



Office of the Public Advocate

OPA Research Paper

Two steps forward, one step back: an analysis of five years of Community Visitor annual reports, 2003-2007

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Introduction

The Community Visitor annual reports have been an important documentation of the standards of care and support in government-funded, government-provided and government-regulated supported accommodation services for people with a disability in Victoria for the past twenty years. These reports provide insight into the way people with a disability live their lives in these services and how the state supports and cares for these vulnerable Victorians with a mental illness, intellectual disabilities, acquired brain injuries, dementia and other cognitive disabilities.

In the five-year period covered in this paper, over 500 Community Visitors made more than 5000 visits each year. These visits demonstrate significant involvement by the Office of the Public Advocate (OPA) in monitoring the rights of people with a disability in Victoria and helping to ensure a good standard of support and care as expected by the community and as required by legislation.

Aim

This paper summarises the findings from a document analysis of five years of Community Visitor annual reports: 2002/03 to 2006/07 inclusive. The aim of this analysis was to identify the range of themes noted in the reports for each stream (Disability, Mental Health and Health Services) and across streams, to track the development of themes over this time and, where possible, to identify any policy action that has arisen from the reporting of these issues through the annual reports.

Community Visitor annual reports are tabled in Parliament each year and provide an opportunity for Parliament to formally consider the issues raised and to respond. This opportunity is, however, often overshadowed by the large number of reports tabled at the same time and provides little opportunity for careful analysis and response from Parliament or the community.

OPA uses the release of the annual report to focus the community's attention on the issues reported. This is done through the media, and throughout the year, program representatives meet with the relevant personnel in the Department of Human Services (DHS) to raise and seek resolution of emerging issues. However, given the range of competing issues attended to by government, the important issues raised in the Community Visitor annual reports are not always closely attended to or addressed.

It is anticipated that this paper will re-focus attention on the issues reported in this five-year period, be a reference for considering progress in addressing the range of issues raised each year and to highlight the common issues that emerge year after year. It is also a reference for identifying important areas for policy advocacy, research and systems advocacy in disability residential services, supported accommodation service development and treatment and care practice in disability and mental health.

Structure of the paper

Each annual report for each stream was closely read, using a framework for thematic analysis based on the functions of the Community Visitor Program, as outlined in

legislation. Finally, common themes across the streams were identified and are discussed at the end of the paper with reference to human rights principles.

An analysis of each stream is provided separately. These analyses provide an overview of the reporting in the stream over the period. They draw on key themes, outline examples where reported issues have been addressed, highlight where particular issues continue to be raised and describe how some issues have developed over the period.

The human rights and disability rights framework used in the final section of the paper highlights the commonality of issues raised in Community Visitor reports and discusses them from this rights-based perspective, rather than the more narrow 'stream specific' and 'facility-focussed' perspective given in the separate reports.

This discussion highlights the shared rights of the people who use these services, and suggests the need to advocate from the rights of people 'out' to the community through the Community Visitor annual reports. Article 19 of the *UN Convention on the Rights of Persons with Disabilities 2006* (the 'convention') is used as the key reference for considering this approach.

Community Visitor functions

Community Visitors are the community gaze within government-funded, provided and/or regulated disability and mental health residential and treatment facilities. They report from this perspective and, as such, provide independent observation and frontline advocacy for the rights of people with a disability.

The functions of Community Visitors are outlined in the legislation that applies to each stream; for the disability stream in the period covered by this report there were two pieces of legislation: the *Intellectually Disabled Persons Services Act 1986* – effective until July 1, 2007 and the *Disability Act 2006* effective from July 1, 2007. The *Mental Health Act 1986* and the *Health Services Act 1988* outline the functions of Community Visitors in these sectors. The three sets of functions as defined in the three pieces of legislation are outlined in Table 1.

A reading of these functions indicates that, across the streams, the focus of reporting is: the appropriateness of the services, the adequacy of services in meeting peoples' needs, the standard of facilities, appropriateness of opportunities for participation in leisure, recreation and skill development, whether the facility provides treatment and care as required by the legislation and the adequacy of complaints mechanisms.

In practice, each stream focuses on how the facilities and their services are functioning and how this impacts on the rights of people who reside in them. In particular, they report on whether the services meet community expectations and service standards set by legislation and government policy. Importantly, the Community Visitors have powers to report on these standards and how they impact on the rights and quality of life of people who reside in such services.

Table 1 Functions of Community Visitors by stream/legislation

Disability Stream <i>Intellectually Disabled Persons Services Act 1986 [until July 1 2007]</i> <i>Disability Act 2006</i>	Mental Health Stream <i>Mental Health Act 1986</i>	Health Services Stream <i>Health Services Act 1988</i>
<p>s30</p> <p>The functions of a community visitor are to visit any premises where a disability service provider is providing residential services in the region for which the community visitor is appointed and to inquire into —</p> <p>(a) the appropriateness and standard of premises for the accommodation of residents;</p> <p>(b) the adequacy of opportunities for inclusion and participation by residents in the community;</p> <p>(c) whether the residential services are being provided in accordance with the principles specified in section 5;</p> <p>(d) whether information is being provided to residents as required by this Act;</p> <p>(e) any case of suspected abuse or neglect of a resident;</p> <p>(f) the use of restrictive interventions and compulsory treatment;</p> <p>(g) any failure to comply with the provisions of this Act;</p> <p>(h) any complaint made to a community visitor by a resident.</p>	<p>s109</p> <p>The functions of a community visitor are to visit any mental health service in the region for which the community visitor is appointed and to inquire into —</p> <p>(a) the adequacy of services for the assessment and treatment of people with a mental disorder; and</p> <p>(b) the appropriateness and standard of facilities for the accommodation, physical well-being and welfare of persons receiving treatment or care for a mental disorder; and</p> <p>(c) the adequacy of opportunities and facilities for the recreation, occupation, education, training and rehabilitation of persons receiving treatment or care for a mental disorder; and</p> <p>(d) the extent to which people receiving treatment or care for a mental disorder are being given the best possible treatment or care appropriate to their needs in the least possible restrictive environment and least possible intrusive manner consistent with the effective giving of that treatment or care; and</p> <p>(e) any failure to comply with the provisions of this Act; and</p> <p>(f) any other matter that an official visitor considers appropriate having regard to the objectives specified in section 5; and</p> <p>(g) any complaint made to a community visitor by a person receiving treatment or care for a mental disorder.</p>	<p>s117</p> <p>The functions of a visitor appointed for a region are—</p> <p>(a) to visit any designated public hospital or supported residential service in the region; and</p> <p>(b) to inquire into—</p> <p>(i) the appropriateness and standard of facilities for the accommodation, physical well-being and welfare of residents of the hospital or service; and</p> <p>(ii) the adequacy of opportunities and facilities for the recreation, occupation, education and training of residents of the hospital or service; and</p> <p>(iii) whether services are being provided for the hospital or service in accordance with the principles specified in section 10; and</p> <p>(iv) any failure by the proprietor of the hospital or service to comply with the provisions of this Act; and</p> <p>(v) any complaint made to a visitor by a resident of the hospital or service or on behalf of a resident of the hospital or service.</p>

Part One – Overview of each stream

1.1 Disability Services

The five years 2002/03 – 2006/07 represent a significant period in the story of Disability Services in Victoria. During this time, DHS began implementing the *State Disability Plan 2002–2012*, Kew Residential Services (KRS) was redeveloped and closed with more than 600 people moving from institutional residential living to community living, and new disability legislation, the *Disability Act* was developed and came into effect on July 1, 2007.

This new legislation brought with it a raft of new policies affecting the way disability accommodation services are planned and delivered and how the rights and opportunities for people using these services are understood and responded to. This included the development of the Office of Senior Practitioner, the Disability Services Commissioner and the demise of the Intellectual Disability Review Panel, which was developed around the same time as the Community Visitor Program and along with it formed an important plank in advocacy for the rights of people with a disability.

OPA made submissions to the review of disability legislation and the development of the *State Disability Plan* that were strongly based on the reports of Community Visitors. This ensured that the work of Community Visitors informed these important disability service reforms and helped to focus attention on the rights of people with a disability living in residential services. Much of the information in the annual reports in the years 2002/03–2006/07 reflects this focus. Likewise, the reports from 2003 reflect Community Visitor awareness of both the opportunities inherent in the reforms and the challenges they raised. Importantly, the Community Visitor reports maintained a focus on the needs and rights of the people most likely to experience the impact of these reforms; those who rely on accommodation services.

In Victoria, supported accommodation services for people with a disability are provided by government and non-government (community) services, with DHS being the primary funder of these services. Supported accommodation services account for the highest proportion of expenditure in disability services in Australia (47.3 per cent) and they are accessed by 16 per cent of all service users (Australian Institute of Health and Welfare, 2008). The Victorian government spent \$612.8 million on accommodation services in 2006/07 (AIHW, 2008); this included expenditure on in-home accommodation support as well as group homes and institutional accommodation support. In the reporting period 2006/07, 4,551 people with a disability in Victoria were using ‘group home’ accommodation support. These people reside in the services visited by Community Visitors.

Community Visitors in the disability stream make the most visits to the most facilities of any stream. The following section outlines some of their work, reflects on how the Community Visitor Program highlighted the issues in their annual reports, and identifies, where possible, how these issues were responded to in subsequent years.

Disability Services Community Visitor annual reports: 2003–2007

In 2003, the Disability Services Community Visitor Program made 2,389 visits. By 2007, this had increased to 3,090 visits. The number of facilities visited over this period increased from 1,007 to 1,085, explained by the introduction of visits to Community Service Organisation (CSO) houses and the increase in community houses resulting from the redevelopment of KRS. The number of Community Visitors also increased in this time from 231 to 312. This represents a 25 per cent increase in Community Visitors, a 20 per cent increase in visits made and a 7 per cent increase in facilities visited.

