

# **Office of the Public Advocate Community Visitors Program**

**CONFERENCE  
8 June 2007**

**Closing Address by Ron Tiffen Manager, Community-Based Programs.**

## **VISION, VOICE and VOLUNTEERS *Thoughts on the future for the Community Visitors program***

Today we celebrated 20 years of achievement. We took the opportunity to focus on the positives.

While there have been many improvements in the facilities and service system, we know there is room for much improvement.

I believe we are on the right course and should not make changes for the sake of change. We will however continually seek to improve how we work to better achieve results.

I am keen to identify a particular emphasis and purpose in our future inquiry, reporting and advocacy. My aim here is to link our mission to significant changes in policy and resourcing as I see them. The changes may affect the people we represent and therefore raise important issues for us to consider as we go forward.

A detailed plan for the future will emerge later in the year and through a process of consultation with the new Boards. Together we will revise the CVP strategic plan.

The ideas I outline here will go into the mix with the Boards, you the volunteers, Unit staff and selected stakeholders.

The themes I have chosen to arrange the ideas are:

- Vision
- Voice and
- Volunteers.

**Vision – Community Visitors working as a Community of Champions,  
Promoting understanding and opportunity for people with a  
disability**

You have championed much change to date. I believe the opportunities for further change will be different in the next stage of our work. The residents and patients we represent will need even stronger champions to bring about the next set of changes we want to see realised.

### **Institutional Change – Our mission to date**

In this our 20<sup>th</sup> year, we celebrate the closure of Kew Residential Services (KRS). There are two smaller institutions in the disability stream one currently being considered for closure but the significance of the KRS closure is profound for all streams of our program.

It signals the end of a history of large-scale institutions in the mental health and disability field in Victoria.

The genesis of our program came from the institutional systems in mental health and disability. There were Inspectors and Official Visitors in various institutions. Today's CVP was created in the wake of the 1986 platform of legislation, which was about deinstitutionalisation. There was a sense of major reform and uncertainty. Our program was an early quality assurance mechanism and much more.

The CVP of 1987 was designed as an evolution of the official visitors and purposely joined with OPA to provide a function of advocacy. The first Annual report of OPA (1988) reflects the mission of the (then) new Community Visitors program with the heading:

### **Community Visitors as Agents of Change**

The annual report includes the following quote from a panel report of a particular facility:

“As community visitors we know these people (the residents) well. We do not deny their disabilities or underestimate the problems of adjustment they will have. We do not see community living as a panacea. We believe, however, that while life outside may go well or badly, depending on how vigorous a commitment comes from the government and the community, life inside has no possibility at all. It cannot be right for a person to be fed, clothed, sheltered, and left like a penned ox for sixty years. The waste of human lives....is immoral. The Centre cannot be salvaged”<sup>1</sup>

In the 1980s, people simply could not access mental health services in many areas and the hospitals lacked a diversity of programs. Most clients registered with Disability Services were in large congregate care facilities.

In 1985, there were 3000 people in large congregate care facilities and 200 people in state auspiced community residential services. Today there are fewer than 200 people in congregate care facilities and 5400 in community residential settings.

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<sup>1</sup> P71 OPA Annual Report 1988

From the 1950s, families in Victoria with a member who had a mental illness or other disability were demanding supports.

The 1986 legislation reflected a major achievement for a generation of advocacy by families experiencing the joy and pain of supporting their loved ones at home and with little assistance from the state.

Policy makers and service providers embraced the idea of moving away from a model of care, which was dominated by a set of large-scale institutions, the flagships of the system.

### **Setting new benchmarks for change**

We now need to define the next generation of major change that the CVP dedicates itself to achieving.

Just last week at the DHS State-wide Forum for Disability Services, the Minister for Community Services, The Hon. Gavin Jennings observed that the field had now lost its historical benchmark – the institutions - and now needed a “new policy conversation” to set new benchmarks for our vision and purpose.

I believe we are in advance of the ‘conversation’ and have been developing the ‘new benchmark’ for some time.

Our vision must be to promote the social conceptualization of disability.

Our benchmark must continue to be the people and the services they need rather than the facilities that shelter them.

We must advocate for the service providers to do more than provide a safe and secure facility for people. We will advocate to ensure the people we visit are respected as people with aspirations, needs, talents and rights, which can be met when programs assist them graduate to situations of their choice.

