

COMMUNITY VISITORS ANNUAL REPORT 2006

HEALTH SERVICES ACT 1988

PROMOTING THE RIGHTS AND DIGNITY OF PEOPLE WITH A DISABILITY,
ENSURING THAT THEIR VOICES ARE HEARD

OFFICE OF THE PUBLIC ADVOCATE
AN INDEPENDENT STATUTORY OFFICE ACCOUNTABLE TO THE VICTORIAN PARLIAMENT



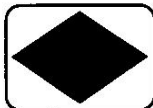
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Community Visitors Annual Report 2006
Health Services Act 1988

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COVER ART: Heather Carter, 2005

Heather Carter was diagnosed with Bipolar Disorder six years ago. Heather has developed her art through Prahran Mission's Second Story and Stables Art Studio. She hopes her artwork can de-mystify mental illness and encourage other people to seek help.



OFFICE OF THE
PUBLIC ADVOCATE

1 September 2006

The Hon. Gavin Jennings MP
Minister for Aged Care
Level 22, 50 Lonsdale Street, Melbourne 3000
MELBOURNE VIC 3000

Dear Minister

In accordance with the *Health Services Act 1988*, please find enclosed the Annual Report of Community Visitors.

This annual report has been compiled by the Community Visitors (Residential Services) Board elected at the Annual General Meeting of Community Visitors.

Yours sincerely

JULIAN GARDNER
Public Advocate

ALAN NICHOLS AM
Board Member

PAULINE MUSGRAVE
Board Member

Ordered to be printed

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EXECUTIVE SUMMARY

When they were first established, supported residential services (SRS) mainly provided care to older people who needed some assistance with daily living. For a variety of reasons, many of the people who now live in these pension-level facilities are younger people with a mental illness, intellectual disability, acquired brain injury, poor health problems or a history of drug and alcohol addiction. These people often have few social supports and some have a history of homelessness. Others are at risk of homelessness because of their support needs and the limited accommodation choices available to people with complex needs.

This year Community Visitors appointed under the *Health Services Act 1988* made 1528 visits to 205 SRSs in Victoria to inquire and report on the care provided to residents. Community Visitors report that many SRS proprietors and staff are providing good quality care. However those providing accommodation, meals and care and charging less than or just above pension-level often struggle financially and this struggle is sometimes reflected in the care provided.

Issues reported by Community Visitors and discussed in this year's annual report include: problems arising from the complex resident mix, the quality of care provided, a lack of activities, inadequate staffing, the absence of tenancy rights, the physical environment, and poor documentation.

Community Visitors congratulate the Victorian Government on its announcement of the *SRS Supporting Accommodation for Vulnerable Victorians* initiative in the 2006 state budget. This initiative will provide \$29.41 million over four years to implement a range of measures to improve the viability of pension-level SRSs and the quality of life of SRS residents. Community Visitors hope these resources will advance the standard of care in SRSs and expand the opportunities and choices available to people living in SRSs in Victoria.

Community Visitors also commend the government on legislative reforms to strengthen requirements in relation to residential statements, the management of resident finances, and notification to residents and their families when an SRS closes.

There have been some major improvements in the SRS industry over recent years but there is still more to be done to ensure that SRS residents are able to live-in a home-like environment and participate in their community. Some residents continue to live in poorly staffed facilities in conditions that would not be acceptable in other aged and disability residential services or tolerated by the general public. Standards need to be strengthened and alternatives created.

RECOMMENDATIONS

Community Visitors make the following recommendations to the Victorian Government:

1. That the Victorian Government adopt a whole of government approach by establishing a committee of all departments or sections of departments that have an interest in accommodation support for vulnerable Victorians with the aim of producing a coordinated strategy and joint budget submission to increase the accommodation and support options available to this group. (See sections 2 and 3.1)
2. That the Department of Human Services more rigorously monitor SRSs and ensure compliance with the legislative standards and principles that apply to the care and accommodation of residents in SRSs, given the expanded financial contribution by government to support pension-level SRSs. (See sections 3.3 and 3.4)
3. That the department and members of parliament encourage community groups to provide activities and choices to SRS residents in their local area to promote community participation and reduce social isolation. (See section 3.2)
4. That the department continues to improve the standards of care provided in SRSs by requiring and supporting all direct care staff to obtain first aid and emergency management training. The goal should be to have at least one trained staff member on the premises at all times when residents are in the facility. (See section 3.3)
5. That the department considers legislative reform to ensure that SRS residents have the same rights and protections afforded to rooming house residents under the *Residential Tenancies Act 1997*. (See sections 3.8 and 4.2)
6. That the department works cooperatively with WorkSafe, fire authorities, and other relevant agencies to improve emergency management prevention and practice in SRSs throughout Victoria. Community Visitors believe fire evacuation plans should be a condition of SRS registrations. (See section 3.7)
7. That the department repeat the SRS census undertaken in 2003 in order to provide accurate up-to-date information about the SRS population and the development of the SRS sector. (See sections 1.1 and 2)

1 INTRODUCTION

1.1 What are supported residential services?

Supported residential services (SRSs) are premises registered under the *Health Services Act 1988* to provide accommodation and care to older people and people with a disability who require support in activities of daily living. Most SRSs in Victoria are privately owned facilities which are licensed and regulated by the Victorian Government. On 30 June 2006 there were 200 registered SRSs with 6785 beds in Victoria. Five SRSs closed and two opened during 2005-06.

Within the SRS sector there are two main types of facilities defined by the level of fees paid by residents:

- The above-pension or pension-plus SRSs, which usually have a population of older, frail adults.
- The pension-level SRSs, with a population of adults who are likely to have a mental illness or disability, chronic health or drug and alcohol problems and a history of homelessness.

Some SRSs also provide a mixture of pension-level and pension-plus beds. All SRSs are expected to provide some 'special or personal care', as well as accommodation.

SRSs vary considerably in size. One SRS has only five residents while some others have more than 60 beds.

1.2 Who lives in supported residential services?

Initially the SRS industry concentrated on the provision of accommodation and low-level care for frail, older people. However, the population of pension-level SRSs has changed over time.

The 2003 SRS Census (TQA Research 2004), the most recent data available, states that 45% of residents in the pension-level SRS have a psychiatric illness, 14% have an intellectual disability, 8% have an acquired brain injury and 2% have serious medical issues. Only 3% were reported to have no disability. Many of these residents are people who would have difficulty surviving independently without some level of support. Some are people whose behaviours have led them to be judged unsuitable for other shared accommodation options. Some are at risk of homelessness. More discussion about the issues related to the current SRS demographic can be found in sections 2 and 3 of this report.

1.3 The role of Community Visitors

Community Visitors are independent volunteers who visit a variety of residential facilities in Victoria to safeguard the interests of people with a disability. There are three streams of Community Visitors: Health Services, Disability Services, and Mental Health Services.

Community Visitors who visit SRSs are appointed by the Governor in Council under the Health Services Act. They usually make unannounced visits to SRSs between six and twelve times per year and report issues of concern to the person in charge of the SRS at the time of the visit. If the issues raised cannot be resolved at the time of the visit, they may also be reported to the SRS proprietor, the Department of Human Services, and/or the Office of the Public Advocate for follow-up.

At some SRSs, Community Visitors are the only independent observers to regularly visit and talk with residents. In the 2005-06 year, Health Services Community Visitors made 1528 visits to 205 SRSs.

VISITS CONDUCTED THROUGHOUT VICTORIA 2005-06 BY HEALTH SERVICES COMMUNITY VISITORS BY REGIONS:

REGION	SRS Number	CVs Number	VISITS Total 2005-06
Barwon SW	12	10	99
Eastern	62	26	450
Gippsland	6	4	58
Grampians	13	8	89
Hume	2	5	26
Loddon Mallee	7	8	49
North & West	34	19	207
Southern	69	30	550
TOTAL	205	110*	1528

*This figure is the number of CVs (including trainees) as at 30 June 2006. For further information about the Community Visitors Program see Section 5 of this report.

