Office of the Public Advocate

Community Visitors

Annual Report 2018–19

Safeguarding the rights and interests of people with disability

Disability Services
Mental Health
Residential Services

Chris Thomas
My World
Mixed media

About the cover image by artist Chris Thomas

The mixed media artwork, *My World*, was purchased from State Trustees' annual CONNECTED exhibition for the cover image of this year's Community Visitors Annual Report.

It could represent the often-confusing world for vulnerable Victorians with disability and mental illness in 24-hour care.

Though, for many, their world now includes support from the NDIS, they remain vulnerable to abuse, neglect and exploitation due to social isolation and cognitive impairment.

Community Visitors play a crucial role in both identifying risks for those they visit and opportunities for improvement in their world.

About the case studies

All names and some identifying features have been changed in the case studies used throughout this report to protect the privacy of the individuals involved.

Safeguarding the rights and interests of people with disability

Community Visitors Annual Report 2018–2019

ISSN: 1836–3296

Report is printed on Ecostar, a recycled and environmentally responsible paper stock made carbon neutral with 100% post consumer recycled waste and Forest Stewardship Council certification.

Ordered to be published

VICTORIAN GOVERNMENT
PRINTER
2019
No 56 Session 2018–19

Letter of transmission

17 September 2019

The Hon. Luke Donnellan
Minister for Child Protection
Minister for Disability, Ageing and Carers

The Hon. Martin Foley
Minister for Mental Health
Minister for Equality
Minister for Creative Industries

Level 22, 50 Lonsdale Street
Melbourne VIC 3000

Dear Ministers

In accordance with the *Disability Act 2006*, the *Mental Health Act 2014* and the *Supported Residential Services (Private Proprietors) Act 2010*, please find enclosed the Community Visitors Annual Report 2018–2019.

This year, the findings have been drawn from 5527 visits by 424 volunteer Community Visitors across the state.

The report identifies a range of issues critical to the safety, treatment, care and human rights of Victoria's most vulnerable citizens who, due to their disabilities, require 24-hour care in state-regulated or managed services.

These issues include a 23 per cent increase in abuse and violence, particularly resident-on-resident and patient-on-patient as well as issues relating to people failing to access or benefit from the NDIS, Community Visitors being denied access to incident reports, insufficient accommodation for people with a mental illness and fire safety in Support Residential Services.

The Combined Community Visitors Board commends the report to you and looks forward to your response to the considerable work within.

Yours sincerely

Colleen Pearce

Colleen Pearce
Public Advocate and Chairperson of the Combined Board

Contents

Report from the Public Advocate

As Public Advocate, I believe that volunteers are an important part of civil society and play an essential role in supporting people with disability.

The Community Visitors Program is a practical strategy consistent with this. Indeed, the first Public Advocate, Ben Bodna AM, established the program as a direct extension of the work of the office.

Abuse

The key role of Community Visitors is the protection and promotion of the human rights of people with disability. For many years, they have documented serious concerns in this area. This year, Community Visitors reported 510 abuse-related issues, representing a 23 per cent increase over last year.

Community Visitors' role in raising public awareness of these important matters cannot be underestimated and their work over 32 years ultimately contributed to the public pressure to establish the national Royal Commission into Disability Abuse as well as several other past government inquiries and investigations.

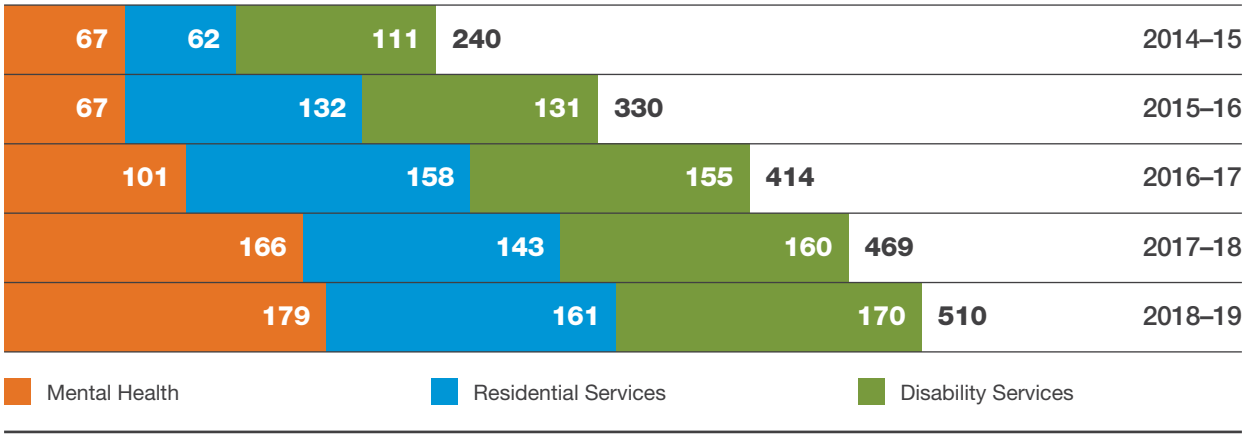
State Government funding for the development and rollout of an abuse detection training program for Community Visitors was welcomed this year. After attending a training session, one volunteer wrote:

> *"I have a better understanding about how my Community Visitor role fits into the process of identifying, responding to and reporting abuse."*

NDIS

This year, Community Visitors continued to report on NDIS-related issues which affect their clients, including their eligibility, their difficulties in understanding NDIS processes, the inadequate funding of plans, long delays in plan approvals, extended waits for equipment, especially in regional areas, lack of communication from support coordinators and between agencies, as well as the quality of support provided by NDIS workers.

Figure 1. Community Visitor reports of abuse, neglect & assaults across all streams, 14/15–18/19



The Long-Stay Patient Project 2018-19, a biannual survey conducted since 2009 found only one-third of 92 long-stay patients have an approved NDIS plan.

Further, this year, a survey conducted by my office and the Residential Services stream of the Community Visitors Program found just 51 per cent of SRS residents under 65 years of age have an approved NDIS plan.

As well, SRS residents experienced long delays in finding out if they were eligible for NDIS. One SRS manager reported they had two residents with similar needs, but their funding varied greatly - $18,000 compared to $50,000. Some SRS managers reported neglect and poor-quality care by NDIS support workers.

While many residents in group homes benefit from their NDIS plans, some expressed frustrations with inadequate funding which have led to a decreased participation in activities and programs. House staff reported poorer or inadequate outcomes when they were not involved or consulted on clients' NDIS planning. Residents and staff expressed concern over inadequate funding for transport and the expense of using taxis, some of which do not support clients in wheelchairs. Houses reported concerns about the potential loss of buses due to inadequate transport funding. Community Visitors also highlighted clients not utilising their NDIS-funded hours due to the lack of staff.

Access to NDIS plans continues to be an issue both for Community Visitors and for some house staff who struggle to support residents without understanding the goals of their plan.

NDIS Quality and Safeguards Commission

Community Visitors look forward to working with the NDIS Quality and Safeguards Commission when it commences in Victoria on 1 July 2019. The Commission's role will include complaints management, registration of providers, oversight of restrictive interventions and reportable incidents. My office is developing a Memorandum of Understanding with the Commission and hopes to meet with it regularly.

Access to Incident Reports

Access to incident reports provides Community Visitors with an understanding of what has occurred between visits. The best performing services use a range of mechanisms to facilitate Community Visitor access to incident reports. However, in many cases Community Visitors are

> This year, Community Visitors reported 510 abuse-related issues, representing a 23 per cent increase over last year.

frustrated by the myriad of reasons as to why incident reports cannot be accessed at services they are required to visit by law.

Since November 2018, Community Visitors have recorded whether incident reports were accessible during their visit. This acts as a reminder to services to address access issues. An analysis of reports since the project commenced shows Residential Services Community Visitors accessed incident reports during 70 per cent of visits, Disability Community Visitors during 59 per cent of visits and Mental Health Community Visitors during just 51 per cent of visits. While accessing incident reports is most problematic in mental health facilities, all services have serious access issues.

In the coming year, the Community Visitor Program will score services on key indicators, including access to incident reports, and publish the results as a scorecard.

New operating model for Disability Community Visitors

In February 2019, the Community Visitors New Operating Model Steering Committee was convened to respond to changes in the disability space, including amendments to the *Disability Act 2006*, the rollout of the NDIS and the commencement of the Quality and Safeguarding Commission. It is also considering facilities to be visited, whether current visit arrangements need modification, training for Community Visitors and how issues of concern can best be escalated.

It comprises key staff from the Department of Health and Human Services (DHHS), Department of Justice and Community Safety (DJCS), the Public Advocate, a volunteer-elected Disability Services Board member and senior OPA staff.

The committee is also developing a new operating system for the disability stream of the Community Visitors Program.

The impact of the transfer of the regulation of tenancy in Specialist Disability Accommodation from the Disability Act to the *Residential Tenancies Act 1997*, and, hence, under the purview of Consumer Affairs Victoria, is also being considered. Community Visitors now have the right to visit a broader range of disability services under the transfer of this regulation. The changes are welcomed as they enable greater protection to more people with disabilities residing in Victorian disability accommodation.

Transition to the new model and expanded legislative obligations comes at a cost. Community Visitors will only be able to carry out their critical safeguarding role if there are enough resources to enable the program to recruit, train and retain volunteers who are the heart and soul of the program.

Violence in Group Homes

More than 5000 people with disability live in SRS in Victoria.

Following deinstitutionalisation, many people with cognitive disability moved into group homes, which typically housed six or seven residents. Many did not have much choice in these arrangements.

Violence and abuse between co-residents in shared supported accommodation, such as group homes and SRS, is common:

- ten per cent of the 1041 incidents reported to the Disability Services Commissioner (DSC) last year related to allegations of physical or sexual assault or abuse between co-residents in disability services
- between one third and half of all serious incidents in disability services reported to the Public Advocate by Community Visitors in recent years relate to violence or abuse between co-residents
- a NSW report found that resident-to-resident assault accounted for 44 per cent of all injuries in residential care.

An analysis of the last five years of Community Visitors' reports found that Disability Community Visitors reported 26,000 issues and, of them, 772 concerned abuse. Resident-on-resident violence, including assault and psychological abuse, accounted for 58 per cent of Community Visitors' abuse referrals to the DSC this year.

Violence and abuse between co-residents with disability rarely results in the proactive, protective responses expected in family violence situations. Violence perpetrated by and towards persons with disability is not always described as such but, instead, is often described as 'behaviours of concern' or 'resident incompatibility' and dismissed.

In June 2019, I convened a forum to bring together key policy and practice leaders to discuss violence and abuse between co-residents with intellectual disability in group homes. The objective was to develop a shared understanding of the issues, identify best practice responses and build a shared commitment to possible solutions. My office is preparing a report including recommendations from the forum in the hope that this will contribute to the public debate and action on this ongoing and serious problem.

Mental health

One of the main difficulties for a person with a mental illness is finding stable accommodation. There have been countless studies over recent years that highlight what a critical factor this is in a person's recovery journey.

While the government provides accommodation in Community Care Units for patients discharged from acute units, they have insufficient beds and a maximum stay of only two years.

Many Victorians with a mental illness struggle to secure private rental accommodation. Initiatives, such as the Wellways Doorways project, which assist people with mental illness to enter the private rental market, have been helpful, however, Doorways is limited to only three geographic areas and cannot meet demand.

This year, Community Visitors have documented more people being discharged from mental health services to homelessness. The findings of the Long-Stay Patient Project support this, with 27 per cent of patients unable to be discharged because of a lack of suitable accommodation.

Community Visitors hope the Mental Health Royal Commission will recommend a solution to this intractable problem.

Fires safety in SRS

This year, Community Visitors became increasingly concerned about fire safety in SRS. Their concerns centred around residents smoking in their rooms, the disabling of fire alarm alert tones by SRS staff, the frequency of evacuation drills, the ability of residents to comply with emergency management procedures, and staff understanding of fire safety systems.

Following three notifications about fire safety concerns in the Southern Division, Community Visitors observed a petition being developed by SRS residents and heard their concerns about their safety and fears that the fire safety system was compromised. Community Visitors also identified inconsistency in the management and understanding of the fire alarm systems by SRS staff and the discrepancy in the DHHS responses to these issues.

DHHS clarified that its responsibility was only for emergency management and referred fire safety concerns to the relevant local governments which agreed to bring forward their annual assessment of fire safety systems.

When the Community Visitors Residential Services Board raised this issue with DHHS, it became apparent that there was no system of ensuring that building and fire safety issues identified by local government were relayed to DHHS, the department responsible for ensuring SRS residents' safety and wellbeing. The protection of vulnerable residents is paramount. Urgent action is required to ensure that landlords, proprietors, local government and DHHS have a framework for open lines of communication on all fire safety issues.

Thank you

The findings of Community Visitors outlined in this 32nd annual report are the result of services provided freely by volunteers, many of whom have retired from paid work. In their precious latter years, they donate their invaluable services for those who, due to disability, are less fortunate.

Without them, the reach of the vital work of my office would be much shorter, its outcomes less impressive and the lives of the state's most vulnerable a great deal poorer.

I applaud them yet again and, on behalf of the State Government, I thank them sincerely.

Finally, the OPA staff of the Community Visitors Program and the OPA support programs around them are heavily involved in this effort. They also bring substantial personal commitment to improving the lives of Community Visitor clients and I thank them too.

Colleen Pearce
Public Advocate and
Chairperson of the Combined Board

2018–19 Snapshot

424

Community Visitors

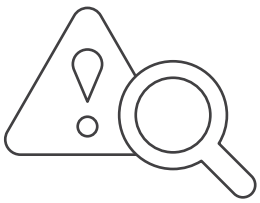
248

requested visits

5527

statutory visits

up 5% from 17–18



1446

facilities visited

5915

issues identified

3102

continuing issues

7 yrs

average of Community Visitors volunteering in the program

12

Community Visitors with 20 years + of service

22%

Community Visitors with 10 years + of service

133

abuse referrals to Disability Services Commissioner

395

new issues with National Disability Insurance Scheme

197

continuing issues with National Disability Insurance Scheme

Introducing the Combined Board

Public Advocate and Board Chair

Dr Colleen Pearce

Colleen Pearce has been Victoria's Public Advocate since September 2007.

In this role, she is the guardian of last resort for adults with disabilities in Victoria. Under legislation, she is also chair of three Community Visitor boards, one for each stream of the volunteer program.

Colleen fearlessly advocates for the human rights and interests of people with a disability and a mental illness, and is outspoken on the significant issues of abuse, neglect and exploitation.

She has more than 30 years' experience managing community and health services in both the government and non-government sectors.

Colleen's outstanding contribution to community services in Victoria has been recognised with a Commonwealth Centenary Medal, membership of the Victorian Honour Roll of Women and an honorary doctorate from RMIT University.

Colleen is a proud Yuin woman from southern NSW.

Disability Services Board

David Roche

This is David Roche's third term on the Disability Services Board having served one year in 2009-2010 and subsequently being re-elected twice.

He is chair of the Combined Board's Policy Review Steering Committee, a Panel Secretary and a former Regional Convenor and has served on the Training Steering Committee.

He lives in South Gippsland and has a history of active involvement in local and regional community-based organisations.

David has qualifications in public policy and management, business and project management and training.

He views collaboration and openness to change as key roles of the Board to ensure that Community Visitors remain a primary safeguard for those with a disability.

Rosemary Shaw

Rosemary Shaw has been an active Community Visitor since 1999 and this is her second term on the Disability Services Board.

She worked part-time for Yooralla for eight years until the end of 2014 providing one-on-one personalised care services.

Her community activism is extensive as she volunteers with the Young People in Nursing Homes National Alliance supporting young people in aged care and those likely to go into it due to the shortage of suitable accommodation.

She is also a committee member with the Uniting Church, supports the Royal Children's Hospital and founded Kids Under Kanvas, a camping program for children and young people with disabilities, now under the auspice of Wesley Mission.

In 2014, Rosemary was awarded an Order of Australia for her service to the community through volunteering with 14 organisations, mainly in the disability sector.

Mental Health Board

Debra Sevastianov

Debra Sevastianov was appointed as a Community Visitor in 2013. She is a Regional Convenor for the Community Visitors Program and a Mental Health Board member.

She is qualified in aged care, disability, finance, education and mental health, volunteers with her local CFA and runs her own construction business.

Debra has a lived experience of mental health issues and enjoys contributing her time to the Community Visitors Program because it means she can make a difference for others with similar lived experiences.

Jenny Martin

Jenny Martin was appointed as a Community Visitor in 2015 and extends her contribution to the program over the past year in her first Board term.

She is panel secretary for the Austin Emergency Department and the Psychiatric and Assessment Planning Unit as well a panel member for the Austin Secure Extended Care Unit, the Adult Acute Unit and the Mothers and Babies Unit.

Jenny is past panel secretary for Austin - Community Recovery Program, Transition Support Unit, the Heidelberg PARC and the Northern Hospital Psychiatric Units 1-2 and its Emergency Department. Her experience in inpatient and community services has provided her with a wide view of consumer and, at times, carer experiences of mental health services.

Jenny has worked as a mental health service social worker and is a social work academic. She is committed to improving the quality and safety of mental health services for consumers through her role on the Board representing the views of the Community Visitors.

Residential Services Board

Marj Munro

This is Marj Munro's second term on the Residential Services Board.

She was appointed a Community Visitor in the Disability Services stream in 2009 and, the following year, became a Regional Convenor in that stream. Her involvement as a Residential Services stream Community Visitor started in 2010. She now concentrates on Residential Services and has been a Regional Convenor in the stream since 2011.

Marj taught history, English and politics for over 30 years and served two terms as a municipal councillor. She is still actively involved in her community.

Lynn Wallace-Clancy

Lynn Wallace-Clancy was first appointed as a Community Visitor in the Residential Services stream in 2012, is a Regional Convenor and this is her first term on the Residential Services Board. Her involvement as a Community Visitor started in 2010 in the Disability Services stream.

She has a Masters of Arts (Communications). In her previous career, Lynn worked with Adult Multicultural Education Services for more than 20 years assisting in the settlement of refugee communities. Since her retirement, she has spent six months in Timor Leste as a volunteer teaching local English teachers.

Lynn enjoys contributing to the Community Visitors Program as it makes a real difference to the residents visited.

The Board (L-R)
Lynn Wallace-Clancy, Marj Munro, Debra Sevastianov, Colleen Pearce, Rosemary Shaw, Jenny Martin, David Roche

Community Visitors

Background

Community Visitors are independent volunteers who safeguard the human rights of people with a disability by engaging directly with them on an ongoing basis. They are supported by the Community Visitors Program which is part of OPA.

The work of the volunteers has had a profoundly positive impact on the lives of Victorians with a disability or a mental illness since the first group of 238 visitors was appointed in 1986.

Since then, their public findings have been responsible for shining a light on the human rights of thousands of people vulnerable in the care of others. They have been responsible for the closing, to date, of all but one of the state's institutions and, in recent years, highlighting the issues of abuse and violence in the sector. This has led to a series of state and federal inquiries including a Royal Commission.

The program

The program is organised into three streams to reflect the type of services visited:

- Disability Services where visits are conducted to the last Victorian institution and community-based facilities for people with disability
- Mental Health where visits are made to consumers and residents in mental health facilities providing 24-hour care including the community stepdown or stepup facilities, Prevention and Recovery Care (PARC) services
- Residential Services where visits are made to people who reside in supported residential services (SRS) and require additional support.

