



Southern
Region

Southern Metropolitan Region extends from inner-urban suburbs such as Port Melbourne to the Mornington Peninsula, eastward across suburban and industrial areas through to Pakenham and numerous small towns on the metropolitan and rural fringe.

The region's communities are diverse and include rapidly changing inner-urban communities and outer suburbs with enormous growth.

This region has a population of approximately 1,126,223, which represents 23 per cent of the Victorian population.

Southern Metropolitan Region

Southern Metropolitan Region mental health services are managed by Peninsula Health, Southern Health and Bayside Health.

Mental Health

There are seven adult acute inpatient units, four aged persons acute units, six aged persons mental health residential units, four community care units, one secure extended care unit, one adolescent unit, one mother and baby unit and one eating disorder unit.

A total of 257 visits were made to these facilities.

Accommodation needs

Patients are often accommodated in facilities which were not designed for their current purpose. For example, the mother and baby unit at Monash Medical Centre is not purpose-built and shares its location with the eating disorders unit. Although different philosophies are used to provide treatment for these patients in this unit, the same staff are responsible for providing care to both units. Community Visitors look forward to progress in the rebuilding of the mental health site at Dandenong Hospital, with the expected completion of three-four years.

There is a significant lack of suitable accommodation for people with a mental illness in the region. This leads to some residents remaining in a community care unit for longer than is necessary. There have also been several instances where staff have difficulty identifying and securing suitable accommodation for patients with complex needs, such as a dual disability, acquired brain injury or progressive neurological condition. This has affected discharge planning and, in some cases, caused excessively long stays in acute mental health units

that are unsuitable environments for these patients. Community Visitors have been pleased to see some innovative programs to address patient's long-term needs. For example, the Opening Doors program, a partnership of Alfred Psychiatry and the Mental Illness Fellowship, offers a 'step-down' model to provide continuity of care for residents of the community care unit.

Environment

Community Visitors report that the physical environment of facilities is generally adequate. Refurbishment of the mental health units at Caulfield aged care and Dandenong adult acute have brightened the atmosphere for patients. However, the community care units in the region, which are now over 10 years old, would benefit from additional funding to improve the physical environment, replace furniture, curtains, and undertake garden maintenance.

Cleaning remains a problem at some facilities, despite Community Visitors reporting inadequate cleaning of the courtyard areas at the adult acute inpatient unit at Monash Medical Centre at almost every visit for the last two years. The problem remains unresolved. However, Community Visitors over the last year have been able to achieve a more consistently clean environment for patients at Dandenong Hospital through their active advocacy for patients.





Opportunities for recreation, occupation, education and rehabilitation

There are innovative therapy programs and activities. At Carinya, the Frankston aged persons mental health residential unit, there is an active diversional therapy program, and patients can access television, DVDs and music. Sensory gardens were also completed last year.

Least restrictive environment

The adult acute inpatient unit at Frankston Hospital has the lowest level of the use of seclusion in the state, and Community Visitors have observed a significant cultural change in staff attitudes towards the use of seclusion. At the Alfred Hospital, seclusion rates have been reduced by one third in six months following changes in the high dependency unit, including increased staffing and the introduction of group programs.

Staffing

Community Visitors have reported that staffing has been an issue across the region, and have been concerned by the length of time taken to fill some vacant positions.

In several facilities, patients reported concern to Community Visitors regarding the use of agency or casual nursing staff who may not be familiar with their specialised needs.

The absence of a psychologist for a period of 10 months at the mother and baby, and eating disorders unit at Monash Medical Centre has been of concern to Community Visitors, as it has meant that patients do not have an opportunity to participate in individual counselling.

Similarly, Community Visitors report a period of nine months without a dedicated Occupational Therapist and four months without a social worker at the aged persons acute inpatient unit at Dandenong Hospital.

Health Services

In 2007-08, Community Visitors conducted 433 visits to 60 SRSs in the Southern Metropolitan Region. Of these facilities, 25 were pension-level and 35 above-pension.