2 AT RISK OF HOMELESSNESS

2.1 Mental health and disability

Some residents of SRSs are at risk: care is inappropriate; they have little professional support; they are socially isolated; and they are at risk of a cycle of homelessness.

One reason is that an increasing proportion of residents are referred from mental health services. The most recent census of SRS residents (TQA Research 2004) showed 45% of people living in pension-only SRSs had a psychiatric disability. In 2006 Community Visitors believe this figure has increased. The level of care which SRS residents require also appears to be increasing. As more and more are referred from psychiatric wards and mental health services, it is clear that some of these people require more personal care than SRSs are designed to give, and they demand more skill and training than SRS staff usually have. But where else will these people go?

During this year, Community Visitors witnessed a young man cutting himself, apparently attempting to commit suicide. This was a very confronting experience. While the manager of the SRS had the situation quickly under control, the man had done this before in front of witnesses. But what effect did it have on the other residents?

In another SRS the incident book noted three recent serious incidents: an attempted suicide; a man armed with a knife threatening to cut himself; and a resident threatening to cut out his eye with a coat hanger. In yet another SRS, staff found a resident sitting on her bed with a lamp cord around her neck, holding to an end of the cord with each hand. She told staff she was going to kill herself. These are very disturbing events, and it is a serious question whether SRS staff are trained or equipped to handle them.

Community Visitors have also been concerned during the year at the increasing usage of SRSs for respite care by hospitals and nursing homes. Some SRSs have virtually rented out several beds for respite, and invite such referrals. This means more short-term stays in SRSs, which might be disturbing for other residents, who regard their SRS as their 'home'. Community Visitors also report residents being supposedly placed for a short period but then remaining for lengthy periods in a residence not able to meet their needs.

The other situation which Community Visitors have reported is younger residents moving into SRSs where mostly older people live. Their wants and needs are entirely different. There can be some value if younger residents are going to part time work or regular activities, but their interests are quite different. Some of the younger residents have an intellectual disability.

Sandra, a 26 year old woman, was placed by her case worker in an SRS as a temporary measure. Five years later she was still there. As she attended a "Futures for Young Adults" program with daily activities, she was often not at home when the Community Visitors visited the SRS. Community Visitors only became aware of her situation in late 2004. Community Visitors are concerned about Sandra's vulnerability as she lives in an SRS where the majority of residents are older men, rather than people of her own age. During 2005-06, Community Visitors have advocated for more suitable housing for Sandra. She is on the waiting list for Disability Services supported accommodation but suitable accommodation has yet to be found.

Many residents with intellectual disability have comprehension or communication difficulties that make them vulnerable and at risk of exploitation by others. Some came from institutions to an SRS; others moved to an SRS after the death of a parent or primary carer. As a result, many have limited family and social supports.

There are also a number of SRS residents with an acquired brain injury. arbias, an organisation that specialises in working with people with alcohol and substance related brain injury in Victoria, said in their 2005 annual report that they provided recreation services to residents from 19 SRS facilities in 11 local government areas in the Melbourne metropolitan area.

Many people who have a cognitive disability also have a physical disability such as diabetes, epilepsy, arthritis, or an injury that affects their health and mobility.

It is clear from all this that more alternatives in accommodation are needed, to provide appropriate support to each category of need.

2.2 Social exclusion

Many SRS residents show the signs of anomie or social exclusion. First described by Emile Durkheim in the 1930s and later developed by Max Weber and other philosophers and social scientists, this can describe either a society or an individual. Within a society where standards and sanctions no longer work effectively because people have come to ignore them, a state of anarchy (lawlessness) or anomie (social collapse) follows. In the case of individuals, the normative order has broken down for them, and they have become socially excluded. They are on the edge of society, and are frequently at risk of homelessness. Their relationships are broken, and they have become detached from circles of trust, from family, and from neighbourhood.

Community Visitors have been perceiving for some years an increasing number of people coming into SRSs in this state. Living in an SRS actually

provides some stability for their lives, but when they frequently move on to other premises, the cycle of social exclusion continues.

The following true story illustrates this:

Robert calls in every week to a drop-in centre and regards it as part of his 'home and family'. He is 59, and has been on medication for an unspecified psychiatric condition which he calls 'nervous disorder'.

His risk of homelessness started at age 18 when his parents threw him out of the family home. His brother charged him with stealing some of his clothes, and he finished up in jail for nine months. This completed the break with his family.

When he came out, he wandered around regional Victoria, getting various short term jobs. No job lasted very long.

He had 'episodes' which put him into Larundel Psychiatric Hospital, where doctors could not, he said, diagnose exactly what he had, but they put him on a strong medication regime. 'I am not schizophrenic, and I don't have bipolar affective disorder,' he said. While Robert took his medication regularly, he functioned in a social and work environment.

He took on a life partner who already had two children, and they lived in a family home for some years. But they became irreconcilable, and she went to live in a hostel for her protection.

In this period he wandered from one SRS in the northern region of Melbourne to another. He was put into an SRS by a case worker, but felt uncomfortable with so many residents with brain injury and psychiatric problems. He stayed in another SRS but left alleging financial malpractice – he said that the manager was 'ripping off' residents' pensions. He then went to a nearby SRS, but felt uncomfortable sharing a room.

Over the years he has stayed in hostels, rooming houses, and even lived in the streets - all for periods of no more than about nine months at a time. The longest in one place was when he had the partner and they lived in a family home.

He now lives in a bed-sitter in Preston, is on disability pension, and the State Trustees look after his finances and give him \$14 a week for smokes and \$45 a week for food and outings. They pay his rent direct to the landlord and pay his electricity bills. He knows he is well off compared to many residents of SRSs. He feels he is nearly ready to work again, but this depends on staying with his medication.

Robert wants to campaign for more community housing for people like himself, who have been in and out of homelessness all their lives.

When Community Visitors at the annual conference in June 2006 discussed this case history, they felt they knew many residents of the SRSs they visit who are like Robert. Maybe the details are different, but critical events are similar – breakup with family, short-term relationships, temporary work, in and out of different residential situations. Social exclusion seems an appropriate term.

Sociologist Peter Berger identifies mediating structures as a solution to the problem of social exclusion. According to Berger, groups in society between the extremes of society and private life can provide a focus for social activity and a point of attachment (Bulmer 1987; Wright Mills 1977). The Community Visitors Program is one such mediating structure.

2.3 Poor health and ageing

SRSs were originally designed for older people who need support and accommodation but who do not qualify for hostels or nursing homes. By definition, many of them will suffer from frailty or sickness. Because of this, they need individual care plans which inform SRS staff how to plan meals, activities, medication and outings which connect them to their families, if possible, and to their communities.

During 2005-06 we have seen a number of beds in pension-plus SRSs being leased to public hospitals for post-operative or respite care and for palliative care. This is a new development, but has not yet turned into a consistent or significant use of SRSs. It poses the obvious difficulty of two tiers of health care in one home: 24-hour nursing for post-hospital patients; and a quite different level of support for 'ordinary' residents.

Of course, in the pension-plus sector, residents often have access to their own doctors, who usually call on their patients where they live, and they are more accustomed to exercising choice over their health needs as well as other needs.

The new announcement from the Victorian Government that residents of SRSs will be assessed to see if they require additional support may assist people with complex needs. Many of these people clearly cannot be catered for properly within the SRS sector, whether in the pension-plus or the pension-only streams.

Community Visitors have concentrated on making sure care plans exist for each resident, that they are updated and followed. The care plan should be matched by characteristics of the home which meet the legislative ideals for SRSs – a safe home-like environment which offers privacy, adequate support, activities of choice and the right to manage their finances.

The conclusion of Community Visitors is that there continues to be a pressing need for more alternatives in accommodation to meet a wide range of residents' needs.