The ongoing support, training and recruitment of the Community Visitors and the boards is the responsibility of staff in the Safeguarding, Inclusion and Volunteer Programs Unit.

The powers

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

- *Disability Act 2006*
- *Mental Health Act 2014*
- *Supported Residential Services (Private Proprietors) Act 2010*

The legislation establishes three respective boards: Disability Services, Residential Services and Mental Health which are responsible for reporting the activities, issues and findings of the Community Visitors to the Victorian Parliament each year, through the relevant minister.

Community Visitors are appointed for three years by the Governor in Council. They are empowered by legislation to visit specified facilities, to make enquiries of residents and staff and examine selected documentation in relation to the care of people residing at the facilities.

Community Visitors usually make unannounced visits in a team of two or more.

The findings

At the conclusion of each visit, the Community Visitors prepare a report summarising the findings and indicating items where action is required. A copy of the report is provided to the most senior staff member at the facility or the proprietor in the case of an SRS.

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

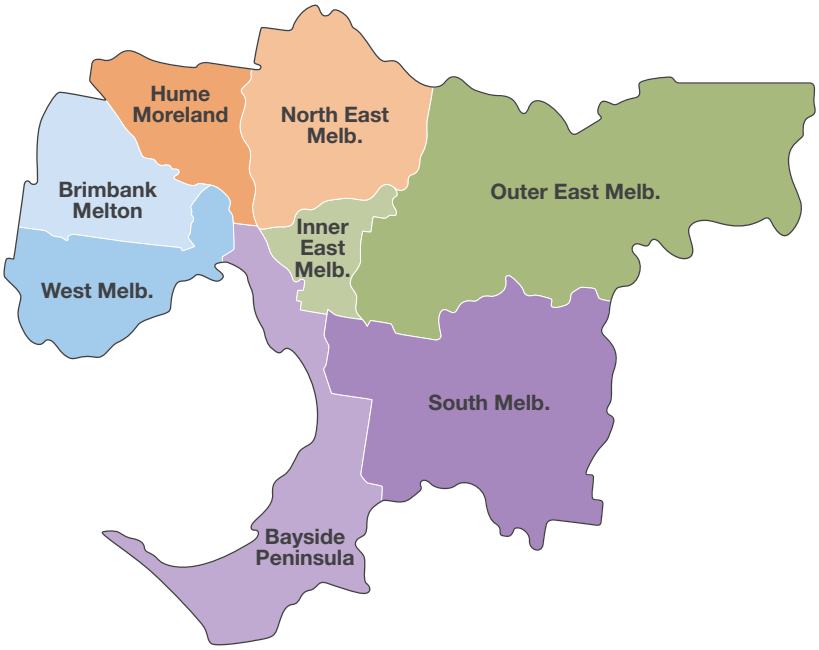
While the vast majority of visits are scheduled and unannounced, a significant number are in response to specific complaints. This includes referrals to the program via OPA's Advice Service. On occasions, repeated visits are necessary to certain facilities over a short period, in response to serious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

Table 1. Numbers of Community Visitors and numbers of visits, 18/19

Stream	Community Visitors	Visits
Disability Services	266	2952
Mental Health	80	1670
Residential Services	78	905
Total	**424**	**5527**

Note, there was approximately a 5 per cent increase in visits over last year

Reporting Divisions



East Division

- Goulburn
- Ovens Murray
- Outer East Melbourne
- Inner East Melbourne

North Division

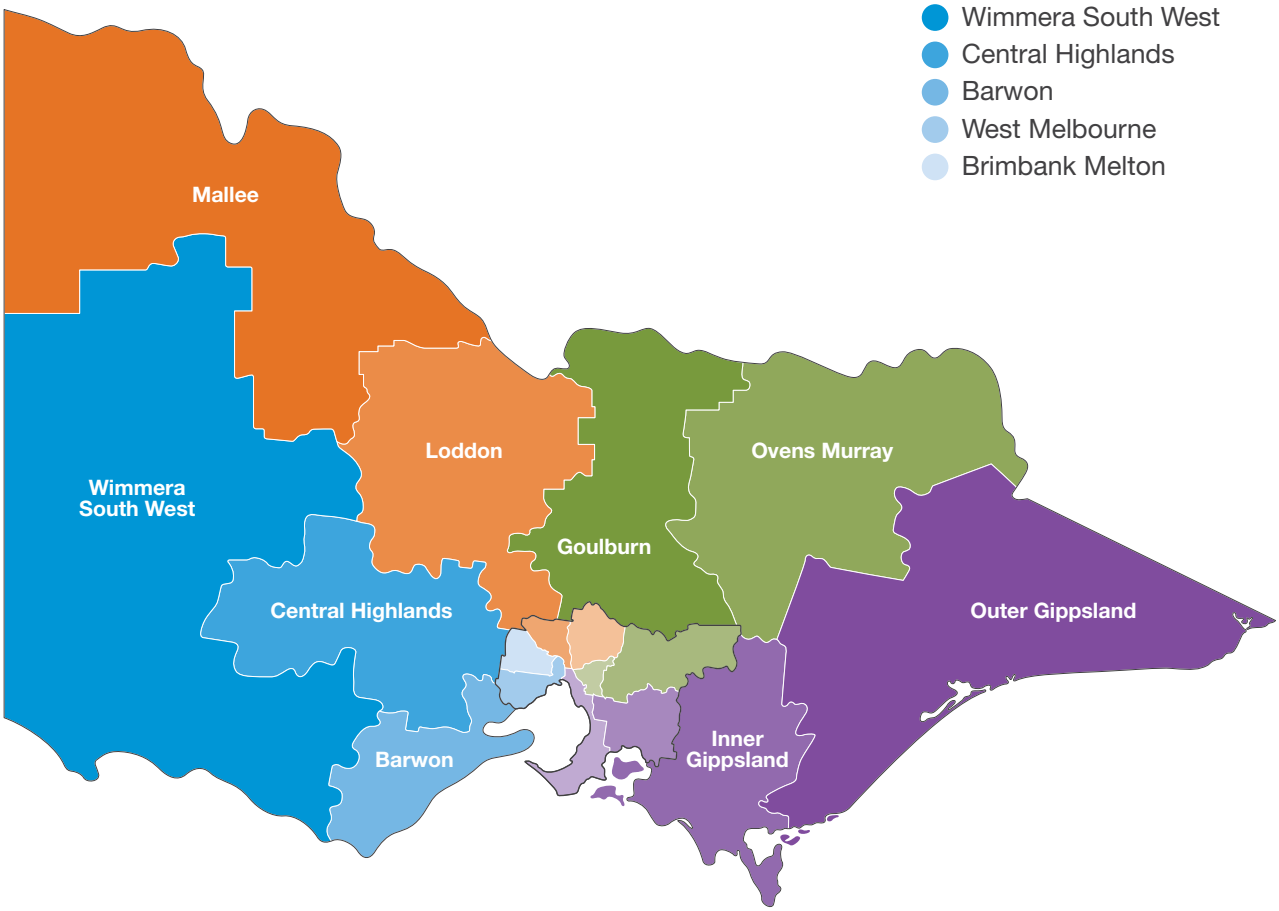
- Mallee
- Loddon
- Hume Moreland
- North East Melbourne

South Division

- Outer Gippsland
- Inner Gippsland
- South Melbourne
- Bayside Peninsula

West Division

- Wimmera South West
- Central Highlands
- Barwon
- West Melbourne
- Brimbank Melton



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Disability Services

> Resident-to-resident violence and abuse remains a significant concern. Community Visitors continue to receive reports from residents living with others whose behaviours of concern place them at ongoing risk.

Recommendations

The Community Visitors Disability Services Board recommends that the State Government:

1. actively support the development of a new operating model for Disability Services Community Visitors and sufficiently fund the transition and any resulting program changes
2. require disability workers to complete mandatory abuse detection and response training
3. create and sufficiently fund a specialist Family Violence Initiative for sustained and persistent group home violence between residents
4. create emergency accommodation to address situations of sustained and persistent group home violence
5. introduce an open disclosure regime for all incidents of violence or sexual assault as well as full public reporting of aggregate data
6. strengthen human rights protections to make choice and control more meaningful in group homes by funding supported decision making initiatives, peer support and individual advocacy
7. advocate for a stronger National Disability Insurance Scheme Code of Conduct (Workers) to reflect the existing Victorian code that requires zero tolerance to abuse
8. require all National Disability Insurance Scheme workers entering group homes to display visible identification including the organisation name
9. note that the next Annual Report will provide a service provider report card on abuse, their responsiveness to visit report issues within 28 days and Community Visitors' access to incident reports
10. fund the Community Visitors Program to enable it to recruit and support adequate numbers of volunteers and use technology to efficiently and effectively carry out its critical safeguarding role.

Statewide Report

Introduction

Community Visitors in the Disability Services stream of the Community Visitors Program are a critical safeguard for vulnerable Victorians residing in disability accommodation.

Their role in improving the lives of residents and working to eliminate abuse and neglect has arguably become more important, particularly as disability services undergo fundamental changes. These include the NDIS rollout in Victoria, changes to the *Disability Act 2006* to move tenancy rights to the *Residential Tenancies Act* under Consumer Affairs Victoria, and the transfer of government-owned disability accommodation to Community Service Organisations (CSOs).

This report reflects the work of Community Visitors in advocating on behalf of residents on a range of issues.

This year, Community Visitors identified 3806 new issues impacting on residents ranging from reports of abuse to concerns about quality of staff support, physical wellbeing and residents' participation in the NDIS. This figure does not include issues that are resolved during visits and do not require further follow-up.

Disappointingly, the State Government has yet to respond to last year's Community Visitors annual report and its recommendations. Consequently, the recommendations in this report were drafted without the benefit of the State Government's input. It means that the volunteers are unaware if their previous report has been heeded.

Abuse and neglect

This year, 170 issues of abuse and neglect were recorded by Community Visitors with 18 notifications made to the Public Advocate regarding the most serious.

Resident-to-resident violence continues to figure prominently in reported cases, while staff-to-resident abuse is also concerning. There are multiple instances where residents have expressed to Community Visitors how fearful they are in their own homes, and how they often choose to stay in their rooms rather than interact in shared living spaces. The trend towards an increase in the number of incidents reported is also disturbing.

Nearly half of all serious incidents in disability group homes reported each year relate to violence between co-residents. However, despite the number of recent inquiries into violence against people with disability, the specific issue of violence between co-residents has received little practical attention. These incidents rarely result in the sort of protective responses which we have come to expect in family violence situations. The right to choose where they live and who with is so constrained for many people with disability, that they are left feeling unsafe and fearful in their own homes.

On the other side, people engaging in violence do not always receive the supports they need to manage their behaviour and frequently end up in inappropriate accommodation or homeless

Table 2. Total visits Disability Services stream, 18/19

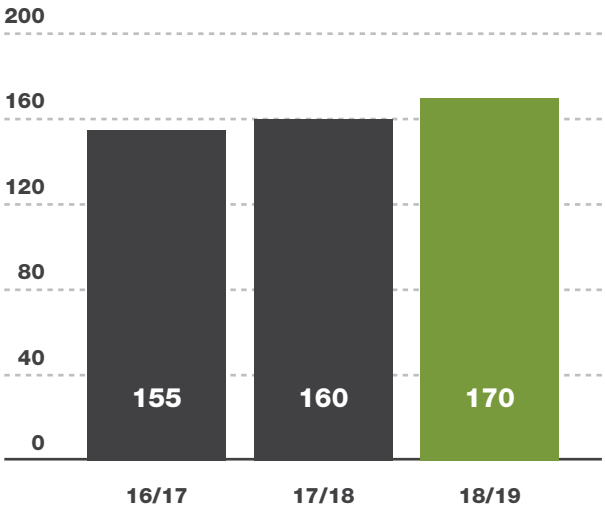
Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	373	79	32	981	**1013**
North Division	242	58	34	400	**434**
South Division	268	69	20	707	**727**
West Division	265	60	10	768	**778**
Total	**1148**	**266**	**96**	**2856**	**2952**

if evicted. Finding an effective solution which meets the needs of both victim and perpetrator is challenging. The task is further complicated by the National Disability Insurance Scheme (NDIS), which alters the roles and responsibilities of accommodation and support providers in ways which are not yet fully understood.

> ***Case study***
>
> One divided house where three residents reside has frequent assaults, property damage and other incidents, placing residents, staff and community members at risk.
>
> Casual and agency staff frequently fill the roster. Department of Health and Human Services (DHHS), the Disability Services Commissioner (DSC) and the Office of Professional Practice (OPP) have all been involved, but the three residents have different support coordinators and each of the residents' families has refused the limited alternative accommodation options offered, judging them unsuitable.
>
> The situation is at a stalemate. None of the residents can easily live in shared accommodation and other accommodation options are extremely limited. Community Visitors have advocated strongly for the needs of all three to be met more effectively and will continue until a workable solution has been arrived at to benefit all three residents.

Lack of continuity in staffing contributes to situations of abuse with high staff turnover, and reliance on less-familiar and experienced casual staff, placing residents and other staff at greater risk. Conversely, appropriately trained and skilled staff, careful planning and clear behavioural support strategies can make a positive difference and create safer households. In some cases, a sustained multi-disciplinary approach is needed to address intractable situations of abuse in houses; such an approach would require investment to create flexible, alternative accommodation options with enough staffing as well as access to a range of specialist resources.

Figure 2. Issues of abuse, neglect and violence identified in Disability Services stream, 16/17–18/19



Community Visitors have continued to refer serious matters of abuse and neglect to the DSC, referring 133 matters to the end of April. The response from the DSC to the matters raised has been limited, however, the process of gathering such information will assist with the preparation of a response to the Australian Government's Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. The Community Visitors Program has also rolled out abuse detection training to Community Visitors this year, to enhance their capacity to identify and report incidents of abuse and neglect.

The different initiatives targeting abuse will assist to affirm the 'zero tolerance' approach endorsed by the State Government, which the program strongly supports. Community Visitors would like to see this stronger approach adopted federally

Table 3. Breakdown of issues included in referrals to the Disability Services Commissioner, 18/19

Primary abuse allegation	Number
Physical assault—resident to resident	43
Physical assault—resident to staff	29
Physical assault—staff to resident	8
Physical assault—resident to outsider & vice versa	11
Sexual assault	10
Verbal/psychological/emotional abuse—resident to resident	36
Verbal/psychological/emotional abuse—resident to Staff	24
Verbal/psychological/emotional abuse—staff to resident	8
Verbal/psychological/emotional abuse—resident to outsider and vice versa	14
Neglect—staff to resident	25
Financial abuse/exploitation	2

via the NDIS Code of Conduct. The national code only requires service providers to make their best efforts to prevent abuse, however, the safeguarding of people with disabilities needs to place a premium on them being able to live safely and free from abuse. The NDIS has created a multiplicity of service providers in the lives of people with disability, which can make them more vulnerable than ever, and the absence of individual case management means service providers can now operate in an environment that is increasingly difficult to monitor.

Physical wellbeing

Errors made in the administration of medication continue to be reported frequently by Community Visitors. Sometimes, such errors require treatment or even hospitalisation. Further training and more consistent staffing by service providers would reduce the frequency of these occurrences.

Another area of concern is residents' diet. Ideally, a balance should be achieved between resident choice and the promotion of healthy eating. House staff have a key role in supporting healthy diet and exercise choices for residents which improves their health and wellbeing.

Appropriateness of residential environment

Maintenance works and upgrades have occurred in many houses to ensure that they meet NDIS accommodation standards. The improvements are welcomed, however, there has been some evidence of poor workmanship and ill-conceived renovations that have required further work.

In other houses, there are many longstanding maintenance issues that remain unresolved, with long delays that impact on residents' wellbeing. Often these relate to the fabric of the house itself and the upkeep of outdoor environments.

Community Visitors are also concerned where major renovation works take place in houses without the residents being relocated as it may be detrimental to resident health.

Quality of Staff Support

Some staff are clearly attuned to residents' needs and goals and work actively with them to achieve them. Community Visitors are aware of cases where house staff have devoted the time and effort to support residents while they have been inpatients in hospital, for instance. In other cases, there does not appear to be enough effort and attention given to providing stimulation and skill development to residents.

Service providers do face the constant challenge of retaining suitably qualified and skilled staff. There are ongoing issues with staff turnover, while the frequent use of casual staff impacts on the consistency and quality of support provided to residents.

Documentation in houses is often inaccessible, of poor standard or out of date. Absent or incomplete information compromises the care provided to residents, particularly when new or casual staff are reliant on it.

Sometimes insufficient staff are rostered on for particular shifts. This may limit, or even preclude, some resident activities or confine them to a set routine, for example, going to bed earlier than they wish.

Concerns have been raised regarding the lack of communication between service providers, for instance, between house and day program staff, or house staff and NDIS one-on-one support providers. Better communication between all service providers involved in a resident's care can only benefit them.

Greater change and complexity in the sector

Residents in disability accommodation services and their families are encountering an increasingly complex and transitory service environment where multiple safeguarding arrangements exist simultaneously.

Government-managed Disability Accommodation Service (DAS) houses in Victoria that are in the process of being transferred to one of five nominated service providers have been deemed by the National Disability Insurance Agency (NDIA) to be 'in-kind' arrangements, so they remain under the State Government's safeguarding regime. Staff in these houses are on secondment from DHHS to their new CSO employer for a transition period. So, the DSC will continue to deal with complaints and safeguarding in these houses until the full changeover to the NDIS occurs.

In other houses, most residents have transferred to the NDIS so the federal safeguarding regime would apply. But some in these same houses are ineligible for the NDIS as they are over 65 years of age, so they will receive Continuity of Support (CoS) funding for their continued tenancy and support in group homes. These residents are expected to be covered by the State safeguarding framework as will houses managed by ACSO under Disability Justice, the five Bendigo houses opened by DHHS following the closure of the Sandhurst Centre, as well as some respite facilities. So, one disability group home could have several safeguarding systems operating simultaneously.

Community Visitors are concerned that the increased complexity of safeguarding arrangements means greater difficulty for residents and families in navigating the service system and addressing concerns as they arise.

Liaison with DHHS

There has been increasing difficulty in sustaining a liaison relationship between the Community Visitors Program and DHHS due to the ongoing transformation of the latter in the disability space.

While these challenges are acknowledged, Community Visitors are disappointed that there has been no usual Statewide Liaison Meeting since October 2018. There are many issues relating to the provision of disability services where DHHS remains a key stakeholder, and it is unfortunate that the key liaison meeting has not been given greater priority by the department.

Compliance with the Act

While there have been improvements, some service providers still consistently fail to provide timely responses to issues raised by Community Visitors. In some cases, the response to issues may be received many months after the issues have been flagged and, in a few cases, not at all. This does not give Community Visitors the confidence they need to execute their role.

Community Visitors continue to encounter difficulties in accessing incident reports across many facilities. Incident reports provide crucial information, highlighting issues that impact on residents' welfare and documenting the responses to serious matters.

Increased reliance on electronic information management in houses can pose access difficulties. Sometimes, there are difficulties with passwords or with house staff (especially casual staff) not having any access to electronic information. Electronic reporting systems are designed to facilitate the flow of information within agencies including to management, however, house-level access to the systems is highly variable.

