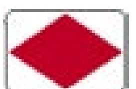
Office of the Public Advocate

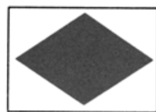
Community Visitors **Annual Report 2007**

Health Services

OFFICE OF THE PUBLIC ADVOCATE

AN INDEPENDENT STATUTORY OFFICE ACCOUNTABLE TO THE VICTORIAN PARLIAMENT





OFFICE OF THE
PUBLIC ADVOCATE

3 September 2007

The Hon. Lisa Neville MP
Minister for Aged Care
Level 22, 50 Lonsdale Street
MELBOURNE VIC 3000

Dear Minister

RE: COMMUNITY VISITORS (HEALTH SERVICES) ANNUAL REPORT

In accordance with the *Health Services Act 1988*, please find enclosed the 2006-07 Annual Report of the Community Visitors Residential Services Board.

This year, Community Visitors celebrated 20 years of the program. We commend this report to you.

Yours sincerely

BARBARA CARTER
A/g Public Advocate

ALAN NICHOLS AM
Board Member

PAULINE MUSGRAVE
Board Member

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The Community Visitors Program is a program of the Office of the Public Advocate. Its aims are incorporated within the mission of the Office.

The mission is to provide a responsive and accessible service that informs and engages with Victorians to promote and protect the rights and dignity of people with a disability, and reduce exploitation, abuse and neglect.

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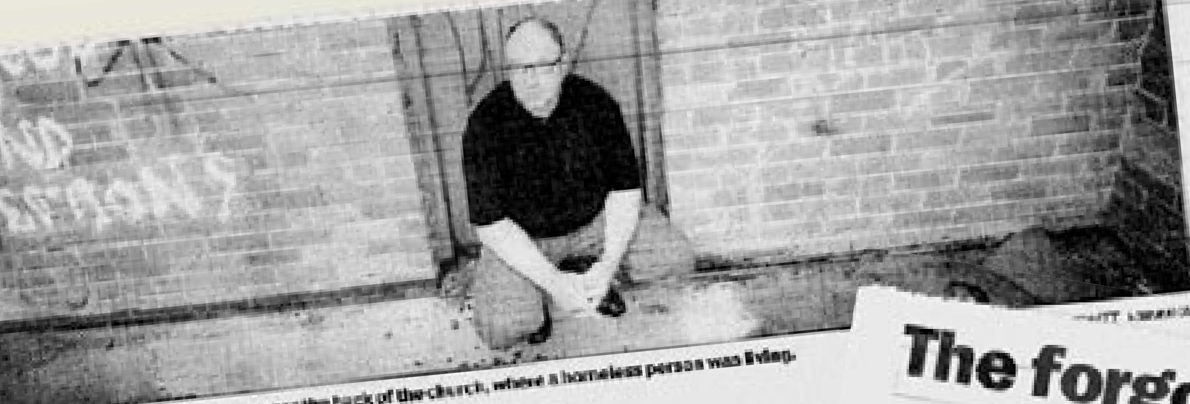


...Doug Faircloth at a doorway near the back of the church, where a homeless person was living.

Give dignity, says

The forgotten people

Being homeless is not a lifestyle choice. The attitudes of the prosperous towards those less fortunate have to change to ensure help is there when it is needed.

By CHRIS MIDDENDORP

EARLY in December, Kevin Rudd disclosed an experience of childhood poverty that clearly left an indelible impression upon the new federal Opposition Leader's character. After the premature death of his father, Rudd's mother and her children were evicted from their Queensland farm and left with nowhere to go. They were all forced to sleep in the family's car until they could find accommodation. Rudd said that the ordeal left him with the conviction that nobody should have to experience...

capital cities and rural communities to assess how adequately the Australian citizen's right to housing was being fulfilled. Kothari was shocked by the lack of affordable housing options in our cities and appalled by the poor standard of housing in indigenous communities.

In his preliminary report, the Special Rapporteur swiftly identified that this economically prosperous land had failed to build sufficient housing options for the most vulnerable in our community.

He pointed to overcrowding, unaffordable private rentals, inad...

Stopping to really see them

Maroondah **Leader**

In sight, out of mind

Dozens of Melbourne's most vulnerable residents bunk down each night in Maroondah, largely unnoticed and supported by a hardy few.

Special report pages 6-11.

Money is tight

Friends help you to 'survive'

Did you know?

1 Executive Summary

Supported Residential Services (SRSs) are privately run facilities registered under the *Health Services Act 1988* to house and support people who require assistance with daily living. At 30 June 2007, there were 193 SRSs in Victoria.

Of these, 77 are provided at the cost of a social security allowance ('pension-level') with about 2,400 residents and 116 are provided at a cost above a social security allowance ('pension-plus') with over 4,000 residents. Most pension-plus facilities are regarded as providing good quality care. However, Community Visitors continue to report significant issues of concern.

Community Visitors report that there are even more young people with a disability or mental illness living in pension-level SRSs than last year. In some instances, there is no clear plan to move these residents to more suitable accommodation. Community Visitors are dismayed that congregate care facilities are being accepted as a long-term option for young people who need opportunities for development to lead more fulfilling lives.

Community Visitors are also very concerned about the mix of residents in many pension-level SRSs. The young, usually with an acquired brain injury, sometimes, with an intellectual disability or mental illness, live with the frail aged. They are not compatible in diet, entertainment, mobility or companionship. Their interests are entirely different.

Community Visitors believe there is a link between the inappropriate placement of people with complex needs in some SRSs, poor staffing ratios, and the increased number of serious incidents. The incidents include threats with knives, assaults, and the death of several residents in concerning circumstances. Some problems relate to the capacity of staff to handle the complex mix of residents. Community Visitors will advocate for the Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) funding to result in more skilled staff, a better standard of care in pension-level SRSs, and an improvement in the quality of life for residents in pension-level SRSs.

Community Visitors have given increased priority to checking care plans, and with specific care plan training for proprietors and staff, this aspect of documentation has improved in some SRSs. However, further work is required.

Improvements are also needed in relation to the residential rights of SRS residents, some of which are inferior to those of people living in community residential units, rooming houses and other private accommodation.

Community Visitors had hoped that 2007 would have seen the completion of a pilot project in Dandenong to improve emergency management, including fire safety, in SRSs. However, the Department of Human Services (DHS) decided to discontinue the regional pilot, and joint meetings between DHS and the Country Fire Authority, WorkSafe, local government, and the Community Visitors Program lapsed. No further progress on statewide strategies was apparent by the end of the reporting period. Community Visitors are aware of four recent fires in SRSs and remain concerned that residents' lives are at risk.

While acknowledging that many SRS proprietors and staff strive to provide quality care on extremely tight budgets, Community Visitors remain concerned that there are still vulnerable people living in shared rooms in large, poorly maintained facilities. These people have minimal support to live fulfilling and meaningful lives.

2 Recommendations

1	That the Victorian Government continues to explore and expand the range of accommodation and support options available to people with a disability and people with a mental illness who have ongoing support needs and limited incomes.
2	That the government urgently reviews the living situation of all Supported Residential Services' residents under 35 years of age and creates more appropriate accommodation and support options for these people.
3	That the government develops the terms of reference for the evaluation of the Supporting Accommodation for Vulnerable Victorians Initiative in consultation with key stakeholders, including the Community Visitors Program, to ensure an improvement in the quality of life for residents as well as the viability of Supported Residential Services is a result of this initiative.
4	That the Department of Human Services establishes a task force to investigate and then address the unacceptable number of violent incidents occurring in pension-level Supported Residential Services.
5	That the Department of Human Services works with local government, WorkSafe, fire authorities and Victoria Police to better educate Supported Residential Services proprietors and staff about fire prevention, to address fire safety hazards, to ensure the development of emergency management plans, and to implement strategies to improve the safety of Supported Residential Services residents.
6	That the Department of Human Services continues to promote a consistent statewide approach to the monitoring of the care of residents in Supported Residential Services, and to the improvement of documentation including care plans and residential statements.
7	That the government strengthens the tenancy rights of Supported Residential Services residents through further amendments to the *Health Services Act 1988* or the development of a new, stand-alone Act to strengthen the legal protections for Supported Residential Services residents.
8	That the government increases the number of Authorised Officers in order to increase the capacity of the Department of Human Services to respond to issues at Supported Residential Services.

3 Message from the Public Advocate as Chairperson of the Health Services Board

For 20 years, Community Visitors have been informing government of issues affecting the most vulnerable members of our community. The Community Visitors are the eyes, ears and voice of the community. The Community Visitors also provide a voice for people with a disability who may be unable to advocate for themselves.

This Annual Report is based on the dedicated work of the Community Visitors in the Health Services stream of the program who conducted 1,279 visits to Supported Residential Services (SRSs) in 2006-07.