3 A HOME-LIKE ENVIRONMENT?

'Home means not only the bricks and mortar of a house, but the unique environment within which we all seek to create that which is ours, a place that gives us a sense of security, a sense of pride, a place of privacy, retreat and sanctuary and an accepted place in the community.'

(Community Living Project 2005, viewed 3 August 2006 <<http://www.clp-sa.org.au>>)

To many people, SRSs are home. While there are some residents who regularly move in and out of SRSs and other accommodation options, this group is a small percentage of the total resident population. Some SRS residents spend many years in one facility. For these people, the ongoing standard of care and support, the sense of freedom and autonomy, physical environment, and compatibility with other residents is particularly critical.

In the 2005-06 year, Community Visitors (Health Services) reported 961 issues in relation to SRSs. A graph showing the type of issues reported is presented in the Appendix of this report. Some of the key issues are discussed in depth in the next pages of this report. Three hundred noteworthy examples of good practice in SRSs were also reported by Health Services Community Visitors this year and some examples of these are also provided.

3.1 Resident mix

A major issue raised by Community Visitors this year was that sometimes the mix of residents in an SRS is unsuitable. Mixing individuals with acquired brain injury (who may be case managed by the Transport Accident Commission or WorkSafe) with people with an intellectual disability (who may be case managed by the Department of Human Services); with mental health patients (who may be case managed by the Mental Health local office) and other patients just released from public hospital wards can be an uncomfortable or even toxic mix.

In several SRSs now, local hospitals are funding beds for respite or the placement of people who cannot return to their homes after hospital admissions. These residents often have high medical needs and are confined to bed for long periods of the day. This year Community Visitors have also noted residents on oxygen, self administering morphine or in receipt of palliative care.

Concerns relating to the sometimes volatile mix of residents reported by Community Visitors include:

- several instances of assaults or verbal altercations between residents

- an 82 year old with severe vision impairment and dementia who lives with younger people with a mental illness has become very unsteady on his feet and has had a recent fall
- three young men with drug and alcohol issues and psychiatric disabilities being placed in an SRS with very little external support
- a male evicted from an SRS with alcohol problems and placed in a lock down dementia facility
- a female on an intervention order who had supposedly been transferred, still in the SRS
- a large turnover of residents with psychiatric problems in a facility with a large number of residents with increasing age, drug and alcohol issues, and dementia

In one SRS, which has a mixture of elderly and younger residents, three residents complained that an elderly resident was harassing other residents, causing stress and anxiety. One resident said that she had been called names and pushed against the door. On the same visit, a younger resident told Community Visitors that she was unhappy because her boyfriend had been banned from the premises. The manager said it was because he was charging residents money for taking them shopping and repeatedly using the premises' facilities without paying.

Some residents can present a real challenge to those trying to assist them. This extract from a Community Visitors report illustrates this.

Robert has become extremely difficult – he sacked his doctor and chemist and he has the heater on 24/7 in his room even if absent. He refuses to turn it off. He turns the heater on in the main lounge room usually from 10pm and often the rest of the evening. He won't let other residents control the television. He is very aggressive to the manager and complains frequently. His case manager from the local mental health service has suggested he should look at other facilities if he is not happy.

However, in other instances, people of different ages and backgrounds seem to live compatibly together most of the time.

Community Visitors acknowledge the excellent provision of quality care and services provided to many residents with complex needs who often have nowhere else to live and few other resources and support.

3.2 Activities

The diversity of residents now living in pension-level SRSs, many of whom are young people with psychiatric or other disabilities, has led to an increased demand for more activities and recreation opportunities. Many

residents seem to have little to look forward to and they often report feeling lonely or bored.

Community Visitors report some commendable efforts by pension-level SRS proprietors to provide their residents with enjoyable activities. Several proprietors have purchased large screen televisions or other facilities such as a billiard table for the enjoyment of residents. Gardening is an activity an increasing number of residents have become involved in. In one SRS, residents also shop and buy their own food and cook for themselves once a week. Other activities include barbeques, outings and even trips interstate.

Community Visitors were pleased to hear that many residents had the opportunity to travel to Queensland for a holiday in May, 2006. This has become an annual event with approximately 15 residents, the proprietor and staff travelling to Queensland by bus for nine days.

The residents stay in motel accommodation enjoying all the modern conveniences. The first night they stayed at Narrabri, in NSW the next six nights were spent in Brisbane, the last night back to Narrabri. This year a resident from a nearby SRS joined in, having a great time, returning with a lovely tan.

The cost to each resident is approximately \$1100; this includes all food, motel accommodation, bus fare, and spending money. The residents save money throughout the year for their trip.

The residents enjoyed many outings including Movie World, Sea World and Dream World. They spent two hours on a ferry, had a barbeque at Jimboomba, went on shopping trips, and to the movies. On their way home they stopped at the Burren Junction Artesian Bore (Natural Spa).

Community Visitors commend these very caring proprietors for giving their residents the opportunity to experience and enjoy what most of us take for granted. This is a pension-only SRS with the majority of residents having a disability. Due to the success of these trips the proprietors have planned a trip to Tasmania.

However it has been sadly noted by Community Visitors that there are still many pension-level SRSs which do not provide activities and programs, often because of a lack of funds or low staffing ratios. In one SRS, residents enjoyed dancing lessons until the funding for this ceased.

It is pleasing to note that some proprietors are working with community agencies to provide outings and other social activities and interests. For example, at one SRS, a local disability service takes residents fishing. In a second, arbias (a service which assists people with alcohol and substance related brain injury) provides art and craft sessions and the residents' paintings are put up on the wall. In a third, an agency is providing a variety of activities, including literacy and numeracy for ten weeks.

Many pension-plus SRSs are able to provide a wide variety of activities including:

- an empty room converted into an art studio. A resident with an art background teaches other residents
- the installation of a bowling green
- provision of a bus for community visits
- in house activities including church services, art and craft, gentle exercise, podiatry, hairdressing, concerts, bingo, jigsaws, a games afternoon, computer, billiards, bowls, a library and facials
- visits to musical performances, swimming.

Unfortunately there are still reports that residents are missing out on leisure opportunities, sometimes because of restrictive policies, sometimes because of community attitudes, transport issues or a lack of other supports:

- in one instance, activity group and shire staff said they were not permitted to put residents into vehicles for outings
- in another, elderly citizens refused to allow a group of residents to bowl with them
- one elderly resident with significant vision impairment feels imprisoned as he has little opportunity to go out
- there is a lack of weekend activities and outings in many places.

It is pleasing to note that in one instance where residents and staff were dissatisfied with the day programs offered, a meeting with all stakeholders led to improvements.

In summary, some residents in SRSs are offered a wide range of activities and are free to make their own choice in regards to participation. In pension-level SRSs there are sometimes fewer organised activities and residents frequently request more. It is exciting to note that *The SRS Supporting Accommodation for Vulnerable Victorians Initiative* in the 2006 Victorian budget includes some money for non-government service providers to facilitate social supports and activities. Hopefully this will reduce the social isolation of some SRS residents.

3.3 Quality of care

Community Visitors have observed both positive and negative examples of care in the past twelve months. Many SRS proprietors and staff in both pension-level and pension-plus facilities provide good quality care and Community Visitors commend these people for their work. Positive comments from Community Visitors such as the following are not unusual:

A change of proprietors has wrought a complete transformation in this residence. The proprietors have set up a gymnasium for the residents. The residents are better clothed and taking a pride in their appearance.

All residents spoken to seem happy. Fresh fruit on tables. Facility clean and cool (hot day). Activity Board displayed many activities planned for the coming month. We viewed three residential statements and noted excellent social profile in folder, clearly showing relevant information about the resident. All staff have undertaken RACE training which includes fire evacuation procedures.

On a very hot day, Community Visitors observed cold water being given to residents to ensure liquid levels were maintained. This was done even though water is available in every room.