Multiple incident reporting systems operate in Victorian disability services, including the Client Incident Management System (CIMS) in some CSOs, and the *NDIS (Incident Management and Reportable Incidents) Rules 2018* in others. The obligations for service providers are increasingly complicated, confusing and difficult for Community Visitors to navigate. There are ongoing concerns for Community Visitors about incident under-reporting as well as them being inappropriately classified, as many incident reports do not adequately capture the impact on residents.

Next year's annual report will provide a service provider 'report card' to highlight these issues and their seriousness for Community Visitors. The report card will document how service providers perform on three key indicators: Community Visitors reporting on abuse, access to incident reports and the timeliness of written responses to issues raised in visit reports. The protocol between the Program, DHHS and National Disability Services (NDS) specifies that written

responses should occur within 28 days of the visit, so that is the third measure to be applied to individual agency performance.

NDIS

The NDIS is still being rolled out across Victoria.

As part of this process, people with disabilities living in residential accommodation are adapting to a new model where funding for physical premises in which they live, Supported Disability Accommodation (SDA), is distinct from funding for personal care required for everyday living, Supported Independent Living (SIL).

This year, Community Visitors have reported 323 new issues relating to the NDIS, with 200 continuing from last year yet to be resolved.

Community Visitors have reported positive outcomes for many residents, where their NDIS plans have accurately reflected their support needs and substantial funds have been allocated. This has enabled many residents to access a broader range of activities and experiences than they have been able to previously.

Despite this, Community Visitors have continued to highlight many difficulties encountered by residents and their families with the scheme. These include frequent delays with planning processes, including plan reviews. In many cases, the delays may be due to difficulties in arranging specialist and allied health assessments from professionals such as occupational therapists and speech pathologists.

Participants may also encounter obstacles when seeking SDA funding approval. This may be delayed, because participants require plan reviews to move from one SDA to another. In some cases, participants' level of approved SDA funding may not match the level required to move into a house. This can be frustrating for prospective residents, their families and service providers who may have difficulty filling vacancies for long periods of time.

> ***Case study***
>
> A female resident suffered traumatic abuse from another female resident at her group home in 2018 and has had incidents of unexplained bruising since.
>
> Her mother approved her moving to a group home managed by another SIL provider. Despite the DSC and the resident's legal advocate supporting the move, the resident has been unable to move because she needs a plan review to move to another SDA.
>
> In order to get NDIS approval, an occupational therapist's assessment, usually a ten-week wait, is also required. An additional complication is that NDIA pre-approval is required before the assessment can occur.
>
> The matter has been rescheduled several times since February because the NDIS delegate or the resident's lawyer have been unavailable.

While residents may have approval in their plans to access support workers, they may be difficult to engage. There has been discussion relating to the NDIS and the prevalence of 'thin markets' where availability of specific services and supports, particularly in regional areas, does not adequately meet demand. There is high turnover of NDIS support workers in some cases, and Community Visitors have expressed concerns about the lack of continuity with NDIS supports and the detrimental impact on residents.

Community Visitors may inspect NDIS participant plans for residents. However, many have had difficulties accessing the information. Some providers appear unclear about Community Visitors' entitlement to view the information, while, in other cases the SIL providers themselves will not have access, as the information is being managed elsewhere (for instance, by a family member). This poses difficulties in determining whether residents are utilising their supports and whether they are achieving their goals in their NDIS plans.

These circumstances limit Community Visitors in exercising their functions and duties under the Disability Act. Further clarity is needed from the State and Australian Governments to ensure that Community Visitors can fulfil their primary safeguarding role for residents of group homes.

Some residents continue to experience unacceptably long waits for essential aids and equipment, such as wheelchairs. With the transition from the Statewide Equipment Program (SWEP) to NDIS-responsibility for these items, outcomes for residents have been variable. Significant delays impact on residents' health and wellbeing as well as limiting their independence in many cases.

Staff in houses may have a limited understanding of the NDIS. Service providers should provide further training on the scheme so that staff are well-acquainted with NDIS plans and processes, and they can support residents to access and utilise funds appropriately.

Community Visitors continue to identify a trend in reduced utilisation of facility-based respite services. Service providers are reconsidering whether to continue operating some respite services although some agencies are adapting effectively to the changes. Despite the increased flexibility available for families under the NDIS, it is concerning if there is less facility-based respite available in some locations, as it is a support option that works well for many families.

Case study

A client has been accessing facility-based respite services for the last 17 years.

Over the last three years, the client has accessed increased respite support as her main carer's health has deteriorated. In 2018, she accessed respite almost weekly due to her main carer requiring treatment and a lengthy period of hospitalisation.

The client's access to respite was reduced to once a month in 2019 due to insufficient funding in her NDIS plan.

The CSO managing the respite facility said that the family are in a very difficult position, with another family member needing to become the primary support for the client and her previous main carer.

The CSO liaises regularly with family members to monitor the client's wellbeing, particularly as these changes can exacerbate her behaviours of concern.

Figure 3. Issue groups and number of issues identified in each, 18/19

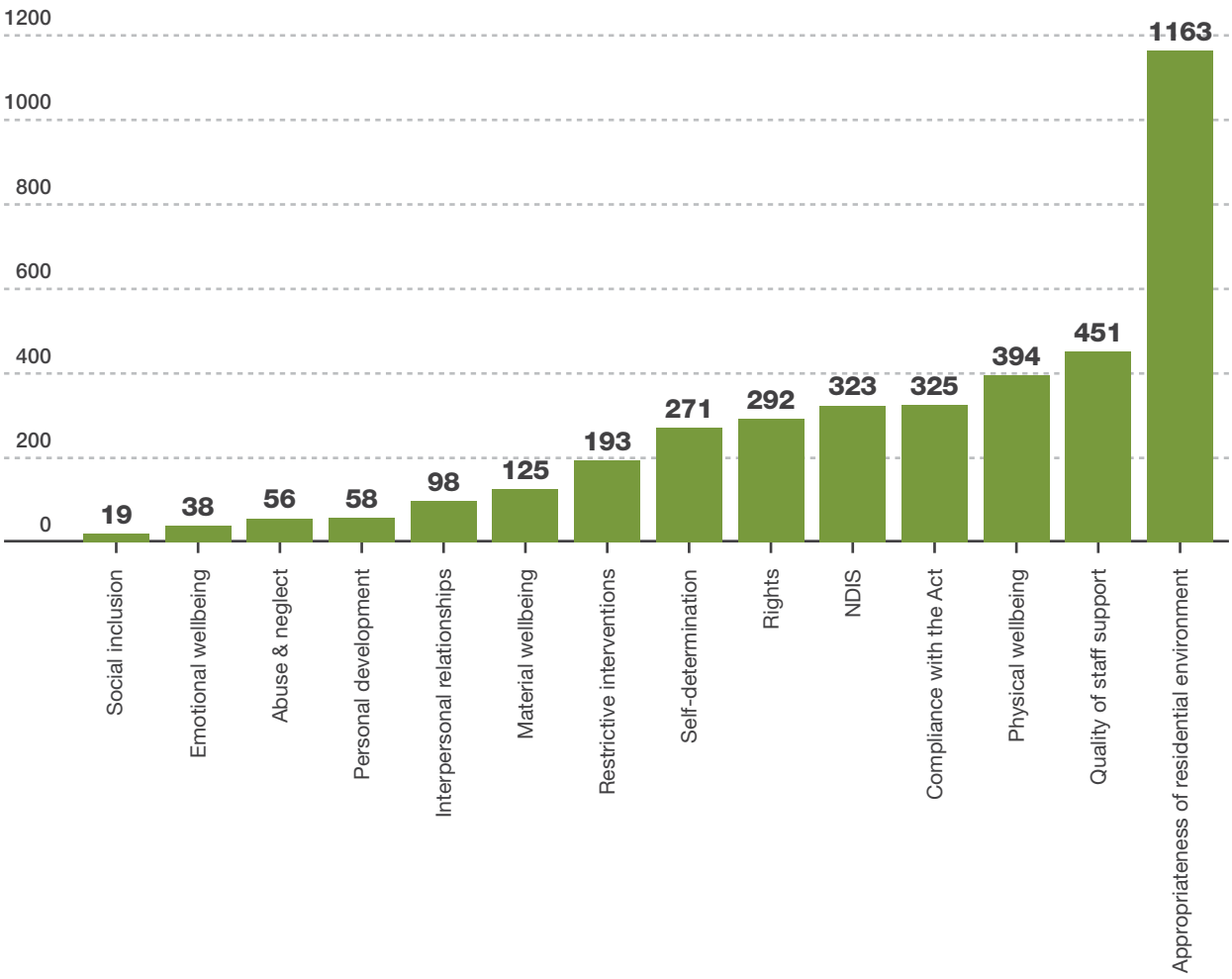
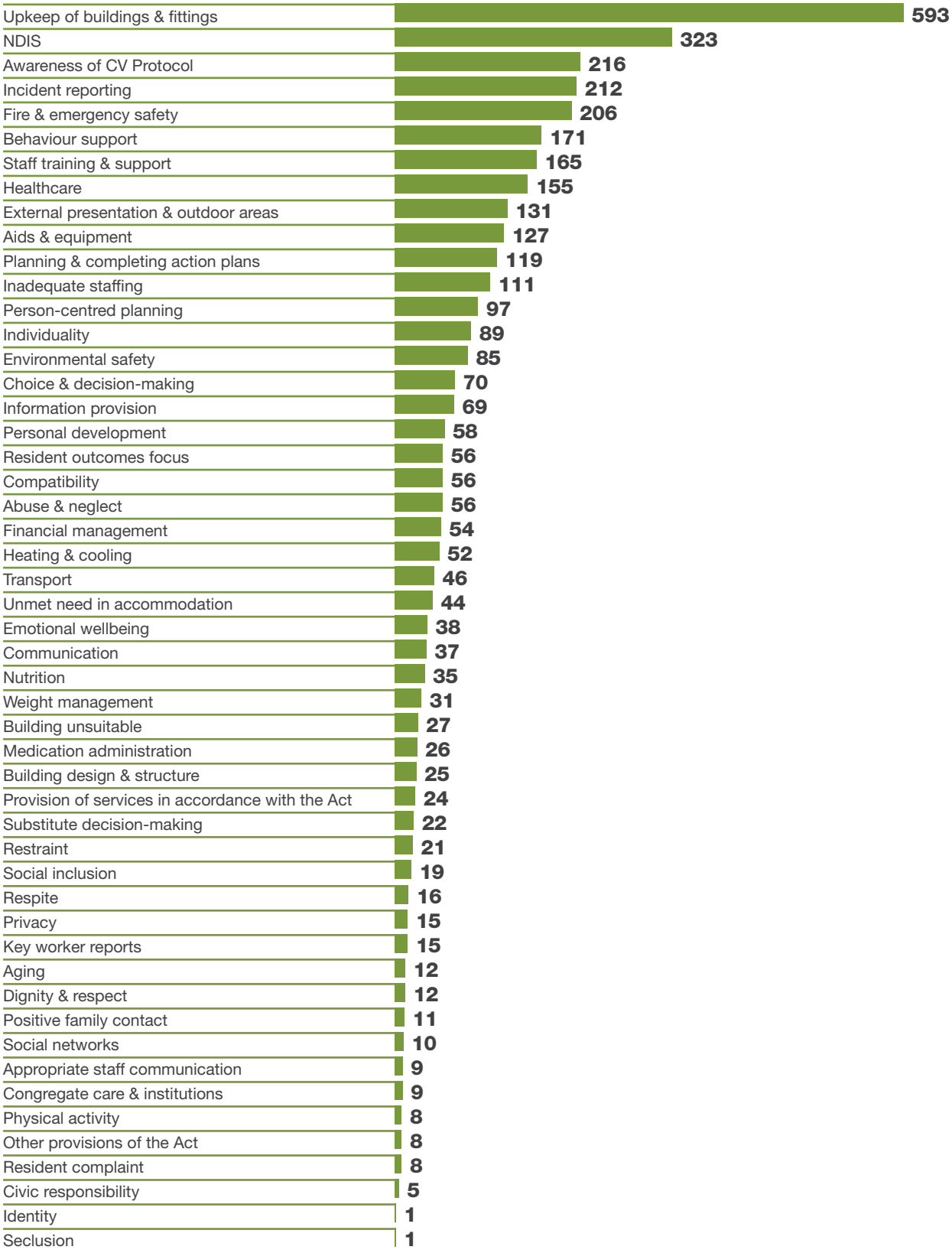


Figure 4. Issue types identified and number for each, 18/19



Divisional Reports

East Division

East Division includes Eastern Metropolitan Melbourne, comprising the DHHS areas of Inner Eastern and Outer Eastern Melbourne, and the regional area of Hume, which, in turn, comprises the DHHS areas of Ovens Murray and Goulburn.

Eastern Metropolitan Melbourne

Abuse and neglect

Resident-to-resident violence and abuse remains a significant concern. Community Visitors continue to receive reports from residents living with others whose behaviours of concern place them at ongoing risk. Some residents can be volatile, causing extreme stress for other residents and staff. The risk of abuse occurring between residents is exacerbated in houses where there is high staff turnover and vacant rosters filled with unfamiliar and less experienced casual staff.

Case study

Community Visitors alerted the Public Advocate to one resident's persistent and serious verbal abuse and physical abuse towards another resident.

In last year's annual report, Community Visitors highlighted the incompatibility of two residents with particularly challenging behaviours who were each moved in late 2017 to a vacant CSO house. This move was to be into two separate units within the house and, although a partition door was subsequently installed, frequent altercations became the norm as the two residents were required to share bathroom and living areas.

Verbal abuse is normal, can last for several hours, is unprovoked and occurs even when the targeted resident is not in the vicinity but can be heard throughout the house. Physical assault, slamming doors, hitting and biting occurs regularly and sometimes the targeted resident will retaliate. On one occasion, police responded to a complaint of fighting; staff tried to explain the situation though this was difficult as the resident was in tears and kept telling the officers he was poorly treated.

Although staff have tried a variety of behavioural support strategies in conjunction with prescribed changes to medication, the resident who has been abusive has been waiting for an assessment with a Behaviour Support Specialist

since June 2018. The service provider eventually sought alternate behaviour support assessment services via a support coordinator, however, the assessment is not yet finalised. Following protracted negotiations with DHHS, the service provider will undertake renovations to create two separate bathrooms.

The residents have told Community Visitors they do not want to live with each other, however, due to the complexities of the NDIS planning process, both residents are being denied the right to live in a place where they feel safe and happy.

In contrast, Community Visitors document that abuse and distress can be mitigated by skilled and appropriate staff training. Planning can transform a difficult house into one that is well managed.

In one Disability Accommodation Services (DAS) house, young and strong residents with extreme behaviours of concern are mainly segregated but can escalate with virtually no notice. Permanent staff wear a safety pendant and are the key to managing these residents. There has been ongoing unresolved tension between staff and management about placement of a central, one-way door lock which allows one resident to get to another to assault him.

In another house, Community Visitors carefully monitored a resident with extreme behaviours of concern. Persistent screaming and shouting was alleviated with more staff and training despite minimal reinforcement of strategies from the family. Community Visitors are alert to the impact of new staff or casuals.

Community Visitors observe the effect of poor-quality support plans for residents in need of a high level of behaviour support. Many plans do not adequately reflect a person's needs, which increases pressure on staff and disturbs others in the house.

For example, a new resident caused upheaval in a well-presented, purpose-built DAS house with all-female residents. DAS invested additional staff support and training to develop appropriate strategies and Community Visitors were pleased to learn that staff were proactive, putting up a screen so residents going up and down the corridor could not see each other and set off conflict. In another house, Community Visitors were also pleased with the DHHS response when they reported that one resident was targeting another resident who regularly retreated to her room.

DAS committed to investigating behavioural supports, monitoring of behaviours and extra training of staff.

Case study

Over many years, as John's bullying behaviour increased, Roger and Ben, who he lived with, felt increasingly insecure in their own home, creeping into the house when they returned from work, staying in their rooms and eating behind their own locked doors.

For over ten years, Community Visitors advocated for the three men, recognising their differing psychological and social needs. The distress experienced by Roger and Ben was alleviated when they were temporarily relocated to a serviced apartment.

The two men always spoke of returning "home", but not to live with John, who remained living in the five-bedroom house alone. Removed from their home for over two years, Roger became so anxious when his key worker went on holiday that he was hospitalised.

John's family eventually agreed to accept alternative accommodation and Roger and Ben were finally able to return home. At a recent visit Community Visitors found the house newly renovated, warm, welcoming, and the men confident and caring of those around them and their house mates.

Despite the existence of several long-standing vacancies in excellent facilities, some residents continue to live in unsafe and incompatible environments. Residents and service providers are frustrated by delays in obtaining SDA and SIL funding, and difficulties they experience using the accommodation portal, the Housing Hub.

Case study

A group of five residents visited the park and returned home.

Later it was discovered that a resident was accidentally left in a toilet and was still there when the staff member returned to look for her several hours later.

A doctor confirmed there were no injuries and the policies for taking residents out was revised.

Appropriateness of residential environment

With the introduction of NDIS, Community Visitors welcomed a program of maintenance to bring ageing buildings and fabric up to NDIS SDA standard.

Community Visitors raised concerns about a DAS house where five male residents with autism and behaviours of concern, food allergies and sexualised activity were required to share one toilet. Following the recent upgrades, there is now a second toilet and an outdoor pergola which is designed to provide sun protection for a resident who is not able to be in sunlight.

Although much of this work was long overdue, and despite a significant investment of funding, Community Visitors report poor quality workmanship at some houses and some long-standing maintenance issues remain unaddressed. Many of these issues are a risk to the health and safety of residents, requiring substantial repair and, in one case, a complete renovation of a house that is not fit for purpose. In one DAS house, cracks and holes in walls were filled two years ago yet painting was not completed. At another house, new lino flooring stopped at the laundry door.

Inappropriate floor coverings can significantly impact the health and dignity of residents. A service provider acknowledged the role of Community Visitors in advocating for a resident to have his bedroom carpeted.

Community Visitors reported on multiple occasions that urine in a resident's bedroom had soaked through the carpet and into the timber floor underneath. Instead of replacing it with laminate flooring, DAS arranged for steam cleaning every six weeks, an inconvenience for the resident and staff, and ineffective in removing the odour of urine.

At a DAS house, a resident with mobility issues moved to another DAS house but was unable to move throughout it independently as no rails were provided. Community Visitors highlighted the resident's loss of independence and, following an occupational therapy assessment, rails were manufactured and installed.

Over many years, Community Visitors have received feedback that residents in a DAS house in the outer east area might be relocated because of fire risk. Over summer, this house has access to a dedicated bus in case of fire emergency. The bus is borrowed from another house causing logistical challenges for both houses.

Well-maintained exterior landscape and garden facilities are essential to the wellbeing of residents. Community Visitors visit a busy DAS respite facility with regular outings and activities, however, the front courtyard impedes residents as stones, mud, and old tanbark make it difficult to use.

Quality of staff support

This year, Community Visitors commend several service providers and staff across the area for their kindness, dedication and professional care in providing a broad range of supports to residents in managing their daily needs including grooming, cleaning, food preparation, attending outings and holidays. Some houses are purpose-built and present as a family home.

In one house, caring staff supported an elderly resident until she moved into aged care for palliative care, a resident diagnosed with dementia and another waiting for open heart surgery. In another house, staff advocated and supported a resident to move to Perth to be closer to family. Another resident can video call his parents and one young man has an overnight stay each weekend with his father.