Complaints

Residents do not always have access to information about their rights. In some cases, residents may need assistance to understand their rights due to their disability, but have difficulty getting such help. Even when residents are aware of their rights, Community Visitors have observed situations where they are reluctant to speak up about their concerns for fear of reprisal. There are some proprietors who appear to view feedback as an unwarranted interference, rather than as an opportunity to better meet the needs of residents. For example, the proprietor of one facility has refused to display a Community Visitor poster. As a compromise, the phone number for Community Visitors has been included in a list of contacts by the telephone. During a visit to another SRS, several residents informed Community Visitors that they had all been provided with a letter asking them to stop spreading rumours. When questioned, the proprietor of the facility said that this was an established practice. This demonstrates a lack of an adequate complaints mechanism for residents.

Environment

Standards of cleanliness and maintenance vary significantly across facilities. Community Visitors have again reported concern at the length of time taken to address some maintenance issues, particularly in pension-level SRSs. Many of the issues raised by Community Visitors present a safety or health risk to residents, such as:

- frayed and soiled carpet acting as tripping hazard
- cracked and broken floor and bathroom tiles
- dangerously hot water in the bathroom
- poorly maintained outdoor and garden areas
- sheds used to store rubbish and clothing, thereby attracting vermin
- inadequate lighting
- broken windows, damaged flyscreens and window coverings
- dirty toilets and bathrooms
- strong urine smells.

Some facilities were simply not built or equipped to provide a home to a large number of residents with complex support needs. For example, Community Visitors have raised ongoing concerns about the poor physical environment and lack of maintenance at one heritage-listed facility. At this SRS, Community Visitors have reported that many residents share rooms, there are plumbing problems which result in pools of water on the floor, residents' clothes are stored in an open shed outside, and heating is often inadequate. Similarly, Community Visitors identified problems with maintenance at a number of pension-level facilities. Many of these were resolved with Community Visitor input and some were referred to DHS for follow-up.

There are many caring staff in both above-pension and pension-level facilities. However, a small number of proprietors demonstrate a lack of understanding of their residents and treat them with a lack of respect and dignity. At one SRS, Community Visitors observed a staff member telling a resident to "shut up". This was denied by the proprietor. At another facility, Community Visitors were approached by a resident who uses a wheelchair. The resident complained that he had difficulty using the rear entry to the building, and on a previous attempt to enter had fallen from his wheelchair. When Community Visitors raised the issue with the proprietor, he commented that it was "good therapy" for the resident. Community Visitors subsequently referred the issue to the DHS Authorised Officer for investigation.





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Some proprietors cite cost as a deterrent to providing adequately sized or wholesome meals. At another facility, residents are served dinner at 4.45pm, which suggests institutional, rather than individualised, practices. Community Visitors have noted some instances of nutritious meals, particularly in above-pension facilities. For example, Community Visitors at one SRS reported the meal was “mixed grill, fresh green beans, potatoes, tomatoes, mushrooms, eggs and chutney”.

Food safety issues observed this year have included rotting fruit and vegetables, out-of-date food, and problems with pest control. At one SRS, Community Visitors found jam that was almost four years past its ‘use-by’ date. In some SRSs, staff appear to have little training in appropriate kitchen procedures. For example, Community Visitors observed one cook preparing meals without an apron or gloves.

Individuality

Community Visitors have previously advocated for improved care planning for residents. Again this year, Community Visitors report a number of instances where care plans were out-of-date, lacked critical detail or failed to address residents’ personal interests. At one facility, Community Visitors viewed care plans which failed to acknowledge the incontinence of a resident.

The number and type of activities for residents varies significantly across facilities. Community Visitors have expressed concern about the lack of activities on offer in some SRSs. However, there have also been instances of good practice. For example, Community Visitors acknowledge staff at one SRS who have supported one resident to continue her charity work. Similarly, one resident at a pension-level SRS, previously identified as having complex behavioural needs, told Community Visitors that his problems were due to boredom and he was happy now that he had activities.

Safety

In addition to food safety concerns, Community Visitors have reported a number of other safety issues, including:

- malfunctioning exit lights (on each visit over a six-month period, Community Visitors found the exit lights at one SRS not working)
- locked and obstructed exit doors (thereby preventing residents access to an escape route in the case of a fire)
- fire-hose reel cupboards obstructed and used for storage
- hazardous placement of electrical and extension cords
- evacuation packs that need updating.