New guidelines for reporting were implemented in 2003. These were: adequacy of housing and accommodation, the residential environment, personal welfare and wellbeing, availability of transport, hygiene and personal care, dignity, choice and participation and sufficient disposable income. Prior to 2003, reports were primarily organised by region with a section that drew together statewide themes. While regional reports have always been a feature, the introduction of these new reporting guidelines in 2003 enabled broader issues to be used as the basis for reporting.

Reporting approaches changed in this time in light of changes to policy and, most significantly, the change in legislation in 2006 (not in effect until July 1 2007, therefore not fully reflected until the 2007 report). While the functions of Community Visitors did not change significantly with the new legislation, the orientation of disability supports and services did – towards an enhanced focus on individualised planning, participation, inclusion and community.

In general in the five years to 2007, Community Visitors reported on the appropriateness of residential service premises, inclusion and participation opportunities, provision of residential services in accordance with the legislation, access to information by residents, abuse or neglect, use of restrictive interventions, compliance and complaints. These areas comply with the functions of Community Visitors set out in both the *Intellectually Disabled Persons Act 1986* and the *Disability Act 2006*.

Main themes

Residential services are defined in the Disability Act as “residential accommodation with rostered staff provided by, or on behalf of, a disability service provider for the purpose of providing disability services to – (a) one or more residents in a community residential unit; or (b) one or more residents in a residential service other than a community residential unit”. While there are a range of services that fit this definition, the most common model visited by Community Visitors is the group home or Community Residential Unit (CRU). Group homes are located in the community with up to six residents; disability support workers are rostered to support the residents in a range of ways including personal care, meal preparation, skill development and general household duties.

As well as group homes, there were three ‘proclaimed’ residential institutions operating during this period: Sandhurst (Bendigo), Colanda (Colac) and Kew Residential Services. During this time, KRS was redeveloped and almost 600 people were moved into houses throughout metropolitan Melbourne and regional areas. One hundred people remained in group homes (up to six residents per house) on the former

KRS grounds. There are other congregate-care facilities that are not proclaimed as residential institutions but have the same model of care as these institutions. These are run by non-government Community Service Organisations. Most reports, however, make a clear distinction between the issues of institutions and those of community houses. The following section reflects this approach, noting that there are key issues about institutional services that need to be raised separately.

Institutions

There has been an ongoing focus in the annual reports on the need to close all institutions. In the 2003 report, there was a special feature that provided an overview of the Community Visitor Program's involvement in advocating for the closure of residential institutions (pp 20-27). This overview is in line with the consistent message that institutional and other congregate residential models cannot provide appropriate housing and support for people with a disability. In 1989, it was reported that "Victoria's large institutions cannot provide care that will meet the standards of today" (OPA , 2002a, p. 20).

While recommending the closure of institutions, Community Visitors simultaneously recommended improvements to the services and supports provided to people who remain in institutions like Colanda and Sandhurst noting, in particular, the need to address the institutional nature of the care provided in these facilities.

The redevelopment of KRS was a focus of reporting in the five years to 2007. These reports provided a commentary on the standard of supports and services for people still at KRS and a review of the redevelopment process. Reports noted the inadequacy of the physical environment and the lack of appropriate planning and provision of supports available to residents. The 2007 report highlighted that despite the progress of the redevelopment, services and supports for people who remained at KRS (awaiting a move either to community houses or the onsite houses) many were still not receiving person-centred plans, opportunities to participate in the community, and even, in some cases, adequate nutrition and dietary requirements.

So, while reports in this period congratulated the government on the redevelopment of KRS, they also made recommendations for the redevelopment to be completed on time and in a way that did not negatively impact on the standards of care and support for all KRS residents.

The Community Visitors acted as the community gaze into KRS during this very significant time. Through their reports and representation on committees and at forums, Community Visitors had input into and reported about the redevelopment process and outcomes for people who moved into the community.

KRS has now closed; however, the government has not committed to the closure and/or redevelopment of the remaining institutions, Colanda and Sandhurst. At the time of writing, neither had they made any announcements about addressing the residential service models of the Oakleigh Centre and Plenty Residential Services. The Community Visitor reports have continually raised concerns about these remaining institutions and the need for closure, redevelopment and improved supports and services while they remain a part of the disability accommodation service system.

The Public Advocate has continually raised this issue in media releases following the tabling of reports and has put forward the Community Visitors' strong message of institutional closure both in this period and since the first Community Visitor report in 1987. The important role played by Community Visitors in the KRS redevelopment has also been publicly acknowledged by government (see box 1).

Box 1 Media Release

“...Ms Garbutt said the decision to close Kew was supported by numerous independent Community Visitors Reports, including the latest report released last month.

“The Community Visitors report concludes that KRS is an outdated institution and its conditions are unacceptable for people with intellectual disabilities,” Ms Garbutt said.

“There is an urgent need to move ahead with the redevelopment and the latest Community Visitors report urged the Government to expedite the project to provide certainty to residents and families.”

(Media Release, Minister for Community Services, Nov 13 2003)

Institutional closure remains an important disability advocacy issue. The Public Advocate¹ and other advocacy organisations readily refer to Community Visitor annual reports to support the need to close institutional and other congregate care services.² Community Visitors have provided an important and ongoing focus on this issue and have successfully advocated for progress towards deinstitutionalisation of services. However, the task still remains to close all residential institutions.

This goal is reflected in the *UN Convention on the Rights of Persons with a Disability (UN – CRPD)*; Article 19 of the Convention notes, “[the] Convention recognizes the equal right of all persons with disabilities to live in the community” (UN 2006, p.13). Advocacy organisations have interpreted this article as providing a clear direction that all institutions should be closed, with Inclusion International noting, “the discussion is no longer should institutions close but when they will close” (Inclusion International, 2008 p. 18). The *Community Visitor Annual Report 2008* has, as its first recommendation, that the government “...dismantles and redevelops all remaining institutions forthwith” (OPA, 2008 p. 4). This indicates that deinstitutionalisation remains a priority advocacy issue for the Community Visitor Program.

Shortage of residential services

All reports from 2003–2007 highlight the shortage of residential services and the unmet need for accommodation. They call for growth in residential services to alleviate what each year is called the “current crisis”. Indicators of the need include the number of respite facilities where people are using respite beds because there are no long-term residential placements, incompatibility of residents in accommodation services and people living with ageing parents.

¹ Oakleigh Leader November 2008

² See Valid, Star, AMIDA and Reinforce (2008) *Submission to inquiries into supported accommodation for those with disability and mental illness*
http://www.starvictoria.org.au/docs/Submission_to_Inquiries_into_Supported_Accommodation.doc

Each report from 2003 to 2007 calls on the government to increase funding and to develop more services that are of a high standard. The 2007 report recommends:

That the government urgently prepares a strategy to plan and build more disability specific accommodation of the community residential unit type, to avoid an escalation of the crisis in unmet accommodation needs and eliminate the use of respite beds for emergency accommodation.

The heading, “Accommodation shortage – continuing crisis” in the 2004 report highlights the importance of this issue. This report and the 2005 report note a “crisis situation for children, adolescents and young adults with complex care needs” (2005, p. 13). This issue is linked in these reports to the inappropriate use of respite services for long-term accommodation. The 2004 report notes, “Community Visitors are aware of more than 30 respite beds being used across the State for long-term accommodation” (p. 8). This issue is again raised in 2006 and 2007.

Reporting on accommodation shortages is not an identified function for Community Visitors; however, their responsibility to report on the appropriateness of services and supports enables them to highlight such shortages. They highlight an important service gap in respite, which impacts on the appropriateness of services for people using respite services who are sharing with long-term residents wrongly placed there.

Research indicates that, in the period 2006–07, there were 24 per cent more people using disability services than four years prior and the largest increases were seen in respite care, which accounted for 46 per cent of service use (AIHW, 2008). Inadequate numbers of accommodation-based respite beds, lack of in-home respite and other respite options all impact on, and are impacted by, the overall shortage in disability accommodation services. This is despite the government reporting an increase of 88 per cent in respite funding since 1999 (DHS, 2006a). The ongoing reporting of shortages in appropriate respite placements suggests a need for a review of current approaches to the provision of respite.

DHS through the State Disability Plan is reorienting disability services through developing new approaches to support including individualised funding. However, it also continues to fund traditional service-based models of support. Residential accommodation support accounted for almost half of the total disability budget in 2005/06 (\$501.6 million), with an additional \$125.7 million spent on individualised supports and \$111.1 million used for primary support, of which there were 18,565 episodes of respite. Together, this reflects a commitment to addressing the range of issues raised in Community Visitor annual reports; however, shortages and service gaps still exist and are reported.

Policies that promote individualised support and the provision of individualised funding packages, which are designed to enable people to move from supported to more independent accommodation, do not seem to have alleviated the issue of shortages raised continually by Community Visitors in the reporting period. In the DHS report on the implementation of the State Disability Plan (DHS, 2006b), it is reported that the Support and Choice growth initiative, “had given 100 people the chance to move from their existing shared supported accommodation to independent

community housing” (p.6). However, the Community Visitor annual reports note that there are still incompatible house groupings where the lack of available long-term options leads to people with varying needs living together and that there is an ongoing shortage of long-term, shared supported accommodation.

Appropriateness of residential services

Recommendations for improvement to the physical environment were raised in all reports from 2003 to 2007. These included improving response times for maintenance work, the need to purpose-build new houses based on the needs of residents rather than the health and safety needs of staff, and the need to undertake audits of existing stock. While Community Visitors do report on more salient issues, the standard and condition of residential premises is an important item in their reports.