Although there has been investment in staff training towards 'zero tolerance' of abuse and person-centred support, staff remain under pressure to complete a broad range of incidental tasks, and frequently choose not to involve residents in the running of their own home. Community Visitors were unable to enter a DAS house despite knocking loudly for an extended period and moving around the exterior of the home. Residents could be seen unattended in the hallway. Community Visitors sought an explanation from DHHS which simply advised that staff were unavailable as they were attending to other duties.

Community Visitors continue to identify outdated support plans and client documentation that is incomplete and not filed correctly. In one house, staff commented on the physical and mental decline of residents as they aged and the need for greater staff numbers to support them. Community Visitors question whether the absence of relevant documentation compromises staff ability to provide appropriate care and limits an accurate reassessment of residents' changing needs.

> ***Case study***
>
> The impact of high staff turnover was particularly apparent in a DAS house with residents who all have substantial physical support needs.
>
> Only one resident can vocalise and, therefore, she often gets the most attention. Client documentation is often disorganised and out-of-date.

Community Visitors are concerned about the detrimental effect of poor communication between a resident's day placement and home.

One day, house staff were contacted to collect a resident who had just arrived at his day program which was cancelled without the house staff being alerted. In contrast, following a resident incident, the house staff sought a medical review, notified family and worked closely with day placement staff to facilitate greater communication between the two services.

At service provider liaison meetings, Community Visitors were informed of constant efforts to minimise staff turnover and recruit new casual staff. A lack of suitably qualified and experienced candidates means that new casuals gain their experience on the job, sometimes with limited supervision.

Good practice

Community Visitors approached a DAS group home and heard extremely loud banging on a rear, glass door and high-pitched screams.

Susan, a young female resident, was experiencing an acute mental health episode following a recent visit to her psychiatrist who had altered her medication. For the duration of the visit, Susan moved around the house banging loudly on the fence and screaming expletives. Staff explained that they let her "burn her stress out" until she settled.

The acting house supervisor finished her shift leaving one regular staff member and a new casual. Community Visitors concluded the visit with the staff member and residents sitting around the dining table with colouring books and pencils, completely calm while the outdoor chaos continued.

Community Visitors commend the staff member for her care and skill to support the other residents to remain calm and happy.

Case study

Last year, the Community Visitors annual report described a young male with severe behaviours of concern who moved from his parents' home to a DAS house.

Initially he smashed windows, kicked doors and destroyed other residents' property, as well as assaulting other residents and staff.

Community Visitors were alerted that the resident was likely to be relocated to another DAS house. Community Visitors questioned the benefits and risks to the other residents and strongly advocated against the move.

With constant positive behaviour support and monitoring of his health and diet, the young man has gradually turned his behaviours around and has not needed to be moved.

Physical wellbeing

A resident with sleep apnoea trialled a continuous positive airway pressure machine, with assistance and encouragement from staff. After six months, the resident's GP began to investigate other options. In the meantime, staff are monitoring the resident every half hour during the night.

When Community Visitors enquired about support provided to a resident who had their blood sugar level regularly checked, they were surprised to find out that no initial training had been provided to staff. At their subsequent visit, Community Visitors were pleased to learn that staff training had finally occurred.

Community Visitors queried the support provided to a male resident who is regularly seen in the local community; he manages his own money and is known to have a gambling problem. He begs for food and money at the local shopping centre, stays out late missing his medications and compromising his physical health. Community Visitors suggested permanent stable staffing and behavioural counselling for the resident to assist him to overcome these behaviours.

In a purpose-built house divided into separate units, Community Visitors are unable to have direct contact with four male residents with autism and with major behaviours of concern, however, they observe that residents' health and wellbeing is effectively supported by a team of permanent, skilled, and committed staff.

Physical wellbeing is compromised by worn-out furniture. For example, a resident with health and mobility issues was observed sitting in a low, dilapidated couch with no support. Community Visitors were concerned this could exacerbate her condition. Although appropriate furniture was sourced, the service advised that new couches would not be purchased until the capital expenditure application had been approved.

Good practice

Community Visitors commended a service provider for recognising and supporting a transgender individual's needs in the residential environment.

Rights

Some residents cannot access communication aids or are forced to use broken equipment. While familiar staff can interpret for them, it is limiting for the individual.

Where residents face challenges with communication, Community Visitors request assessments to increase residents' opportunities to communicate with others. In one house, Community Visitors queried the possibility of broadening some individuals' communication skills using pictorial representations or an iPad. In another, Community Visitors requested to use the communication dictionary available when speaking with one resident.

There is a pressing need for service providers to initiate opportunities to assist people to communicate in their daily life within and outside the home.

Community Visitors regularly visit a teenage male resident living alone. With intensive support, the resident attends school in the mornings and has limited access to his community. While he has good family support, the only place he can move around freely is in his home where he is under constant staff supervision. It is difficult to determine his interests day-to-day as they change frequently and his behaviour can escalate quickly. Community Visitors continue to visit and to advocate for his future.

A female resident who is reliant on a walker frequently exits the house to check the letterbox. When unfamiliar staff are rostered, she is known to wander up the street to a busy intersection. Community Visitors raised concerns for her safety as the front door is fully accessible and other residents have high needs which require constant support and observation. DHHS advised the resident was free to leave the house at any time, however, agreed to work with the house supervisor to review strategies and identify any risks.

Residents' circumstances sometimes necessitate independent advocacy. A young man residing in a DAS house is not an Australian citizen and requires advocacy to assist with a VCAT matter. In another example, a service provider is investigating a possible case of Munchhausen Syndrome by Proxy as the resident has been medicated at a parent's insistence for many years apparently for no known reason. Community Visitors were sympathetic to a young male resident who cannot go on a supported holiday due to his parents' refusal.

Good practice

Two residents seeking to get married were supported to hold a commitment ceremony and are exploring options for their honeymoon.

Compliance with the Act

Although some service providers made additional efforts to meet their responsibilities under the Community Visitors Disability Services Protocol by responding to issues in a timely manner and ensuring access to incident reports, others are not so responsive.

Variability in the format and quality of client documentation is also a concern. One service provider has houses where files are up to date with access to monthly lists of incident reports. This is not the case in others. Monthly incident summaries are very useful and critical information regarding follow-up is available on request.

NDIS

There is strong evidence that a comprehensive NDIS plan and effective support coordination enables people to have an improved quality of life.

An older resident moved from a group home where he was bullied to another where he lives with a friend he has known for many years. Staff at the new group home set up garden tubs as he had to leave his behind at the previous house. Another resident received an increase in staff supports and now has 2:1 staff support, five days a week.

However, there are significant deficits for many people whose planning processes did not incorporate all appropriate assessments or information so that their needs were not properly articulated. Delays in health assessments are extremely distressing for people in great need and warrant government action to strategically bolster service provider numbers in key areas.

Other residents are impacted by delays and difficulties experienced finding suitable support workers as fewer workers are willing to work short shifts of three hours.

Resident neglect is also noted in reports this year. A year ago, Community Visitors spoke to a severely disabled resident who needed a new wheelchair. The resident waited for an NDIS review and, although this is complete and funding allocated, she is yet to receive appropriate equipment.

Residents who enjoyed a stable routine were severely impacted by changes to a new service delivery model for Knoxbrooke day programs. Two residents at one DAS house showed increased behaviours of concern, including assaults, when their day program was cancelled at short notice. Both men are still working with support coordinators to find placements with other providers.

Community Visitors enquired about the suitability and accessibility of a bathroom for ageing residents. DHHS advised that the house supervisor was going to check with the NDIS support coordinators to ascertain if the residents had funding for home modifications in their plans.

Community Visitors are also concerned about another group of ageing residents with declining health. Although they have NDIS packages, they do not have adequate SIL funding as no individual quotes were prepared for DAS house residents.

There is an urgent need to resolve complaints of inadequate transport funding.

> ***Case study***
>
> Despite having a new house bus, residents don't have enough money to constantly travel on EastLink for day programs.

Hume

Abuse and neglect

Community Visitors noted several serious incidents of resident-to-resident abuse and aggression.

> ***Case study***
>
> A family member alerted Community Visitors to multiple incidents of aggression by a resident towards other residents and staff at a DAS house.
>
> Residents were taken to hospital on separate occasions and they were unable to participate in regular activities during their recovery.
>
> In a separate incident, staff locked themselves in the office and waited for the police to arrive. In response, DAS arranged additional staffing at peak times and engaged behaviour support specialists. Despite some improvement, DHHS acknowledged the dysfunction was exacerbated by changes to management and staff shortages.
>
> The resident with behaviours of concern was relocated to more appropriate residential accommodation. Unfortunately, due to a shortage of independent living units, the solution to this problem then precluded another resident from transitioning to their long-awaited accommodation.

Staff-to-resident abuse was also a significant concern.

> ***Case study***
>
> Community Visitors became aware of multiple allegations of serious abuse and assault by a staff member at a CSO house, despite being unable to access incident reports.
>
> In response to Community Visitors' questions, the service provider advised that an internal investigation had substantiated allegations that a non-verbal resident was spat at and hit with a shower head on three occasions.
>
> The staff member's employment was terminated and the matter referred to police. The CSO also acted in response to Community Visitors' concerns that the allegations of abuse were witnessed by staff but not immediately reported.

At another house, a distressed staff member gave Community Visitors a letter of complaint concerning inappropriate physical treatment of a non-verbal resident by a senior staff member and the reluctance by DHHS to act on previous complaints.

In response, DHHS advised that the senior staff member was being supported to improve her practice and that the complainant would be invited to discuss the complaint but would not be advised of the outcome for privacy reasons. Although the DHHS Workplace Relations Unit were to review the complaint to ensure a fair and reasonable process, the Community Visitors observed that the staff member who made the complaint was relocated while the staff member who was the subject of the complaint remained in the house. Community Visitors question whether internal investigations normalise abuse and call for a closer examination of the protections offered by service providers for staff who report abuse.

At a DAS house, a resident with a sore arm was transported by ambulance to Goulburn Valley Health for X-rays. An orthopaedic surgeon identified calcification and surgery to treat a fractured upper arm was cancelled. Testing and further investigation suggested the resident may

have had a previous fracture from a fall several weeks prior. Staff were unable to identify when or how the injury occurred and reported the matter to the DSC. Community Visitors reported that client file notes were missing but were eventually located.

Community Visitors witnessed a resident in the middle of a pseudoseizure. Although a frequent occurrence, the client management plan had no identified author or any reference to medical advice sought in its preparation. The plan advised to give medication PRN, however, there was a further note in the plan where the GP had cancelled this treatment.

Appropriateness of residential environment

Community Visitors found the washing machine at a DAS house broken and residents running out of clean clothes. With only one staff member per shift, staff were unable to get to the laundromat. A new machine was purchased and installed the day after the visit.

The Community Visitors Program received a call to assist a resident who had moved from a CSO group home to an independent living unit at the same address. The unit was vacated following the death of the previous resident and Community Visitors observed walls in need of painting and heavy staining from the toilet across the bathroom floor. Due to unsanitary conditions, the new resident was advised not to use the bathroom until cleaning was arranged. In response to Community Visitors reports, the CSO and DHHS negotiated to undertake bathroom repairs.

At a CSO house, a broken television was replaced after eight weeks, however, it took five months to replace the oven that had stopped working.

In May 2019, DAS houses in the Ovens Murray area transitioned to one of the five outsourced providers. The transition was well-managed, however, DHHS did not rectify long-standing unresolved issues such as the widening of a narrow outdoor pathway to accommodate a resident's walker prior to the transfer.

Community Visitors were pleased that a new respite house opened with all new equipment, however, not all fire safety equipment was tagged.

Quality of staff support

The health of a resident with severe mental illness was stabilised in an acute inpatient service and an extended transition plan created to provide high levels of support to the person and other residents on her return home. Additional funding for increased staffing in the home provided opportunities for co-residents to engage in activities away from the home. A flexible approach to the transition was essential to minimise behavioural incidents between residents.

Community Visitors identified three serious medication errors made by one staff member over six months. The service provider issued a formal warning to the worker and provided further training and monitoring.

> ***Case study***
>
> Community Visitors are deeply concerned about a service provider's challenge in balancing duty of care, a resident's right to choose and the wellbeing of co-residents.
>
> Rose, a vulnerable young woman with intellectual disability, asked to move to Shepparton to spend more time with her boyfriend. The service provider supported her to arrange an advocate to discuss where she would like to live.
>
> Community Visitors reported that her relationship negatively impacts her emotional and physical health and she frequently calls the service provider and police for emergency assistance while away from home for long periods.
>
> The service provider is trying to empower the resident to speak up and know who she can contact when at risk and to maintain daily contact with the house supervisor regarding her whereabouts and safety. Staff, however, are regularly called to collect her many kilometres away.
>
> Multiple services hold serious concerns for her long-term well-being and, although she has been referred to other services for support, the lack of case management means that these efforts remain uncoordinated.

Community Visitors noted the excellent work of staff who continued to support a resident with complex physical needs in hospital until the end of his life.

Physical wellbeing

Community Visitors questioned the appropriateness of a resident in his forties moving to an aged care facility away from family, friends and a supportive rural community. The resident was ill and required ambulance transport to Maroondah Hospital where he receives regular review and treatment. However, the ambulance

took the resident to Goulburn Valley Health in Shepparton instead and then transferred him back to the DAS house with the incorrect PEG-feeding tube in place. The house staff were not equipped to deal with this situation, so the resident was then taken to Maroondah Hospital.

The resident received an apology from Ambulance Victoria and Goulburn Valley Health acknowledging the problems and delays in providing treatment. Clinicians subsequently arranged for the resident to move to an aged care facility in another rural town where a registered nurse would be available to assist with PEG-tube feeding. Community Visitors believed that, with advocacy support and flexibility to retain his bed at the group home while recovering, this resident may have returned to live with co-residents for many years, closer to his aging mother and supportive community.

Rights

Community Visitors report ongoing difficulty accessing incident reports.

In the Goulburn area, a meeting of Community Visitors and house supervisors discussed options to improve the system for accessing incident reports on a consistent basis. A new system was implemented and refined over several months. Coordination across the entire service and a willingness to rectify the Community Visitors' concerns paid off when staff at all houses were able to provide incident reports during the final visit of the financial year.

Community Visitors appreciated the steadfast efforts of Kirinari and Providing All Living Supports to maintain a system which enabled ease of access to incident reports at all visits.

NDIS

The NDIS is being rolled out in the Goulburn area with most residents waiting for plans to be approved. In the Ovens Murray region, Community Visitors and residents are developing their understanding of the impact of individual participant funding and the requirement for a support coordinator to arrange access to services not affiliated with the SIL provider. Community Visitors observe SIL manager and support coordinators working closely to maximise funds to meet a participant's goals.

North Division

North Division includes Northern Metropolitan Melbourne, comprising the DHHS areas of Hume Moreland and North Eastern Melbourne, and the regional areas of Loddon and Mallee.

Loddon Mallee

Abuse and neglect

> ***Case study***
>
> A resident verbally threatened other residents and made allegations against staff.
>
> These were investigated by DHHS and police. Despite the allegations being deemed unsubstantiated, some staff were transferred elsewhere.
>
> The resident seems inappropriately placed as she is sharing with non-verbal residents with high needs. She is negotiating with State Trustees and exploring rental properties with the goal of moving.

Appropriateness of residential environment

Maintenance issues have included plaster cracks, wall damage that is a year old, broken doors and tiles, missing safety railing and inadequate air conditioning.

> ***Case study***
>
> Residents were excited they were getting a bathroom upgrade as they loved to take baths.
>
> They were disappointed to find it was impossible to safely step into and out of

their new bath, creating a health and safety risk for both residents and staff.

The residents' needs were not properly determined beforehand so a costly mistake occurred.

Over a year later, and there is still no date to replace the bath.

Quality of staff support

Community Visitors are concerned that residents in one house had more than 20 new staff within a short period. The organisation had transferred experienced staff to provide one-on-one activity support to individuals with NDIS funding. However, Community Visitors remain apprehensive about the impact of so many new staff on the standard of care.

In another house, community interaction and outings have been curtailed as staff hours are insufficient to support three residents whose health has deteriorated.

Case study

Two teenage brothers needed only one staff member on duty.

Community Visitors asked why one brother seemed concerned about who was coming. They discovered new staff worked only two 'shadow shifts' with an experienced staff member before working on their own. This exacerbated the brothers' anxiety about the many "strangers" caring for them.

Staff were requested to have more time in the shadow role to build relationships with the brothers. This has not occurred.

Community Visitors will advocate further with the organisation on this issue.

Good practice

Community Visitors were pleased to find very caring and supportive staff in one residence who communicate effectively with each other and residents, reflecting an awareness of individual needs.

The staff also had an exceptional administration system with a yearly planning guide displaying residents' medical and health review dates. Detailed resident information was easily accessed by new staff.

Community Visitors visited a young man who had no planned activities apart from walking to the shops to buy lunch when he could afford it. Community Visitors asked the resident about the experiences and activities he enjoyed and discussed his interests with staff who became proactive in organising daily activities. This included visits to the dog park, library and assisting the resident to choose a bike. Without the Community Visitors' encouragement of staff to become more proactive, this young man would still have very limited opportunities to enjoy a more positive life.

NDIS

Staff are often excluded from the NDIS application process and, as a result, residents' funding is insufficient to meet their needs and NDIS plan reviews are required. Staff are not always informed of service agreements, funded activities and appointments. Limited communication poses difficulties for staff co-ordinating residents' needs.

Good practice

A service provider sent a support worker to take a resident out for a one-on-one activity without having previously met the resident.

The house staff member refused to allow this until the support worker had been informed of the resident's preferences, communication abilities and tools, mobility issues and behaviour support needs.

Once confident the resident was going to be properly cared for, the house staff member introduced the resident to the support worker.

Compliance with the Act

Community Visitors are concerned that, due to a shift towards electronic records, incident reports are unable to be accessed during visits. Responses to visit reports are not always timely nor do they adequately address the questions.

At one CSO house, the new manager and staff did not know about Community Visitors and their role.

Northern Metropolitan Melbourne

Abuse and neglect

Case study

Community Visitors remain seriously concerned about issues at one house including a resident with multiple unexplained bruises, misuse of a resident's iPad by staff, loss of a resident's wallet and ID cards, and a resident being left in a urine-and-faeces-stained bed for prolonged periods.

Another resident leaves the house around midday and doesn't return until late at night or early morning. He is a diabetic but his meals cannot be monitored and his medication is left in the microwave for him to self-administer, possibly posing a risk to other residents.

This resident was banned from local shopping centres following an alleged theft and police involvement. Community Visitors could not access incident reports, so it was difficult to accurately assess the situation and actions taken.

Often it takes months or even years to resolve situations where residents are at risk. In one case, a resident who assaulted their co-resident has remained in a unit while the victim has slept on a fold-out bed near the staff office since November 2018.

In another case, a new resident's violent behaviours and property damage led to holes in walls, bedroom and other doors being locked, and residents using plastic knives, forks and plates. Alternative accommodation is reportedly being investigated for this resident but disruption at the house has gone on for more than 12 months.

Case study

One resident went home to live with his mother, 84, after another resident poured boiling water over him.

His family wants the person who assaulted him relocated so he can return to the unit. The lack of suitable accommodation alternatives has led to this situation remaining unresolved for over a year.