On the other hand, Community Visitors continue to report issues in relation to the provision of care.

Health and wellbeing

We found a gravely ill resident, lying in bed, who appeared in our view to require hospital care. The proprietor said the doctor was involved and the resident would 'bounce back', dismissing our concerns. The resident was admitted to hospital sometime later and ultimately died.

The carpet in the room of an older resident who has incontinence problems was putrid. The proprietor had placed plastic over the carpet which in the words of one of the Community Visitors 'squelched' and smelt 'appalling'. This issue was reported to the department. The carpet in this resident's room was subsequently removed and replaced with a vinyl floor covering. An Aged Care Assessment Service assessment for the resident was also organised.

Other issues include:

- residents looking unkempt, in dirty clothes or with their hair unbrushed and personal care not attended to
- a resident informed Community Visitors he was in bed as he was sick. Community Visitors noted that there was no bottom sheet on his bed.
- one resident's upper denture was loose, slipping when she was eating and speaking. This lady had marked weight loss
- incidents of falls, some of which have led to hospital admissions. One fall resulted in the death of a resident with dementia
- care plans being out of date or not including significant information regarding changes in health status or personal needs and preferences.

In one instance, Community Visitors had been reporting for years, concerns about the care provided at one large SRS that provided accommodation to a transient population as well as to a large number of long-term occupants. In December 2005, the Community Visitors reported the following concerns to the department.

Rubbish and broken glass on the south side of the premises; three broken windows in the dining room; the dining room and passage floors downstairs were filthy; a broken toilet pan in the male downstairs toilet; internal rubbish bins overflowing and unclean table tops in the dining room. Of more concern were a couple of tip-offs we received. The first was that there is no staff staying overnight on the premises. The second is quite disturbing. Prior to 2004, there was a mother and her young son at the SRS... For whatever reason, they have now returned to the SRS and are living under assumed names and the paperwork is showing the boy as 17 years old. (Community Visitors believed he was about 13)

In the early months of 2006 Community Visitors continued to raise a variety of concerns in their reports. In April 2006 an administrator was appointed by the Minister to manage this SRS. According to *The Age*, when the administrator arrived, one person was living in the laundry, a cold concrete room with dripping taps. Several windows were smashed. For three months the residents were served only pasta. A man who had suffered a terrible car crash injury was living there 'because no-one else would take him in'. It is an inappropriate environment but it is home to many with very few alternatives. (14 June 2006 pg.3) At the time of reporting, this SRS was still open but under the management of an administrator.

The lack of care and respect shown in some SRSs is unacceptable and it would not be tolerated by the general public.

Staffing

Previous sections in this report have noted that staff are often required to support a wide range of people in large congregate care settings. The effective provision of care requires capable staff with suitable skills, knowledge and experience.

Given the vulnerability and complexity of the SRS population, the Community Visitors Board again expresses concern that the *Health Services (SRS) Regulations 2001* only require that there is one member of staff (a personal care coordinator) qualified to a Certificate III level on duty for not less than 38 hours a week. In many pension-level SRSs, the majority of staff are untrained and Community Visitors continue to report instances of residents at home with untrained staff or a sole staff member who is also responsible for cooking or cleaning at the facility. Sometimes these staff have limited English as well. At one 35 bed facility, Community Visitors found one staff member on duty with her young child also in attendance.

According to the 2003 census of the SRS industry, 81% of SRS proprietors employ at least one family member full-time and, of the 2088 staff working in the sector at the time of the survey, 505 staff were family members. Work in an SRS, providing care to a large number of individuals with different needs, can be challenging. Community Visitors believe that all staff providing personal care should be trained in first aid and emergency

management, and staff should also have training relevant to the needs of their residents.

This year there has been some serious allegations made against staff. In one instance a manager was accused of physically abusing and verbally humiliating residents for some years. In another facility, residents said that a male staff member had been 'touching up' some residents and verbally abusing others. Unfortunately in both these instances, it was only after there were changes in staff or proprietors that these allegations were raised with Community Visitors. Some residents said they had been too frightened to tell Community Visitors what was going on as they thought they would get into trouble or suffer further abuse. In both these situations, the allegations of residents were passed on to the department and the police for investigation. In another facility, however, Community Visitors were able to report resident concerns and see that they were addressed.

A number of residents complained about a particular staff member who they said was unresponsive and not interested in their welfare. They also alleged that he had raised his fist at them. The person in charge spoke with the proprietor but nothing changed. Community Visitors then reported the residents' concerns and queried the staff member's suitability. The proprietor spoke with the staff member and the matter was resolved to the residents' satisfaction.

Support from external agencies

Fortunately, some SRSs receive support from a range of community agencies to assist them in their work with residents with complex needs. These included mental health services, health services, the Royal District Nursing Service, arbias, Disability Client Services and day programs, housing support services and non-government organisations such as Wesley Mission. Support includes case management, activities, food and nutrition programs, health education, and support for residents to attend medical or legal appointments. Some SRS proprietors have told Community Visitors they would appreciate more support from mental health services.

One SRS sought assistance from their local mental health service when the behaviour of a resident, Pam, caused increased concern. On this occasion, Pam had been wandering around town in the early hours, fallen over in a park and ambulance and police had been involved. The police requested that something be done about her, she was becoming a nuisance to police. SRS staff were told by the local mental health service that behavioural problems were not their concern.

Privacy, dignity and choice Issues

Issues related to resident privacy and dignity continue to be noted by Community Visitors. In many SRSs it is difficult for residents to receive and make telephone calls in private. In one facility a resident complained that a

manager opened her mail. In another, residents complained about Authorised Officers taking photos of their bedrooms without seeking permission first.

One male resident wanted help to fix his electric razor which the Community Visitors found dirty and broken. Staff said this was a communal razor, only a few months old. Community Visitors suggested residents should all have their own razors but staff said the residents couldn't afford them.

At another SRS, Community Visitors reported that there was no toilet paper in the toilets. The proprietor said this was because one resident was continually blocking the toilet with toilet paper. She thought it was acceptable that residents were supplied with their own roll which they could take with them when they went to the toilet. Community Visitors thought this was degrading to residents and reported the issue to the regional Department of Human Services office some months ago. The purchase of an alternative toilet paper dispenser was suggested but to date this issue remains unresolved.

In another SRS, Community Visitors observed the Royal District Nursing Service treating several residents in the bedroom of one resident rather than the room of each individual who required treatment. The resident's wardrobe was also used to store dressings and continence aids for everyone, rather than just their personal necessities. This practice has changed since being questioned by Community Visitors.

Many SRSs still have shared rooms, some without any screening or curtaining to allow privacy. Community Visitors reported the death of a woman who was in a shared room. The body of the resident could not be removed until after a medical officer had noted the time and cause of death and this took some hours. The resident sharing her room was disturbed by this.

On a positive note, in another facility where a long-term resident passed away, a memorial service was held for residents to pay their respects.

In one SRS, resident meetings are held regularly, with relatives included. The minutes are printed and put on a noticeboard. However, such meetings are rare. Most residents have little control or input into decisions that affect them or the environment in which they live. Community Visitors think more effort could be made by proprietors and staff to involve residents in the planning of menus and activities and decisions about the purchase of new furniture and the decoration of rooms.

The routines of some SRSs are very institutional and they seem designed to meet the needs of staff rather than residents. For example, Community Visitors have reported tables being cleared after lunch before noon and evening meals being served before 5pm. In another pension-plus SRS, residents were told they had to either be home by 8pm, pay overtime penalty rates to staff, or make alternative arrangements. According to the

SRS's newsletter, 'The emergency night staff person is employed to respond only to emergencies – they are not paid to provide care, give medication, meals or assist residents to bed. The home is locked after 8pm for protection of all residents and staff. If you return later, the person returning you must see to your needs and ensure you are assisted safely to bed.' Community Visitors do not believe that it is a home-like environment if residents are required to be home by 8pm.