Seven categories of reporting relate to the physical standards of the houses: ambiance and comfort, heating and cooling, fire safety, external presentation and outdoor areas environmental safety (these are grouped under ‘residential environment’), building structure and design, upkeep of building and fittings and landlord issues (these are grouped under ‘fabric and maintenance’). In 2007, these categories accounted for 43 per cent of reported issues statewide. Prior to 2007, these issues were not grouped into these two categories, however, a review of the reports from 2003 to 2006 indicates that issues relating to the appropriateness of the residential service (called housing, residential environment, maintenance and design, capital works and design issues), accounted for around 45-50 per cent of reported issues.

From 2003 to 2006, there was consistent reporting on the need to ensure people do not have to share bedrooms unless they choose to. The 2003 report identifies the number of shared bedrooms in each region, noting the highest number of shared bedrooms is at KRS. By 2005, only one region still had shared bedrooms (apart from those people still in institutions) and, by 2007, this was not reported at all.

The Community Visitors use ‘community standards’ as the basis for their reporting. However, disability residential services also have set standards. The Community Visitor reports indicate that residential service premises must meet both of these. They ask for houses that are both homely and that have the required amenities to adequately house people who have specific needs.

‘Appropriateness of services’ is a broad category and the reports from 2003 to 2007 reflect a breadth of issues relating to this category. However, it seems the main focus is on physical aspects of the houses with some broader interpretation of issues like privacy and overall homeliness.

Community Visitor reports on the appropriateness of services could be seen to have had an impact on funding and service development in housing. However, as indicated below, the levels of funding and timelines for redevelopment are reported as inadequate. The DHS report on the implementation of the State Disability Plan indicates that, between 2002 and 2004, a congregate-care facility housing 24 residents was redeveloped, four new community-based facilities were developed and residents were “progressively moved to new homes designed to meet their support requirements and preferences” (DHS, 2006b, p.7). The *Community Visitor Annual Report 2002/03* for this region notes that:

Two very inadequate houses have been very satisfactorily replaced this year. However, three houses...are still recognised as unsuitable for particular residents and a house in the outer area has been described by Community Visitors as needing 'bulldozing' (OPA 2003a, p. 69).

This report goes on to note that only one house is able to be replaced each year by DHS and that this is not nearly enough to address the reported issues.

Inclusion and participation opportunities

Barriers to community access and inclusion are raised from 2003 to 2005. These barriers include inadequate staffing to enable individualised community access opportunities and access to transport to enable participation.

The 2003/04 report recommended that funding be made available to allow appropriate support for "everyone to participate in enjoyable and meaningful leisure". This report noted that "ready access to transport is essential for people to truly lead inclusive lives in the community" and went on to recommend that DHS fund additional transport for DHS-managed houses. The 2004/05 report again makes the point that more access to transport is needed and that sharing of vehicles between houses is not suitable.

In 2005/06, the report noted that limited access to transport needed to be addressed, in particular, for people in geographically isolated areas. Transport issues are noted as being four per cent of all issues reported in 2005. This report discusses transport needs under the heading 'community access and inclusion' and notes that the "unavailability of transport can be a further barrier when the house is isolated from public transport or lacks easy access to a taxi service" (OPA, 2006a). This report also highlights that staffing constraints mean all residents go out to the same community-based activities and that this limits people's individual choices.

There is some internal inconsistency in the recommendations made by Community Visitors in annual reports about the issue of transport. Some reports note the need for each house to have its own transport, while others put forward the position that more staff support would mean more individualised inclusion in community activities through using community and public transport. There is some need for further debate as the two opinions, to some extent, could be seen as contradictory.

Restrictive interventions

Restrictive interventions are raised in each of the reports from 2002/03 to 2006/07. These issues are reported and discussed under a range of categories including: restraint and seclusion (2002/03), locks (2004/05), risk management (2005/06), restrictive practices/locks (2006/07) and two separate categories 'restraint and seclusion' and 'restrictive practices such as locks' (2007/08). The Community Visitor functions in the Intellectually Disabled Persons Services Act required visitors to report on 'restraint and seclusion' whereas under the new Disability Act they are required to report on the 'use of restrictive interventions' and 'compulsory treatment'. This might account for the range of categories used to report restrictive interventions over the period 2002/03 – 2006/07.

A strong focus has been the locking of houses, rooms, cupboards and doors. Some annual reports have highlighted issues in relation to restrictive behaviour management

practices although these were not reported on in detail. In the 2006/07 statistical report (Appendix 2 in the 2006/07 report) it is noted that there were 20 issues raised in relation to restrictive practices including locks and 24 about restraint and seclusion. The latter issue was not outlined in detail in the report.

Many of the supported accommodation services visited by Community Visitors could be described as locked environments. In the 2004/05 and 2006/07 reports, issues about the use and monitoring of locked doors and cupboards were raised, in particular, a lack of clear policy or practice in this area. They also note that locked environments are a fire safety issue, decrease the homeliness of the houses, and limit choice and freedom for residents.

Community Visitor reports note that, while there can be legitimate reasons for using locks in some instances, the routine practice of locking cupboards and doors raised considerable concerns about the balance between duty of care and a person's right to maximum choice and freedom. In particular, they raise the need to find a balance between work-safety practices and the need to have supported accommodation services that are homelike and reflect choice and freedom.

Reporting on the 'use of restrictive interventions' as required under the Disability Act encompasses many issues beyond those discussed under the category of 'locks and locked environments'. Therefore, it could be expected that this issue will be more fully reported in future reports, given the increased focus on addressing restrictive interventions, through the work of the Office of the Senior Practitioner.

Individualised planning and support

Planning

There was a consistent focus on improved individual planning for people who used supported accommodation services in the reports from 2003 to 2007. In 2006 and 2007, planning for and with people was beginning to be undertaken using different approaches. The Intellectually Disabled Persons Services Act outlined regulations for the development, implementation, monitoring and review of Individual Program Plans (IPPs), however, the Disability Act and policies and practices preceding the implementation of this Act had begun to phase in a range of approaches to individualised planning. This shift in practice is reflected in the Community Visitor reports of 2006 and 2007. However, earlier reports highlighted ongoing concerns about the quality, focus and use of individualised plans.

In 2003, the Board questioned whether IPPs were being used as a "working document" in supporting people or whether they were more often seen as meeting a legislative requirement and not used to guide the way people were supported. One issue identified in the 2003 report was that IPPs were filed away in the office and not available for staff to see. In 2005, a recommendation was made that "All residents have individualised or person-centred plans which are meaningful, reflect individual goals and aspirations and involve extensive consultation with everyone involved in the person's life". This recommendation reflected the changes that were to occur with the Disability Act focus on individual and person-directed planning.

Community Visitors reported in 2007 that, while they were aware that services should be developing and implementing individualised and person-directed plans as required under the new legislation, it was evident that not all services were undertaking such plans. The statewide summary of issues in this report indicates that there were 247 issues raised about individualised planning/person centred planning. This was a very slight decrease from the previous reporting year; however, a common theme in all reports for the period 2003 to 2007 is the need for individualisation of plans and evidence that the person is actively involved in their planning.

Individuality is reported as an 'issue' in the annual reports. In 2007, this area accounted for 12 per cent of all issues reported. Individual planning and other issues may have been reported under 'individuality'. These could include, 'community inclusion', which accounted for eight per cent of issues in 2007 and 'welfare and wellbeing' which accounted for 20 per cent of all issues reported. Before 2005, these statistics were not reported in annual reports as a percentage of total issues, and in 2005 'individuality' was not reported as an issue at all. The 2005 report collapses the issues 'welfare and wellbeing', 'personal care', and 'choice and participation' and reports that these comprise almost half (46 per cent) of all issues reported. This variation in counting and reporting between 2003 and 2007 makes it difficult to understand trends that relate to individualisation of supports and services.

Health

Healthcare is raised as an issue throughout the reports of 2003–2007. Most reports raise issues about general personal care that are discussed as having disadvantageous health outcomes; these include issues about nutrition, diet and hygiene. Interventions by Community Visitors are noted as leading to health assessments:

A person was noticed as having gained weight and was reducing his engagement in his favourite activities following a change of medication. Concerns were raised over a series of visits until this man was referred to the Centre for Developmental Disability Health Victoria for a complete review of his behavioural, physiological and medical needs (OPA, 2003a).

Other reports focus on specific health needs including preventative healthcare and the need for early intervention in dental health (2007) and women's health (2006). Most health issues are raised under the 'welfare and wellbeing' category of the reports.

Accessibility of health services, both general health and specialist preventative health services like breast screening is a consistent theme. The reports note two kinds of issues: the accessibility of the services, including some instances where people with a disability were not given access to the service, and the lack of planning and support for people to use these services. Linked to this latter issue is the importance of monitoring specific health needs like breast health. These two areas are identified in almost every report between 2003 and 2007.

Progress in this area is noted in the 2007 report: "There are more healthcare plans but improvements are still necessary" (OPA, 2007a p.24). However, this report also notes that the quality of these plans is variable with some being thorough and others not truly reflecting the person's health status and needs. This report highlights the importance of a coordinated approach to health-care planning.

Medication and the link between medication and behaviour are also raised consistently throughout these reports. The 2005 report notes:

Community Visitors are concerned about practices used in the administration of medication and the fact that prescribed medication is not regularly reviewed.

Community Visitor reports regularly note problems with medication record keeping, the apparent lack of monitoring of medication and inadequate healthcare planning.

Where statistics on 'issues raised' are outlined in reports (2006 and 2007), health-care consistently rates high (i.e. around 25 per cent of reported issues), indicating that this is an important issue. As noted earlier, some health related issues are embedded within the category of 'welfare and wellbeing'.