OPA's Advice Service was contacted about a resident's ongoing aggressive behaviour which included defecating in a neighbour's driveway, breaking a neighbour's windows and being verbally and physically abusive towards staff and residents. Community Visitors were concerned that some residents could have suffered post-traumatic stress as a result.

OPA was also contacted regarding alleged staff abuse and neglect at a DAS house. The resident was in hospital for several months because of a fractured foot which her parents alleged occurred because staff did not put her shoes on properly. The family also allege their daughter was over-medicated after being taken to the GP without their permission. Community Visitors could not find evidence to support the allegations.

Another parent wrote to OPA about injuries to his son (significant bruising and an eye laceration). Community Visitors visited the resident's house to look into the matters raised, but the parents had already removed their son from the home. Incident reports were not available but progress notes said the residents had experienced frequent falls.

Accommodation demand

Harmony in houses is essential to resident wellbeing and is often underpinned by careful consideration of vacancy management and long-term consistent staffing arrangements. When this does not happen, disturbances, stress, anxiety and marginalisation for residents can result. Transition to NDIS has drastically transformed the vacancy management process.

Case study

A new resident was moved into a house in January with no introductory visits beforehand.

She had no day placement organised despite this being in her transition plan. Within days, she began to abuse the other three residents who were frail and in their 50s. This mid-20s woman physically fought the residents and staff. She was eventually removed from the house by police after assaulting paramedics called to the house.

However, in April, when Community Visitors visited, DHHS had still not provided counselling for residents. One resident was so traumatised she would toilet in her room rather than risk an encounter with other residents.

The process of matching and introducing a new resident to the house had been mismanaged. The failure to provide counselling to the residents has impacted on residents' health and wellbeing.

Case study

Several older, non-verbal residents with high support needs reside in a house with another resident who is much younger and high functioning. One of the older residents called OPA requesting that Community Visitors visit and was able to explain how marginalised she felt being in a house with no other residents who she could readily communicate with.

She had been waiting over three years to be placed in a more suitable home.

Community Visitors could find nothing in the paperwork about what strategies staff might adopt to make some part of the house more peaceful for her rather than having her simply retreat to her room.

A similar situation was observed in a house designed specifically to care for residents needing ventilator assistance. The staff were caring and highly trained to meet the specific physical and medical needs of the residents but one young woman spoke to Community Visitors about how she felt "boxed in". She seldom left her room although she had contacted her support worker for assistance in achieving her goals of finding office work and getting out more. Community Visitors felt she was very isolated. There were no strategies that staff might adopt to improve socialisation within the house, so Community Visitors raised it with the service provider for action.

Appropriateness of residential environment

Maintenance at many houses has improved as the State Government provided funds to upgrade DHHS-owned houses to meet SDA standards.

High standards, though, are not universal. Several houses run by Housing Choices Australia have only had cosmetic changes like painting and floor coverings. They are not fit for purpose with upstairs bedrooms, corridors too narrow for wheelchairs or only one toilet and bathroom for five residents and staff.

Case study

Community Visitors reported that the condition of a DHHS house was the worst they had seen in many years of visiting.

One resident has been waiting since 2017 for modifications to a wardrobe so a ceiling mounted hoist can be fitted. He and another resident are put to bed by 7.30pm as two staff need to assist them. The roster only allows for one staff member after that time.

A ceiling-mounted hoist is needed in the bathroom; the roof leaks; the walls are patched in many places and in need of paint; and flooring is in very poor condition. Blinds are needed to replace the torn lounge curtains while the back rooms need heating and cooling.

Community Visitors report that the staff are excellent, however, it is difficult providing care for residents with significant challenges in such a dismal setting.

Case study

Premises were renovated in late 2018 with the unfortunate result that the only commode chair in the house could no longer fit over the renovated toilet. Consequently, a female resident was forced to use a bucket placed under the chair which had to be tilted back for her to use it. This situation continued until April this year, which impacted on the dignity of the resident.

Due to deficiencies with the NDIS, an occupational therapist could not be found to undertake the required assessment before equipment was purchased. After escalation of the issue, Community Visitors learned that a replacement commode chair could have been hired while the assessment was pending.

The renovations in the house resulted in the wrong lock being fitted to the front door. If staff and residents had to go out, the house could be locked but, to get back in, staff had to climb the back fence to enter by the back door.

The staff in the residence are excellent and it is only by their tireless efforts that a reasonable standard of care is provided.

Quality of staff support

There are examples of exemplary staff support and record-keeping although a lack of activities and strategies to engage and communicate with residents remains a problem in some houses.

Good practice

Community Visitors were pleased to hear that staff facilitated a resident visiting their mother in hospital. Contact, either in person or by phone, to the level requested by the resident and their family member was encouraged.

When Community Visitors spoke with the resident, she told them how important it was to her that she could contact her mother regularly including while she was in hospital.

Several houses have whiteboards in unobtrusive areas which show residents' daily routine, support needs, family visits and alerts. This enables staff to assess quickly if resident needs are being met and so they now do not need to consult paperwork before helping residents.

Compliance with the Act

Identification of incidents involving abuse and neglect of residents often relies on access to relevant records.

Community Visitors are frequently unable to access incident reports and other documents. Some staff assist with access to documents on the computer, however, casual staff often cannot. Only the most serious incidents are captured on the DHHS *Client Incident Management System* (CIMS) while other issues are recorded as non-critical or 'behaviours of concern'.

Case study

At one house, there were 26 non-critical reports in three months about a resident's disruptive behaviour including throwing items, yelling and entering other residents' bedrooms.

The resident's parents think her behaviours relate to the return of a staff member from leave. However, the service says it will not move staff solely in response to parental objections.

One CSO uses an electronic management system with no documentation held in houses. When a Community Visitor arrives, they can only chat with staff and residents and look around to see how things are going. The CSO proposed that a staff member log into the system using their username and password and sit with the Community Visitors looking through files. This is unacceptable as it diverts staff resources away from supporting residents. Community Visitors should be able to access information without the need for staff intervention or presence.

NDIS

The NDIS has made a positive difference to some residents' lives, enabling them to participate in activities or achieve long-standing goals, but there are also problems being reported. Some NDIS funding packages do not adequately meet residents' needs. In many houses, staff do not understand how funds can be accessed and used. Staff need better training on the operation of the NDIS.

The time taken to review plans places stress on residents, families and staff, with delays to access specialist assessments common.

One resident has displayed increasing behaviours of concern. A plan review determined that she needed extra behaviour support funding, however, delays in processing put pressure on all staff and residents at the house. One resident whose wheelchair had become unsuitable eventually had approval to purchase a new one, but there was a significant wait for individual fittings. Another woman needed a commode chair that would safely fit over the house toilet, facilitating some independence. NDIS funds were delayed and she is using a commode borrowed from her family which must travel with her on visits to them.

Good practice

Ivanhoe Diamond Valley Community Centre Inc. uses a separate folder to record individual support funded by the NDIS.

At the end of an activity, a support worker enters the outing location, any costs and a brief evaluation. This provides house staff with information about activities, food eaten, skills support, costs, and enjoyment. The NDIS worker and house staff work together for the benefit of the resident.

Community Visitors applaud this cooperative arrangement, as it shows how the NDIS improves people's lives.

Good practice

A CSO house has an individual booklet for each resident in case of hospital admission.

As the NDIS does not fund support when a resident is in hospital, this is the service provider's response to a difficult situation and to ensure the individual needs of residents could be communicated to hospital staff.

South Division

South Division includes Southern Metropolitan Melbourne, comprising the DHHS areas of Bayside Peninsula and Southern Melbourne, and the regional area of Gippsland, comprising Inner and Outer Gippsland.

Gippsland

Abuse and neglect

There have been multiple violent incidents at a DAS house that will be transferred to a CSO later in 2019. There are ongoing concerns for the welfare of residents and staff, and Community Visitors query the compatibility of the residents. Also, of concern, is that a resident is currently not attending day program, and this lack of structure is not beneficial to him. DHHS has advised that specialist support is being accessed and strategies are being put into place to address the concerns. However, Community Visitors will continue to monitor this house closely.

Appropriateness of residential environment

Ongoing maintenance issues in Gippsland can take a long time to address, impacting on residents' wellbeing. For instance, doors need to be widened to allow for better access to a unit, walls repaired, bathrooms updated and repaired, and painting is needed, while gardens and landscaping all require attention. The outside environment of houses is also important for the wellbeing of residents. In a CSO, there is an unsightly three-metre-high internal wire fence separating the units. It was originally built to prevent a resident from absconding, however, that person left more than two years ago and the fence remains in place. The service provider stated that families and residents want the fence to remain as it provides residents with their own space and privacy. For Community Visitors, the existence of the fence is reminiscent of a more institutional environment.

Quality of staff support

During a visit to a CSO house, a resident expressed concern that she is being put to bed at 7.30pm every night which is much earlier than her preferred bedtime. The staff advised that two staff members were required to put the resident to bed, as a hoist was required, and one shift finished at 8.00pm, then there was only one staff member on duty. The resident likes to knit in the evening but cannot do so once she is in bed.

The CSO organised for an occupational therapist to attend the site and complete an environmental and manual handling assessment. The subsequent report recommended a change to the procedure for hoist transfers for the resident as well as additional alterations to the set-up of her bedroom. The changes have now been implemented, allowing the resident to stay up till 9.30pm.

NDIS

The rollout of the NDIS this year has been problematic in many ways.

Access to NDIS plans has been difficult in some cases – one CSO advised that such plans were kept by the families and CSO staff could not access them either. Some residents have also experienced extensive delays with planning as well as plan reviews.

There is a direct correlation between transition to NDIS funding and reduced numbers of clients in facility-based respite since the rollout began in Gippsland. Respite services are being underutilised. In one instance, a CSO-managed

respite house was closed for a week due to declining numbers. The service provider said that many clients had not received the respite funding expected, with several clients requesting plan reviews to obtain more funding for short-term accommodation. The situation has improved for some, following these reviews.

Another respite house managed by DAS has also experienced a significant reduction in numbers. DHHS advised that these concerns have been raised with the NDIS. Steps were also taken to communicate with schools and planners to ensure that they were aware of the resource, which has resulted in increased usage, although not at previous levels.

Difficulties can arise with the support services that residents receive as part of their plans. In one house, staff took a resident to visit her mother as the NDIS provider was not available. Staff are conscious that residents need to utilise their support funding otherwise they are in danger of losing funds when plans are reviewed.

Southern Metropolitan Melbourne

Abuse and neglect

Residents with challenging behaviours can impact on the quality of life for other residents in houses. If resident compatibility is an ongoing issue, options to relocate elsewhere may be limited.

In one CSO house, staff and residents have been subjected to multiple angry outbursts from a resident. One resident took out an intervention order against the resident after being verbally abused at a local social venue by them. The order applies both at home and the social venue, posing challenges for the staff in managing contact between the two residents.

> ***Case study***
>
> In early August 2018, a female resident of an SRS displaying serious assaultive behaviours was urgently relocated to a tranquil CSO house grieving from the recent death of a long-term resident.
>
> Her transition to the house was sudden and scant background information was provided to staff. Residents witnessed staff assaults and violent behaviour at day placement, the doctor's surgery and towards a family member. Staff were given specific behaviour support training. The resident was admitted to hospital for a psychiatric review, remaining there for eight weeks.
>
> While there, her serious dental pain, which may have contributed to her behaviour, resulted in extraction of nine teeth. She was unable to return to the house and, in February 2019, was living elsewhere with two-to-one support.

A female resident's mother reported an alleged request by a taxi driver that the young woman "show him her private parts". She reported this three weeks after the incident. Staff followed up with the taxi company, however, they had no success in identifying the perpetrator. They also asked the resident's GP to speak to the resident about the importance of immediately reporting inappropriate behaviour.

> ***Case study***
>
> A resident of a CSO house reported that he had no money in the bank to buy his lunch.
>
> The resident's sister managed his finances, had reduced his monthly allowance and was not paying his bills. Community Visitors noted unpaid surgeons, dentist and pathology bills, and a pharmacy bill of $1800.
>
> CSO management escalated this matter to DHHS while an advocate was engaged from VALID who assisted with an application to VCAT. State Trustees was appointed administrator for the resident at the hearing.
>
> Once appointed, State Trustees investigated further allegations of financial abuse by the sister involving the resident's inheritance from his father's estate.

Following an OPA Advice Service request, Community Visitors visited a house managed by a CSO where a new resident had hit two other vulnerable residents, causing emotional distress. The new resident had a history of assaultive behaviours requiring police and Crisis Assessment Team (CAT) interventions, but Community Visitors were unable to view incident reports to gather further information. However, following Community Visitors reporting their concerns, staff at the house were provided with further training in behavioural support strategies, while management agreed to facilitate better access to incident reports in future.

At another house run by the same CSO, Community Visitors had concerns regarding the aggressive behaviour of a resident. Other residents had told Community Visitors that they were afraid and staying in their rooms because of this resident's behaviour. There was concern that the traumatic impact of the exposure to violent incidents, even where residents had not been assaulted themselves, was not adequately captured in incident reporting. The CSO responded that "CIMS [the electronic Client Information Management System] have not been completed for the emotional abuse on other residents as the documentation process would take hours to complete".

A resident in a group home was lured to a room and sexually assaulted by a day placement participant. She was able to flee and informed staff that she wanted to report the incident to police which she did with the assistance of the house manager. Supports were put into place including counselling while the police Sexual Offences and Child Abuse Investigation Team (SOCIT) unit pursued charges against the perpetrator. The psychiatrist stated that, in her opinion, the quality of immediate support was a crucial factor, in empowering the resident to report and process the events. Prior to the incident, residents had received education on a 'zero tolerance' approach to abuse, followed up by discussion on issues including sexuality, relationships and abuse. The offender no longer attends day placement and charges by police are pending. The resident has ongoing staff support when needed.

Appropriateness of residential environment

It was pleasing to see significant and long-overdue spending on maintenance works and upgrades of houses to meet NDIS SDA standards prior to the houses transferring from DHHS to CSO management. The benefits to residents and their wellbeing are obvious.

Despite this, Community Visitors continue to see long-standing maintenance issues. Several facilities are in a very poor state of repair. In one home, the leaking bathroom ceiling put a bathroom out of action for four months. In others, cladding had peeled from the bathroom wall and detached at the wall-floor junction, causing mould; laundry walls and ceiling were covered in dust because the flue from the dryer wasn't sealed; walls were beautifully painted beside chipped skirting boards and door trims.

The responsibility for the upkeep of houses is still with DHHS while the supports are now managed by a CSO. CSOs repeatedly report that maintenance issues have been logged with DHHS, but there are significant delays in the work occurring. In some cases, the standard of maintenance work is poor.

One CSO house has multiple ongoing maintenance issues including a broken evaporative cooling unit, doors that cannot be opened, locks that fail sometimes locking out staff, faulty bathroom floor repairs, tiles needing replacement and intermittent intercom operation to units. Some were urgently repaired while others remain outstanding.

In a CSO house, repairs to bathroom walls and flooring have been outstanding for at least ten months. In one DAS house, renovations completed to the bathroom needed to be reversed as a resident in a wheelchair was unable to access the toilet. Community Visitors have been reporting this issue since February 2018.

Quality of staff support

At one CSO house, Community Visitors noted the absence of prominent information essential for staff to initiate emergency procedures stipulated by a surgeon for one resident.

There are ongoing issues with service providers finding and retaining staff with sufficient training and experience. This seems to have been exacerbated by jobs created by the NDIS, however, service providers still need to be accountable for understaffing which puts clients at risk. For instance, staff in one CSO facility are regularly called during a shift to other houses managed by the same CSO, leaving only one staff member present at the facility.

Community Visitors also visit one house with six residents including one whose PEG feeding tube must be monitored for up to 17 hours. Community Visitors have highlighted the continuing need for a third staff member in the afternoons.

Many houses are being transferred to new service providers which has resulted in anxiety about the impact of changes in funding and service delivery on clients. In a respite house, staff were concerned that the new provider wanted the house to become "lock-free" but staff did not believe this was appropriate. The incoming provider confirmed that it would not change the lock policy, however, the introduction of a new house supervisor and staff training in restrictive interventions and positive behaviour support were expected to have a positive impact.

Good practice

Staff in some houses perform an excellent job facilitating contact between residents and remaining family members, including taking residents to visit less-able relatives and use of video calling technology.

As well, staff devote themselves to facilitating access to or organising appropriate community or household events to engage residents, such as AFL Grand Final barbeques with hot dogs, and Oaks Day attendance in formal attire either in the house or at the races.

Good practice

Once it was known and documented in his Behaviour Support Plan (BSP) that a resident's anger was triggered by his mother telling him what to do, a staff member was observed moving quietly into the room as soon as their mother arrived and intervening quickly when tensions escalated.

This action limited both the physical damage in the house, as things were commonly thrown, and the resident's anxiety.

Good practice

In a house with residents with dual complex disabilities, Community Visitors observed empathetic and caring staff.

They reported that residents had access to many opportunities for training, such as LGBTQI inclusiveness, de-escalation techniques, suicide prevention and personal safety.

Physical wellbeing

There are significant medication errors in some houses, some due to incorrectly filled blister packs supplied by pharmacies and others because of administration errors by house staff.

Community Visitors were concerned by reports of two unexpected deaths in different DAS houses of residents who choked on food. Such tragic occurrences are reminders of the need for thorough staff training around feeding support to residents and response to critical incidents, including first aid.

Rights

Access to full incident reports and monthly summaries in electronic or paper form continues to be problematic. This is compounded by the lack of a universal reporting system with three different electronic systems currently used by different service providers. In some houses, only the author can access an incident report, thus, restricting Community Visitors' access.

Staff may not realise that an incident report should be completed or categorised. When Community Visitors were unable to find an incident report for a resident hospitalised for a week, staff reported that it wasn't necessary to complete one because the resident was admitted directly from a clinic to hospital.

There appears to be a reduction in incidents that require immediate reporting under the CIMS in CSO houses. For instance, significant incidents may be categorised as 'non-major' because there is no perceived harm to residents. Consequently, the Community Visitors' task of gathering information and following up issues becomes more difficult.

Community Visitors query whether cases of emotional or physical abuse or trauma are being appropriately reported. Assaults are frequently not reported to police despite the relevant guidelines requiring this to occur.

An older resident wanting to retire from day placement has been waiting for a planning discussion with his family, day placement and their new provider since November 2018.

Good practice

An Aboriginal resident in a Yooralla house is participating in a research project exploring how inclusive and culturally sensitive the CSO is to Indigenous residents.

The resident attends meetings in the city for the project as a highly valued participant in the process.

Good practice

A few years ago, a resident going on a holiday was unusual. Now, most residents enjoy an annual holiday away from their home and housemates, even if only for a few days.

Compliance with the Act

Community Visitors continue to be frustrated by the failure of service providers to respond to issues raised in reports in a timely manner. There are also increasing challenges in accessing information in houses as providers adopt the CIMS.

At one CSO house, Community Visitors were unable to sight Residential Statements which are routinely kept in a secure filing cabinet or at the agency's head office "as they contain financial information".

NDIS

There have been lengthy delays in the rollout of NDIS planning and in the commencement of services, with some residents still waiting for plans to be developed and approved, as well as for services to be put into place.