On behalf of the Health Services Board, I thank all Community Visitors for their commitment, time and energy in promoting the rights of people residing in SRSs. The Community Visitors perform a most valuable role and the production of this report is an important part of the advocacy effort of the program.

No resident in an SRS has the security of legislated tenancy rights or the protections provided to people with a disability in other accommodation sectors. SRS residents are among the most disempowered people in our society.

The SRS sector is diverse with varying levels of comfort and support. The majority of SRSs (116) charge more than the Centrelink pension. Many of these 'pension-plus' SRSs provide a high standard of accommodation and activities for the residents. Community Visitors report positive comments by residents and their families on numerous occasions.

The other group of 77 SRSs provide accommodation for people who have only the Centrelink pension. These SRSs are referred to as 'pension-level'. Many, but certainly not all, struggle to provide high standards of care. In some of these SRSs, Community Visitors report that there are profound problems. They report that people are residing in facilities that have problems such as an inappropriate mix of residents, often where many residents have complex needs but staffing levels and skills are inadequate to address these needs. With insufficient programs and support and generally poor quality documentation, some of these facilities mirror the worst conditions of institutional environments of the past, and this is unacceptable. Life in these facilities can be volatile and dangerous.

There are concerns for residents in pension-plus facilities also. Basic safety issues such as fire safety, as well as building conditions, and food and hygiene issues across the SRS sector are included in this report.

I commend the government for its SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI), which is an offer of funding ($29.41 million over four years) to all pension-level SRSs to assist them to remain financially viable and improve the quality of life for residents. Though still to be implemented, I hope the initiative benefits the sector and has a direct effect on the lives of residents. The Office of the Public Advocate will monitor the impact of SAVVI.

I also acknowledge the support and cooperation provided by DHS staff at regional office and central program areas in the Community Visitors Program's efforts to help protect the rights of residents on a day-to-day basis. Many issues are resolved throughout the year by the good work and cooperation between the agencies.

Julian Gardner, the former Public Advocate, was a member of the Health Services Board for all but two months of the year. The Board, Community Visitors and staff thank Julian for his vision, inspiration and support. I also thank the Community Visitor members of the Health Services Board for their many hours of work in producing this report and their many other valuable contributions this year towards improving the lives of people who live in SRSs.

Barbara Carter
Acting Public Advocate/Chairperson,
Community Visitors Health Services Board

4 Introducing the Board

Barbara Carter
Acting Public Advocate/ Chairperson of the Community Visitors Health Services Board

Barbara Carter has been the Acting Public Advocate between the appointments of Julian Gardner and Colleen Pearce. She has been with the Office for 15 years and her substantive position is Manager of advocacy and guardianship (West). She first joined the Office of the Public Advocate as the co-ordinator of the Community Guardianship Program and she has substantial experience working in volunteer programs as well as being a volunteer in the community.

Barbara started her working life as a secondary teacher in the technical education system and after post-graduate study was a Lecturer in Political Science and Political Philosophy at Monash University.

Alan Nichols AM
Volunteer Board member

Alan Nichols is an Anglican minister who has served as CEO of a welfare agency, as Archdeacon of Melbourne, and as a refugee worker in Asia. He has written extensively on ethics, refugee matters, especially in Rwanda, and tolerance. He is a canon of the Church in Rwanda, and received an AM in 2006 for services to social policy and refugees. He has been a Community Visitor in the northern region of Melbourne for five years, and has completed two years on the Community Visitors Health Services Board.

Pauline Musgrave
Volunteer Board member

Pauline Musgrave retired from teaching three years ago, having spent the previous 15 years as principal of Yarrabah Special Developmental School. She has been a Community Visitor since her retirement and has served two years on the Health Services Board, represents the Board on the Training Steering Committee, and is also an Independent Third Person. Pauline's other roles have included assistant district governor, president and secretary for Rotary Clubs, current vice president of a Probus Club and a co-opted committee member for the recently formed Frankston Peninsula Carers Incorporated. Pauline received a Paul Harris Fellowship from Rotary in recognition of 'service above self' to the community.

5 Message from the Program Manager

This year the Community Visitors Program celebrated 20 years of service.

At our annual general meeting and conference, we focused on achievements and celebrated the fact that the service system for people with a disability in Victoria has undergone major reform in many areas.

While there is much to celebrate, we were mindful that there is a continuing need for the inquiry, reporting and advocacy of the Community Visitors Program.

The need for the Community Visitor function is nowhere more important than in the SRS sector. The sector, however, needs to be understood as a diverse range of accommodation services. The majority of people in pension-plus SRSs enjoy a standard of care that is far removed from that experienced by people residing in a subgroup of SRSs within the pension-level SRSs. This annual report highlights some of the worst examples of the care provided in the subgroup of facilities. Many issues are raised for the consideration of government.

In addition to reporting on issues, Community Visitors aim to identify and report on innovations and good practice in the facilities. The objective is to share the ideas and give recognition where it is due. This report also acknowledges several important improvements throughout the sector. The report states that practices around financial management are clearly improving and several other examples of good practice are provided.

There is, however, an increasing sense of frustration with the repetition of reporting, over consecutive years, similar findings of poor care and delays in initiatives to improve such fundamental things as fire safety within SRSs.

Community Visitors are monitoring the deterioration of some people, residents with specialised care needs who are simply in a service never designed for them.

Much is expected of SAVVI. It remains to be seen as to the degree of change that will be possible through SAVVI. Our sense is that more profound reform is needed to ensure that the resident group in problematic SRSs are effectively supported. Many of these residents probably require health care or accommodation services with far more supports. The trends that were evident in the 2003 SRS Census are clearly continuing. The census found that only 3 per cent of the people in pension level SRSs had no definable disability. The most common disability was mental illness (45 per cent), followed by intellectual disability (14 per cent) and acquired brain injury (8 per cent). Complex care needs are common and the demands are overwhelming some SRSs.

The government has recognised that poverty plays a role in the lack of accommodation options, and the growth of opportunities around non-institutional accommodation must be available to people in SRSs. Too often, case management services lapse for those who are placed in an SRS.

I wish to acknowledge the work of the staff of the program, particularly Leonie Swift, the Coordinator responsible for supporting the Health Services Board. Leonie has primary responsibility for consulting with the senior policy and program people at DHS on SRS matters and advising the Office of the Public Advocate in relation to SRS policy and advocacy priorities.

Ron Tiffen
Manager, Community Based Programs

6 Introducing the Staff

The recruitment, training and ongoing support of the Community Visitors is the responsibility of staff in the Community Based Programs Unit.

Back row: Leonie Swift, Coordinator, Health Services; Ruth Moeller, Training and Development Coordinator; Ron Tiffen, Manager, Community-Based Programs; Jacqui Schultz, Coordinator, Mental Health Services; Nik Vracatos, IT support;

Front Row: Jo Hallenstein, Coordinator Disability Services; Mary Macgregor, Recruitment Coordinator; Jennifer Watt, Coordinator Continuous Improvement; and our colleague Julianne Fogarty, Coordinator, Independent Third Persons Program.

The Community Visitors Program is also ably supported by Administration Officers Margaret Canzoneri and Liz Smith.

7 Introducing Community Visitors

Community Visitors are independent volunteers who safeguard the interests of people with a disability. The Community Visitors Program is part of the Office of the Public Advocate. The Program is arranged in three streams to reflect the types of services visited:

- Health Services – Visits are made to people who require assistance with daily living who reside in SRSs.
- Disability Services – Visits are conducted to institutions, congregate care and community-based facilities for people with a disability.
- Mental Health – Visits are made to patients and residents in mental health facilities providing 24-hour nursing care.

The legislative framework is derived from the following Acts of Parliament:

- *Health Services Act 1988*
- *Intellectually Disabled Persons Services Act 1986**
- *Disability Services Act 1991**
- *Mental Health Act 1986*

* Replaced from 1 July 2007 by the *Disability Act 2006*.

The legislation also establishes three Community Visitors Boards: Disability Services, Health Services and Mental Health. The Boards are responsible for reporting the activities, issues and findings of the Community Visitors to the Victorian Parliament each year, through the relevant MInister.

The Community Visitors are appointed by the Governor in Council. They are empowered by legislation to visit specified facilities, to make enquiries of residents and staff and examine selected documentation in relation to the care of people residing at the facilities. Community Visitors usually make unannounced visits and visit in teams of two or more. At the conclusion of each visit, the Community Visitors prepare a report summarising the findings and indicating items where action is required. A copy of the report is provided to the most senior staff member at the facility or the proprietor in the case of an SRS.

Where an issue cannot be resolved at facility level, it is usually taken to a more senior manager in the agency and/or the DHS regional office. Serious matters may be referred for action within the Office of the Public Advocate and dealt with as part of the Public Advocate's broader powers.

Community Visitors who have served 10,15 and 20 years of volunteering.

7.1 Visits by Community Visitors

Community Visitors made 5,620 visits this year, representing a decrease of 8 per cent from the previous year, due to budget constraints.