While Community Visitors acknowledge that it can be difficult to make ends meet in pension-level SRSs, the actions of some proprietors seem unnecessarily penny-pinching and demeaning to residents.

Karen, an SRS resident, had a birthday. A staff member brought out the top half of a six inch diameter iced sponge cake with one candle. Residents sang 'happy birthday', the cake was taken away and cut into 31 minute morsels. This constituted the residents' morning tea.

3.4 Tenancy and finance issues

Community Visitors have noted several instances where SRS residents have been vulnerable to exploitation because they do not have the legal protections that boarding house residents have under the Residential Tenancies Act 1997. For example, there is no legal requirement for bonds or entry payments to be lodged with an independent body and the conditions under which such payments are returned appears to be governed solely by the residential statement developed when the person first becomes an SRS resident.

Community Visitors have reported entry payments as high as \$100,000. If entry payments are under \$10,000 there are currently no protections for SRS residents and no recourse to an independent tribunal. If the payments are over \$10,000 and the SRS comes within the definition of a retirement village under the Retirement Villages Act 1986, an ingoing contribution of \$10,000 triggers responsibilities under the Act. Community Visitors report that in one rural facility residents are charged \$8000 when they move into the SRS and it would appear that after three months they forfeit their right to the return of this entry fee. One resident passed away after four months and her family had no recourse to any of this money.

The *Health Services Act* says that proprietors are required to provide new residents with a residential statement within 48 hours and this is to be signed by the proprietor and the resident or the resident's guardian or administrator as soon as practicable. The residential statement should spell out the services the proprietor agrees to provide as well as any conditions about the resident's tenure or stay at the service. It is therefore a key reference in relation to the responsibilities and protection of both SRS proprietors and residents.

On several occasions this year, Community Visitors have reported that SRS staff or proprietors have either been unable or unwilling to produce copies of residential statements upon request. When queried about this, some proprietors have claimed they provide a copy of the statement to the residents but do not keep copies themselves. Community Visitors also report statements being unsigned or scant in information in regard to matters such as fees charged, notice to vacate, and rent increases. Community Visitors believe residential statements need greater monitoring by the Department of Human Services .

A new Disability Act (to come into effect in 2007) will also provide people with a disability who live in community residential units more protections than those currently available to SRS residents. For example the new Act requires rent receipts, 60 days notice of rent increases, and places restrictions on the amount of rent that can be charged in advance. Community Visitors believe that SRS residents should also be afforded these protections.

Several residents raised financial concerns with Community Visitors in 2005-06. Most of these were fairly easily resolved after follow-up with administrators or discussions with the SRS proprietor.

At one SRS, Community Visitors were told that a resident had to miss a social group for people with acquired brain injury because she didn't have sufficient funds. Community Visitors followed this up with the SRS proprietor and the resident's administrator at State Trustees and State Trustees provided additional funds so the resident could regularly attend the social group.

Community Visitors were informed that a gentleman had not had his rent paid by State Trustees for several months. When Community Visitors contacted State Trustees they were advised that the resident's house was in the process of being sold. The sale of his house was completed and his debts paid.

3.5 Physical environment

Maintenance and cleanliness

A large number of issues of concern raised by the Community Visitors this year relate to maintenance and cleanliness. Quality of care is often compromised by maintenance issues, particularly in pension-level SRSs and older run down buildings. The most common issues raised related to strong urine smells, carpets requiring cleaning and/or replacing, soiled and smelly bathrooms and broken or missing lights. Other issues of concern noted include: damaged and soiled window coverings, painting upgrade needed, overflowing gutters on roofing, broken steps and ramps, poor heating and cooling, cigarette butts lying around internally and externally and unkempt gardens.

It is pleasing to note among the Community Visitors' reports that there are a number of proprietors who, with the cooperation of owners, are ensuring ongoing improvement in maintenance and facilities. Improvements include: new air conditioning and heating, ongoing maintenance to furniture, extensive new furnishings and carpet, replacement of plumbing fixtures, extensive painting and the maintenance of gardens.

One panel of Community Visitors noted changes to the poor fabric of premises as a result of the introduction of self assessment and the desk audit conducted by Department of Human Services. Re-registration depends on major improvements such as replaced carpets, fittings in bedrooms being repaired/replaced and major improvements to cleaning etc. Community Visitors are very pleased to see this happening given that these have been issues over many years.

Heating or the lack thereof has again been reported by Community Visitors this year. In some instances, Community Visitors have noted low temperatures and found SRS residents still in bed or sitting around with blankets wrapped around them because of the cold.

Safety issues

Two recent fires in SRSs in the Southern Region continue to highlight the need for well planned emergency management. Community Visitors have noted many SRSs have emergency management plans and regular fire drills in place but there are still too many SRSs that don't. Some of the other fire safety issues reported are exit doors locked or blocked, fire alarm panels being switched off or broken, fire hoses obstructed, cigarette burns in the carpet, electrical equipment not being checked, and evidence of residents smoking in bed. One resident also had cardboard boxes, paper and rubbish stacked from floor to ceiling at the end of his bed.

Many SRSs have only one staff member 'on call' overnight who sleeps on the property. While all SRSs are now required to have sprinkler systems, Community Visitors remain seriously concerned about the ability of residents, many of whom have limited mobility, to be safely evacuated in the event of a fire.

A range of other hazards and safety issues have been noted by Community Visitors during the course of the year:

- Flammable materials stored close to the gas hot water service in an unlocked plant room with a can of petrol and container marked 'flammable liquid'
- Electrical cables hanging from the roof
- Wet towels and water left lying on the floor of a shower/toilet room
- Loose packets of medication in the bottom drawer of an unlocked trolley in an unlocked kitchen
- Water in the hand basins scaldingly hot. When Community Visitors raised this issue with the department, they were told that the SRS

regulations only require the water temperature in baths and showers to be controlled to avoid the risks of scalding (not hand basins).

Several food safety issues were also noted. In one case Community Visitors viewed the fridges and freezers and noted that there were sliced bananas that appeared furry and black. The Community Visitors were told that the bananas were caramelizing for the next day's sweets! In another instance, Community Visitors, visiting at 11am, noticed that milk was already in cups ready for lunch to be served about noon. In one case, a health officer from the local council inspected a facility and confiscated food after Community Visitors reported unhygienic conditions in an SRS kitchen. The proprietors were asked to prepare a food safety plan and provide a detailed cleaning schedule to council.

The freezers are overpacked. Blackened vegetables are in the fridges along with uncovered food. Use-by dates on frozen food are well passed – January 2004 lasagne with visible mould. There would have been a dozen blackened heads of cauliflower. There was mice poison on the floor.

3.6 Viability

Community Visitors have reported a number of SRSs struggling to remain open and financially afloat due to low numbers of residents, cash flow problems, major building problems, and delays in renovations which need to be financed by the owner of the building.

As more people are supported to remain in their own homes until they have high medical or other support needs, the need for low level care facilities is likely to reduce. Some SRSs report increased vacancy levels after the establishment of Commonwealth funded facilities in their local area.

As reported earlier in this report, some facilities have started taking respite care clients or developed agreements with local hospitals in order to stay open. One SRS planned to supplement their income by running day programs but this did not proceed as there was little interest, despite widespread advertising. The risk is that if proprietors are desperate to fill vacancies they may accept anyone as a resident, even if staff do not have the skills to meet the person's needs or the person's behaviour is likely to upset other residents.

According to Department data, at the end of the reporting year there were 200 registered SRSs with 6785 beds. In 2005-06 five SRSs closed, two new SRSs opened and 22 transfers were approved. While 135 beds were gained overall, none of these were pension-level beds. The closures resulted in the loss of 83 pension-level beds in the SRS sector.

The Victorian Government has acknowledged the financial plight of pension-level SRSs in their 2006-07 budget. A new initiative and other

possible solutions to resolve the current issues in SRSs are discussed in the next section of this report.