The reports highlight that Community Visitors see healthcare as both an individual advocacy issue and a broader systems or policy advocacy issue as examples are given where reporting has both resulted in outcomes for individuals and changes to policy and practice.

Ageing

Planning to enable residents to age in place, and the need for policy and planning for transition to aged care, and/or care provision that reflects the needs of the ageing resident, are raised in each report from 2003 to 2007.

Reports from 2003 reflect a view that the most significant gap in the area of ageing was a lack of consistent practice in planning for people who are ageing. Reports indicate that some services were addressing this; however, this was not within a policy framework. The 2004 report notes that this planning should not occur "in a vacuum" and cautions about the development of congregate-care models for older people with disabilities. This report notes that 'whole of life' planning processes were needed to ensure people's lifestyles could reflect their changing needs, interests and abilities as they age. In 2005, the notion of 'ageing in place' appears, repeating the need to be aware of emerging models that might congregate people together based on age and the movement towards larger residential facilities for older people with disabilities. By 2006, the report broadens the issues to include palliative care and death and dying. The 2007 report discusses ageing in relation to flexible funding and support, rather than focusing on ageing specific issues.

These reports indicate that Community Visitors are aware that there are significant issues for people with a disability who are ageing that require an individual response, and a system-wide response. The presence of these issues in all reports for the five-year period suggests that further work is needed to address this issue; however, the reports do indicate that each year there has been some progression of this issue, evident in the changing focus of these recommendations.

Abuse and neglect

Reporting of "...any case of suspected abuse or neglect of a resident" is a function of Community Visitors under the Disability Act s30 (e). The 2007 report indicates that there were 28 issues reported as abuse and neglect; in 2006 there were 25. However, there is little discussion of these issues in the body of the reports. Prior to 2006 these issues may have been addressed under 'welfare and wellbeing' although a close

reading of these reports fails to provide a clear picture of the range of issues or incidents that are either reported as, or associated with, abuse and neglect. This may be due to a lack of access to incident reports, a lack of reporting at the service level of incidents of abuse or neglect, or a lack of awareness at the service level and/or by Community Visitors, of what constitutes abuse and neglect. In 2006 and 2007 there were 52 (2006) and 36 (2007) reported issues statewide about incident reports.

Issues of abuse and neglect could also be embedded in other categories of reporting: reportable deaths, healthcare, personal care and restrictive intervention (previously 'restraint and seclusion'). Broader research finds that people with disabilities living in residential services are at high risk of abuse and neglect (Cambridge, 1999; Conway et al 1996; Emerson et al 2000; Healy, 2008; Robinson, 2008; Sobsey 1994), however, a significant issue identified in this research is the difficulty people have reporting incidents and the inadequacy of current approaches to responding to incidents. The Community Visitor reports would concur with this. The low number of reported issues about abuse and neglect in Community Visitor annual reports, seen in the context of what the research indicates to be a significantly under-reported but highly prevalent issue, indicates the need for further investigation. Through the Disability Act, Community Visitors are charged with the responsibility to report any 'suspected' cases of abuse and neglect. This suggests that there is a need to consider on what basis suspicions are founded and what Community Visitors can do to report them.

Staffing

Staffing and staffing practices are referred to throughout the reports under a range of categories, for example, in 2007 the following categories were reported on: support/care/assistance from support staff, facilitating/encouraging independence, participating/engagement/inclusion in the community. Staff training, staffing levels, staffing models and professional development are regularly referred to in the recommendations of the annual reports.

The 2005 report recommends that workforce and training requirements for disability support staff be updated and that advanced professional development opportunities are needed (OPA, 2005a), whereas the 2007 report in the executive summary notes: "Emphasis is placed on the importance of well-trained, capable staff in supporting residents to achieve their maximum potential and in providing quality care" (OPA, 2007a, p.3). A DHS report on progression of the *State Disability Plan* (DHS, 2006b), indicated that "the percentage of disability staff in the government sector who are trained or completing qualification increased from 52 per cent in 2001 to 93 per cent in 2005" (p.10). This reflects a significant commitment to meeting the recommendations put forward in the Community Visitor annual reports.

The 2003 report links inadequate staff/client ratios to a lack of leisure opportunities for people with higher support needs, whereas, the 2004 report on Kew Residential Services highlights the lack of appropriate interactions between staff and residents as contributing to a lack of suitable leisure activities naming this as "institutional practice". This issue has been persistent over the five-year period.

Community Visitors have an important opportunity to observe resident/staff interactions during their visits. These reports indicate that, in doing this, they are able

to comment on the impact that a range of staffing issues have on outcomes for residents. Importantly, the Community Visitor reports reflect the way that Community Visitors are linking policy to practice in residential services. The 2007 report reflects the Community Visitors' awareness of current best practice in residential support noting:

That the Department of Human Services and all community service organisations commit to enhancing the skills and abilities of all disability support staff in order that active support strategies are comprehensively used to improve the daily living skills and independence of all residents (OPA, 2007a, p. 4).

This type of recommendation reinforces the importance of Community Visitors being aware of current best practice and their understanding of how these practices are implemented in residential services.

Disability summary

The information contained in the Disability Stream annual reports 2002/03 –2006/ 07 indicates that Community Visitors have raised a number of important issues about standards of supports and services in disability accommodation services. Some of these have been addressed and/or progressed through individual and broader advocacy; however, the persistent reporting of issues relating to the service standards and standards of care suggest that continued improvement is needed in all areas of reporting.

In some way, this could be described as the nature of the provision of shared supported accommodation. There will always be standards set, changed standards and the ongoing issue of providing a high standard of accommodation, care and support underpinned by expectations of an individualised focus, within a shared environment governed by a bureaucratic system. Each year, there are changes to the way services and supports are managed and to policies and practices that govern the way services and supports are provided, however, these reports indicate that there is some consistency of issues.

The bar might be seen to be raised at certain times, which is evident in the development of a focus on individualised and person-centred planning and support over these years, however, the focus has not changed. Since the Intellectually Disabled Persons Services Act there has been an expectation that people using disability shared supported accommodation will be seen as individuals and their needs and aspirations used to determine the support and services they receive. Likewise, it has always been expected that they will be safe, secure and able to exercise their rights within these environments and will be supported by skilled and competent staff.

More than anything, the reports of the five years from 2003-07 indicate that, while some gains are made towards recognising these expectations, and that different themes do emerge over time (eg ageing in place, active support, residential rights), there remains a consistent focus on improvement of the standards of supports and services so they do meet community expectations.

The challenge is to ensure that such reporting has a clear and well-managed internal focus while being able to remain the 'community gaze'. Therefore it is important to

use the conclusions that emerge from these reports to both improve the 'internal' system (house-by-house and disability services more broadly), and to influence the broader 'external' system that needs to know and care about standards of support, services and care for people who rely on these services to live their lives.

Community supports and services do need to be informed of the inadequacy of current approaches to inclusion of people with a disability. They need to be informed about the lack of healthcare for people with a disability, the need to enable community inclusion through active engagement by people with a disability in their communities and addressing issues of ageing for people with a disability as a community issue and a disability issue. Likewise, the internal system cannot continue to ignore poor standards of housing, lack of access to shared supported accommodation, the inappropriateness of institutional and other congregate-care models, incompatibility of residents and lack of individualised supports.

Ongoing themes put forward in these reports are:

- advocacy for deinstitutionalisation and the closure of all residential institutions and congregate-care facilities
- the need to cease practices that enable houses to be locked environments and to improve supports so people can live safely and freely in their homes
- improved healthcare planning, in particular for people who are ageing with an intellectual disability
- consistent approaches to individualised planning and implementation of plans by trained and competent staff using best practice support approaches
- attention to abuse and neglect and reporting of abuse and neglect in residential facilities
- development of more long-term shared supported accommodation places with concurrent development of out-of-home respite facilities

1.2 Mental Health

Community Visitors are appointed under the Mental Health Act, to visit a wide range of residential facilities that provide 24-hour nursing care for people with a mental illness. These include: acute care units, mother and baby units, forensic psychiatry units, community care units and residential services for aged persons with a mental illness.

The goals of the Community Visitors have remained consistent over the five-year reporting period. They are drawn directly from the functions of the Community Visitors as described in Table 1.

Mental Health Community Visitor annual reports: 2003 – 2007

Reform has occurred in mental health policy, and service delivery, since the 1960s with the most intensive period of reform, including deinstitutionalisation, occurring in the 1990s. By the mid 1990s, stand-alone psychiatric institutions had closed, and been replaced by mental health inpatient services, co-located within: general hospitals, community-based systems of clinical assessment, treatment and care and non-government support services.

Much critical examination of mental healthcare, both nationally and statewide, has occurred over the past few years as mental health issues have gained prominence as a political issue. Commencing with the Mental Health Council of Australia's *Not for Service* report in 2005, which documented the widespread experience of injustice and despair experienced by people with a mental illness, numerous reports have been written about the failure of governments in the process of deinstitutionalisation, to provide an adequate investment to support people with a mental illness living in the community.

In Victoria, as in other states, there has been a heightened debate, and policy response, to the growing crisis in mental health. In addition to the enormous personal and social cost to individuals, their families and communities, the economic impact of mental illness is said to be around \$5.2billion annually in Victoria (Boston Consulting, 2006).

There is a recurring theme in the advocacy sector, that the shift from institutional psychiatric care to deinstitutionalisation has had serious pitfalls. OPA has frequently expressed concerns about the lack of accessibility and responsiveness of the public mental health system. OPA made multiple submissions to Victorian and national inquiries and reviews on these issues. These recommendations are strongly based on the recommendations made from the observations and reports of the Community Visitors Program. It is clear from Community Visitor reports that in the move to community-based, mental healthcare, there have been significant shortfalls in government funding commitments in the areas of bed-based care (both step-up and step-down), and in community-based accommodation and support.