	04/05	05/06	06/07
Disability Services	3,008	3,210	3,090
Health Services	1,617	1,528	1,279
Mental Health Services	1,489	1,374	1,251
TOTAL	**6,105**	**6,112**	**5,620**

While the vast majority of visits are scheduled and unannounced, a significant number are in response to specific complaints. This includes 412 referrals to the program via the Office's Advice Service. On occasions, repeated visits are necessary to certain facilities over a short period, in response to serious issues identified.

7.2 Visits by Community Visitors in the Health Services stream

For 2006-07, there were 1,279 visits to 204 facilities in the Health Services stream. There is no legislative requirement relating to the regularity of visits to SRSs. The Community Visitors Health Services Board, however, requested that, in 2006-07, Community Visitors aim to visit all SRSs with 80 per cent or more pension-level beds 10 times a year, other SRSs with pension-level beds seven times a year, and pension-plus SRSs quarterly.

8 Goals 2006-07

Each year, the Community Visitors Health Services Board provides Community Visitors with a set of goals to report against in the course of their visits. These goals focus on the quality of life for residents and are linked to the requirements of the Health Services Act, and Health Services (SRS) Regulations 2001 (the Regulations).

The findings by Community Visitors this year are presented under the goal headings in the next section of this report.

Goal 1	Residents have high quality health care and personal care.
Goal 2	Residents live in a home-like environment.
Goal 3	Residents are safe.
Goal 4	Residents are treated with respect and dignity and they have opportunities for privacy.
Goal 5	Residents enjoy activities of their choice.
Goal 6	Residents have social independence and they can participate in the life of the community.
Goal 7	Residents have the right to manage their finances (wherever possible).
Goal 8	Residents are treated fairly and are able to comment on the provision of services.

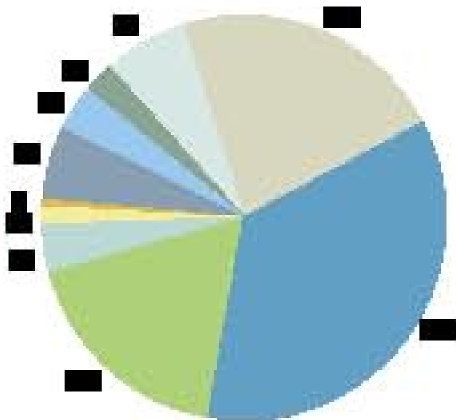
9 Findings

In 2006-07, Community Visitors in the Health Services stream reported 830 issues that needed attention and 113 examples of good practice. A graph outlining the number and nature of the issues reported is provided below. Examples provided in the text to follow drawn from Community Visitor reports and the of the SRSs concerned have been forwarded t

It is worth noting that of the 204 SRSs visited b Community Visitors, 31 SRSs account for 649 the 830 issues reported.

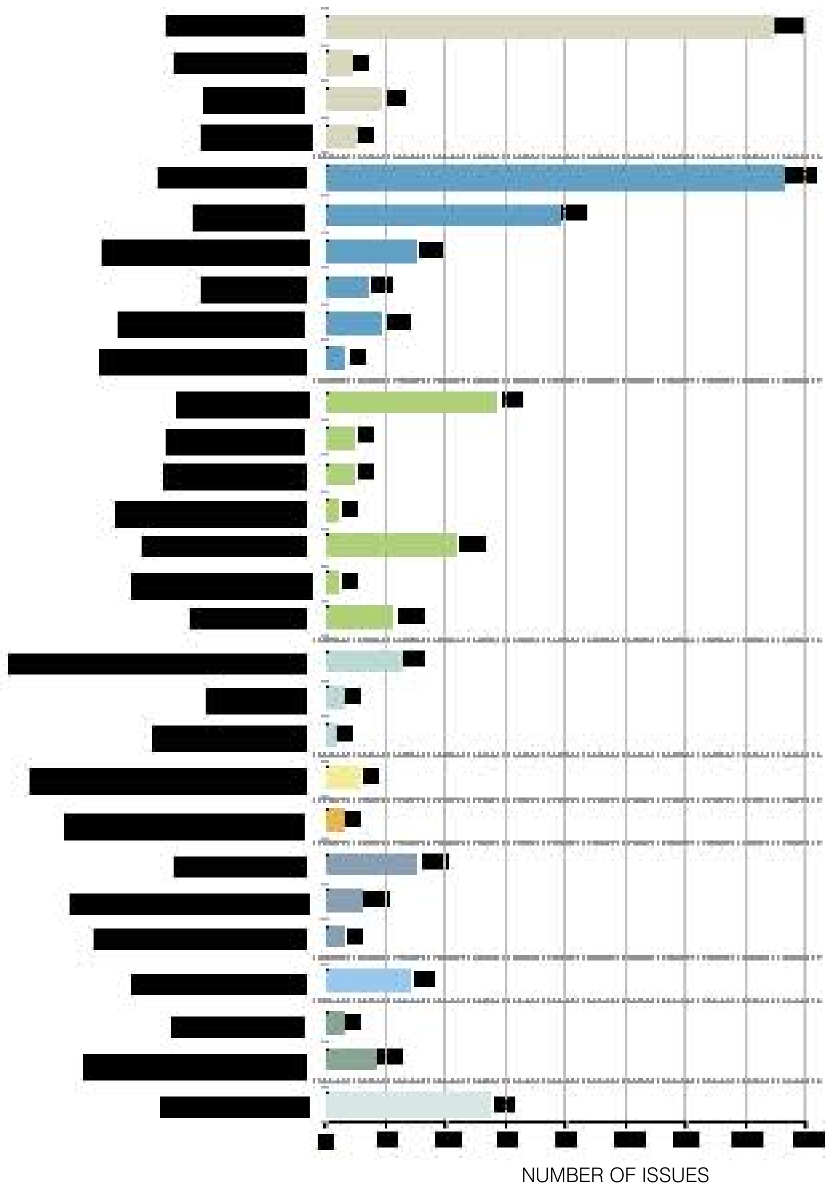
Health Services Statewide Summary of Issues Reported Against The Goals

July 2006 - June 2007



Health Services Issues Reported Statewide

July 2006 - June 2007



*NB 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.

9.1 Findings against the goal of residents having high quality health care and personal care

(a) High quality health and personal care is evident in most pension-plus SRSs, which cater for the majority of residents in the SRS sector. Instances of poor care occur in a small but significant minority of SRSs and these are mainly pension-level SRSs.

Community Visitors often report that pension-plus SRSs are of very good quality. Residents often have family and friends who keep contact and good provision is made for them to visit. A Community Visitor in the eastern suburbs of Melbourne reports:

> *According to the residents, the quality of life is very good for them. Every effort is made for them to exercise choice in how they spend their time. They are encouraged to retain their own possessions such as furniture and paintings. There are regular meetings with the relevant staff who care for them. Their families are invited to these meetings too.*

At many of the pension-plus facilities in other regions, Community Visitors also report that residents speak highly of the staff and they appear well cared for and comfortable in their surroundings.

However, Community Visitors have reported a number of concerns related to resident health and personal care throughout SRSs in Victoria. These include:

- unlocked medication storage and incidence of incorrect medication being administered
- infestations of head lice
- gastroenteritis and influenza epidemics (in one case 14 residents were affected though no-one was hospitalised)
- residents unshaven and with strong body odour, dressed in dirty or ragged clothes
- a resident being continually strapped in a wheelchair
- a resident being left in wet clothes for 12 hours after an SRS fire
- residents sharing electric razors
- resident falls
- continence issues and strong urine smells
- residents not receiving encouragement and access to regular health checks such as mammograms and prostate examinations
- residents reporting dogs being loose in the kitchen and living areas of an SRS
- delays in obtaining podiatry, physiotherapy, dental and other medical services for residents.

At one SRS, eight or nine male residents were sharing one razor. The personal care coordinator said that the razor was cleaned but not disinfected between shaves. After Community Visitors discussed this with the manager, it was agreed that funding from State Trustees would be sought to purchase a razor for each of the residents requiring one.

(b) People assessed as requiring higher level aged care services are kept in SRS accommodation because of behavioural issues.

In some cases, residents were assessed by an Aged Care Assessment Team (ACAT), and the SRS obtained additional support from DHS or community agencies after Community Visitors reported their concerns. Ironically, even though some residents have been assessed as having care needs sufficient to qualify for a hostel or nursing home placement, they have not been transferred to these facilities. The ACAT is required to document the behaviour and psychological aspects of the resident, and residential aged care providers will not accept a resident if they are concerned that a new resident's behaviour will place other frail aged residents at risk.

Community Visitors ask why an SRS with mostly untrained staff and a low staff to client ratio, as well as a vulnerable client group, is considered more suitable than a Commonwealth aged care facility where staff are more highly qualified and each bed receives a government subsidy. If existing aged care services cannot cope with older people with challenging behaviours, then other funded alternatives need to be developed.