Community Visitors are concerned the number of long-term unfilled vacancies in houses. One house has had a vacancy for 13 months. The long delays in SDA funding approval appear to contribute to this, and problems can also arise where prospective residents are not approved for the appropriate level of SDA funding for a house.

> ***Case study***
>
> A resident applied for a vacancy in a CSO house and was accepted in March 2019.
>
> In May 2019, three days prior to the move (with the removalist booked and the family preparing the room) DHHS rescinded the offer because the approved SDA funding level of "improved liveability" did not match the "high physical support needs" funding required for the house. This was despite the prospective resident having significant vision impairment and mobility issues.
>
> The family and the CSO were aggrieved that the offer was retracted just before the resident moved and queried the level of SDA funding allocated given the resident's high-support needs.
>
> The resident has an OPA guardian who is continuing to advocate on these issues.

Community Visitors frequently have difficulties accessing NDIS plans to confirm goals and determine whether residents are making progress towards achieving them. In some cases, the service provider does not have access to the plans while, in others, they keep the plans at their head office. Community Visitors query how carers can provide adequate support without access to this information on site. At one house, Community Visitors were advised that they would not be able to access the plans without the consent of the resident's parents.

Changes to funding under the NDIS have impacted on facility-based respite services with two children's respite houses closing over the last year and concerns raised about the viability of another adult facility. A service provider informed Community Visitors that the closure of a house was due to respite being underfunded in NDIS plans. While changes in funding may afford greater flexibility in how families use respite funds, many families still prefer and depend on facility-based respite so any reduction in these services will be detrimental.

> ***Good practice***
>
> Where residents have had their NDIS plans approved and supports put into place, obvious benefits have resulted.
>
> For instance, residents have increased access to one-on-one support, permitting activities more aligned with their interests. Also, engagement has increased as well as physical activity.
>
> One resident with autism was reluctant to engage with people, however, they now regularly assist as a volunteer in an animal shelter with their carer.

West Division

West Division includes Western Metropolitan Melbourne, comprising the DHHS areas of Brimbank Melton and Western Melbourne, and the regional Victorian areas of Barwon, Central Highlands and Wimmera South West.

Barwon

Abuse and neglect

A resident in a CSO house told Community Visitors they were punched by another resident. Community Visitors reported that the resident had been supported by staff, family and a chaplain, and did not want to take the matter any further.

A subsequent visit revealed that issues between the two residents continued to pose challenges. New strategies were being developed with family involvement. Hopefully, these strategies will help reduce tensions between these residents who were previously best friends.

A DAS resident who assaulted a staff member is receiving counselling from a psychologist to learn how to cope with her anger. Community Visitors reported in March that the resident still had challenges with her outbursts and aggressive behaviour, however, the counselling, along with psychiatric consultation, medication, and staff behaviour support training have helped ameliorate these behaviours.

Appropriateness of residential environment

Community Visitors commented on the unsuitability of a CSO house for ageing residents who are all sisters. The house has become increasingly difficult to navigate for the residents: one sister now uses a wheelchair, while another finds it increasingly hard to move around. In 2017, the house was earmarked by DHHS for a priority SDA rebuild, and approval for the modifications occurred in October 2018. There has been no further progress.

A resident living in a DAS unit has been waiting for a larger unit to be built for over a year as their current one is too small for independent living. The unit is now constructed, however, some further work is still required.

A DAS house has undergone extensive renovations, however, problems remain. Community Visitors have reported on issues with the renovation such as removal of a fireplace, cracked driveway concrete and flooring needing to be replaced in a resident's bedroom. These issues were raised in October 2018, yet remained outstanding in June 2019.

Rights

Community Visitors expressed concern about the proposed move of two very vulnerable residents into an already complex living situation. The residents have been in their home for many years and require familiar staff with minimal environmental stimuli. One of the resident's guardians opposed the proposed move. Community Visitors have been advised that the move is no longer going ahead.

In a DAS house, one resident's behaviour significantly impacts on the other residents. The resident is largely confined to one area of the house and other residents need to keep their doors locked. Specialist behavioural strategies and staff training have been implemented. Despite this, two residents have now moved to other accommodation, while another resident told Community Visitors that they found it hard to live there, due to the resident's behaviour. These behavioural issues continue to impact on the remaining residents.

Compliance with the Act

Community Visitors are concerned about the increasing difficulty in accessing documentation as service providers move towards a paperless system. Difficulties arise with information only being accessible online with passwords, or where staff have system access.

NDIS

One resident ran out of support coordination funds six months before their plan was due for review, while other residents have experienced lengthy wait times in accessing both support coordinators and one-on-one supports.

Colanda

The last Victorian institution for people with disabilities, Colanda, will close at the end of 2019.

Community Visitors are pleased to see residents they have known for many years transitioning positively to new, well-appointed facilities. In one house, Community Visitors report staff and family observed "positive changes in behaviour and a level of calmness" among residents.

However, concerns have been raised in one house around equipment upgrades for residents with changing needs.

Central Highlands

Abuse and neglect

One resident's escalating behaviours have impacted on the health and safety of other residents and staff.

At times, this has led to them being locked in the office for an hour or more. A peephole was installed in the door to allow staff to observe the lounge in order to safely exit the secure area. Escalating behaviours have reduced since a medical review, psychiatric assessment and an analysis of the BSP.

Staff witnessed another staff member grab a resident's arm and twist it behind his back. The staff member involved was dismissed and the resident checked by his GP and offered counselling.

Staff witnessed and reported a resident being slapped by a relative. However, the staff member was not interviewed, and the report was found to be unsubstantiated.

Due to several recorded instances of bruising, a service provider has set up a register for residents with unexplained bruises.

Community Visitors felt uncomfortable at the lack of respect shown to a resident by a staff member when she arrived on shift. The staff member, without greeting the resident, told them to "get out of the way". The same staff member asked a colleague if the resident had been changed as she could smell him. A tirade from this staff member followed about the resident invading staff space.

On another occasion, the same staff member yelled at a resident to come and get her dinner even though she was unwell and had spent most of the day in hospital. DHHS has initiated a performance management process with the staff member in question.

A staff member in a CSO house told a resident who had accidentally vomited on them that they were "f-----g disgusting". The resident appeared distressed and other staff and residents heard the remarks. The service provider stood the staff member down.

Appropriateness of residential environment

Maintenance issues continue with delayed response times and poor workmanship. Flooring issues are evident in at least eight properties with repairs needed to worn linoleum, non-slip bathroom floors and shower areas.

Community Visitors query a plan in one house to replace only half of a lounge room carpet. In another case, residents have waited ten years for flooring to be upgraded.

Physical wellbeing

A resident with weight and mobility issues had several falls and was in hospital without stimulation for three months. She was unable to return home until issues with lifting equipment were addressed. A portable hoist was available, but no sling to fit the resident.

A therapist recommended that a resident use a wheelchair at all times as the resident had lots of seizures and falls. However, it is difficult for staff to implement the recommendation as the resident is reluctant to stay in the wheelchair. Community Visitors hope that a solution can be found that addresses safety as well as independence and choice.

Community Visitors commend the efforts of staff after a resident who had been in hospital for 11 months with respiratory issues returned home: he required specialised nursing care beyond the expectations for staff in a group home, which was provided. Subsequently, the resident passed away in hospital.

NDIS

Residents have experienced lengthy delays in accessing funds and equipment.

A case study in last year's annual report highlighted a resident waiting two years for a new wheelchair. The resident experienced further delays which required further escalation of this issue. Community Visitors have been told the resident will receive his chair in the coming weeks.

In a DAS house, three residents had varying experiences obtaining supports through their NDIS plans. One resident was unable to attend day placement and she was restricted in activities she could participate in due to delays in fixing her wheelchair. A second resident, who waited for a scooter for a considerable length of time, needed to make another application for funding to NDIS. The third resident received a new wheelchair within a reasonable timeframe. Staff reported to Community Visitors that she has been much more "engaged and alert" since accessing the new equipment.

There have been some obvious benefits with the NDIS, however, funding and plan implementation remain major issues for many residents.

A resident had a substantial wait for an occupational therapy assessment to enable her to take part in activities. Inadequate funding in another resident's plan prevented her from attending day placement. The service provider put interim funding in place while waiting for a plan review.

Community Visitors have remarked on a lack of continuity with NDIS workers supporting residents, as well as communication problems between NDIS workers and house staff. Community Visitors are concerned about the impact on residents. In one example, an NDIS worker was not aware of a client's epilepsy.

Respite houses still struggle to fill places even though a lot of families are under stress and in need. One resident has had their respite reduced from 50 hours a year to five.

Good practice

Community Visitors were pleased to see an excellent initiative from a house supervisor. Progress documentation has been implemented to monitor NDIS action plans for each resident which keeps staff up to date on residents' progress.

Western Metropolitan Melbourne

Abuse and neglect

Community Visitors are concerned about the lack of accommodation for residents with complex needs as they seem to be missing out under the new system, which exacerbates untenable living arrangements.

Case study

Resident-to-resident assaults have been an ongoing concern in a DAS house.

One resident was the subject of targeted physical aggression from a co-resident and required hospitalisation after two separate assaults. Time apart over the Christmas break, along with behaviour support strategies, appeared to break the assault pattern.

Community Visitors recorded no serious incidents in their March 2019 report.

DHHS have attempted to find alternative accommodation for the targeted resident. The family is supportive of the resident moving anywhere in the state, however, suitable accommodation has yet to be found.

Community Visitors noted reports of a resident assaulting a member of the public. The behaviour-related incidents were not typical and it seemed they were the result of medication changes by the GP. The service provider consulted with the OPP and the GP has returned the resident to their previous medication regime.

Appropriateness of residential environment

One DHHS-owned CSO house is over 100 years old and requires major renovations. It urgently needs restumping as the large cracks in the walls and ceiling indicate. Community Visitors question its suitability as a group home, however, there are no plans for major renovations.

In another CSO house, there are no plans to repair large cracks in the front wall, windows in disrepair, or the rising damp.

Community Visitors reported many houses have outdoor areas unsuitable for residents' use due to a lack of facilities, stored rubbish, or not being wheelchair-accessible.

Many dilapidated fences pose safety and security risks for residents. On one CSO property, the side fence appears on the verge of collapse. This remains unresolved despite being raised since April 2018.

In December 2018, the rear and side fences of a CSO house collapsed. At June 2019, the fences are still not repaired. Community Visitors understand that consultation with neighbours about fence repairs may take time but question such long delays for residents waiting for outdoor areas to be secure.

Out-of-date first aid items and a lack of resident information in evacuation packs has been reported in many houses this year. These issues were all addressed but Community Visitors question the lack of process to ensure this occurs routinely.

Community Visitors reported a good outcome after querying the excessive number of electrical cords in a sensory room. The service provider responded by promptly installing more power points.

It is not a requirement for most houses to have locked cupboards or laundries. However, Community Visitors reported five houses where cupboards containing chemicals should have been locked for residents' safety.

Community Visitors were concerned to learn that a casual staff member shaved the pubic hair of a resident, supposedly to make them more comfortable. The service provider followed up with the resident, staff member and the resident's family, and advised that appropriate action had been taken to prevent it happening again.

Quality of staff support

Community Visitors question whether residents were encouraged and supported in activities of daily living as there was little documentation to suggest this was occurring. On at least one occasion, they observed residents either in bed, watching television, or doing nothing.

A lack of documentation around residents' progress towards their goals was also noted in some houses.

Physical wellbeing

Community Visitors were shocked that residents were not moved out while major renovations occurred in a CSO house as one resident had just returned from being hospitalised with pneumonia, while another displays complex behaviours. A visit occurred while a complete renovation of a bathroom was underway, spreading considerable dust throughout the house. Workmen were coming and going with tools, removing rubble, and with an industrial blower to dry the concrete. Concern was raised for the health of residents living in what was, essentially, a construction site.

In another CSO house, residents were also home during extensive renovations of the kitchen and living room flooring.

Evidence of risk assessment and possible alternate accommodation options were not evident to Community Visitors, and house staff were unaware of renovation timelines and progress. This resulted in residents being unprepared for disruptions resulting in an increased risk to their physical and emotional wellbeing.

Rights

Community Visitors are uneasy about the education of two young people residing in separate CSO houses.

Case study

One young resident, mentioned in last year's annual report, has not had schooling for two and a half years.

The implications of limited education for this resident may be serious as he turns eighteen very shortly. Concerns have been documented about the deterioration in his verbal communication skills, however, Community Visitors report him being more communicative on recent visits and interacting well with staff.

It is hoped that with the implementation of his NDIS plan, a speech therapy assessment will take place soon. A young housemate has moved in, however, social interaction continues mainly with adults rather than between the residents.

Another young CSO resident in a separate home has not been to school for over a year. The reasons for this included a major renovation at the school, a lack of case management and him posing a risk to staff and students. Investigation of alternative options has proven unsuccessful.

Compliance with the Act

As houses move to electronic records, Community Visitors have had increasing difficulties accessing resident information. Issues include paper copies no longer being available, casual staff with no computer access, limited or no access to documents such as incident reports, and staff being unclear about Community Visitors' rights to access information.

These issues need to be resolved urgently so that information is complete and easily accessible, enabling advocacy work to occur.

Case study

A resident in a CSO house had regular visits from a sister who previously had very little contact with her.

The sister indicated that she felt the resident was unable to make decisions and applied to VCAT for a guardian. She wanted to be informed about her medical appointments and health needs and for her to find alternative accommodation.

Community Visitors reported the resident was quite happy at the house and she related well to staff. She was very upset with her sister and told the Community Visitors of her concerns, including highlighting that an order for some red,

custom-made shoes she was looking forward to receiving had been cancelled by her sister.

Follow-up revealed that the resident had secured legal support which led to the guardianship application being unsuccessful. At the resident's request her sister no longer visits her.

NDIS

Case study

Staff at a CSO house reported that community access for a resident was significantly compromised due to the inadequacy of his wheelchair.

An assessment for a new wheelchair was completed by an occupational therapist in September 2018. A request was sent to SWEP as the resident had not yet transitioned to the NDIS.

By the time extra funding was sourced in January, the resident was an NDIS participant and had to wait until his April planning meeting to apply for a new wheelchair through his NDIS plan.

As of June 2019, nearly a year later, the resident still does not have it and has to hire an interim wheelchair.

The case study above highlights the unacceptable waiting times for residents transitioning to the NDIS who need necessary equipment to enhance their quality of life.

Wimmera South West

Abuse and neglect

Challenging behaviours can result in incidents of verbal and physical assaults to residents and staff.

A family refused to have their son in a CSO house at the same time as another resident due to safety concerns, so he stayed in the respite house next door. The agency had to work closely with families to reconfigure the house placements.

Case study

Community Visitors were shocked when they became aware of neglect issues in a CSO house.

Documentation highlighted concerns around hygiene including residents wearing the same clothes for two weeks, dried faeces on bed linen and door handles, a lack of clean clothes, and a continence bin overflowing with dirty pads.

A notification to the Public Advocate occurred so a complaint was made to the DSC.

A previous annual report documented a case of abuse in the same house. The concerns were investigated by the DSC and recommendations made to improve the service, however, it did not prevent a second case from occurring.

Appropriateness of residential environment

Upgrades in houses include painting, flooring and bathrooms. However, older houses still need regular maintenance.

A DAS house with five male residents has only one bathroom and toilet. Two residents require toileting and bathing support which can prevent other residents using the facilities, leading to personal hygiene challenges.

Physical wellbeing

Although strict procedures and protocols are in place, medication errors still occur regularly. In one case a resident needed CPR and was taken to hospital after being given incorrect medication.

Community Visitors have been alerted to an increase in weight of some residents since they have been accessing one-on-one support. Resident outings often involve a lot more snacking rather than other physical activities, which has had an impact.

Choice versus duty of care can be a difficult issue to navigate when it involves residents' health. Community Visitors are concerned about two residents' increasing weight. One diabetic resident hoards unhealthy food in her room, as well as making unhealthy choices when in the community. Another resident is morbidly obese and rises very early to raid neighbourhood bins for food.

Good practice

During a visit, a resident spoke about his drumming ability.

He was asked by a Community Visitors if he would be interested in playing at the Warrnambool Music Eisteddfod.

He was very excited, accepted the offer and played in front of a 50-strong audience. He was placed third and came home very proud.

Quality of staff support

Community Visitors note a more consistent staffing regime in most houses and acknowledge that staff are dedicated to the care and wellbeing of residents. In one case, a resident spent many months in a hospital an hour's drive away. Staff are to be commended for visiting at least twice a week during her stay.

When Riding for the Disabled was no longer available for a resident, staff found an alternative in another town and arranged for the resident to participate.

Good practice

A local Warrnambool musician has developed an all-abilities choir called *Find Your Voice*. It consists of 150 members and includes participants from residential houses in Warrnambool, Hamilton, Portland and Terang.

They recently performed at the Rotary Peace Concert to a packed house. This has become an exciting highlight for many of the residents involved, particularly as they are currently practising for *Australia's Got Talent*.

Compliance with the Act

For over three years, Community Visitors have had very little response to the issues they have raised with a CSO. This is despite many assurances from the organisation's CEO that it would respond to Community Visitors' reports. To date, despite changes of some personnel, no improvement is evident.

NDIS

Community Visitors have noted some positive outcomes for residents who are NDIS participants with opportunities for a greater variety of activities and experiences, such as outings to sporting events, new work opportunities, gym memberships, music, art and walking groups.

However, there are concerns about providers choosing not to engage people with more complex needs, so some residents with challenging behaviours are not able to access individual supports.

Other concerns include delays in plan approval and implementation, long delays in obtaining occupational therapy and speech pathology assessments, limited funding for transport, and lack of communication between NDIS workers, house staff and family.

Material wellbeing

The unsuitability of a house bus was raised by Community Visitors in November. Staff have described the bus as a "mobile hazard". The issue was still unresolved in March.

Seat belts do not function, there is no storage for residents' mobility aides, no rear windscreen wipers or air conditioning. The response from the service provider was that a work order had been placed. Community Visitors remain concerned about how long safety issues take to resolve which put both residents and staff at risk. Staff are reportedly using their own vehicles to transport residents.

Community Visitors were saddened that a resident who they had advocated for over 18 years, passed away early in 2019 after a lifelong battle with physical, psychological and health issues. His tenacity and self-advocacy to achieve his goal of living independently were sometimes difficult to navigate but he was truly inspirational and they felt privileged to have known him.

2

Mental Health

> Reports from Community Visitors demonstrate that Victoria's public mental health system is not effectively meeting the needs of people with serious mental illness.

Recommendations

The Community Visitors Mental Health Board recommends that the State Government:

1. increase the number of mental health beds and adequately staff mental health services to meet demand in line with population growth
2. continue to invest in and expand strategies like the Safewards program to reduce assaults, aggression, keep consumers safe and create positive, recovery-focussed environments
3. publish and implement a commitment to reduce and eliminate the use of restraint and seclusion in inpatient units
4. mandate guidelines to ensure open air access is available to all mental health consumers for a minimum of two hours daily and the reporting of any such failures to the Chief Psychiatrist
5. overhaul the two statewide Transition Support Units' model of care including appropriate staffing levels and the necessary expertise to enable consumers with dual disabilities (intellectual disability and mental health) to gain access to them and get the high-quality recovery support they need
6. mandate that all hospital discharge processes include discussion about advance statements
7. improve mental health outcomes by ensuring the data provided by mental health services is accessible and relevant to the Chief Psychiatrist
8. introduce measures to improve the monitoring of long-stay patients and to address the underlying causes of long stays
9. fund the Community Visitors Program to enable it to recruit and support adequate numbers of volunteers and use technology to efficiently and effectively carry out its critical safeguarding role.