Shortages of bed-based care have left consumers unable to access the care they need at the time they need it. In addition, shortages of community-based accommodation and support have resulted in limited discharge options for consumers of bed-based services. The system also has problems with continuity of care, and security of accommodation and support. Staffing shortages have resulted in services being unable to provide the level and type of care required, particularly in rural areas. There are

shortages of psychiatrists, nurses and allied health staff. Gaps in support for consumers with dual disabilities, and complex needs, were also identified in the reports.

The 2003 to 2007 reporting period was an important period in relation to mental health policy and legislation, with the following notable developments:

- In 2004, amendments were made to the Mental Health Act providing for more stringent protocols for involuntary treatment orders.
- The Prevention and Recovery Care Program (PARC) was piloted in 2004, and new programs funded. These included, the Multiple and Complex Needs Initiative (MACNI) and the Integrated Rehabilitation and Recovery Care Program (IRRCP) for long-stay consumers in Community Care Units (CCU) and Secure Extended Care Units (SECU).
- Policy reviews were completed at the federal and state levels, by both government and Community Service Organisations.
- The Senate Select Committee final report, *A National Approach to Mental Health – from crisis to community* (2005) illustrated the extent of the crisis in mental health, resulting in the *National Action Plan on Mental Health 2006-2011*. The subsequent 2006 Council of Australian Governments (COAG) planning led to significant state and federal funding commitments (\$1.8 billion dollars from the Commonwealth and a further \$170 million over five years from the Victorian Government).

Main themes

During the 2003 to 2007 period, Community Visitors made recommendations that demonstrated a strong link between their direct experience in the field, and the policy, program and service developments occurring in Victoria.

Inpatient bed shortages

Large numbers of mental health hospital beds were closed during the rapid period of deinstitutionalisation in Victoria in the 1990s. In 2002, after the closure of large institutions including Laurundel, Mont Park, and J Ward at Ararat prison, there were 1965 beds in the mental health service system compared to 3560 beds mentioned in the first annual report in 1988 (Community Visitor annual report 2003). By 2004/05, there were 1160 inpatient beds in the Victorian mental health system.

Community Visitors have reported critical inpatient bed shortages every year since 2003 in the areas of acute and sub-acute care, and in secure extended care. They report that bed shortages impact on individuals, their families and on the system as a whole. Around 65 per cent of funded mental health beds are inpatient beds (including SECUs, acute, and specialist beds), while the rest, around 35 per cent, are community-based beds (including CCUs, PDRS and PARC beds) (Boston Consulting Group, 2006).

Community Visitors report that there are not enough acute beds in the system to meet demand. Annual reports over the 2003-07 period show that the impact of acute bed shortages on consumers and the system as a whole has been unremitting. These shortages have resulted in consequences such as: premature discharge, people being

kept in general hospital wards or emergency departments for extended periods of time, people in crisis not being able to gain admission, and the locking of wards due to limited numbers of high dependency beds in acute units.

Secure Extended Care Units (SECUs) were established between 1995 and 1999 within mainstream public hospitals and were built to replace locked institutional wards. They provide intensive treatment and support for consumers with unremitting and severe symptomology of behavioural disturbance that inhibits their ability to live in the community. SECUs provide a critical discharge point for high-risk consumers in acute units who require longer-term care (DHS, 2008).

There is a chronic shortage of SECU beds across the system, the impact of which has been consistently reported by Community Visitors, since 2002/03. In 2003 and 2004, Community Visitors reported delays in accessing SECUs due to limited beds. In 2005, Community Visitors reported patients waiting in acute units for long periods of time awaiting access to a SECU. In 2006, they reported that there were significant waiting lists of people needing to be transferred from acute units to SECU units in the Hume, Southern and Barwon South West regions and at Austin Health.

Community Visitors have noted that in rural areas, where there are limited or no SECU beds, the situation is critical. In Barwon South West for example, Community Visitors reported long delays for patients in acute units awaiting discharge, with examples of patients remaining in acute units for more than eight months (OPA, 2007b).

Community-based accommodation and support discharge options

The 1993 report from the National Inquiry into the Human Rights of People with Mental Illness (Burdekin, HREOC 1993) stated that “the policy of deinstitutionalising psychiatric patients or of not hospitalising them in the first place was conceived in the belief that most people with a mental illness would be better off living and being treated in the community”, however, there was little evidence that a commensurate commitment to resourcing had occurred.

There is evidence today, as there was fifteen years ago, that the closure of psychiatric facilities has not gone hand-in-hand with an adequate expansion of community-based accommodation and support. The National Mental Health inquiry raised this as a key issue again in 2006. Housing continued to be on the priority list across jurisdictions in a follow-up inquiry in 2008.

The shortage of accommodation, and community-based services, is arguably one of the biggest obstacles to quality of life for people with a mental illness, and has been a key issue reported by Community Visitors since 1999. Such shortages have had a range of consequences for consumers, their families, and on the inpatient system as a whole.

From 2003 to 2007, Community Visitors reported that throughput in acute, CCU and SECU settings, was impeded by a lack of community-based accommodation, and support discharge options. Patients are being detained in mental health units for longer periods than necessary, often in restrictive care settings, while they wait for suitable community-based discharge options to become available.

In other cases, people are being discharged into inappropriate accommodation, with inadequate support, including rooming houses, caravan parks and supported residential services.

Community Visitors also report a lack of community-based accommodation and support models (e.g. PARC) that provide a 'step-up' option for patients living at home who are unable to gain, or unwilling to seek, admission to acute care. The result is, people with a mental illness being left without the support they need, at a critical stage in their illness.

In April 2004, Community Visitors in four regions undertook an accommodation needs 'snapshot', asking facility managers to identify how many people could be discharged if suitable accommodation options were available; 77 people were identified. Following this, a more focussed data collection project was undertaken in 2007 that identified a serious lack of accommodation options for patients with specific care and accommodation needs. Community Visitors found 60 patients who had completed their treatment, but were unable to be discharged, due to blockages in the system caused by insufficient community accommodation, and support discharge options.

Services for people with dual disability and complex needs

In 2003, several groups of consumers with specialist needs, that were not being catered for in mental health units, were identified. They were: young people with acquired brain injuries occupying beds in aged-care facilities: people with a dual disability (intellectual disability and mental illness) living in mental health units long after their treatment is complete, people with mental health issues under 65 years of age living in aged-care facilities because their needs cannot be met by existing programs, people living in acute wards who require secure extended care or aged residential care.

These issues continued to be reported from 2003 to 2007. Reports have included that people with intellectual disabilities whose mental health has been stabilised, continuing to occupy mental health beds for extended periods of time. For example, one patient spent 180 days in an adult acute inpatient unit, because DHS's Disability Services Division was unable to provide a placement in a community residential unit.

In 2005, people with dual diagnoses and complex needs were again highlighted as needing additional support. The focus of recommendations was on limited coordinated service provision. The annual report stated that:

Community Visitors have remained concerned that clients with multiple and complex needs cannot access appropriate accommodation or services and remain inappropriately placed in acute or long-term psychiatric units for unacceptable periods of time.....there is limited evidence of cooperation between mental health services and relevant service providers to progress the provision of services and accommodation for these clients. (OPA, 2005b, p 5)

This theme continued in 2006 and 2007 with Community Visitors focussing on the need for cross-sectoral partnerships between disability services and mental health services. In 2006, Community visitors recommended:

The extension of the coordinated and cooperative approach to the provision of services to those with a dual disability and complex needs, particularly in fostering effective partnerships between Disability Services and the Mental Health Branch within the Department of Human Services. (OPA, 2006b, p 2)

In the mid 2000s, the Victorian government funded several programs that utilised cross-department collaboration to address the needs of people with complex needs and dual diagnoses³. In 2007, Community Visitors recommended increased funding for two of these programs, the Multiple and Complex Needs Initiative (MACNI) and Integrated Rehabilitation and Recovery Care Program (IRRCP).

Discharge practice and planning

Discharge planning and hospital discharge practice is determined by individual healthcare service policy and practice. Such policy is guided by the National Standards for Mental Health Services (1996)⁴ and the Office of the Chief Psychiatrist guidelines for discharge planning (2002). The Chief Psychiatrist guidelines promote collaborative discharge planning, and recommend that discharge planning is formalised at the time of entry to the service with input from consumers and carers.

In practice, there is pressure on hospitals to discharge patients back into the community as soon as treatment is complete. Community Visitor reports suggest that discharge is often poorly coordinated, and that medical staff do not adequately consult with consumers, families and carers.

DHS reported in 2008 that a high proportion of people with mental illness admitted to adult acute inpatient units (31 per cent) did not have contact with a public specialist mental health service within the seven days post-admission (DHS 2008). Further, “some people who leave an acute inpatient unit are discharged into a state of homelessness” (DHS, 2008 p.97). Discharge planning and post-discharge care are critical factors that impact on a person’s recovery and, where not planned well, can lead to deterioration in health and the requirement for further hospital admissions.

The Community Visitor reports, 2003-07, highlight poor discharge-planning practice including inadequate discussion with families and carers and inappropriate and early discharge of patients. In 2004, Community Visitors called on the Government to:

‘Substantially improve discharge practices to better involve community agencies and general practitioners and to promote the active participation of consumers and carers in the planning process’ (OPA, 2004b p.5)

The issue was also referred to by Community Visitors in relation to a 2004 Coroner’s report that recommended that GPs, family and friends should be consulted during the

³ The Victorian Dual Disability Service (VDDS), the Multiple and Complex Needs Initiative (MACNI), the Dual Diagnosis Initiative, the Community Brain Disorders Assessment and Treatment Service (CBDATS), and the Integrated Rehabilitation and Recovery Care (IRRCP) all aim to support clients more effectively by overcoming the silo approach among and within departments (e.g. mental health, disability services, alcohol and drug services).