(c) There are a number of incidents where poor management may have led to serious injury and, in a small number of cases, the death of residents.

This year, there have been a number of serious incidents involving alleged assaults, unexplained injuries or the death of residents. In one instance, a resident came home with a head wound and was found dead in the morning. In another, a staff member's account of the events differed markedly from that provided by the SRS proprietor. In both these instances, the Office of the Public Advocate contacted the Coroner's office to ensure the circumstances of these deaths were investigated.

In another instance, an older SRS resident with dementia was admitted to hospital with bruising and bleeding on the brain, reportedly resulting from a fall. The doctor reported that the resident's injuries were inconsistent with a fall and the matter was reported to Victoria Police. Despite advocacy from the Community Visitors Program, the police would not investigate the matter without a written report from the doctor, who had moved to a rural region shortly after making a verbal report to police. The police accepted that the resident's son did not want the matter further investigated.

A further incident involved the death of a resident who was given weekend leave from an acute psychiatric unit.

At approximately 5.30 one morning, a resident fell from the balcony of a pension-level SRS. An ambulance was called and the resident subsequently died in hospital. The resident had been on weekend leave from the adult acute psychiatric unit of a major hospital where she had been a patient for several weeks. Community Visitors report that the SRS proprietor said that the resident had arrived late afternoon by car with a support worker. There was no paper work or hospital report and the resident's medication for three nights was handed over in a paper bag. It is believed that the woman intended to take her own life. The matter was reported to the State Coroner by the Office of the Public Advocate.

(d) The standard of care plans and related documentation varies across the state. Too many do not contain critical information about the needs of residents.

Community Visitors have been advocating for improved care planning for many years. While there has been some movement to improve the care plans, there are still reports of care plans being out-of-date or lacking in key information related to the individual health needs, disability and interests of residents. For example, Community Visitors reported that in one care plan there was no acknowledgement of a resident's incontinence or evidence of action planned to address his needs.

Sometimes, Community Visitors are told by proprietors or staff that care plans are not on the premises as they are in the process of being updated or are on the computer. Often, there are no progress notes or any evidence of a plan's implementation or review. The standard of care plans is particularly disappointing given DHS has funded consultants to run care plan training throughout Victoria in recent years. Community Visitors have raised their concerns about care plans with regional DHS staff and managers of DHS' Aged Care Division who have agreed to consider the issues further, in consultation with the Community Visitors Program.

Again this year, Community Visitors have also noted instances of residents being transferred from other facilities without documentation and of people arriving from hospitals or other forms of accommodation without proper medical information or adequate medication. This makes it difficult for SRS proprietors and staff to develop effective care plans for new residents.

(e) There is a continuing trend for young people to be placed in pension-level SRSs that do not adequately provide for their support and care needs.

Community Visitors are distressed that increasing numbers of young people with an intellectual disability or mental illness are being placed in pension-level SRSs and that some welfare professionals seem to accept this as a valid long-term living option for them. In the Disability Services sector, it has been unacceptable for some years to develop congregate care options for people with an intellectual disability. However, some SRSs are becoming

Many residents move from one SRS to another or they live on the streets and then return to hospital or acute psychiatric facilities.

congregate care options by default. Community Visitors do not have comprehensive data on the SRS population and younger residents are often not home during the day when Community Visitors usually visit, but Community Visitors know of many people under 35 years who are living in SRSs.

Some of these situations are tragic.

'Cliff' is 21 years of age and he has Down's Syndrome. After a significant family crisis and eight months in respite care, Cliff was placed in an SRS with 28 residents in September 2006. He was still there in August 2007. Cliff lives with residents who are predominantly aged and frail/sedentary (70 per cent) and other residents who have a mental illness or acquired brain injury. According to a report from his doctor, Cliff's diet at the SRS reportedly consisted of white bread, processed food, and meat. Food supplements in the form of multi-vitamin and fish-oil brought to the SRS were not given to him and antibiotic cream prescribed for severe acne on his back was not applied. Cliff does not voluntarily brush his teeth or trim his nails and he requires support with personal care. His main recreational activity at the SRS consists of watching television. DHS now provides Cliff with up to 15 hours of staff support per week to assist with showering, toileting and other activities. DHS acknowledges that the SRS is not appropriate accommodation for Cliff. However, he has been unable to gain priority status on the Disability Support Register or to obtain alternative accommodation.

In another instance, a 20-year-old man wih an intellectual disability was placed in an SRS by his guardian when he was found living in squalor with his grandmother in a caravan park. There appeared to be no other options available for him. In the same SRS, there are residents aged in their 60s and 70s. At another pension-level SRS, there are 35 residents aged between 22 and 92 years of age. Community Visitors also recently learned of a 17-year-old indigenous youth with a mild intellectual disability (still at school) living in an SRS.

In 2005, Community Visitors reported on the situation of a young woman with intellectual disability and epilepsy, 'Susan' who was placed in an SRS in 2001 as a "temporary measure". Community Visitors thought the resident was vulnerable at the SRS as most of the residents were men, considerably older than her. This year, Susan moved to another large SRS where there are more people of her own age. She now has her own room with an ensuite. However, the move has not been ideal as Susan was left without a day activity program for some months after the move. Community Visitors believe Susan still needs shared accommodation where she can be supported by staff who have expertise in supporting people with an intellectual disability.

(f) Residents often hold staff and management in high regard, particularly in pension-plus facilities. However, the resident mix in many pension-level SRSs is problematic, with large numbers of residents with complex care needs congregated with too few skilled staff to provide the necessary programs and supports. This is causing great stress to residents and staff. At worst, it sets the scene for increased violence and other harm to residents.

In some SRSs, staff and management are held in high regard by the residents and their next of kin. Common comments are "nothing is too much trouble" and "they are kind and caring", but this is usually in pension-plus residences where the people are mainly frail aged. In pension-level SRSs there are also many caring staff and proprietors who do the best they can with the resources they have. However, their jobs are often very challenging.

Community Visitors since 2005 have reported their concerns about the deteriorating mental state of one resident. He has become self destructive and violent, often destroying furniture and equipment belonging to others. His admission to psychiatric wards has increased to the degree that he now spends more time there than at his SRS. On discharge, he is provided with additional support at his SRS (funded by DHS's Aged Care Division). The Community Visitors view this as bandaid support as there have been no long-term gains observed from this additional assistance. It is quite clear this person needs to be placed in a more secure environment with staff who are skilled in dealing with people with a mental illness. This would be for his own protection and the safety of other residents.

In previous annual reports, Community Visitors expressed concern about the resident mix in some pension-level SRSs and the difficulties that some SRS proprietors and staff have in coping with large numbers of residents who have a mental illness, acquired brain injury, intellectual disability or dementia.

It is clear that some of these residents need more support than the majority of SRSs can provide and Community Visitors believe that there needs to be more funded facilities with staff who have the training and experience to support residents at the 'hard end' of the system. At the moment, many of these residents move from one SRS to another or they live on the streets and then return to hospital or acute psychiatric facilities. Staff at one SRS with 74 residents estimate that 95 per cent of these residents have a mental illness and many of the residents have dual disabilities.

At one SRS, a man with Huntington's disease became disorientated and wandered away from an SRS where he was a new resident. He was located many kilometres away in such a bad state that he was admitted to the Austin Hospital where he stayed for five weeks. A key pad entry was subsequently reintroduced to the SRS.

(g) Some SRSs do not conform to minimal standards for staff numbers and there is sometimes confusion about responsibilities on the part of the staff.

The Regulations require that, as a minimum, an SRS must have on duty at least one special or personal care staff member for each 30 residents or fraction of 30 residents at the service. At night, sufficient staff must be employed to ensure the safety of the residents. Again this year, Community Visitors report finding only one staff member on duty in a large facility and, in some SRSs, the only person the Community Visitors were able to find on duty was a cleaner, chef or kitchen hand. In one instance, two staff who were present at an SRS both denied being in charge. At another SRS, the only staff present could not speak English.

A young single mother with an 8-week-old baby was employed to do the overnight shift in one SRS with 29 residents. Community Visitors were concerned about a baby being at the SRS because there were a number of residents with complex needs. They were also concerned about the ability of the staff member to effectively carry out her duties, while caring for such a young baby. This matter was reported to DHS and the young mother is no longer working at the SRS overnight.

(h) Some proprietors and staff do not appear to have a sound understanding of the principles and details of the Health Services Act and SRS Regulations.

As in previous years, Community Visitors also express concerns that the managers of facilities do not necessarily always know the requirements of the Health Services Act and the principles behind the Act. DHS now requires all proprietors to undertake an assessment before an SRS registration is approved but some proprietors have little, if anything, to do with the running of an SRS on a day-to-day basis. In these cases, the appropriate person for assessment and training is the on-site manager. This is an increasing concern as large companies move into the SRS market, purchasing several SRSs in different parts of the state, and the proprietors delegate the everyday management of the facility to others.