At one facility, Community Visitors received no response to a test of the alarm system, with staff responding when questioned later that they were “too busy” to respond. However, Community Visitors commend the staff at one facility, who demonstrated concern for their residents by placing non-slip strips in the shower to improve safety.

Disability Services

Appropriateness and standard of facilities

Environment

Community Visitors have reported on the significant variability in the houses in this region. Both the atmosphere and physical environment varies greatly, depending on a range of factors including the age of the house and the attitude of staff. New, purpose-built houses generally provide excellent accommodation but older houses often have poor facilities such as inadequate bathrooms and narrow passageways. In particular, many bathrooms, although recently renovated, have an institutional feel. Community Visitors also reported that there is no separate toilet in a number of DHS houses, which has a significant impact on individuals' privacy.

Community Visitors have also reported that maintenance continues to be a problem, with repairs sometimes taking many months to resolve. This is most concerning where the issues threaten residents' safety. For example, Community Visitors repeatedly appealed to house management to repair damaged floor covering at the top of the stairs, which was a significant hazard to one resident with a visual impairment. However, almost a year passed before the repairs were completed. Similarly, Community Visitors have requested the removal of a dead tree outside a house owned by the Office of Housing and managed by DHS for over nine months.

Safety

More accurate recording of incidents has been observed by Community Visitors in some houses and this assists in providing more appropriate, individual support. However, in many houses, incident reports often remain difficult to access. Community Visitors look forward to increased consistency of access to these reports in DHS houses following implementation of the 'CRU Office Management Project'. This initiative in departmental houses is an attempt to standardised office procedures and record keeping.

In Southern Metropolitan Region (SMR), there are 78 Shared Supported Accommodation services (SSAs) managed directly by DHS's Regional Disability Accommodation Services. A further 125 facilities are managed by 20 Community Service Organisations (CSOs).

Community Visitors undertook 571 scheduled, unannounced visits.

Further visits were also made as a consequence of individual requests to the office.

Regional Conveners and Community Visitors also attend regular meetings with CSO service providers and quarterly meetings with regional DHS management.

Staffing

Overall, Community Visitors have observed that the new legislation has been embraced by most staff and they commend all who are concerned with the transition to the new requirements. However, staffing levels are often inadequate to allow residents to make real lifestyle choices and to participate in individual activities. Consistency in staffing is also critical to ensure support strategies can be implemented on a regular basis. Further, there is often insufficient flexibility to provide staff support in meeting resident's changing needs. The appointment of temporary staff, including house supervisors, can have a negative impact on long-term planning of residents' needs such as holiday preparation or changing support requirements due to ageing. After the loss of the cook in one congregate-care facility, staff were required to cook for 14 residents. This resulted in less time for staff to pursue other responsibilities and to support residents to engage in community activities.



Compatibility

Over the last year, Community Visitors in the region have reported on situations of incompatibility among residents. These situations may arise because the placement is not always based on individual interests, characteristics or needs, but rather insufficient availability of places. Often existing residents are not consulted about newcomers who are to fill a vacancy. Community Visitors were concerned to learn that DHS was planning to transfer one young resident with significant behaviours of concern, to a home with older residents. However, according to DHS “the consultation process raised a number of issues, unrelated to age, which has resulted in the person not transferring to this CRU”.

Community Visitors reported in a number of instances where the behaviour of one resident had a detrimental effect on the emotional or physical health of other residents. Lifestyles can also be affected when restrictions placed on one resident have an impact on the freedom of the others. Community Visitors reported some instances where residents live in fear of another resident. In one situation, DHS management proposed to install a new lock and reinforce a resident’s bedroom door to address this. Community Visitors were pleased to learn that these strategies were not necessary and, instead, the central matter of resident compatibility was addressed. In another example, an individual has been isolated from other residents in another part of the house with few plans apparently in place to resolve the situation.

Opportunities for recreation, occupation, education and rehabilitation

Individuality

Following the introduction of the Disability Act, Community Visitors have noted a gradual introduction of individual support plans. The quality and content of these plans are contingent on staff training. Community Visitors observed a number of excellent plans, particularly when they have been developed after a period of person-centred active support. However, there is a lack of consistency across agencies, and concern that there is often limited ongoing review of plans and documentation of progress against goals.

