning etc.
- Lounge/Recreation Area with easy access from eat-in kitchen and within view of kitchen to facilitate supervision of residents
- Kitchen benches cupboards/sink at heights for wheelchair access.
- Eat-in Kitchen to accommodate four wheelchairs and bench tops and heights to facilitate resident observation/participation of food preparation.
- Front and Rear access to each Cottage/Villa in accordance with fire safety regulations
- Wide doorways and hallways to facilitate movement of wheelchairs, hoists etc.
- Rear courtyard, small garden with covered area for outdoor entertaining/barbeque etc.
- Space for large washing line (to minimise use of dryer).
- Bathroom/Toilet designed to accommodate physical aids, including hoists for spa bath/toilet chairs/change table/large shower recess with hand held shower/vanity cabinet. Space for pad disposal units; residents personal care needs.
- Large Laundry with Washing Machine/Dryer/Laundry Tubs/ rear access to washing line/storage cupboard for cleaning products/ hygiene needs

(b) The "Village" Model

We propose that the "Village" Model would comprise 2, 3 or 4 purpose-built single storey buildings each sleeping up to 10 residents, with one or more Manager's Offices and some Live-In accommodation. This model is similar to the Cluster Model, but offers the benefits of scale and accommodates more people.

Each Village building to contain:

- 8-10 bedrooms; each client to have own bedroom. Bedroom to accommodate wheelchairs/hoists/access to orthopaedic bed. Built in wardrobe; personal furniture etc plus small area to relax in.
- 2 small lounge areas
- One larger Lounge/Recreation area
- Communal eating Area with two tables to seat 6-8 people. To retain the sense of family, tables should be no larger than the everyday dining table and there should be no more than 2 tables in the Eating Area.
- Kitchen: Suitable for preparation of meals in large quantities. Alternatively, meals could be prepared in bulk in a separate area on or off site but that would involve reheating, packaging and delivery to the Village. In that case, each Village building should nevertheless contain a small kitchen suitable for training residents in independent living and for providing access to snacks between meals and tea and coffee for residents and visitors.

- Medicine Safe
- 2 Large Bathrooms: designed to accommodate physical aids, including hoists for spa bath/toilet chairs/change table/large shower recess with hand held shower/ vanity cabinet.
- 2 Separate Toilets: large enough for wheelchair/toilet chair access.
- Village to be built with wide hallways and doorways to accommodate wheelchairs/hoists
- Each Village building to function individually with staffing levels appropriate to client needs.

Facilities shared between the Village buildings would include:

- Outdoor space central to all Village buildings with communal space for cluster to facilitate weekend BBQs Christmas/Birthdays etc.
- Ideally, a (heated indoor) fenced pool or spa area.
- General store
- Cafe
- Music room
- Sensory room
- Large Community room
- Gym
- A Live-In Manager responsible for administration and staffing. Office to include computer/fax/photocopier.
- 24 hour Registered Nurse

5. PRIORITIES

It is proposed that priority be given initially to develop Model (a) as a short term goal, attainable on large suburban blocks of land, with Model (b) as part of a 5-year plan. In view of the fact that the Metro North Area was the first to trial the Group Home Model and can provide expertise from first hand experience of large residential care and group home models, we feel that this region would be most suited to trial the proposed model . Metro North currently has a large number of Group Homes, most accommodating people with high support needs or challenging behaviours. Metro North also has residents with high support needs currently accommodated in the Lachlan Centre.

Ideally, one cluster in each area, i.e. Hornsby, Ryde, Central Coast, Manly/Warringah, should be established by DADHC as a pilot study to establish set up and recurrent funding costs, and create guidelines for future funding of such models if submitted to tender by non-Government agencies.

Any large suburban block with existing older house to be demolished would be a suitable site for Model (a). Similar cluster Villas/homes have been built extensively throughout the Metro North Area on large suburban blocks by developers.

Whilst building commences on the first Cluster, research should be conducted into the Village Model based on the experience in other parts of Australian and other parts of the world. Again, we would suggest a prototype be developed which can then be replicated elsewhere. Potential sites for these developments which require more land than a Cluster

would include the land on site at Macquarie Hospital or the near the Pennant Hills Hostel or the Department of Defence land on South Creek Road in Dee Why.

6. PEOPLE WITH SEVERE AND CHALLENGING BEHAVIOUR

It was noted that people with challenging behaviours require specialist intervention and environments which minimise disruptive patterns of behaviour whilst people with high support needs and specialist medical needs required nursing care and a physical environment with physical aids.

Therefore, these clients should not be accommodated in the same villas/cluster.

CONCLUSION

The Metro North Disability Support Group is focused on providing **CHOICE** to families of people with disabilities, particularly for those with high support needs and challenging behaviours. Whilst the current Group Home model works for some people with disabilities, there is sufficient evidence that there is an urgent need for alternative models which address the problems of an ageing population of carers, the greater health needs of people with disabilities, maximises resources of nursing staff/health care specialists and residential care workers, and minimises costs of equipment and housing.

In this paper we have proposed a variety of models which we consider suitable for people with high support needs and challenging behaviours, as the target group identified in the Discussion Paper. However, the models may be adapted to suit other people with disabilities. We believe that providing a choice of models:

- minimises social isolation by facilitating socialisation outside the home with minimal effort/cost
- enables more appropriate matching of clients
- Due to the larger numbers of clients in each development, allows greater flexibility of activities to suit a wide range of needs
- Provides support on hand for staff in case of emergencies, and a broader group of carers who are familiar with clients.
- Facilitates better networking
- Provides a more efficient base for visits by specialist staff, i.e. Physios/OT/Speech Therapists/Work crews and Maintenance Crews.
- Maximises resources and minimises costs
- Provides for privacy and independence of the individual
- Provides a choice currently not available for people with a disability.

We would be happy to work with DADHC further to explore this proposal and provide further information. We commend exploring choice for people with disabilities, so they have the same choices in accommodation models as other members of the community.

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