In the year under review, a particular problem emerged with an interstate proprietor with a chain of three SRSs in Melbourne. One SRS closed because it was unviable due to empty beds over a long period. Another in the chain tried to change its clientele from frail aged to severely disabled adolescents. A third in the chain, after receiving residents from the closed SRS in the chain, had a flood because of a plumbing problem, and has maintenance issues. It then closed. Among other complications, the fact that the proprietor lived 2000 kilometres away meant personal oversight and communication about emerging issues was difficult.

9.2 Findings against the goal of residents living in a home-like environment

(a) Many residents in pension-plus SRSs enjoy aspects of a home-like environment but too often individual choice is overridden by institutional routines.

Community Visitors report that many residents have the opportunity to exercise choice in how they spend their time and are encouraged to retain their own possessions including furniture and paintings. At many pension-plus SRSs, residents are encouraged to invite their friends and family to visit regularly and often have separate areas where they can entertain their guests, including for meals.

Little touches like the proprietor or staff personally saying goodnight to residents or remembering birthdays and other significant occasions can mean a lot to residents. The display of residents' photos or artwork in communal areas and the provision of fresh flowers or linen napkins and tablecloths can also make residents feel valued.

Many SRSs, both pension-level and pension-plus, have institutional routines. Meals are usually served en masse in communal dining rooms and residents rarely have input into menus. Community Visitors frequently report lunch being completed by 11.30am or noon and evening meals being over by 5pm or 5.30pm. Some facilities offer supper or provide their residents with tea and coffee making facilities, but many do not. In most SRSs, breakfast is offered between 7.30am and 8.30am every day of the week. There are no weekend sleep-ins for SRS residents who want breakfast!

At one SRS, Community Visitors noted that the evening meal was served at 4.30pm for residents in the dementia wing. The next scheduled meal was at 8.30am and although staff said they can provide sustenance upon request, Community Visitors think this is a very long time between meals for people who may not have the capacity to request fluids. At another SRS, Community Visitors arrived at 11.50am and meals were on tables getting cold. Residents are not allowed to eat until a bell sounds at noon, meaning they get fed warm to cold meals, not hot.

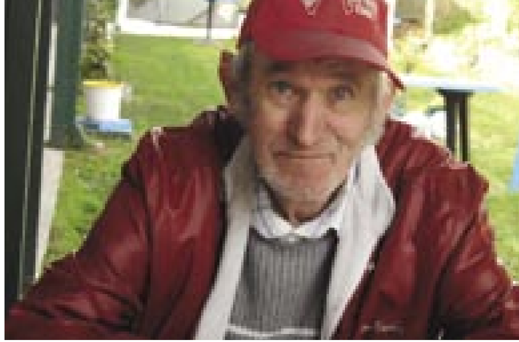
(b) Food and beverages provided to residents vary in terms of quality and quantity.

In most pension-plus SRSs, the food is regularly of a high standard, various needs are met without fuss, likes and dislikes are catered for and the residents have input into the menu. A menu review committee has been established at one such SRS where residents and staff meet regularly to discuss menu options and any issues of concern expressed by the residents. Often extra care is taken when residents are identified as having special needs and all desserts have been made diabetic-friendly so residents are not singled out if they have diabetes.

Unfortunately, there are still too many residents, particularly in pension-level SRSs, who do not receive the same quality of care in food and beverage service.

Pension-level SRS residents frequently voice their dissatisfaction with the quality, quantity and variety of food provided. Community Visitors also frequently express concerns about the nutritional value of meals and, in particular, a lack of fresh fruit and vegetables. At one SRS, Community Visitors reported that lunch consisted of dim sims, baked beans and a dinner roll, and at another it was corned beef and mashed potatoes (with no other vegetables).

When Community Visitors talk to proprietors about the quality and variety of food they are sometimes told that cost is the issue. In other instances, the person acting as a cook or chef has no formal experience or training in this role and they are required to cook for 30 residents (as well as undertaking personal care tasks) because there is no-one better qualified to undertake this task.



(c) There are variable standards of cleaning and maintenance across the SRS sector.

Standards of cleaning and maintenance vary greatly across the SRS sector.

Many visitors report that pension-plus facilities are very clean, with contract or designated cleaners to thoroughly clean in all areas as well as the daily tidying and cleaning by personal care attendants. Surfaces are kept dusted and external windows cleaned regularly.

As in previous years, Community Visitors continue to report a large number of issues related to the maintenance and cleanliness of pension-level facilities. Issues that require the repair or renovation of a facility are particularly difficult to resolve when a proprietor leases rather than owns the property and the owner is reluctant to spend money on the premises. However, Community Visitors are frustrated that some ongoing cleanliness issues could be simply addressed with a little more effort from proprietors and staff. The ongoing nature of some issues shows a lack of respect for resident comfort and quality of life.

Issues raised by Community Visitors include:

- inadequate heating, cooling or lighting
- unclean toilets and bathrooms and toilets without seats or with broken seats
- damaged or missing flyscreens
- unkempt gardens
- door handles missing and doors in need of repair
- damaged shower curtains or room dividers in need of replacement
- stained or threadbare carpets and damaged furniture
- large cracks in walls
- strong urine smells and repugnant odours.

Ongoing cleanliness issues could be simply addressed with a little more effort from proprietors and staff.

9.3 Findings against the goal of safety for residents

(a) Too often, residents in pension-level SRSs do not feel safe. There is an alarming growth in serious incidents.

Community Visitors believe all residents have a right to feel safe, relaxed and comfortable in their homes. Community Visitors report that most pension-plus residents seem to feel safe because they have ‘upright’ or active night staff, but most pension-level facilities are currently only able to afford sleepover staff.

This year, there have been several SRSs where police have been called to incidents involving residents who have been violent towards other residents or a proprietor or staff member. In four instances, knives were used by residents to threaten or injure a proprietor, staff member or a resident. In another incident, one SRS resident attacked another SRS resident with a knife and this resulted in a death. The alleged perpetrator is currently remanded in custody.

There have also been a number of reports of assaults, arguments between residents or damage to property. While most proprietors seem to record incidents appropriately, Community Visitors have reported incident records are not always kept up-to-date or accessible.

Another serious incident involved an intruder breaking into a room occupied by two elderly female residents in a rural SRS, one of whom alleged she was assaulted by the intruder. Fortunately, the manager answered a call bell and was able to evict the intruder. Victoria Police investigated the matter. At another SRS, a male resident broke into a female resident’s room and the lock on the door had to be replaced. At the same SRS, 12 serious incidents were noted in one month.

Fire safety issues continue to be of serious concern.

(b) There are inconsistencies around the recording of incidents.

The Health Services Act requires that details of injuries and incidents must be recorded but there is no requirement regarding the record format. Some SRS proprietors keep records of incidents on individual resident files. Community Visitors find it difficult to gain an overall picture of the life of an SRS and note incident trends when incident reports are placed separately on individual resident files rather than being kept in a collective record such as an incident report book.

(c) Fire safety is an ongoing area of major concern. Action on this issue has been slow and resident lives are at risk.

Fire Safety issues continue to be of serious concern. SRS residents often have limited mobility or cognitive capacity and Community Visitors do not see how these residents could be evacuated safely in the event of a fire, when there is often only one staff member on sleepover with between 20 and 70 residents. Fire prevention is, therefore, of critical importance. While many proprietors do have their fire equipment regularly checked, Community Visitors continue to report faulty systems and fire hazards. These include:

- unsafe heaters
- bedrooms with stacks of highly combustible material
- flammable cleaning materials near a heater in a plant room

- residents smoking in bedrooms or upstairs living rooms
- combustible material in backyards, sometimes with cigarette butts among it
- fire exit doors or fire reel cupboards being locked, blocked or jammed
- fire alarms or emergency call buttons being turned off or not working
- fire hydrants in need of checking
- exit signs missing
- room dividers close to the ceiling that may affect the operation of the sprinkler system
- outdated floor plans showing the previous name of the facility and the wrong configuration of rooms.

In some cases, where proprietors have not taken action to address identified hazards, Community Visitors have contacted the Metropolitan Fire Brigade or Country Fire Authority or local government authorities. In the main, Community Visitors have been pleased with the response of these authorities in inspecting facilities and requesting action to ensure the safety of residents.

In its last three annual reports, the Community Visitors Health Services Board discussed fire safety issues and called on DHS to work with WorkSafe, fire authorities, and other relevant agencies to improve emergency management prevention and practice in SRSs. Last year, the Board advocated that fire evacuation plans should be a condition of SRS registrations. Community Visitors are disappointed at the lack of action by DHS to address these matters.