We have moved our benchmark from facility type to service improvement and we need to take even greater emphasis on outcomes for residents and patients.

We are supported by the recent research into outcomes for people in accommodation services. The clear findings are that the worst outcomes result from grouping many people with similar disabilities into accommodation, which lack relevant programs<sup>2</sup>. We could argue that some of the facilities we visit may well have been designed for poor outcomes.

Jeffrey Chan, Senior Practitioner, Office of the Senior Practitioner, DHS, addressed a meeting at OPA and characterised past models of care as being organised on containment and medical care lines. He describes facilities in

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<sup>2</sup> Dr Paul Ramcharan, lecturer RMIT Division of Disability Studies presented an overview of research on accommodation services and outcomes. See <http://www.dhs.vic.gov.au/ds/staewideforum>

N.S.W., which were referred to as “homes for the incurables” where the assumption was that people would simply never change and never leave.

He outlines a new model of citizen participation and community engagement. The CVP applauds this direction as it is completely in line with our views but we must challenge any suggestion that such a model has been realised<sup>3</sup>.

Several facilities we visit can be categorized as a modern version of the “homes for the incurables”. In all streams, we can identify services that are too slow or simply do not adequately assist the graduation of the residents/patients to the best outcomes.

### **Highlighting good practice and documenting the reality of the care and conditions in facilities**

We will continue to document good practice and successful outcomes for people. We will be balanced in our reporting and we will seek to encourage learning from success. A key role for us will continue to be as a reality tester for the policy makers.

### **Focus on outcomes for residents – graduating people from facilities**

I would like to see the CVP focus on documenting the efforts to attain improved outcomes for individuals and promote the possibility of graduation out of the facilities wherever possible.

To do that we need to be more systematic about monitoring care plans and the promotion of opportunities for people to be able to participate in society.

### **Enhancing the living options for people with a disability**

I believe there are positive signs and room for (a little) optimism.

The most important development as I see it, is the growth of support and choice type programs and numerous social housing options which may be the future for some of the people currently in facilities we visit.

The most encouraging sign is that many policy makers are now saying that the reason people stay in the facilities is related to the poverty which is associated with their disability rather than the disability itself.

The challenge for program developers will be to build accommodation models and match flexible support arrangement to new forms of accommodation.

In the past year, there have been encouraging initiatives in funding, for example an announcement of \$300 million for ‘social housing’ and programs such as the Disability Housing Trust. Right now, the only program we know where government and private sector align to create accommodation services is the supported residential services (SRSs). There will be several other

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<sup>3</sup> The Senior Practitioner was not arguing that we have in fact moved to the new model but that we are desiring to

developments as policy makers talk about creating “intentional communities’ through the Office of Housing and jointly with the private sector.

As new accommodation options become available, the benefits of having good plans and programs that promote people’s life skills will be more important for us to advocate for in order to ensure people can access the new options.

Recently, I heard an address by the CEO of Melbourne Affordable Housing (MAH). She outlined some terrific programs and in discussion observed that, to date, relatively few disability services were seeking accommodation for their clients. She told of a service that used MAH as a temporary arrangement because a facility urgently needed refurbishment.

The residents moved from shared supported accommodation to their own self-contained unit. The MAH agreed to the arrangement provided the agency allowed the residents to stay if they wished. The agency was agreeable but assured MAH that the residents would certainly want to return to the shared supported accommodation. The residents were delighted with the self-contained units.

The story raises the most salient point that many people never really get to choose because they never get to have the experience of a possible alternative.

In 1987, deinstitutionalisation was a leap of faith in the quest to improve the lives of people with a disability. It was time to give it a go. Now we need case managers and service providers to strive to promote the potential of all residents and patients in the facilities we visit. The service providers need to seek out new options and create choice for people with a disability.

### **Futures for the CVP – Do we have a role in new service types?**

Facilities in all three streams we visit will continue for the near future. As new models of accommodation expand, the CVP and our authorising body will need to consider whether our inquiry, reporting and advocacy can add value for people in some other forms of accommodation.

This has already started in the mental health stream with Prevention and Recovery Care facilities which do not have 24-hour nursing support.

### **Some changes may be a backward step.**

While there are signs that afford us hope, there are signs that should cause us some concern.