Summary

Community Visitors see all the issues discussed in this report as crucial ones for the protection and enhancement of people living in SRSs. Our concern arises directly from the legislative brief for Community Visitors under section 117 of the *Health Services Act*:

to inquire into the appropriateness and standard of facilities for the accommodation, physical well being and welfare of residents of the service: the adequacy of opportunities and facilities for the recreation, occupation, education and training of residents; and whether services are being provided in accordance with the principles specified in section 10.(of the Act)

4 POSSIBLE SOLUTIONS

4.1 Government initiatives

For many years, Community Visitors have called on government to increase the accommodation and support choices available to people with complex care needs and to improve the quality of life for those people who live in SRSs. Community Visitors applaud the Victorian Government on initiatives in their 2006 budget which assist people with disabilities, people with a mental illness, and older people in Victoria.

Support for pension-level SRSs and their residents

The key initiative that will directly impact upon SRS residents is called the *SRS Supporting Accommodation for Vulnerable Victorians* initiative. The government has announced \$29.41 million over four years to provide a range of measures to improve the viability of pension-level SRSs and the quality of life of SRS residents. These measures include:

- Indirect facility cost relief: non-government organisations will be contracted to manage facility cost relief funding for a cluster of pension-level SRSs. This is expected to assist 2000 SRS residents.
- Health and social assessment of residents: these assessments will be undertaken by appropriate service providers, to build knowledge of the nature of resident complexity and support needs. They will also promote better access to social, health and community services.
- Service coordination and support services: non-government service providers will be funded to work with proprietors and health and community services. They will facilitate social support and activities to reduce isolation and assist service access for particularly vulnerable residents. Larger SRSs or those that have a high number of residents with a psychiatric disability or difficult behaviours will be targeted for these services.

The government has also stated that the initiative will look at options to improve SRS building fabric and the physical living environment and safety for SRS residents. However these options will not commence until after July 2008. Community Visitors believe they are urgently needed.

The cost relief funding component of the SRS initiative follows a successful pilot project that funded seven pension-level SRSs in Victoria (via non-government organisations) from 2004-06. The project demonstrated that financial assistance from government can improve the viability of pension-

level SRSs and benefit the lives of residents. The Community Visitors Annual Report 2005 included several positive stories that illustrated this. Community Visitors are very pleased that the government will now expand the program to pension-level facilities throughout Victoria.

The 2006 state budget also contains a number of other strategies to reduce homelessness and increase the accommodation choices for disadvantaged Victorians.

Mental health and disability initiatives

Both the Victorian and Federal governments have made recent commitments to expand and improve mental health services and Community Visitors look forward to their implementation. As discussed earlier in this report, a high percentage of SRS residents have significant mental health and disability issues and Community Visitors have been calling for many years for greater investment in housing and support options for these people.

Many SRS proprietors and staff find it difficult to manage large numbers of people with a chronic mental illness. The proposed expansions of specialist community-based mental health services and post-discharge housing and support services are most welcome.

The 2006-07 state budget also announced some money to assist people with other disabilities. Most of this money is for accommodation and support services of some kind: individual packages, day activities, attendant care, and a program specifically targeted to assist younger people to move from residential aged care facilities.

Home and Community Care Program services which assist older people and younger people with a disability to maintain their independence, and Supported Accommodation Assistance Program agencies which provide assistance to the homeless and those at risk of homelessness, also received some additional resources in the recent Victorian budget. Community Visitors congratulate the government on these initiatives.

Education and training for SRS proprietors

Care planning training sessions for the managers and staff of SRSs have now been completed in all regions of Victoria. Community Visitors are pleased that further sessions on care planning will be run from time to time and training for SRS proprietors and staff on medication management, challenging behaviours, and understanding mental illness have also been introduced. However these sessions are voluntary and only motivated proprietors and staff will attend.

4.2 Legislation and prosecutions

Legislation can have a clear impact upon the standard of living for SRS residents. In last year's Annual Report, Community Visitors reported a number of changes to the *Health Services Act* in relation to the preparation of care plans and residential statements, and the management of resident finances. Since then Community Visitors have noticed some progress in these areas, but there is still room for significant improvement. Community Visitors continue to report care plans being scant in information and residential statements being unsigned or out of date. Community Visitors believe diligent monitoring of these aspects of care by Department Authorised Officers is essential.

Further amendments to the Act are currently before parliament. These amendments strengthen the existing regulations of the Health Services Act and increase the protections available to SRS residents. Community Visitors are particularly pleased that the following amendments are proposed:

- SRS proprietors will be required to provide 28 days written notice of closures to both residents and their next of kin.
- Protections in regard to the management of resident finances will be strengthened.
- Residential statements will be required to include information about services offered.
- Fit and proper assessment of prospective SRS proprietors will take into account their management of other establishments and existing complaints.

However, SRS residents still have very few tenancy rights in comparison with other members of society and further action by government is needed to improve their legal protection. Under the Residential Tenancies Act, rooming house and boarding house residents have a number of protections that SRS residents do not have. For example:

- If a bond is charged, the bond must be lodged with the Residential Tenancy Bond Authority.
- No more than 14 days rent can be asked in advance and a receipt must be provided.
- If either a resident or a rooming house owner breach their duties under the Act, the other party has recourse to an independent body, the Victorian Civil and Administrative Tribunal.

The new Disability Act does not give people with a disability who live in community residential units (group homes) full rights under the Residential Tenancies Act but, once the legislation comes into effect, these residents will have more rights and protections than SRS residents. Community Visitors believe that SRS residents should have the same rights and protections as people living in other types of shared supported accommodation.

Legislation by itself may persuade proprietors to fulfil their responsibilities but enforcement sends a more powerful message. This year the Department of Human Services has successfully prosecuted several SRS proprietors. In a couple of instances, hefty fines were imposed and convictions recorded against SRS proprietors. Prosecutions related to breaches in respect to maintenance, privacy, cleanliness and residential statements. Community Visitors are sometimes frustrated at the length of time that the Department takes to initiate a case and bring it before a court. Meanwhile, substandard care can continue for years.

4.3 Partnerships

SRS proprietors

Community Visitors have a unique and critical role in the monitoring and improvement of quality in SRSs. In some instances, Community Visitors are the only people with whom SRS residents have regular contact that are not paid to provide a service. However, the role of Community Visitors is limited to identifying and reporting issues and the program must work in partnership with others to address these issues.

Obviously a key working relationship is the relationship between Community Visitors and SRS proprietors and staff. There are many dedicated proprietors and hard-working staff who are keen to do all they can to provide high quality care and to create a home-like environment for residents. Community Visitors appreciate the courteous approach and openness of such people and their willingness to attend to issues brought to their attention by Community Visitors. Unfortunately there are still some proprietors who are defensive, rude or hostile towards Community Visitors and reluctant to provide Community Visitors with access to documentation required under the Act.

Community Visitors also value the cooperation and assistance of many Department staff who do what they can to protect and promote the interest of residents. Quarterly meetings between the Department and Community Visitors representatives were held in all regions and generally Community Visitors report that these meetings are productive. There are other regions where the cooperation and mutual recognition could be further developed. The Board also meets quarterly with managers of the Department's Aged Care Division, who are responsible for the state-wide monitoring of SRSs and related policy development.

In September 2005, a revised protocol between Office of the Public Advocate and the Department's Aged Care Branch was signed by the Public Advocate and the Director of Aged Care. This protocol clarifies the roles of Community Visitors and Authorised Officers and procedures for issues resolution.

New quality processes which involve both agency self-assessment and auditing by departmental staff were implemented this year, and some

Community Visitors have reported positive changes as a result of these processes. Other Community Visitors have expressed some concern that as a result of these new business processes, Authorised Officers appear to inspect SRSs less often and to only visit to carry out an audit (which may be once in three years) or to respond to a formal complaint. However in the year under review the Department has negotiated with the Office of the Public Advocate a clarifying Protocol on the respective duties of Authorised Officers and Community Visitors, which we believe will prove helpful.