In 2005, an emergency management working group involving representatives of DHS, the Country Fire Authority, local government, WorkSafe, Victoria Police, and the Community Visitors Program was established to pilot a coordinated approach to fire safety and other emergency management issues in the Greater Dandenong area. The group, chaired by DHS, has not met since September 2006. The department informed the Board that it plans to undertake a number of statewide strategies instead of continuing the Dandenong working group but, to date, no details of these strategies have been forthcoming. Community Visitors think that action on this issue is long overdue and the lives of people with a disability and older people cannot be placed at risk because of other government priorities.

Community Visitors are aware of four fires in SRSs during the two months prior to the preparation of this report. In at least two instances, residents had to evacuate the SRS. In one SRS, the residents reportedly had to evacuate themselves as the person in charge overnight did not hear the alarm.

(d) Other safety issues present serious risk to residents.

Food safety issues this year include rotting fruit and vegetables out-of-date food including cream, tinned vegetables and cereals. Meals and beverages (pre-mixed) are also sometimes unrefrigerated for long periods.

> *At one SRS, lunch is served to about 75 people at each sitting. On one occasion, Community Visitors counted 19 meals left sitting on tables for one and a half hours. The same meal was reheated for people who were out for their evening meal.*

Other safety issues reported include emergency buttons being switched off, unsafe ramps, steps or carpets, severe wall cracking, inadequate lighting, unsafe outdoor furniture, and a pharmacy store door being left unlocked.

9.4 Findings against the goal of residents being treated with respect and dignity and having opportunities for privacy

(a) The performance of SRSs is highly variable in providing residents with respect, dignity and privacy.

One of the most challenging aspects of living in a large congregate care facility is being treated as an individual and having personal choices respected. It is good practice to provide choices for each resident: cash to spend, a choice of meals, private space to read or entertain guests – all the things that people in their own homes take for granted. In some SRSs, residents are treated with respect, and those who wish are given daily tasks such as posting letters, watering indoor plants, replacing flowers, developing the garden and caring for birds.

However, some choices that most people would take for granted are denied to many SRS residents. For example, at one SRS a resident complained to a Community Visitor that he did not like porridge for breakfast, he would prefer Weetbix. At another SRS, residents complained that they did not like pies and pasties every Friday. In one SRS, residents had to wipe their hands on toilet rolls after going to the toilet. While proprietors often cite cost issues for a lack of individualised treatment, some actions just show a lack of effort and respect for residents.

Morning tea was served during a Community Visitor visit. No plates were used. Biscuits were placed directly onto the table. One was picked up off the floor. At another residence, the tea was mixed with milk and two sugars in a teapot prior to serving.

Some SRSs take the whole of a resident's pension, and toiletries and other goods are purchased in bulk and supplied to residents. It needs to be acknowledged that some residents have cognitive disabilities, their moods change and their short-term memory does not always function well. For them, the proprietor retaining control of the residents' disposable cash or doling out cigarettes each evening may seem a sensible way to handle their choices. Community Visitors are not suggesting fulfilling this goal is always easy.

In most pension-plus facilities, residents have their own rooms with ensuites and there are several living areas where residents can have private conversations with other residents or visitors. At one residence, there is a dining area which residents can book to dine privately with visitors. However, in many pension-level SRS, two to three residents share a room, there are shared bathrooms, and there are very limited opportunities for time alone.

While proprietors often cite cost issues for a lack of individualised treatment, some actions just show a lack of effort and respect for residents.

9.5 Findings against the goal of residents enjoying activities of their choice

(a) The performance of SRSs is highly variable in ensuring residents enjoy activities of their choice. Some SRSs provide a variety of programs for residents; other residents report that they are bored.

Community Visitors report there are many examples in SRSs where staff and external organisations initiate and encourage participation in a wide variety of activities leading to a significant improvement in the life of residents. These include the following:

- horticulture – watering, growing seeds and herbs in pots for sale, vegetable growing
- arts and craft programs
- exercise programs
- visiting musical performers, musical activities and disco classes
- an SRS choir with its own resident pianist
- a visiting library service
- regular 'happy hours' and footy-tipping competitions
- pet therapy: both facility and resident-owned dogs, cats, birds, and fish
- beauty therapy: hairdressers, manicurists and massage therapists visiting regularly
- equipment for residents use including pianos, organs, billiard tables, computers, widescreen televisions, board and card games, jigsaw puzzles, and library books
- outings and a mini-bus for participation in community activities.

There was a lovely atmosphere as we entered. Eight residents were playing bingo. Four residents sat in lounge reading, another doing jigsaw puzzles – a very hard one at that. It was good to see a volunteer who comes in two days a week calling the bingo. The tea trolley came around with tea/coffee scones and jam.

Unfortunately, there are still too many SRS residents who have no involvement in activities and some complain of boredom to Community Visitors. Many residents would like to be more involved in community activities or have more recreational activities outside of the SRS.

Evidence of this finding includes:

- passive environments
- staff not talking to residents or encouraging them in activities
- television turned on all day and simply providing background noise with residents sitting nearby but not watching
- rituals of wandering outside to smoke as the most activity for the day.

9.6 Findings against the goal of residents having social independence and participating in the life of the community

(a) Many SRSs have programs to assist residents to participate in the community. Some SRSs have strong links with the community and activities outside of the SRS but further programs would be of benefit.

It is good when SRS residents are involved in activities within their home but it is even better when they are socially independent and can participate in the life of their community.

In one rural area, Community Visitors report that they rarely find residents at home at one SRS where the residents are encouraged to be active. In several SRSs, some of the younger residents go out to part-time or sheltered employment or they regularly attend day support services. Some residents also participate in bingo sessions, choirs, senior citizen groups, theatre groups and other activities in their local area.

Regular church services are held at some pension-plus facilities and there are other arrangements to transport residents to the church of their choice. A variety of community organisations also provide transport and assist SRS residents to enjoy community activities such as fishing, bowling, picnics, and barbeques and to visit shopping centres, national parks, and other places of interest. One local government, the City of Port Phillip, regularly produces a bi-monthly brochure on low cost and free activities, which is distributed to rooming house and SRS residents.

Community Visitors are pleased that, in the second stage of SAVVI, the government will fund non-government service providers to work with SRS proprietors and health and community services to improve the social supports and activities available to SRS residents.

These services, to commence in 2007–08, are targeted at larger pension-level SRS and those that have a high number of residents with a psychiatric disability or challenging behaviours. Community Visitors hope this initiative will help to reduce resident isolation and boredom.

In last year's Community Visitors Health Services Board annual report, it was recommended to Members of Parliament that they consider how to promote local groups becoming more involved with SRSs in their area and offering activities within SRSs, providing outings and assisting residents to become involved in community programs.

It would be a sign of a healthy community for these opportunities to be developed. Community Visitors again call on Members of Parliament to encourage such participation in their local areas.

Some SRSs have strong links with the community and activities outside of the SRS but further programs would be of benefit.

9.7 Findings against the goal of residents having the right to manage their finances wherever possible

(a) There have been major legislative changes to help protect residents' finances. There are still occasional incidents of unacceptable practices around financial matters and further effort is required to eliminate such practices.

Community Visitors are very pleased that amendments have been made to the Health Services Act, tightening up the management of resident finances.

These amendments (which came into force on 1 January 2007) state that SRS proprietors and their close associates must not act as a resident's attorney, guardian or administrator or be involved in managing a resident's financial or legal affairs. Any transaction between a proprietor and resident involving more than $100 must be reported to the DHS Secretary within 14 days. Despite these requirements, SRS residents are still sometimes financially exploited.

In June 2007, the Office of the Public Advocate's Advice Service was contacted by a solicitor regarding monies removed from his 89-year-old client's account. An SRS proprietor, who had been given enduring power of attorney by his client, had told his client he would avoid an impending 5 per cent rent increase if he paid an upfront payment for 14 months. A cheque for $31,500 was subsequently drawn against his account. The proprietor had mentioned to the solicitor that several other residents had also agreed to make pre-payments to avoid the increase in fees. It is against the law for an SRS proprietor to be an attorney, guardian or administrator for a resident at an SRS where they are a proprietor or close associate. This matter was referred to DHS. The client subsequently made a new power of attorney appointing his children to the attorney role.

Overall, there have been fewer complaints regarding financial matters this financial year. Residents in most pension-plus places seem content with their situation. Some residents in pension-level facilities complain that they do not have any spending money. Sometimes this is because a relative keeps a close rein on their finances, paying their rent expenses but not providing spending money or sufficient money for clothing and other personal items. More often it is because SRS residents in pension-level SRS have only the disability pension to live on and it is insufficient for their needs.

Many SRS residents have the pension as their only source of income and they live in poverty.

SRS proprietors can charge whatever they think the market can bear and some pension-plus SRSs charge around $700 per week and provide high standard accommodation and a high staff-to-client ratio. Unfortunately, many SRS residents have the pension as their only source of income and they live in poverty.