In the past year, the Australian Government signed the UN Declaration on the Rights of Disabled Persons but then came to the table with all states and territories to negotiate the next four years of the Commonwealth States and Territories Disability Agreement (CSTDA) by offering no growth and simply agreeing to continue indexation at 1.9%.

The Commonwealth Government then announced it had offered an amount of \$400 million (the indexation figure).

In the negotiation process, the Commonwealth suggested that the states and territories could make greater economies in accommodation by moving to shared supported accommodation models of 15 residents. I believe we will see a push for shared supported accommodation to be constructed for groups in excess of five residents. We need to clarify our positional statements for any such policy conversations.

In my opinion, the most disappointing aspect of the CSTDA was the apparent lack of demand for advocacy services. I wonder whether growth in advocacy is simply off the agenda. It appears to me that the CVP will increasingly find itself as the most important and powerful advocacy service for people in facilities we visit and we must therefore assume the role of 'champions' and we must look to continually supporting and resourcing each other in that role.

**Voice – Strengthening our role as advocates; finding ways to give residents and patients a say.**

The essential function of community visitors is to assist residents and patients have a voice.

Our inquiries, reporting and advocacy processes are always geared to improving the lot of those we represent through identifying issues that they may not always be able to articulate or where they are inherently restricted in the context of the powerlessness of their position.

We need to support a process of continuous improvement by sharing our learning to become better advocates, better voices.

We need to look for additional ways and means to engage the residents and patients to allow them to more directly voice their issues. To that end, we will seek to consult with stakeholders including those with a disability.

An example of improving voice on behalf of people in facilities is when we design new monitoring systems such as in the mental health services where we are now documenting the long stay residents and working with the OPA advocate/guardian program to better target our advocacy.

I hope that the SAVVI funding will establish a means to provide more attention and develop more responsive services for those in the most desperate situations.

As DHS moves towards greater sophistication in quality, assurance and monitoring in the disability services, we will have a more substantial opportunity to engage in deliberations as to the ways and means to promote better outcomes for people we represent. Service standards and monitoring systems will be strong allies for the CVP in promoting the rights of people in the facilities.

**Volunteers - Supporting those that are responsible for the achievements of the past and next 20 years.**

Today we have celebrated many achievements around changes in services and wins for people we represent.

We should also celebrate the achievement of sustaining a community of volunteers. A community of champions. I understand there is no other program quite like us.

My goal is to ensure we continue to enjoy the success we have to date. A key to that is to look at ways and means to support you. That starts with listening to you and your Boards, ensuring you have a voice in how you program develops. The Acting Public Advocate, all staff in the Unit and myself look forward to working with the 2007/08 Boards.

Thanks to previous managers, the Unit staff and leadership from the volunteers, we have an outstanding scheme by any standard you care to apply to us.

In Australia, 43% of all adults, provide some volunteered time to assisting others. Six to twelve months is an average time for volunteering. The CVP averages around five years. The largest cohorts of the Australian population who volunteer are the baby boomers, those aged over 55 years. We will expect a continued flow of over 55 year olds in our program. The national average time spent in volunteering by that cohort is 173 hours each year. I think most CVP volunteers would be well in excess of that average.

The next largest cohort is the 16 -24 year olds. We will need to look at issues for encouraging participation from that group. As schools and media bring disability issues to public attention we can expect more interest in our program and we should encourage that interest as a means to raise awareness and promote the rights of people with a disability.

At another level, I want to look at the benefits of volunteering and see how we can ensure we deliver those benefits to volunteers.

I believe that the single greatest reason for the commitment is the cause of promoting the rights and wellbeing of the people in facilities.

Volunteers also want a sense of inclusion in the community and a bit of fun in the process.

I recently read a Canadian study of health benefits for people who volunteer. The study compared differences in the health status between people who volunteered and those that did not. The conclusion was that volunteering does wonders for all sorts of things although when I read the evidence about volunteers having lower blood pressure I wondered if many CVs would agree that the job lowers blood pressure!

The point is we can look at ways to get even greater benefits from volunteering in the CVP.

In this (my first year) with the program the strongest message I get from volunteers is that the best support is the delivery of results, seeing change happen.

Clearly, we must look at how we can better achieve and demonstrate results. I look forward to tackling this task with you, your Boards and unit staff.

Ron Tiffen  
June 2007