⁴ These standards were reviewed by the federal Department of Health and Ageing in 2008 and the new standards are awaiting national endorsement.

preparation of discharge plans. The need for more frequent communication between relevant parties was also emphasised (OPA, 2004b).

In 2005, DHS released a publication on discharge planning protocols between Area Mental Health Services (AMHS) and GPs. Following this, DHS funded additional clinicians in each AMHS to assist in the improvement of discharge-planning processes. Community Visitors did not report any specific findings in relation to the impact of these projects. However, in 2006 the Community Visitor annual report noted that discharge-planning processes had changed at Frankston and Dandenong hospitals, and that staff had reported better bed availability and fewer delays in emergency departments as a result.

In 2007, Community Visitors reported on an integrated discharge planning model being trialled in one AMHS between the hospital and a PDRS service. This program was highly commended in the 2008 Minister's Award for outstanding achievement by a team in mental healthcare.

Improvements in discharge planning have been recommended and highlighted by the Community Visitor annual reports from 2003 to 2007. These recommendations highlight the importance of follow-up after acute inpatient care, and the need for this to be planned, and provided, by appropriate community-based services.

It is expected that further policy development around discharge planning will occur at a national level following the COAG recommendation for discharge follow up for patients. It will be easier to measure improvements in this area in the future as the National Action Plan on Mental Health has an indicator relating to this issue.

Staffing issues

Community Visitors have continuously identified shortages of professional staff in mental health services, including shortages of nurses, allied health professionals and psychiatrists.

In 2003, DHS commenced a comprehensive workforce plan, which involved a workforce survey and development of strategies such as re-entry courses, scholarships and refresher courses. Community Visitors reported that DHS also made efforts to attract staff from overseas and offered initiatives such as graduate programs, to address these staff shortages. However, shortages of nursing staff and psychiatrists, and long delays in filling vacancies, continue to be reported in some country hospitals and nursing homes. In particular, Community Visitor reports note shortages of social workers and occupational therapists.

In 2005, difficulties in recruitment, and retention of professional staff, continued to be reported across the state. In rural areas such as Warrnambool, Bendigo and Mildura, Community Visitors reported that hospitals had been unable to appoint psychiatrists to vacant positions. In 2006, Community Visitors recommended that urgent action be taken to address the shortage of psychiatrists in rural regions, and find effective ways to attract and retain skilled staff. There were examples of long delays in filling vacancies for an occupational therapist and a psychologist, in one region.

Community Visitors reported that shortages had hindered the opportunity for therapeutic programs for some patients which resulted in beds being unavailable for longer periods. For example, at the Maroondah Hospital adolescent units, and in the Southern Metropolitan region, there were bed closures for two months due to staff shortages.

In 2007, despite the recruitment initiatives of the Victorian Government, there continued to be shortages of professional and allied healthcare staff. Community Visitors reported long delays in recruitments to key staffing positions, and recommended a continuation and extension of the current initiatives, to increase the number of psychiatric, allied health, and nursing staff.

DHS responded to Community Visitors' concerns about psychiatric workforce issues in their 2006 and 2007 reports by reiterating that there were a number of initiatives in place to attract and retain staff, both in metropolitan and regional centres.

The need to build a sustainable workforce in mental health in Victoria is acknowledged as an important part of the mental health reforms (DHS, 2008). A whole chapter is devoted to discussion of the impact of the current shortages on services for people with mental illness. Further initiatives to address this ongoing problem are, therefore, expected in the immediate future.

Cleaning, maintenance and refurbishment

Community Visitors have been reporting concerns about maintenance and cleaning since 1998. They are the most commonly reported issues (44 per cent of issues raised by Community Visitors in 2006/07 were related to maintenance). Issues include: delays in maintenance and cleaning, compliance with standards relating to conditions inside and outside units, health and safety hazards, inadequate facilities and problems with design.

From 2003, Community Visitors reported delays in maintenance services, and long delays for the refurbishment of buildings. In response, DHS was reported to have conducted an audit of facilities which was expected to help determine cleaning and maintenance priorities. In 2004, Community Visitors made positive reports about the general improvements in cleaning and maintenance, the refurbishment of some facilities, and attention to maintenance issues in some regions where problems had been identified. However, there continued to be problems with ongoing maintenance.

In 2005, maintenance and cleaning deficits were attributed to funding shortfalls, as well as inadequacies in original design, or changed use of facilities. Community Visitors reported that work needed to be carried out which included repainting, renovations and replacement of poorly maintained furniture and floor coverings. It was reported that some maintenance issues dated back to 2002. In 2006, Community Visitors reported that new units were being built and there had been significant improvements to units across the state.

However, inadequacies and problems with the design and fabric and safety of some units, and maintenance issues, maintained a high profile through 2006 and in 2007. Community Visitors wrote that, significant delays in maintenance continued to be a

disturbing trend in some of the state's major metropolitan hospitals providing mental health services. They reported that the overall program of maintenance is variable, with improvements in maintenance and improved facilities in some areas with other areas having unacceptable, poorly maintained buildings.

Mental Health Summary

The overview of Community Visitor findings for the five-year period 2002/03 – 2006/07 portrays a mental health system that, despite the closure of the remaining large institutions in 2002, continues to be under-resourced in relation to demand. Victoria's mental health service system, while recognised as one of the better-serviced mental health systems in Australia, has not yet been able to realign itself to provide either a satisfactory clinical response to acute mental illness, or adequate support and accommodation for people with a chronic mental illness, living in the community.

Evidence suggests that despite the 1993 Burdekin Report and all efforts since, there continue to be huge gaps between what is required of the mental health service system, and what is provided. The most endemic and costly of all issues consistently reported by Community Visitors are shortages in inpatient beds, and shortages in community-based accommodation and support. The ongoing presence of these issues, results in a system which is almost permanently in crisis and is unable to meet consumer need.

Despite the gloomy picture painted by the obvious systemic gaps in the mental health system, there have been many gains in this five-year period. Community Visitors have had a hand in these, including: the opening of the new Austin Health facility in 2006 after many years of reporting the inadequacy of the previous facility on the Austin Repatriation site; the introduction of the Prevention and Recovery Care (PARC) initiative; and the Integrated Rehabilitation and Recovery Project. Appropriate funding is still needed to realise the aims of this project, however, these initiatives do indicate a positive direction in mental health services. Community Visitors have also welcomed large injections of capital funding in some areas, although there are still significant gaps (e.g. shortfalls in the number of SECU beds and rural bed shortages).

There have been gains in the areas of staffing, maintenance and discharge planning, both in relation to government policy direction and the way services 'on the ground' have responded to Community Visitor requests. The reporting of these issues demonstrates that, while in some ways it is, 'two steps forward, one step back', Community Visitors do have an important role to play in reporting issues so they can be raised, in some instances addressed, and often raised again. This cycle helps to drive and inform the mental health reform agenda.

One area where it was expected there would be more reporting by Community Visitors, was in relation to breaches of the Mental Health Act. In December 2004, the Act was amended to include a requirement for treatment plans to be developed for each patient, yet Community Visitors did not report on this issue. In general, it would be interesting to see more reporting around human rights issues and the compliance of mental health services with the Act.

Victoria is currently reviewing the Mental Health Act to ensure compliance with the new Victorian *Charter of Human Rights and Responsibilities* and with Australia's international human rights obligations. The new Act is expected to be operational in 2010. The Community Visitors program will need to be prepared for any additional monitoring in relation to compliance with the Act, as well as any new functions assigned to the Community Visitors' role.

Another policy development in mental health will occur with the imminent release of the Victorian Government's findings from the mental health reform strategy consultations, held in 2008. A new set of policies, principles and funding commitments to guide mental health service delivery for the next decade, are anticipated. It will be important for the Community Visitor Program to have input into and monitor the impact of these reforms, as well as monitoring the implementation of the *National Mental Health Plan*.

1.3 Health Services

In the five years 2003–2007, the sector-wide decline in Supported Residential Service (SRS) beds, which began in the mid-nineties, continued. The sector lost more than 500 beds in this period, down to around 6400 beds in June 2007. Factors contributing to the decline included increased government funding to Home and Community Care (HACC) services that enabled older people and people with a disability to remain at home longer, thereby decreasing demand, and increasing business costs to SRSs as a result of increased regulation and increased complexity of resident needs.

Another longer-term trend that continued over this period was the increasing concentration of younger residents (younger than 60 years) with complex needs in pension-level SRSs, including a fast-increasing proportion of residents with a mental health disability. Each Community Visitor annual report in this period has discussed these changes in the SRS client group and the impact on the sector's capacity to meet the needs of residents (due to the differences in cost of supporting low-care, frail elderly residents compared to those with more complex needs). Community Visitor annual reports state that many of these residents came to SRSs as the result of the closure of institutions for people with an intellectual disability or mental illness – which occurred from the 1980s onwards (2003c, p.15).

Government has stepped up its regulatory role over the period: amending and strengthening the Act and more actively prosecuting proprietors for breaches. The *Health Services (Supported Residential Services) Regulations 2001*, which provide guidance on minimum standards of resident care, supervision and staffing, and other areas, were in place at the start of this review period. The most significant changes to the legislation and regulations affecting SRSs in this period came into effect in January 2005, and included a number of issues that Community Visitors had consistently been calling on government to address. In particular, the regulations were changed to strengthen controls relating to resident finances, residential statements and staffing, as well as to add two new sections addressing resident care plans.

Alongside regulatory and legislative change during this period, government introduced a pilot project to support financial viability and improve services provided to residents, the Supported Accommodation for Vulnerable Victorians Initiative (SAVVI). This was announced in the 2006 budget but not rolled out until late 2007. Community Visitors applauded this initiative but pressed for evaluation of the initiative and speedy implementation.