Some pension-level SRS take 100 per cent of a resident's pension and supply necessities such as toiletries. Other pension-level SRSs charge 85 per cent of the pension and this means that residents are left with about $20 of spending money per week, depending upon which category of Centrelink allowance they receive. It is interesting to note new policies that apply to community residential units registered under the Disability Act. These polices state that the maximum amount that service providers can charge for rent and prescribed services is 75 per cent of a resident's disability support pension and 100 per cent of Commonwealth rent assistance. These limits on residential charges enable residents on low incomes to enjoy some discretionary income.

This year, several residents told Community Visitors that a staff member or another resident had robbed them. It was also alleged to Community Visitors that residents at some SRSs have received a fee reduction or been paid with cigarettes for work undertaken by them. However, upon investigation, most of these allegations have not been substantiated. Confusion about these matters may have arisen as a result of a resident's cognitive impairment.

(b) There has been an improvement in the quality of residential statements this year. Further improvement is required.

The Act requires that, within 48 hours of moving into an SRS, every resident must have a residential statement that accurately sets out the SRS fees and charges, rules and services provided. Community Visitors have noted some improvement in the quality of residential statements this year.

However, Community Visitors still find it a challenge to review residential statements in some SRSs. Two proprietors in different regions told the Community Visitors that they do not keep copies of the statements. Both said they gave the statements to the residents to keep and did not keep a copy themselves. Given the statements are the SRS's financial contract with residents this would seem unlikely or unwise at best. DHS does not require proprietors to use a standard format for residential statements but it provides proprietors with an example form in *Meeting the Need – A Care Handbook for Supported Residential Services*. This form is currently being reviewed as some guardians and administrators have been reluctant to sign existing statements which detail matters outside their legal responsibility.

At one SRS, a resident leaving the facility was charged fees from an updated residential statement that was unsigned by the resident or her representative.

Some residents express a fear of retribution if they are identified as having made a complaint.

9.8 Findings against the goal of residents being treated fairly and able to comment on the provision of services

(a) SRS residents are often disempowered and it is subject to the discretion of staff and managers as to whether they are involved in any decision-making about issues fundamental to their lifestyle. In the worst SRSs, residents are fearful of retribution by staff if they raise issues with Community Visitors.

In most SRSs, care is provided within a passive culture. There are some SRSs where residents participate in discussions about the menu or activities but, in general, residents are not encouraged to have a say in issues regarding their care or changes to their environment.

In some SRSs, residents seem reluctant to report issues to Community Visitors and some express a fear of retribution if they are identified as having made a complaint. This year, several staff have contacted the Community Visitors Program to report the verbal abuse of residents who have raised issues with Community Visitors. It is difficult to know how to address these matters, particularly when they are reported confidentially. The disability and mental health sectors have introduced a number of consumer empowerment and consumer support initiatives. Perhaps DHS could pilot some of these within the SRS sector.

Community Visitor posters are displayed in most SRSs and some SRS residents contact the Office of the Public Advocate Advice Service themselves, asking for assistance. Staff, family members and other members of the community also contact the program on behalf of residents. In 2006-07, the Office of the Public Advocate's database recorded 63 referrals to the Community Visitors Program in relation to SRS issues. A number of other referrals were made direct to the Community Visitors Program.

(b) SRS residents do not have the tenancy rights equal to residents in comparable services.

Community Visitors want the residential rights of SRS residents supported in much the same way that other (comparable) sectors have supported tenant rights. For example, the new Disability Act has strengthened the tenancy rights of people with a disability who live in Community Residential Units. The Act provides residents in shared supported accommodation with access to the Victorian Civil and Administrative Tribunal (VCAT) to resolve disputes. Private tenants and rooming house residents also have this option but SRS residents do not as they are exempt from the *Residential Tenancies Act 1997*. Over the next year, the Community Visitors Program wants to explore, in cooperation with DHS and the Minister, strengthening the residential rights of SRS residents. This may require amendments to the Health Services Act or new legislation, or perhaps it can be achieved in other ways.

The new Disability Act requires that accommodation providers funded under that Act provide all residents with a statement of rights and duties attached to the residential statement that includes:

- the right to see a Community Visitor
- the right to make a complaint
- the procedures for making a complaint or seeking a review under this Act.

Community Visitors believe this would be a worthwhile addition to the content requirements for SRS residential statements.

In recent annual reports, Community Visitors have reported that some SRSs have been charging large bonds. SRS proprietors, unlike rooming house owners, are not required to lodge these bonds with the Residential Tenancy Bond Authority. There is still no obligation on proprietors to lodge any bond monies with an independent body but the issues have been remedied in part with a recent amendment to the Health Services Act. This states that the maximum amount of a resident's money that a proprietor can manage or control is the amount the resident pays for one month's accommodation.

(c) Residents are not easily able to move from one SRS to another.

Several SRS residents indicated to Community Visitors that they were keen to move from where they were living. This can place Community Visitors in a difficult position as some proprietors can get very angry if they believe that Community Visitors are assisting someone to move. Vacancies affect a proprietor's income. However, in several instances Community Visitors have advocated on behalf of a resident to DHS or another agency and a resident has moved with assistance from a guardian, case manager or DHS.

9.9 Findings on systemic issues

(a) DHS regional staff are inconsistent in their monitoring of SRSs and their response to issues raised by Community Visitors.

DHS registers all SRSs and is responsible for monitoring compliance with the Act and Regulations. In previous annual reports, Community Visitors have commented on disparities between regions in relation to the monitoring of the quality of care. DHS has attempted to promote more consistency through the introduction of statewide audit processes and increased centralised training of authorised officers. Some Community Visitors report that, if an issue is registered as a complaint, regional officers are very quick to respond and to provide written feedback on an issue. However, there are still inconsistencies across the state. In one rural region, Community Visitors have been very frustrated at the slow response to a string of very serious complaints relayed to the department.

Community Visitors reported a number of concerns to the department including non-cooperation and threats of violence towards Community Visitors by an SRS proprietor and the proprietor's family, inadequate care plans and residential statements, resident health issues, financial issues and other issues related to the care of residents. The regional office organised for a mediator to meet with the proprietor and representatives of the Community Visitors Program. The Office of the Public Advocate also received a series of confidential reports regarding the treatment of residents, lack of food, and lack of training for staff. Most concerning was a report that the proprietor had lied about the time and circumstances of the death of a resident. This was immediately reported to the department by the Office of the Public Advocate. The authorised officer from the region responded to the allegations by ringing the proprietor and asking her version of events but failed to inspect the SRS and examine contradictory material. It was not until some weeks later, after further advocacy by Community Visitors, that staff from the department went to the SRS to examine incident records and to speak with staff on duty on the day of the resident's death. The Office of the Public Advocate referred the matter to the Coroner. Since this time, there have been further complaints from several sources and the department has agreed to an independent review of this SRS.

Problems with both care plans and residential statements have been reported to DHS. Some regional offices have acted promptly in following these issues up. Others have been slow to respond.

Community Visitors acknowledge positive intervention by DHS in several cases during the year where administrators were placed into highly problematic SRSs. One case in particular, in the western suburbs, was a facility which housed up to 100 people. Community Visitors had raised many issues in relation to this facility over the years and considerable DHS resources were allocated to remedy the situation and improve the quality of life of residents.

(b) Some SRS proprietors are abusive towards and non-cooperative with Community Visitors.

Despite the Health Services Act requirement that the person in charge and staff must give a Community Visitor reasonable assistance, some SRS proprietors remain uncooperative. There have been several reports of SRS proprietors being verbally abusive to Community Visitors this year. In one case, a member of the proprietor's family physically threatened a Community Visitor. These instances were reported to DHS and a formal mediation session was held between the SRS proprietor and representatives of the Community Visitors Program.

(c) The Health Services Board congratulates the government on SAVVI and is pleased that an evaluation of the impact of SAVVI is to be undertaken. The Board keenly awaits the rollout of SAVVI funding to SRSs.

In 2006, the Victorian Government announced it would provide $29.41 million over four years to improve the viability of pension-level SRSs and the quality of life of residents in these SRSs. The SRS Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) has a staged rollout with cost-relief funding for SRSs in the first stage and an assessment of resident needs and increased social supports and activities for residents in later stages of the initiative. Options to improve building conditions and safety of SRS living environments are also to be considered as part of the initiative.

It is a matter of regret that it took the department longer than anticipated to roll out the SAVVI funds to the SRSs approved for this initiative. By the end of the reporting period, no funding payments had been made to SRSs. However, cost relief funding guidelines have been released and approved agencies, known as Partnership Managers, are now working with SRS proprietors to develop formal agreements and expenditure plans so the funds can be released. Fifty to 90 per cent of the cost relief funding must be spent on staffing so Community Visitors are hopeful that the initiative will result in additional and better support for residents.

DHS has agreed to evaluate the SAVVI initiative and to involve stakeholders in the development of the evaluation framework late in 2007. Community Visitors believe the SAVVI initiative must result in better outcomes for residents to be a worthwhile use of government funds and will advocate for the evaluation to assess aspects of care and the impact on residents.