Some residential support staff are diligent in ensuring that individuals’ needs are met, and Community Visitors acknowledge the extra efforts of staff in making houses homelike and comfortable. Community Visitors have been pleased to see staff members spending time to ensure that individuals can achieve their goals, especially where there may be little or no family involvement. In one house, staff set up a woodwork bench in the garage to enable a resident to pursue his interest.

Community Visitors commend a number of CSOs who have demonstrated innovation in supporting individuals to pursue personal interests and have greater involvement in decisions affecting their lives. Examples of this include participation in staff selection (Wesley), the ‘Everyday People Initiative’ (Yooralla), representation on house and residential management committees (Wallerara), and flexibility in providing activities to meet individual interests (Scope). Similarly, Yooralla has developed a comprehensive plan to support one resident to learn to scuba dive.

The availability of transport remains an obstacle to residents pursuing individual interests and participating in spontaneous activity. With most residents relying solely on the disability support pension, taxi cost and reliability continue to prove a significant barrier. Community Visitors reported the story of one resident in a CSO facility who felt obliged to pay for singing lessons he did not attend, as the taxi which had been booked in advance did not arrive.

Health care needs

There have been some pleasing initiatives to address individuals’ health care needs. In one DHS house, residents are able to exercise choice as to which general practitioner they wish to see by selecting from a range of photographs. In other houses, residents have memberships at the local gym or attend weight-loss programs.

Residents’ access to treatment and suitable aids is frequently limited by broader systemic failings. For example, one individual was diagnosed with a perforated eardrum in September 2007, but remains on a hospital waiting list for surgery, despite his resultant distress and an escalation in his behaviours. Similarly, the provision of aids and equipment is compromised by financial difficulties, inflexible funding criteria and time delays. Some residents are in discomfort and sometimes danger because of these factors.



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Other

Accommodation need

There remains a shortage of suitable accommodation for people with disabilities. Although respite places remain in short supply, there have been instances of individuals living in respite for periods of up to six months. One respite facility (managed by Statewide Autistic Services) has an excellent program for young people with autism but the waiting list is closed. In contrast, Community Visitors have observed long-term vacancies in some houses despite the acute need for accommodation. In addition, some residents with Individual Support Packages have been unable to move to independent accommodation because of the cost and availability of suitable rental accommodation. Further, Community Visitors have seen limited use of one DHS respite facility due to its poor physical condition and isolation from community resources.

Case study: Waiting, waiting...

Community Visitors continue to report a shortage of respite and permanent accommodation for people with disabilities. At one specialist respite facility for children with an Autism Spectrum Disorder, there are almost 120 families on the waiting list. Some families have been on the waiting list for over 2 years, and the facility reports that it has now closed the list for new referrals.

The manager of the facility reports that it has been difficult to introduce new families into the facility over the past year due to a high demand for emergency accommodation. For example, in December 2007, there were 20 requests for clients needing emergency respite and housing.

Complaints

When families consider a placement is unsatisfactory, they do not always understand the complaint process. Community Visitors have responded to a number of calls to the office's Advice Service where families report that they are frightened to complain on behalf of their family member because they are concerned that they will jeopardise their family member's placement or ability to access ongoing support if they speak up. Some complaints to Community Visitors suggest a lack of follow up by management regarding resident concerns. Awareness and understanding of the complaints process needs to be improved. Some agencies have responded to this need. For example, Wesley has developed a booklet for families, clearly outlining their complaints process, which Community Visitors consider is an excellent practice.

Ageing

There appears to be an ad hoc approach in addressing resident's long-term needs as they age. Community Visitors acknowledge the efforts of one CSO, Helen Schutt House Association, that is implementing a five-year plan to develop a facility suitable for the needs of six ageing residents. However, Community Visitors are concerned that there is not a coordinated approach, and individual houses are often left to make their own arrangements. One ageing resident, in a CSO house, has been unable to attend day placement since December 2006 due to his visual impairment. He is at home alone with a call button for emergencies, but without staff support or regular organised activities.

It is hardly surprising that when he sees Community Visitors, he tells them, "I'm bored!"