Health Services Community Visitor annual reports: 2003—2007

In 2003, Health Services Community Visitors made 1652 visits to SRSs, which then had approximately 7000 registered beds. The number of registered beds in the SRS sector decreased to around 6400 by 2007. Reflecting this long-term decline in beds (and facilities) across the sector, Community Visitors undertook fewer visits than in previous years: 1279 visits in 2007.

Community Visitor functions are specified by the Health Services Act: in brief, to inquire into accommodation standards, resident welfare and wellbeing, adequacy of recreation and other opportunities for residents, resident complaints (since 2005), and compliance with the principles and specifics of the Health Services Act. These functions guide the sorts of issues raised in the annual reports, but have not dictated the structure of reporting. Community Visitors have used the annual reports to spell out some broad sectoral issues and recommend regulatory funding or other responses from government. Some examples of their focus during this period include complaints about lack of support and appropriate accommodation options for people with a mental illness – who are increasingly ending up in SRSs without rehabilitation opportunities or case management, and concerns about facility capacity to provide ‘home-like’ environments.

There was much consistency and overlap in the issues raised in the annual reports over the five-year period. These themes are presented in the following section

Main themes

Provision of residential support services (for people with complex needs)

Community Visitors have consistently identified serious inadequacies in accommodation and support options for people with complex care and support needs. In each of the years 2003–2007, the reports included recommendations to increase the accommodation options for this group. The situation is particularly concerning for people with complex needs and limited incomes.

In the 2003 annual report, Community Visitors referred to research that indicated bed shortages in hostels and nursing homes as well as in mental health facilities. They stated their concern at the inappropriate placements of people with mental illness or dementia in SRSs which are not able to meet their support needs (p.36). The situation had not improved by 2007, with Community Visitors reporting a need for “more funded facilities with staff who have the training and experience to support residents at the ‘hard end’ of the system” (p.17). Pension-level facilities struggled to cope with increasing numbers of residents with a mental illness, acquired brain injury, intellectual disability or dementia.

The dominant issues and concerns of Community Visitors presented below, including those about staffing and safety, provide support to Visitors’ assertion that pension-level SRSs are often ill-equipped to meet the needs of people with multiple and complex care and support needs.

Community Visitors have identified some well-used pathways into SRSs that highlight gaps in supported accommodation options. For example, health and community service workers indicated that they are forced to place their clients from prison or hospital into pension-level SRSs not because they best meet the person's needs but because "there is nowhere else [they] can afford to live" (OPA, 2005c, p.17). SRSs have filled a gap in the provision of interim or transitional care for people discharged from hospital. In 2005, Community Visitors reported concerns about the impact on other residents of the presence of transient/short-stay residents in hospital leased beds in SRSs (p.17); DHS subsequently introduced regulations about this type of service.

By reporting on emerging trends, like changing service models or whether the needs of new or growing resident groups are being met by SRSs, Community Visitors have helped government identify areas for policy development to protect the sector's vulnerable residents.

Financial viability of pension-level facilities

The majority of the concerns reported by Community Visitors in the Annual Reports relate to pension-level facilities⁵. This is because, although pension-level SRSs are covered under the same legislation and regulations as other SRSs, the client group and the financial capacity to achieve acceptable standards of care are very different. In pension-plus facilities many residents can pay more than double the pension-level fees and residents experience much lower rates of mental illness and intellectual disability (DHS, 2004).

Residents in pension-plus facilities do not complain to Community Visitors as often as people in pension-level facilities about boredom and lack of social activities (OPA, 2006c, p.11). Nor do Community Visitors raise as many serious concerns about building fabric, maintenance and cleanliness, building design or food quality or quantity as they do in pension-level facilities.

Community Visitors recognised that many proprietors of pension-level facilities struggle with the additional expenses of supporting people with complex needs as well as the increasing costs of leasing property in the inner suburbs. They expressed concerns about the potential impact on vulnerable residents of facility closures – government subsequently introduced procedures to minimise disruption and provide support to residents forced to relocate by facility closures.

Community Visitors welcomed the government's SAVVI and the pilot that preceded it, which were both designed to promote the financial viability of pension-level facilities. They identified positive changes in participating facilities resulting from this initiative. Community Visitors made three recommendations relating to this financial support from government to support residents of pension-level SRSs (in 2004, 2005 and 2007). While these recommendations were based on the Community Visitors' concerns about the financial viability of pension-level facilities and the unmet support needs of a number of their residents, the recommendations were tailored to enhance existing or proposed DHS project and funding initiatives.

⁵ Facilities classified as 'pension-level' are those that charge at least 80 per cent of their residents fees less than or equal to the disability allowance plus rent assistance.

Appropriateness of residential services

The Health Services Act sets out eight principles governing SRSs; the second principle states that “residents should be provided with a sufficient level of nutrition, warmth, clothing and shelter in a home-like environment” (Section 10(b)). Community Visitors have consistently reported concerns in relation to these criteria and other factors that they say impact on a ‘home-like’ environment (for example, providing transitional care that increases resident turnover). It is important to note that while there are facilities that have not been the subject of Community Visitor concerns, pension-level facilities have featured more frequently due to the poorer quality of building stock involved (more difficult to heat and keep clean). Resident complaints about the quality and quantity of food provided in some facilities were reported frequently.

Aside from the many maintenance, health and safety, and cleaning issues that Community Visitors have identified and seen addressed over the years, Community Visitors have raised a range of other issues that impinge on the provision of a ‘home-like’ environment. The annual reports present examples of institutional practices in certain facilities: evening meals served at 5pm or earlier; residents locked out of their rooms during the day; residents not permitted to go out in the evening; residents having no input to the menu. Residents can have difficulty protecting their right to privacy because of facility design: many pension-level facilities have shared bedrooms and some have nowhere to make private phone calls (OPA, 2005c, p.36).

Two other basic rights that should be satisfied in the provision of a ‘home-like’ environment are tenancy rights and safety (discussed below). Community Visitors made three recommendations about tenancy rights for residents in the five-year period. These recommendations likely contributed to a gain for residents with the strengthened regulations about residential statements that came into force in early 2005.

To improve the circumstances of residents, Community Visitors have called for more consistency and rigour in DHS monitoring and regulation practices. In recent years, Community Visitors have noted increased action and have commended DHS for successful prosecutions of proprietors for breaching the Act.

Inclusion and participation opportunities

Across the years 2003–2007, annual reports comment on the social isolation and boredom experienced by SRS residents who live in pension-level facilities. This situation contrasts with pension-plus facilities that often run a range of activities, day trips and even holidays. Pension-level residents are isolated by their lack of disposable income and disconnection from community-based recreation activities. Many residents also lack the necessary support to enable them to participate in community activities. Community Visitors note that young, energetic residents, in particular, complain about boredom, and when this issue is raised with proprietors they say they cannot afford to offer more activities.

Because residents of pension-level facilities pay up to 100 per cent of their government allowance in fees to the proprietor, they often have less than \$2.50 to spend a day. This makes residents very reliant on free activities and free transport to allow them to access community engagement opportunities.

Over this period, the government has helped to mitigate resident isolation in two main ways. The Community Connections Program that was established in 1999 has provided support workers across all DHS regions to help isolated residents. The second stage of the SAVVI will contribute to improving social supports and activities available to residents (2007, p.24). Community Visitors also recognise the work of community service organisations and some local governments in this area.

Nevertheless, isolation of residents has continued to be an issue and Community Visitors have twice recommended that government continue to explore ways to promote links between SRS residents and the local community (OPA, 2005c; 2006c).

Resident safety

Community Visitors have raised many concerns relating to resident safety in this period, with particular focus given to fire safety in their recommendations. Other serious safety concerns relate to reports of abuse by staff; the toxic mix of residents in certain facilities that results in assaults and verbal altercations; and residents who do not want to leave their rooms (especially at night) because they do not feel safe.

Because of these concerns, Community Visitors have advocated for the introduction of 'upright' (active) night staff, for fire safety/emergency management training for proprietors, and for controls around the staff who are allowed to work with this vulnerable resident group. Community Visitors have made gains in a number of facilities through advocacy about improvements to food safety and, in particular, safety hazards like hot water temperature and unlocked medicine cabinets.

In the 2007 annual report, Community Visitors reiterated their concerns about fire safety in SRSs; further noting "Action on this issue has been slow and resident lives are at risk" (OPA, 2007c, p.20). While there was insufficient action within this five-year period, the government had previously mandated the installation of sprinkler systems. Between 2003 and 2007, the government established, and subsequently withdrew from, an emergency management working group in Greater Dandenong. In 2008, the department began providing emergency management training to SRS proprietors.

Staffing

In three of the five years, Community Visitors made recommendations relating to staffing. Community Visitors are concerned that there are not enough staff in some facilities to respond to resident needs, and that often staff are not adequately trained or experienced enough to cope with residents with complex needs (for example, self-harm incidents). These concerns apply most frequently to pension-level SRSs where people with mental health problems and other complex needs are more likely to reside.

While the *Health Services (Supported Residential Services) Regulations 2001* specified that a personal care coordinator must be employed for at least 38 hours per week, and have at least a Certificate III in aged care or personal care (or certified equivalent), Community Visitors remained concerned about the lack of minimum training requirements for other SRS staff and night attendants. In 2004, Government made changes to the Regulations and the Act that were intended to strengthen controls on minimum staff requirements and staff qualities. Community Visitors welcomed

these changes but continued to advocate for further controls on minimum staff training to improve care for vulnerable residents.