Some Community Visitors also express concern about the number of middle-market SRSs (SRSs charging just above pension level) carrying significant numbers of vacancies. This can affect the home-like atmosphere of a residence and residents sometimes worry that they may have to move if a place is not financially viable. SAVVI will assist pension-level facilities but will not assist those that charge above pension.

(d) Issues in the boarding house sector this year confirm the need for greater accommodation and support for people with complex needs. The community needs to do more to assist vulnerable Victorians.

Early in 2006-07, there was a series of press articles about the conditions suffered by people living in unregistered, privately run boarding houses and rooming houses. The Board was concerned about the exploitation of vulnerable Victorians and the acute shortage of accommodation these articles highlighted. It was also concerned that a tightening of regulations and the closure of unregulated places could exacerbate the demand on pension-level facilities in the SRS sector. The Board discussed these issues with DHS. At a meeting with the Board, DHS reported that a stakeholder group with representatives from the Office of Housing, Consumer Affairs, DHS and the homelessness sector had met and developed an action plan.

In addition to the SAVVI program already mentioned in this report, the State Government allocated additional resources for affordable housing in its 2007 budget: $7.5 million for accommodation for young homeless people and those at risk of homelessness and over $500 million for additional public housing. The budget also increased government spending for community-based support services for people with a mental illness and people with a disability.

Community Visitors welcome these commitments and urge both state and federal governments to continue to expand the housing and support options available to people with complex needs.

This report shows there is still much for our community to do to ensure that people with ongoing support needs have a home where they can feel safe and comfortable and lead meaningful lives.

The community needs to do more to assist vulnerable Victorians.

10 Health Services Community Visitors at 30 June 2007

The Office of the Public Advocate acknowledges and thanks the other Community Visitors who participated in the program during the financial year 2006-07.

ALCOCK, Joana
ALLAN, Julie
BARLEE, Judith
BEARD, Jane
BEESTON, Kathleen
BELT, Beth
BERNATH, Robert
BLACKMAN, David
BODENHAM, Margaret
BORG, Myra
BORG, Sam
BOX, Margaret
BREWSTER, Ted
BROWN, Max
BUCKLES, Ian
BURNETT OAM, Nina
CARTER, Jo
CESAL, Julie
CHURCH, Thelma
COOK, Gavin
COOKE, Lance
DAVIES, Dorothy
DeCLEVA, Moira
DIMER, Christine
DONKER, Robert
DRAYTON, Robert
DUGGAN, Gerry
ENGLISH, Carole
EVANS, Donn
FITZGERALD, Vicki
FLETT, Lyn
FORSYTH, Alison
FOSTER, Ada
FRANC, Pauline
GARDINER, Bernard
GEORGE, Ian
GIBSON, Margaret
GLEESON, Kathleen
GOLD, Una
GREENLAND, Linda
GREENWOOD, John
HANSEN, Raewyn
HARRAP, Anne
HAYNES, Carol
HEALEY, Pamela
HUNT, Mary
HUNTER, Helen
HURST, Belinda
INGRAM, Chris
JAMES, Alison
JEANS, Bruce
JOHNSON, Lyn
JOHNSTON, Sam
JONES, Philip
KENT, Fred
KERR, Anne
KILEY, Brian
KINCADE, Joan
LANE, Maureen
LURIE, Ralph
MANN, Victoria
MARRIS, Jan
MARWICK, Dorothy
MAYNE, Arthur
McLEOD, Geraldine
McRITCHIE, Grant
MIGUEL, Anne
MUNDY, Elsie
MUSGRAVE, Pauline
NEWSON, Sue
NICHOLS AM, Alan
NINEDEK, Aaron
O'DONOHUE, Peter
ORMROD, Joan
O'SHANNESSY, Patricia
PARKER, Dave
PENRY-WILLIAMS, Peter
PERRY, Jennifer
PINDARD, Charles
PRICE, Carol
RATNAYAKE, Rohantha
REESE, Harvey
REIGO, Margaret
RICHARDSON, Norman
ROBERTSON, Phil
ROBINSON, Richard
ROSIER, Mick
ROWELL, Michael
STANNARD, Mary
STUBLEY, Graeme
TAFT, Leon
TAGELL, Annette
TAYLOR, Katrina
TEW, Diane
TRIBUZIO, Judith
TRUSCOTT, Ann
VALLANCE, Helen
VERGA, Charles
WARREN, Bob
WARREN, Dorothy
WATKINS, Beverly
WELLWOOD, Marion
WHITE, Beryl
WIGHTMAN, Doug
WOLFE, Aileen
WOOLLAN, Ted
WEST, Graham
WRAITH, Junia
WRIGHT, Dawn
ZAMMIT, Lewis
ZAMMIT, Susan

Operators exploit homeless

◄ From PAGE 1

from the Council to Homeless Persons. "There are some very distressing places where people are living and it's difficult to do much about it because some of the proprietors we ourselves are scared of.

"We hear a lot of stories about how people are stood over in these places."

One referral agency chief, who declined to be identified, said his workers routinely sent homeless people into "subhuman" houses that exacerbated their problems. Agencies say they have no choice because there ...

places where we know there is drug use occurring."

The Age visited one of the group's houses this week. Rubbish was piled in shopping trolleys and wiring was exposed in light switches. Tenants told of blocked toilets and a non-functioning smoke detector.

The problem extends beyond one group of men. Welfare agencies say the rooming-house sector has been infiltrated by shady operators taking advantage of the desperate shortage of emergency housing.

Neighbouring terrace houses in one inner Melbourne street ...

Welfare agencies want Government to establish ... mum standards for crisis ... modation and create a reg... legitimate operators.

"There's little monit... what goes on at each ... and no standards... Homeground's Steph... "The reliance on these ... provide shelter for ... people is complete... able ... we need ... interest and recou... this area of activi...

State Gover... Minister Cand... Government ...

In the queue for understanding

Andy Drewitt

CRAIG Burshall pulls up his hand-knitted beanie and leans forward to show me a crusted ... scar on his scalp.

He is keen for me to see the injury marking the spot where everything fell apart, the moment that triggered mental illness and cost him everything – the first brick on ...

Craig Burshall in a corridor with Sebastian in the backyard.

> I felt like I was being watched the entire time.
>
> CRAIG BURSHALL

clothes, transport and ... Mr Burshall has recently returned to work a couple days a month in the ... industry, but says that clothes, which come from ... donations, make it hard for him to fit in.

Another resident, Dave ..., says that if he had money he would go to movies, which he hasn't been able to afford for five years.

Boredom is obvious. ... move restlessly between ... room, TV room, porch and bedrooms, furnished with what they can carry home from hard rubbish collections.

Some try to lighten the ... and one prankster ... leans across to ... Leader journalist ... O'Connell. "Marry me ... he says, his eyes gliding ... the joke. Next day I return ... wait for a few more photos ... is having a bad day ... over his instant coffee ... so close so that no one else can hear. He looks tired.

"Can you please do ... for me?" His voice ... The joke is over. ... ask Brigid to ... place?"

... manager Wilma Reid says her ... charges are often abused, her ... carloads of donations but ... residents back to the ... poverty makes it almost impossible for them to integrate into the community. After paying an average $405 a fortnight for food and lodging, they have about $35 a week for toiletries,

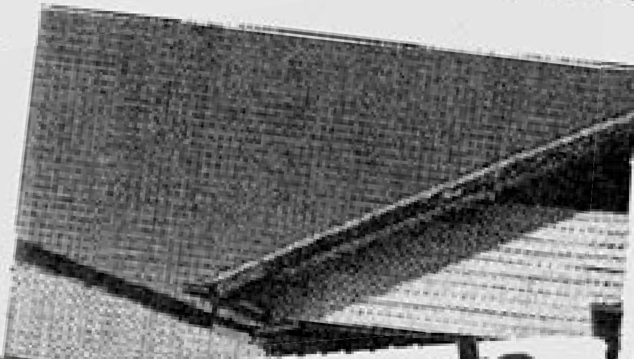
Supporting what's working

Home, not so sweet home,

By DAN OAKES

BRYN Collins' four months in a Northern Suburbs Accommodation property acquainted him with violent drug addicts, a family squeezed into one room ... intimidation over rent.

... think (NSA) bullies and ... lot of people around," ... here are a lot of ...



Sid sleeps in cars.

So bloody hard

This is as good as it gets

Brigid O'Connell

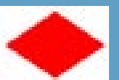
Ms Reid said: "There's nowhere else for them to go but out on the streets."

Eastern Access Community Health project officer ... who delivers outreach programs to Maroondah's boarding ... described conditions ... as "grubby".

... Residential Care Association President Carol Allen, ...

OFFICE OF THE PUBLIC ADVOCATE

AN INDEPENDENT STATUTORY OFFICE ACCOUNTABLE TO THE VICTORIAN PARLIAMENT



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