Statewide Report

Introduction

This year Community Visitors conducted 1670 visits to 170 Victorian mental health facilities and identified 1486 issues.

Visits are usually unannounced to facilities including acute inpatient units, aged person's residential units, Community Care Units (CCUs), Secure and Extended Care Units (SECUs), Prevention and Recovery Care units (PARCs) and specialist units.

Community Visitors hear directly from people about their experience of the mental health system.

Reports from Community Visitors demonstrate that Victoria's public mental health system is not effectively meeting the needs of people with serious mental illness. While staff generally do their best to support people to live well despite their illnesses, they operate within a system that is stretched too thin.

Bed shortages result in patients being directed into inappropriate services or discharged before they are fully recovered. Acute settings can become stressful and violent places because admission is restricted to patients with the most acute symptoms, and community support and accommodation options to assist recovery are too few.

In this environment, staff routinely face aggression and occupational violence, making recruitment and retention ongoing challenges.

Community Visitors commend the many dedicated, caring and supportive staff they regularly encounter.

In this report, the word 'patient' is used to describe people in hospital units and the word 'consumer' is used to refer to people in other mental health facilities.

Serious incidents, assaults and safety

This year, Community Visitors reported 179 incidents of assault and aggression, compared to 166 last year. Safewards and other training programs aimed at de-escalating behaviours of concern have contributed to reductions in assaults at some facilities but the bed pressures and complexity of needs in some settings can make the creation of positive peaceful environments difficult.

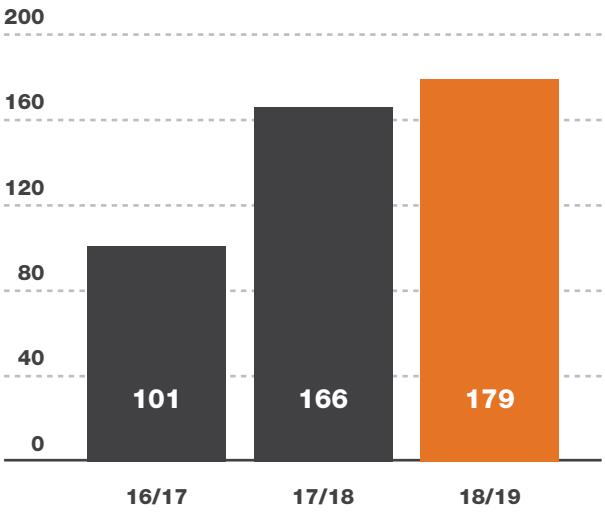
These figures are also the tip of the iceberg, as one recorded issue can represent multiple incidents. For example, on one visit Community Visitors noted 24 incidents involving danger to self and others, yet these multiple incidents appear as one issue in the data.

The high acuity of patients in acute units can increase the risk of violence. Security guards are often present for this reason. Incidents related to safety are, at least in part, created by pressures on the system and are likely to persist until this pressure is relieved.

Table 4. Total visits Mental Health stream, 18/19

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	33	11	14	300	**314**
North Division	40	16	16	354	**370**
South Division	49	27	34	422	**456**
West Division	48	26	22	508	**530**
Total	**170**	**80**	**86**	**1584**	**1670**

Figure 5. Mental Health stream assaults and violence, 16/17–18/19



Gender safety

The Chief Psychiatrist has directed services to report all sexual assaults to his office. Where a patient wishes to report an alleged assault to police, services are encouraged to support them in this process. Authorised psychiatrists also have a duty of care to report alleged assaults to police while considering and acting in the person's best interests. Most services appear to be adhering to the guidelines but allegations of harassment and assault continue, mostly between co-patients. In one instance, the alleged sexual harassment of a patient in an acute unit by a contract cleaner at Bendigo Health resulted in senior management action so that the cleaner is no longer being employed at the facility.

Men are often placed in women-only areas within acute inpatient units because of bed shortages. Co-locating women with histories of assault and trauma with men can add to their trauma and impede recovery, and women frequently report feeling unsafe.

The disproportionate numbers of men to women in some facilities adds to the discomfort of women. On one visit, Eastern Health CCU had two females, along with 18 males on the same site. The SECU in Ballarat usually has one or two females out of up to 20 patients. It has no women-only lounge but there are plans for one.

Assaults in aged care

Aged mental health services continue to experience a high number of assaults. Community Visitors reported a patient punched a nurse in the face and attacked them with a chair. The nurse had to go to the Emergency Department (ED) for assessment.

> ***Case study***
>
> At one facility, Community Visitors noted 13 incidents in two months with 11 patient aggressions towards staff including biting, headbutting and grabbing a staff member's neck. Some incidents occurred while staff were assisting patients with personal needs. Subsequently, treatment plans and strategies were revised by the service.

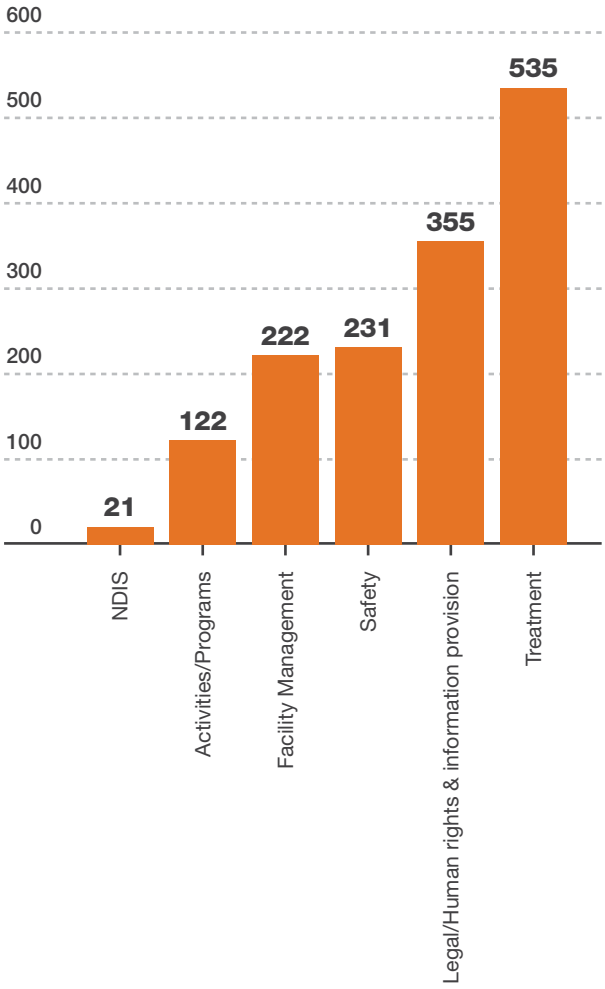
Community Visitors reported physical and sexual assaults including a patient attempting to stab another patient and an aggressive male hitting an elderly female. Verbal abuse of patients by other patients also occurs regularly.

A review of the aged mental health service model is needed. It is imperative that staff have the values, specialist knowledge and skills required to ensure the safety, respect and dignity of older patients. These services need adequate staffing levels and well-designed facilities to provide high quality services. More work is also needed assisting patients with advance care planning.

Suicides and self-harm

Community Visitors reported eight issues related to suicide or suicide attempts and 19 related to self-harm. One suicide occurred during the unit admission process staff handover. In another case, a razor blade hidden in underwear was not detected by wand screening.

Figure 6. Issue groups and number of issues identified in each, 18/19



Treatment and care

Treatment experiences were highly variable.

Good practice

Community Visitors spoke with two patients at the Maroondah Psychiatric Assessment and Planning Unit (PAPU) who complimented the facility, particularly a nurse who they said was perfect for her role and most helpful. Both were actively involved in decision making about their future plans for treatment, including doctor visits and accommodation.

Consumers complained about the type and amount of medication prescribed and their disturbing side effects. In many regions, Community Visitors reported medication errors and inappropriate treatment of physical health conditions. Bendigo Health has introduced a specialist mental health pharmacist to reduce errors.

Case study

During a visit to one hospital unit, two patients complained about medications and their side effects. Community Visitors reported the issues and the treating team discussed with one patient the use of medication and non-pharmaceutical coping strategies. The other patient was immediately provided with information on the second opinion service.

Patients also complained about the quality of meals and lack of fresh food.

Staff shortages are frequent and more pronounced in some regions, such as Hume. They impact on patient care by, for example, reducing the range of activities or the ability to accompany consumers outside.

Peer support is welcomed as a positive workforce development.

Restraint and seclusion

Reports of restraint continue; several patients alleged being physically restrained for many hours in emergency departments and being threatened with injections.

In response to a severe behavioural disturbance, an Eastern Health patient was restrained on a trolley for more than 24 hours. A patient in Bendigo alleged she was physically restrained for many hours in ED and administered medications without her consent. The service response was that this was due to the patient being verbally and physically aggressive, including attacking both a nurse and doctor.

Prevention and Recovery Care services

PARCs provide a step-up and step-down service for people who require intensive mental health assistance but not necessarily a hospital admission. These services are jointly run by clinical staff and community recovery service providers such as Mind Australia. PARCs are generally highly valued by consumers, particularly those in newer, purpose-built facilities. Consumers value the ability to self-refer or to be referred directly by a general practitioner (GP) as well as the respectful living environment.

Community Visitors are concerned that PARCs are responding to an overflow from

acute services, caused by bed shortages and, consequently, admit patients who are ill-suited to the model. It is important that PARCs operate as intended, as they are much-needed, playing an important and separate role to acute units.

Good practice

Austin Health's *Living Well at PARC* takes a holistic approach to promoting a lifestyle that supports physical, emotional, psychological and social wellbeing. Consumers speak favourably about their involvement in meal-planning using fresh produce from the PARC vegetable garden. They enjoy an active group program that includes yoga, mindfulness, external leisure centre visits and an evening stretch and relaxation group. They also appreciate the 'welcome pack' on arrival which includes a recipe book, drink bottle, pedometer, mindfulness CD, stretching instructions, a weekly planner and lists of community activities.

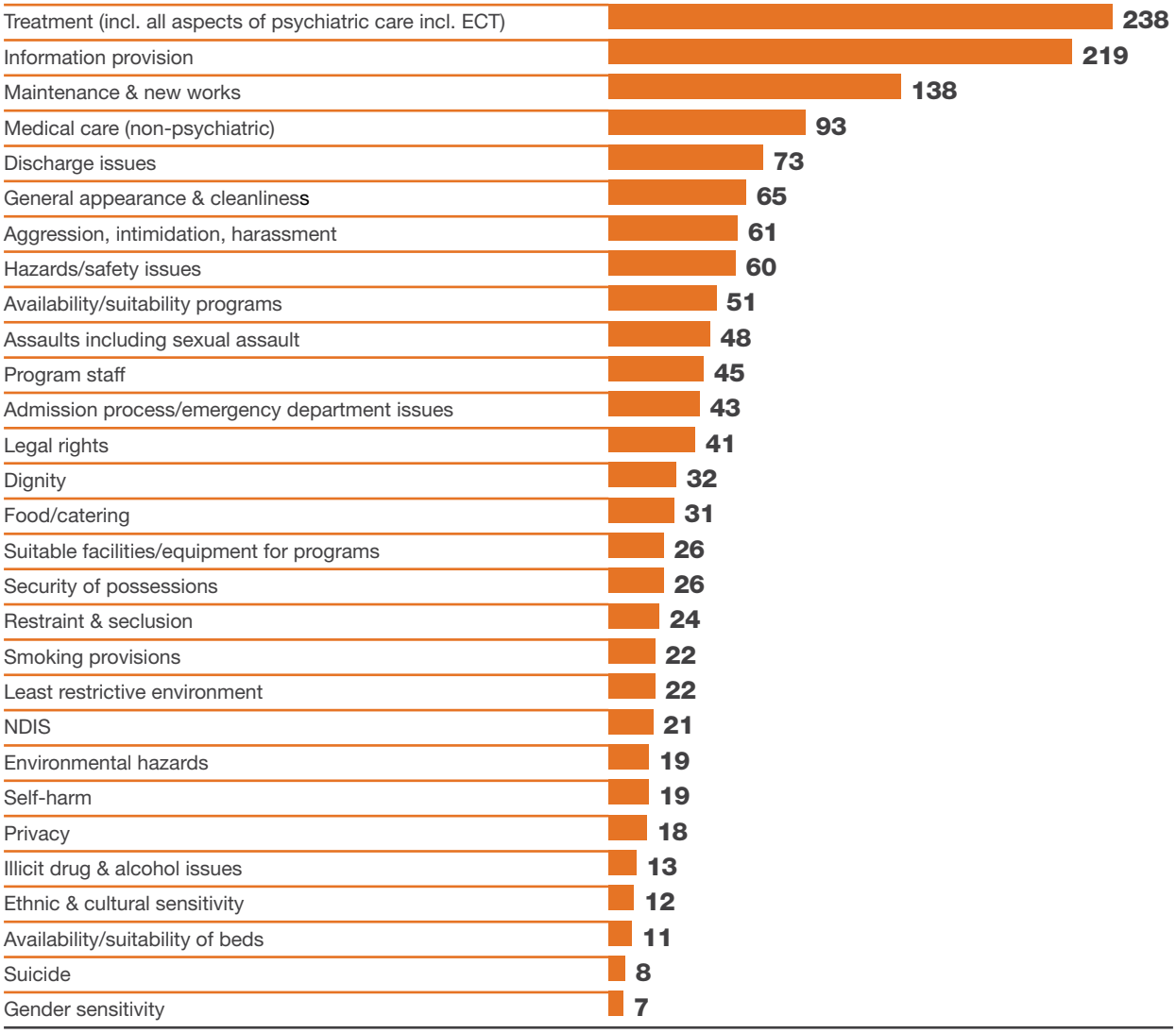
Transitional Support Units

Two Transitional Support Units (TSUs) are operated by Austin Health and Monash Health.

These services aim to provide specialist assistance to people with a dual disability of mental illness and cognitive impairment. The TSU aims to prepare people for community living but hospital meals are supplied.

The service model and referral pathways urgently need review. The main concerns are the units' inability to operate as statewide services

Figure 7. Issue types identified and number for each, 18/19



and the exclusion of people with behavioural concerns. This is particularly worrisome given the vulnerability to abuse of people with cognitive impairments in acute units. Increased staffing may be required to enable these services to deal with higher levels of impairment and acuity.

Bed shortages

Bed shortages are a serious concern that result in inappropriate placements, like two 17-year old patients placed in adult units or a 49-year-old patient admitted to an aged mental health unit as a long-term resident. DHHS has advised adult units can admit patients 16 to 64 years old. Patients who would benefit from specialist care, say, in eating disorder units, are, instead, redirected to acute units.

Accommodation and discharge issues

Pressure on beds can lead to short discharge timelines where consumers are asked to move on very quickly. Discharge is often compromised by a lack of affordable and appropriate accommodation options, particularly in country areas. Too many people with mental illness end up living rough on the streets or spending time in forensic services after periods of homelessness. Some services refuse to discharge to homelessness, resulting in bed blockages and, sometimes, acute-level care for people who no longer need it.

> ***Case study***
>
> One Hume patient was to be discharged to homelessness with a warm coat and sleeping bag purchased by the acute service. The service tried to find accommodation for him but there were limited options and he refused all offers. The Community Visitors Program contacted the Office of the Chief Psychiatrist which liaised with the service. The service provided three nights accommodation and a community mental health service was to assist with medication if he could be contacted.

Delays in the appointment of guardians or mental health consumers' applications for accommodation being rejected can further delay discharge.

The Wellways' Doorways program is a positive initiative to address housing problems but it is only available in three areas of the state. An extension of such programs is strongly recommended.

Long-stay patient project

Community Visitors have reported on long-stay consumers in the mental health system since 2007. Long-stay consumers are those who have spent more than three months in an adult acute inpatient unit, more than two years in a CCU or SECU, or more than six months in any other unit. Data is usually collected biannually using a questionnaire filled in by the Nurse Unit Manager (NUM).

This year, Community Visitors collected information on 92 long-stay consumers across 21 mental health facilities. The figure has increased since 2015-16 when 65 were identified. It is the highest recorded figure since 2010.

Figure 8. Long-stay consumers in Mental Health facilities, 18/19

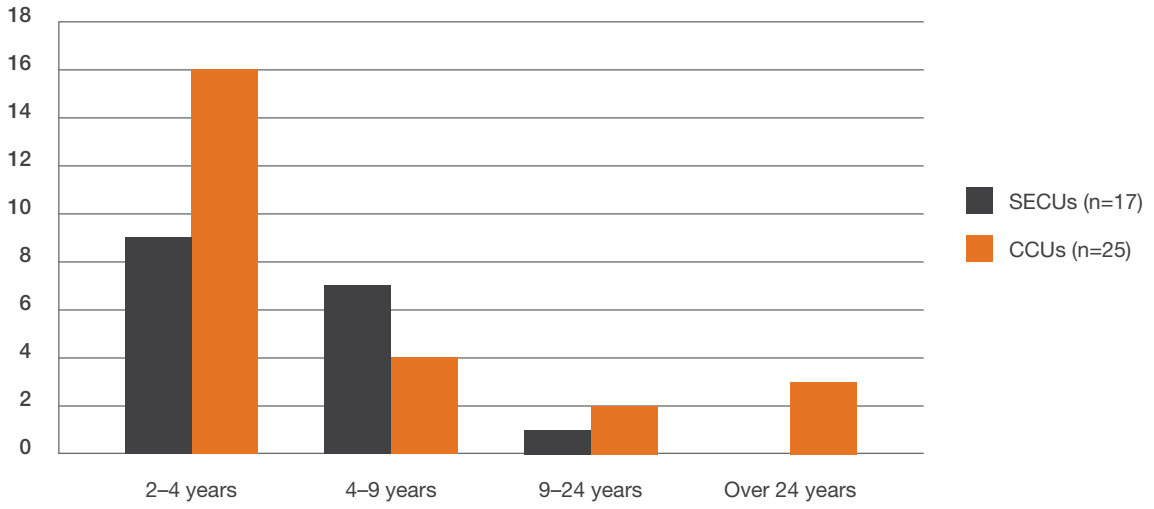
Duration of stay

Forty-four were in nine adult acute inpatient units. The duration of stay varied between three and 26 months.

Six were in a rehabilitation unit which provides up to six months accommodation and support. Their stay ranged between six and 18 months.

In CCUs, the longest stay recorded was over 24 years for three consumers. More than half of long-stay consumers in CCUs and SECUs were living there between two and four years.

Figure 9. **Duration of stay in SECUs and CCUs, 18/19**



Disability

Several consumers had disabilities or health conditions in addition to a diagnosed mental illness, including intellectual disability, physical disabilities, Huntington's Disease, Multiple Sclerosis, Polydipsia and incontinence. Eight had drug and alcohol abuse issues.