Other agencies

There are of course many other agencies and authorities that have some connection with SRSs or SRS residents. General practitioners and allied health professionals frequently visit SRSs. There are also a host of other disability and housing support agencies, mental health and health services, church and community organisations, regulatory authorities and local government bodies who play some role in the monitoring and support of SRSs and SRS residents. Community Visitors are keen to work in tandem with these agencies to further the interests of the people who live in SRSs.

In 2005, an emergency management working group involving representatives of the Country Fire Authority, local government, the Department of Human Services, WorkSafe, and the police, as well as representatives of the Community Visitors Program, was established to pilot a coordinated approach to fire safety and other emergency management issues in the Greater Dandenong area. Training for proprietors and staff was trialled in October 2005 with the aim of promoting awareness of emergency management issues and ensuring the development of emergency management plans. Unfortunately recent inspections by the Country Fire Authority established that, despite having attended the training, many SRS proprietors have failed to develop and implement emergency management plans. This was very disappointing.

The community

The last, and probably the most important, partnership for Community Visitors and for SRS residents is with the broader community. One's home is extremely important, but so is the neighbourhood where the home is situated.

Feeling part of a neighbourhood and being a member of a (geographic or other) community is important to most of us and to our sense of identity. Many SRS residents live isolated lives and they suffer from loneliness. Some have few relationships with people other than family members or paid staff. Others 'burnt their bridges' with families long ago.

Like other people with a disability or mental illness and older people, SRS residents frequently have to overcome barriers to their participation in the community: physical, economic, social and attitudinal barriers. There is still a significant amount of fear and prejudice towards those who have a

disability or mental illness. Often this arises from ignorance and lack of contact.

Some SRS residents maintain a high degree of independence and some participate in specialist day programs or activities. Few seem to be involved in volunteer opportunities or the paid workforce. In Canada, considerable effort has been made to promote the community inclusion of people with an intellectual disability within organisations, recreational activities, schools, employment and neighbourhoods. Those involved have stressed the benefits for society as a whole. (Canadian Association for Community Living 2006, Canada, viewed 4 August 2006, <http://www.communityinclusion.ca/Community_Inclusion_21>) The more that can be done to promote inclusion, understanding and acceptance of all members of a community, the richer that community will be.

In the Victorian State Disability Plan 2002–2012, the government has committed to strengthen communities so that they are 'more welcoming, more accessible and more inclusive of people with a disability' (2002 p.35) and to make public services more accessible and inclusive. However, all involved in the Community Visitors Program know that both policy and resources are required to make these things happen and the timetables and priorities of government are influenced by voters. If we as a community believe that people who live in SRSs deserve a decent quality of life and the same rights and opportunities as other members of a community, then we need to support the allocation of resources to make this happen.

5 ABOUT COMMUNITY VISITORS

The core role of the Community Visitor is to safeguard the interests and rights of people with a disability. Community Visitors are independent appointments by the Governor in Council. As *volunteer* community representatives, they have a unique role in monitoring the quality of services for people who live in eligible facilities. These facilities are defined by the *Mental Health Act 1986*, the *Health Services Act 1988*, the *Intellectually Disabled Persons' Services Act 1986* and the *Disability Services Act 1991*.

The Community Visitors Program is accountable, through the program manager, to the Public Advocate and, through the Community Visitors Annual Reports, to the Victorian Parliament.

The mission of the Community Visitors Program is to promote and protect the rights, dignity and safety of people with a disability, both at an individual and systemic level, through the provision of an independent, credible and respected program of visits to facilities as required by the four Acts establishing the program.

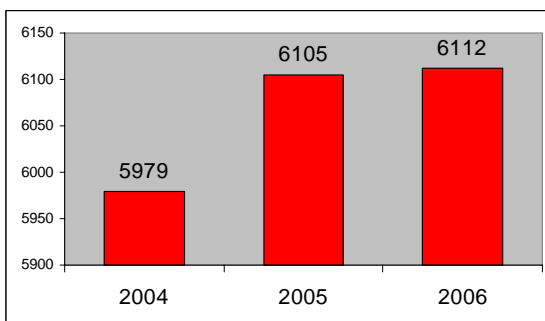
Community Visitors are independent of service providers and through regular visits to facilities, are able to assess whether the service is observing the rights and needs of individual residents or patients, in accordance with accepted community standards.

The credibility of the program is central to its capacity to effect positive change and resolve issues as encountered during visits. To a large extent this credibility is dependent on Community Visitors being fair, reasonable and unbiased. In selecting Community Visitors, the program values broad life experience and volunteers need to demonstrate a commitment to people with disabilities enjoying the same rights as other members of the community.

5.1 Year in review

The Office of the Public Advocate was responsible for training and supporting 594 volunteer Community Visitors across the state during 2005-06. This support and coordination function was undertaken by the Community Visitors Program Unit within the Office.

Number of visits



Community Visitors made 6112 visits this year. The issues raised during these visits represent a significant contribution to improving service quality and also contribute to the systemic advocacy undertaken by the program and by the Public Advocate.

The reports of these visits also contribute to the three annual reports submitted to Victorian Parliament by the respective Community Visitors Boards: Disability Services; Psychiatric Services (Mental Health Services); and Health Services (Supported Residential Services).

Issues and developments relating to SRSs form the basis of this annual report. A summary of issues from the two other annual reports – Disability Services and Mental Health Services – is provided below.

Disability Services

Whilst Community Visitors visiting Disability Services applaud the redevelopment of Kew Residential Services, they call on the Victorian Government to have plans and proposals approved by 30 June 2007 to redevelop the remaining outdated and run-down institutions of Colanda in Colac and Sandhurst in Bendigo. The State Disability Plan 2002–2012 states that all institutions will be redeveloped and the absence of any decision by the government for the future needs of these residents at Colanda and Sandhurst is unacceptable.

Community Visitors welcome the introduction of person-centred planning as a mechanism for ensuring that the disability services sector is driven by the needs, rights and aspirations of individual people with a disability rather than by the needs of service providers. The Office of the Public Advocate has been involved in consultation around the implementation of this approach and remains optimistic about the benefits to people with a disability. What is now required is a commitment to implement this approach in a comprehensive way.

Community Visitors continue to report on:

- the importance of capable leadership and quality staff support across disability accommodation services
- the problems for people with a disability participating in community activities when there is insufficient transport, particularly for those living in geographic isolation
- the importance of health care and regular health monitoring and the right of residents to receive the same range of health services that are provided to the general community
- the need to recognise the significant increase in the number and proportion of ageing residents living in disability accommodation services, and the requirement for consistent and clear policies and practices for them
- a continuing shortage of respite places where demand exceeds supply for facility-based respite.

Mental Health Services

For the past decade there have been persistent reports by Community Visitors about the need for additional and improved quality mental health services within Victoria. Continuing concerns are the need for appropriate accommodation and support for people with severe mental illness, with a severe shortage of acute and extended care beds leading to a lack of clinical care. It has been the Community Visitors – along with the ongoing media, community and political interest – that have continued to identify the priority areas where there is need for improved mental health services in Victoria.

The Victorian Government announced in the recent state budget that they will lead mental health service delivery and reform with a further \$170 million over five years. The Health Minister, Bronwyn Pike, announced on 30 May 2006 that extra funding for Victoria would deliver at least \$472 million under the National Action Plan on Mental Health by 2011.

Community Visitors welcome the announcement through the state budget of improved hospital based care and alternatives to inpatient care, including: additional prevention and recovery care for people who require short-term sub-acute care, the expansion of forensic mental health services, and accommodation for people with ongoing mental illness. A workforce development plan has also been announced to address the ongoing shortage of skilled allied health staff and to promote the delivery of high-quality services.

Community Visitors welcome all plans for increased mental health spending by the Victorian Government and will monitor closely the outcomes for those Victorians with a mental illness and their carers.