Integrated provision of services

Community Visitors have reported that not all SRSs are successfully meeting the care needs (personal, health, psychological) of their residents. Pension-level SRSs often find it difficult to meet the needs of vulnerable residents, having little financial capacity to employ extra staff. Hence, more integrated provision of services, including outreach services that facilitate resident access to physiotherapy, speech therapy or other services would contribute to resident wellbeing.

While Community Visitors made few specific recommendations regarding service provision integration⁶, comments on the benefits of good service integration as well as the lack of service integration and access for many residents run through the annual reports.

Community Visitors raised a number of concerns during this period that had implications for service provision to SRS residents. These included inappropriate placements of people in SRSs that did not meet their needs (and were not linked up with external services), caseworkers who were too overworked to check on their clients' wellbeing, and lack of follow-up from mental health services for residents discharged from mental health facilities.

As well as advocating for individuals including helping people gain access to caseworkers and other services, Community Visitors have been promoting the use of referral papers for residents discharged from mental health facilities and hospitals. These papers help SRS proprietors understand the care needs of new residents and are a first step towards meeting residents' needs.

Health Services summary

Analysis of the Community Visitor annual reports over the five-year period shows that the range of issues raised is very consistent, which was to be expected given the Community Visitor functions in the Act did not change (apart from a stronger provision for Community Visitors to follow up on resident complaints). This does not mean that there have been no gains for SRS residents over the period, with amendments to the Act and the regulations governing SRSs in 2004 and increased government vigilance and prosecutions of proprietors for breaches of minimum standards. Community Visitors have played an important role in getting SRS issues heard in parliament as well pushing for prosecutions of proprietors not fulfilling their duty of care. One example of the potential impact of annual reports was the citing of the Community Visitor annual report (OPA, 2007c) in the lead up to the establishment of the current Parliamentary Inquiry into Supported Accommodation for people with a disability or mental illness.

Analysis also shows that the recommendations published in the annual reports can be an opportunity to suggest improvements to a current government project or initiative

⁶ "That all relevant divisions of the Department of Human Services work together to address the accommodation and support needs of people with disabilities – many of whom are currently accommodated within the pension-level SRS sector ..." (2003, p. 9)

based on their knowledge of the sector, as was the case with SAVVI and the pilot project that preceded it. Other issues raised in annual reports may not yet have elicited government interest: for example, the impact of transitional care provision on existing SRS residents.

Part Two – Common themes: disability rights as human rights

Analysis of the annual reports from the three streams of the Community Visitor Program finds a number of common themes and issues. These are summarised in this section and discussed with reference to the rights-based framework provided by the convention. (UN, 2006).

The convention provides the opportunity to articulate the experiences of people with a disability through a unified statement of rights. Chair of the Ad Hoc Committee on the convention, Don MacKay, notes in his foreword to a Queensland advocacy paper on the development of human rights indicators:

Ultimately, rights are guaranteed, maintained and strengthened through being used. That requires awareness, and knowledge, and determination. (QAI, 2007 p. 8).

The Community Visitor annual reports are normally seen and responded to within the Community Visitor Program context, its legislative context, and the broader Victorian disability and mental health service system context. The discussion that follows attempts to place the findings, recommendations and issues that they report within a human rights and disability rights context. This approach re-focuses the issues on the lives of people with a disability and their rights to equal opportunities with other members of society. The convention preamble notes that it reaffirms:

The universality, indivisibility, interdependence and interrelatedness of all human rights and fundamental freedoms and the need for persons with disabilities to be guaranteed their full enjoyment without discrimination (UN, 2006)

The analysis of the Community Visitor annual reports indicates that the core role of the program is to observe and report on the rights of people who use these services. These rights are articulated within the legislation that governs these services:

Persons with disabilities have the same rights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities (*Disability Act 2006*, s 5 (a))

This section of the Disability Act goes on to outline some of these rights including; respect for human worth and dignity and the right to live free from abuse, neglect and exploitation and to exercise control over one's life.

In addition, the legislation lists eighteen principles for disability services providing a clear framework for how they can meet these rights including: be flexible and responsive to the individual needs of persons with a disability, be designed and provided in a manner that recognises different models of practice that may be required for different people, and be provided in a way which reasonably balances safety with the rights of persons with a disability.

The Mental Health Act provides a similar rights-based framework for the treatment and care of people with a mental illness; people with a mental illness should be provided with timely and high quality treatment, treatment and care should be

provided by appropriately qualified people and within a multi-disciplinary framework and the provision of treatment and care for people with a mental disorder should promote and assist self reliance (s 6A).

In Health Services, the rights of residents are outlined as minimum standards in the Health Services (Supported Residential Services) Regulations. These regulations cover basic needs like nutrition, warmth and clothing and put forward the need for facilities to be 'home like'.

Rights-based legislation has provided a framework for planning, providing and monitoring services for people with a disability for over 20 years in Victoria. Now, through the convention there is a broader, more universal framework that can and should be used to articulate people's rights and advocate for progression of these rights in a way that transcends a 'service provision' framework and 'service user' set of rights.

Common themes

This analysis has found seven common themes across the Community Visitor streams:

- substandard facilities
- an overall shortage of places in residential and treatment facilities for people with disabilities and/or mental illness
- a lack of consistent planning for people using and leaving residential and treatment facilities
- inadequate staffing and a lack of capacity of staff to provide appropriate care, treatment and support
- a systemwide lack of capacity to respond to people with high and complex needs that leads to the use of restrictive practices
- social isolation of people using visited facilities
- high risk to personal safety for people in visited facilities.

These themes indicate that those people who rely on the services provided by these facilities are potentially subject to less favourable life opportunities than people who do not rely on such services.

A central tenet of the UN CRPD and disability discrimination legislation is that people with disabilities should not face inequalities, or less favourable opportunities, than people without disabilities. However, these reports indicate that this is a very likely experience for people relying on the visited services.

The reports indicate that, while government, through funding and service development, has made some progress towards improving outcomes for people using these services, the most basic issues are still not addressed within many facilities. It is not acceptable that people with a disability who use these facilities are living in substandard accommodation, are socially isolated, and are unable to access services that meet their needs, or are unsafe in these facilities.

The five years of Community Visitor annual reports make it clear that the human rights of people with a disability who rely on residential and/or treatment facilities to provide their accommodation and care are under threat.

Progressing the rights of people with disabilities in visited services

OPA, through the Community Visitor annual reports, has an opportunity to advocate for the rights of people with a disability and to articulate these rights as common human rights. The issues identified by the Community Visitor annual reports are about these rights.

The convention read in its entirety makes it clear that such issues as those stated above cannot exist when a signatory state is adhering to the principles and specific articles of the Convention. This Convention provides a useful framework for articulating the issues reported in the Community Visitor annual reports, more broadly than the service-specific perspective currently put forward.

Specific Articles of the convention that provide clarity for such advocacy are:

- Article 28 which states that people with a disability have a right to an adequate standard of living including food, clothing and housing. The Community Visitor annual reports have continuously raised issues about such standards; clearly recommending action to address the poor standards that do exist. These are particularly evident in pension level SRSs where issues relating to nutrition and privacy are regularly reported. While the Community Visitor Program reports across three streams, it is important to note that different standards are not acceptable in different facilities; all people with disabilities regardless of where they reside, have the right, as articulated in the convention, to the same standards of living.
- Article 14 which states that people with a disability have a right to liberty and security and that the existence of a disability cannot justify a deprivation of a liberty. The annual reports reviewed in this paper, all highlight issues where people's liberty is deprived, often due to: lack of resources, inadequate staffing levels and skills, a lack of appropriate accommodation to suit the needs of people with higher support needs, or to meet specific needs. All three areas of the Community Visitor Program report on the lack of appropriate services and supports for people with high and complex needs, in particular, for people with dual disabilities. A common response to this is the placement of people within services that are not equipped to support them adequately. This often leads to increased restrictions on that person's liberty and decreased personal safety.
- Article 19 which states that people with a disability have a right to live in the community, choose where they live, and should not have to live in a particular environment because of their disability. Despite this, the annual reports clearly indicate that people are placed inappropriately which results in increased risk to their safety, decreased opportunities for growth and development, and increased social isolation. Also, that congregate-care facilities that are isolated from the community, need to be closed, and people who move from them need to be adequately supported in the community.
- Article 25 which states that people with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination. However, the lack of appropriate health planning, and inappropriate practices in healthcare, in particular, in larger, congregate placements, is continually reported.

Conclusion

This five-year analysis finds that the most regularly and commonly reported issues by Community Visitors across mental health, health services and disability services is that the physical environments of the visited facilities are substandard. While more salient issues are also reported, it could be argued that all other issues are secondary if the physical environments of these funded and/or regulated services cannot meet community and service specific standards.

The convention states that people with a disability have the right to an adequate standard of living, which includes an adequate standard of housing. While there is no clear definition of what is 'adequate', Community Visitors use their 'community member gaze', and their knowledge of service-specific standards, to determine the quality of the service and supports and to report on these.

The analysis also finds that there are a cluster of issues that are continually reported, and commonly reported across all three areas, that relate to standards of care and treatment. These fall into two categories: operational issues like staffing and funding, and practice issues that relate to the capacity of services and the staff who work in them to provide high level support, treatment and care. The group who seem to be most vulnerable within this system are people with high and complex needs. Their requirements cannot be met by the system that is described in the reports; a system that has significant operational and practice issues.

Community Visitor annual reports do highlight the inadequacy of the government funded and/or regulated residential and/or treatment service system for Victorians with disabilities. This analysis suggests that there are service-wide problems that are threatening the human rights of people with disabilities who rely on these services. It recommends that articulation of these issues within a human rights framework can strengthen the advocacy message of the Community Visitor Program for these Victorians, whose vulnerabilities are increased by virtue of their reliance on these services.

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