Quality Project – Community Visitors Program

The Department of Human Services provided funding for a project to review visiting and reporting of the Community Visitors (Disability Services). The report of this project was received by the Community Visitors (Disability Services) Board and the Department of Human Services in December 2005. The key findings and recommendations have been widely distributed and discussed. While many of the findings and recommendations were specific to the Disability Services stream of the Community Visitors Program, they have relevance for the whole program across all streams. The key findings and recommendations have been put forward for consideration in the strategic planning process which is being conducted for the whole program.

One of the findings of the project was the need for additional coordinators. A fourth coordinator position, which includes a responsibility for quality monitoring within the Community Visitors Program, has received funding from the Department of Human Services for another year at this stage.

5.2 Visits by Community Visitors

Disability Services

In 2005-06 Community Visitors (Disability Services) completed 3200 visits to 1076 places, which remains below the ideal target.

There is a legislative requirement for Community Visitors to visit the three gazetted residential institutions (Kew Residential Services, Colanda Centre and Sandhurst Centre) on a monthly basis. All these institutions were visited on a monthly basis, with a total of 168 visits being recorded for the 26 units (each accommodating a large number of residents) at these institutions.

There is no legislated minimum number of visits to the other 1050 accommodation services, which are generally houses accommodating up to five people. Most places were visited at least twice during the year. The Disability Services Board has set an ideal target of visiting once a quarter, which translates to a target of 4200 visits per year (plus the visits to institutions).

Mental Health Services

The *Mental Health Act* requires Community Visitors to visit each of the 106 approved mental health services on a monthly basis. Of the 1374 visits conducted by Community Visitors this year, 1160 were scheduled routine visits and 214 were callout visits in response to requests from individual patients and/or their families. On this basis there was a shortfall of 112 visits. This has occurred as a consequence of a shortfall of Community

Visitors in some areas and the difficulties in visiting all units against the number of visits as required by legislation. A noted change and possible reason for the shortfall in visits has been the increase and complexity of callout visits, which can involve considerable time of Community Visitors.

Health Services

There is no legislative requirement relating to the regularity of visits to supported residential services. The Community Visitors (Health Services) Board, however, requested that in 2005-06 Community Visitors aim to visit all supported residential services with pension-level beds on a monthly basis, and pension-plus facilities less often. There are difficulties setting accurate targets as the pension-level status of a supported residential service depends on the particular residents at any time.

5.3 Target number of Community Visitors

At 30 June 2006, there were 473 Community Visitors, of whom 406 were appointed and 67 in training. Together with the 121 Community Visitors who resigned during the year (that is 25.5%), a total of 594 Community Visitors were trained and supported over the course of the year.

The number of prospective Community Visitors in training (67) is indicative of the ongoing efforts to recruit volunteers during the year. The process for selecting and training Community Visitors is, appropriately, quite an extensive one. It can take six months before recruiting efforts flow through to an increase in the number of Community Visitors. It is estimated that, to meet the visiting requirements of the program, another 48 volunteers are needed across Victoria (as at 30 June 2006: 37 in Disability Services, 6 in Health Services and 5 in Mental Health). Due to the proportion of volunteers who leave the program each year (25.5% in 2005-06), the need to recruit is a continuing challenge.

5.4 Training and development

Training is a critical factor in the provision of a high quality Community Visitors Program. The Combined Boards of the Community Visitors Program have appointed a training steering committee made up of Community Visitors and the Training and Development Coordinator to oversee the training and development program. Great effort has been put into improving the quality of the training delivered by the program. The feedback provided by Community Visitors who have attended training this year indicates that these efforts have been worthwhile and that the training program in place is of a high standard.

This year, 112 training sessions were conducted for 1043 attendees. Thirty four of these days were run centrally for 692 attendees and a further 79 sessions were run locally with 711 attendees. It is significant that the growth in training days has increased each year, from 13 days in 1999-2000 to 112

this year. The high quality of the training program and the commitment of Community Visitors to attend training are fundamentally important to the quality of the program.

The *Whistleblowers Protection Act 2001* encourages and facilitates disclosures of improper conduct by public officers and public bodies. For the 12 months ending 30 June 2006, the Office of the Public Advocate did not receive any disclosures covered by the Act. The Office of the Public Advocate is committed to the aims and objectives of the Act and a copy of the Office of the Public Advocate's Whistleblower Procedure Manual is available on our website at www.publicadvocate.vic.gov.au or from level 5, 436 Lonsdale Street, Melbourne.

6 REFERENCES

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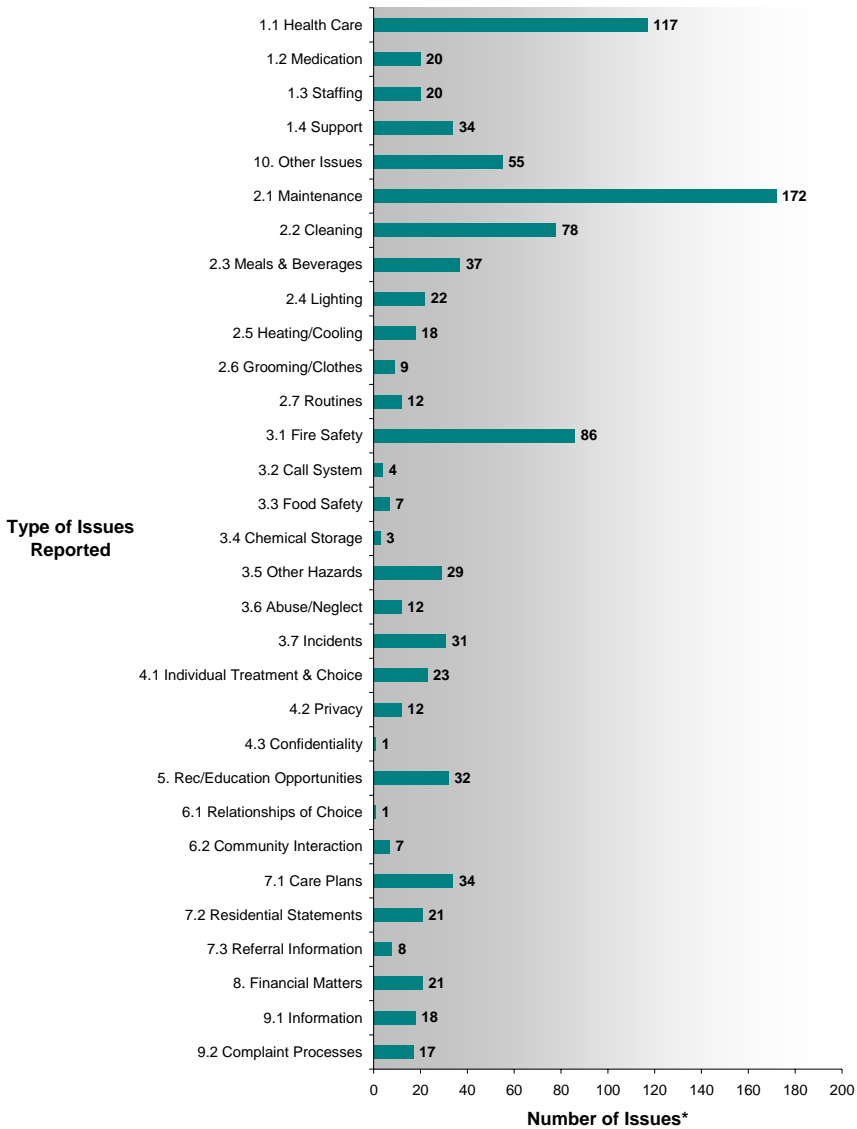
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7 APPENDIX

Health Services Statewide Summary of Issues July 2005 - June 2006



*Please note: issues raised more than once were counted each time they were reported. For example, if an issue was raised three months in a row, it was counted as three issues.