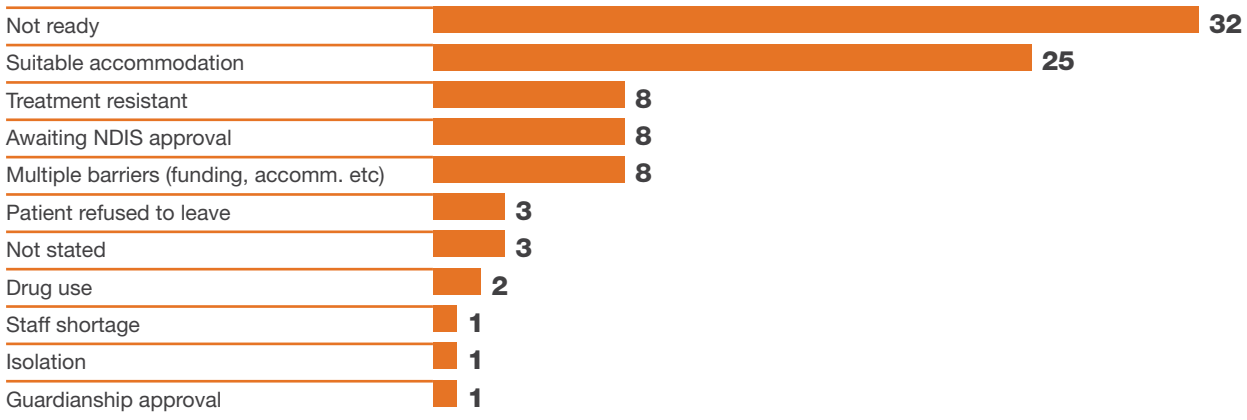
Barriers to discharge

Thirty-two consumers were not ready for discharge due to ongoing treatment; many still require 24-hour support in a clinical setting, particularly those in SECUs. Others needed support from community mental health support in a non-clinical setting.

The lack of suitable accommodation represented the main barrier to discharge.

Only one-third of consumers under 65 years of age had an approved NDIS plan. Many received additional supports provided outside the service through psychologists, NDIS and other community support organisations.

Figure 10. **Discharge barriers for long-stay consumers in mental health facilities, 18/19**



Legal rights and information provision

Community Visitors reported 355 issues related to rights and information provision, an increase of 36 over last year.

Difficulties in Community Visitors accessing incident reports continue to be a widespread problem across the state, despite being authorised in the Act. This was also supported in a 2014 report by the Ombudsman which reinforced the role of Community Visitors as a fundamental safeguard and Parliament's intention that Community Visitors have access to documents supporting their work.

Incident reports are critical for Community Visitors to fulfil their legislative functions of inquiring into the adequacy of services and compliance with the Act. In at least two cases, services refused to share information about consumer deaths, instead advising Community Visitors to wait for the coroner's reports.

Human rights issues raised by consumers included the prescription of ECT and medications; access to phones, interpreters, clothing or toiletries; concerns about family, pets and accommodation; leave arrangements, compulsory status, tribunal hearings; and financial issues.

Some reported not receiving 'welcome packs' or information on entry into services. Posters or brochures about the Community Visitors Program were sometimes not available. These issues were reported to staff and, in some cases, addressed immediately. Others required investigation or referral.

> ***Case study***
>
> A patient reported that their belongings were searched by nursing staff without their knowledge or consent. The acting NUM met with relevant nurses and the patient's concerns were confirmed. The manager apologised to the patient and all nurses were advised to notify and involve consumers when conducting environmental checks.

Dignity

Some consumers reported being spoken to or treated inappropriately by staff.

At Northern Hospital, patients complained for several months about contractors being rude to them. Management said they could not deal with this directly as the employer was a private company. The matter is being pursued by Community Visitors.

Lack of privacy is a commonly reported issue; some facilities have shared bedrooms and/or shared bathroom facilities. One female was reluctant to use the bathroom at night because she witnessed male patients in the corridor.

> ***Case study***
>
> One acute unit patient was allegedly stripped naked with males present while she was in seclusion. She reported to Community Visitors that she felt humiliated and degraded. The patient said she had to wear a seclusion gown and blanket and alleged she sustained a broken ankle as a result of rough handling by security.
>
> The service concerned said the patient, who has a history of high-risk and aggressive behaviours, was escorted to seclusion by staff and security after climbing on top of the nurse's station bench.
>
> While in seclusion she was seen to remove a hidden lighter from her clothing and set the bed on fire. After staff put the fire out, the patient was moved to another room and asked to dress in a seclusion gown in the presence of a male security guard who was deemed necessary for safety reasons. The allegations of undue force were investigated and found to be unsubstantiated.

Facility Management

Community Visitors regularly commented on the state of disrepair or lack of cleanliness in facilities, particularly acute inpatient units. Standards for cleanliness, maintenance and repairs appear lower for mental health units than other hospital units. This is unacceptable. Mental health consumers need to be treated in a dignified environment, particularly when they are most vulnerable.

Several pest infestations were reported, in one case, causing two PARC rooms to be unusable for two months. At one aged mental health facility, it took over two months for faecal matter to be removed from a courtyard.

Damage resulting from violence can negatively affect patient morale and needs to be efficiently fixed.

Case study

In November 2018, Community Visitors reported that a patient had slashed a couch, cut the TV cable and stuck a knife in the wall. In January and February 2019, Community Visitors reported that the television room was open with the television working but the couch was unrepaired.

At June 2019, the couch was still not repaired.

Unfortunately, some health and safety risks, including ligature points, have also taken months to be fixed. Community Visitors reported a locked courtyard on four consecutive monthly visits, reasons given included lost swipe cards and a faulty switch and door.

Some high standards of maintenance, hygiene and cleanliness were reported; positive improvements included the upgrading of bathroom facilities to provide ensuites and improve safety in aged care facilities.

Activities and programs

Community Visitors continue to report that patients are bored and lack meaningful activities. Advertised activities are not always conducted, particularly on weekends or when key staff are absent.

Without meaningful things to occupy them, patients are at greater risk of focussing on their distress and deterioration in their mental health may result in a heightened risk of violence.

Positive practices include a seven-day a week activity program at St Vincent's Hospital inpatient units and self-help meetings in Gippsland run by consumer consultants and other support staff. Other notable activity programs include equine-assisted therapy, breadmaking and cooking classes, music groups, gym activities, gardening, art therapy and clay sculpture.

NDIS

Community Visitors reported significant delays at all stages of the NDIS process: planning appointments, eligibility decisions, plan approvals, and funding allocations. This can halt access to equipment, allied health services and accommodation required for successful discharge.

Staff from a brain disorders unit told Community Visitors: "Mostly each patient has a different NDIS provider…It's months before anything gets done."

Case study

A consumer with acquired brain injury told Community Visitors he felt he was much better off before the NDIS. Now, he no longer had money to go the football and do the things that made him happy because his NDIS money was going to workers' wages.

The individual focus of the NDIS funding model has had an impact on group activities and led to the closure of some programs. This can be especially disempowering to consumers when they are told they do not meet NDIS requirements because they are "too well", though they could benefit from NDIS assistance to maintain their mental health and wellbeing. Many require advocacy support to navigate a changing and challenging environment.

Service provider responsiveness

Community Visitors welcomed the Royal Commission into Victoria's mental health system and the State Government's commitment to implement all of its recommendations. Community Visitors hope it will result in increased beds and funding to augment the reach and impact of mental health services.

Representatives from the DHHS Mental Health Division and the Office of the Chief Psychiatrist have continued to meet with the Community Visitors Mental Health Board throughout the year and responded to issues in a meaningful way.

At a health network and facility level, Community Visitors continue to face frustrating barriers in accessing incident reports. The department needs to ensure that service providers understand the value of the safeguarding role performed by Community Visitors.

Disappointingly, the State Government has yet to respond to last year's Community Visitors annual report and its recommendations. Consequently, the recommendations in this report were drafted without the benefit of the State Government's input. It means that the volunteers are unaware if their report has been heeded.

Divisional Reports

East Division

East Division includes Eastern Metropolitan Melbourne, comprising the DHHS areas of Inner Eastern and Outer Eastern Melbourne, and the regional area of Hume, which, in turn, comprises the DHHS areas of Ovens Murray and Goulburn.

Eastern Metropolitan Melbourne

Introduction

Eastern Health and St Vincent's Health (which includes St George's Hospital and St Vincent's Hospital Melbourne) manage services visited in the area.

Services include five adult acute units, two aged acute units, four aged persons' residential units, one adolescent unit, three CCUs, one PAPU and three EDs. Three PARCS are jointly managed by Mind Australia, Wellways and the two health services.

Serious incidents, assaults and safety

Staff and patients continue to be the victims of serious assaults in acute inpatient units and, at times, police are required to help manage situations.

An aggressive patient at Eastern Health's Upton House attacked a staff member who fell and struck his head requiring emergency treatment. Patients complain of their treatment by security personnel.

In the less-restrictive environment of an aged mental health facility open unit, the behaviour of patients with dementia caused anxiety among other vulnerable residents. Episodes of aggression towards staff led to injuries that required WorkCover leave. Two patients at the Peter James Centre south ward were responsible for seven code greys, which are aggressive or violent incidents, over a weekend.

Due to bed shortages over two-weeks, Eastern Health accommodated six adults in Peter James Centre's aged mental health facility. Some adult patients were involved in incidents requiring security assistance and Community Visitors were concerned for the wellbeing of the aged patients.

Treatment and care

Medication errors continue to occur across mental health facilities.

Non-prescribed colloidal silver was administered to two patients at St Vincent's acute inpatient unit and, as it can be toxic, the error was escalated to senior staff for review. Some aged patients

at St Vincent's Normanby House did not take medication when administered; the tablets were later found in their rooms.

An aged patient had an unwitnessed fall at Normanby House aged acute unit and broke his hip; it took an hour and a half to be seen by a doctor and eight hours to be transferred to hospital. This event triggered a formal review and measures to improve escalation of care processes. Patient care is often compromised by staffing levels. A patient who defecated in her adult diaper had to wait two hours to be changed until another staff member became available.

> ***Case study***
>
> At Maroondah acute inpatient unit, a male was physically restrained on a trolley in seclusion over a weekend for more than 24 hours. Due to highly aggressive behaviour, he had been secured in the high dependency unit (HDU) last year for 50 days with two security staff present. On readmission, he was deemed too violent for Community Visitors to visit as he was the alleged perpetrator of serious assaults on hospital staff.

A young female patient at Eastern Health's Adolescent Unit was treated for more than five months, including five weeks in the Intensive Care Assessment area. During that time, Community Visitors did not have consistent access to written incident reports. This is a serious concern considering the recent Victorian Auditor General's audit into Child and Youth Mental Health Services which identified systemic failures that cause young people to stay in care for longer than needed.

A consumer of St Vincent's PARC overdosed during the night and was discovered the next day at 11am by a PARC worker and a friend. Staff did not follow procedure and let the resident sleep which had the potential to be fatal. The incident was reviewed and new guidelines implemented to improve consumer safety.

Rights and information provision

Community Visitors responded to a phone request from a hearing-impaired patient at St Vincent's who had waited ten days for the assistance of an Auslan interpreter.

Due to a shortage of appropriate inpatient beds, Eastern Health accommodated male patients in the secure gender sensitive areas - usually used by female patients - in Maroondah and Box Hill hospital. Assessments determine which male patients are accommodated.

Eastern Health's Maroondah CCU, which has a maximum stay-limit of two years, displayed considerable flexibility meeting the accommodation needs of a long-term consumer staying five years and another consumer staying three years.

Facility management

At St Vincent Health's Riverside aged care facility, Community Visitors noted faecal matter had been reported in the courtyard on three consecutive visits. The service initially thought it may be related to a cat. However, later it was believed to be related to a resident's behaviour. Cleaning practices were revised and improved to include outdoor areas.

Due to a pest infestation, Eastern Health PARC had two bedrooms unavailable for consumers for two months.

The introduction of individual consumer swipe card access to bedrooms is a significant improvement to patient safety at Eastern Health Maroondah Hospital. St Vincent Health has upgraded all ensuite bathroom facilities at Normanby House to improve safety for aged patients.

Activities and programs

A seven-day a week activity program has been introduced at St Vincent Hospital inpatient units. A wide range of activities are scheduled throughout the day.

NDIS

Staff report the reluctance of consumers, particularly long-term consumers of a CCU, to engage in the NDIS process which results in reduced support and disadvantage.

Compliance with the Act

Health services meet Community Visitors each quarter to review the rights and wellbeing of consumers. Unfortunately, Eastern Health cancelled the scheduled August meeting at short notice and did not reschedule.

Eastern Health and St Vincent's Health services require prompting to reply to requests for written responses. Some responses can take months, despite a protocol with Community Visitors specifying they should ideally be within seven days.

Hume

Introduction

Services include Goulburn Valley Health (Goulburn Valley Area Mental Health Services) and Albury Wodonga Health (North East and Border Mental Health Services). There are two acute inpatient units, two aged acute inpatient units, two aged residential units, two CCUs, two PARCs and two EDs.

Serious incidents, assaults and safety

Community Visitors report increased verbal and physical aggression toward other consumers and assaults on staff. Service providers have made system improvements to enable Community Visitors to view incident reports, however, a lack of consistent access at North East and Borders facilities impedes their ability to monitor services and treatment effectively.

The coroner investigated the death of a consumer at Shepparton PARC who was initially found unresponsive in her room.

Treatment and care

Across all services, Community Visitors continue to observe delays in filling key vacancies including NUM, nurse practitioner and activity officer roles. Despite ongoing recruitment efforts, senior management are continually challenged to attract suitably qualified and interested candidates, with few or no responses to advertising. This remains a critical concern across the region and places additional pressure on staff.

Triage of patients from the North Eastern Border Mental Health Service Kerferd Unit will transition to its off-site NSW call centre where consumer needs may not be well-understood with the loss of local area client knowledge and experienced staff.

The lack of appropriate accommodation and services resulted in one patient discharged to homelessness, a young patient, 17, admitted to an adult acute unit and a middle-aged patient, 49, with an acquired brain injury being admitted to psychogeriatric unit as a long-term patient.

Community Visitors were informed by consumers that Life Without Barriers will cease to operate the Jarrah Retreat PARC on 30 June 2019. Poor communication of this change upset consumers and staff. In future, Albury Wodonga Health will manage the service to increase occupancy, provide increased clinical oversight and opportunities for staff development.

Legal rights and information provision

Goulburn Valley Health Engineering Department was unable to address the soundproofing requirements needed in the Mental Health Tribunal Hearings Room at Wanyarra Acute Inpatient Unit. The Acting Public Advocate wrote to the tribunal to request action to ensure patient privacy and confidentiality.

Community Visitors repeatedly requested North East and Border Mental Health Service provide written responses to address concerns, however, the majority were not provided in a timely manner. Community Visitors welcome the recent appointment of a permanent mental health director in the hope it improves communication.

Facility management

Services applied for funding grants to improve poorly maintained facilities and access much-needed furniture and equipment such as dining suites, lounge chairs, shaded outdoor areas and medical equipment. Goulburn Valley Health Aged Persons Unit received funds from the hospital auxiliary to buy a physical observation machine, suction machine and bedside tables.

Since opening in 2017, no action has been taken to increase the height of the low wall that surrounds the outside area of the women's section. Consequently, nursing staff must accompany consumers there to ensure no one absconds over the wall.

Damaged and lost access passes to the secure women-only unit at Goulburn Valley Health's Wanyarra Unit require the door to remain open at times.

Activities and programs

At the Wanyarra adult acute unit Community Visitors continue to observe that promoted activities are not always conducted. Goulburn Valley Health has advertised four times for an occupational therapist to coordinate an activities program, however, the position remains unfilled. Peer workers now run activities, and a Consumer and Carer Advisory Council barbeque raised $1800 for table tennis and badminton equipment. Additional resources are needed to coordinate meaningful therapeutic activities seven days a week.

> ***Good practice***
>
> All consumers at an Albury Wodonga Health aged residential unit participated in equine-assisted therapy and were enchanted by the presence of a foal.

NDIS

A young man with a dual disability is a long-term patient due to delays in receiving NDIS funding and accessing appropriate accommodation and services.

North Division

North Division includes Northern Metropolitan Melbourne, comprising the DHHS areas of Hume Moreland and North Eastern Melbourne, and the regional areas of Loddon and Mallee.

Loddon Mallee

Introduction

Bendigo Health and Ramsay Health provide services to 11 mental health facilities and two EDs. Additional Community Visitors have been recruited recently to increase the regularity of visits. A dual diagnosis unit has been established by Bendigo Health (Drug and Alcohol) for residential treatment of voluntary consumers.

Serious incidents, assaults and safety

As a result of heightened focus at Bendigo Health on reporting allegations of inappropriate sexual behaviour, such incidents have become more evident to Community Visitors during the year, particularly in the adult acute unit. Eight individuals were involved in sexual incidents in one month. Nursing staff advise that all practicable prevention measures are undertaken. Community Visitors have advocated for improved bedroom and common-area separation, and the service is exploring options.

Case study

One patient said a cleaner had entered her room on several occasions and behaved in a manner she considered sexual harassment. She notified the unit and said the contractor had not been seen since due to immediate actions taken by management.

Aggressive incidents in the acute unit mean patients sometimes report feeling unsafe. Physical aggression by aged residents (Simpkin House), mainly against staff, requires ongoing management, with services such as Dementia Behaviour Management Advisory Services engaged to help continuously agitated residents.

Community Visitors' continuing inquiries into two deaths reported in 2018 noted, recently, that the coroner found Bendigo Health's care and decisions were reasonable and appropriate to the circumstances of the tragic events.

Treatment and care

Consumers have commented favourably on the standard of treatment and care across all units.

In the large Bendigo Health acute unit (35 beds), with intense demands on nursing staff, Community Visitor's advocacy contributed to the creation of full-time positions for a clinical nurse manager, and pharmacist to reduce medication errors. Community Visitors also successfully advocated for specialised services for long-stay patients.

One patient was unhappy about being placed on a 26-week ECT program. Subsequent to Community Visitor advocacy the program was suspended.

Discharge planning has been difficult for Bendigo Health's extended care and older persons units due to a lack of available accommodation or a residential facility with 24-hour support, and GPs not being available to make aged care accommodation referrals. Mildura Base Hospital has been enhancing its discharge planning processes.

Legal rights and information provision

Incident report summaries with minimal details are mostly available to Community Visitors on visits to the Mildura Hospital Acute Unit. Monthly incident report summaries and responses to specific cases are provided electronically by Bendigo Health.

Patients rarely complain about inadequate orientation on admission but are often anxious about the support for tribunal hearings.

Requests for religious and cultural services are usually fulfilled. Use of mobile phones can be a vexed issue and, while usually treated with

sensitivity, exceptional cases have required Community Visitor advocacy.

> ***Case study***
>
> A patient was strapped to a hospital trolley and medicated against her will in the ED after aggressive behaviours.
>
> While nursing staff took this action for safety reasons, the patient was severely traumatised. She spoke tearfully but calmly to Community Visitors a week later about the experience and her request for seclusion rather than being "bound hand and foot".
>
> Counselling had not been provided to her at that stage with nursing staff advising that similar aggression had occurred in the Intensive Care Area and that she had been considered unfit to be interviewed.
>
> Community Visitors had concerns about the patient's admission process and whether the acute unit nursing staff was aware of the extent of the patient's trauma and the need to receive counselling at the earliest opportunity.
>
> The patient was still distressed about the experience when Community Visitors spoke to her several weeks later at the PARC where she had been transferred from the acute unit. Community Visitors were subsequently advised that the Safewards program had commenced in the ED and attention to debriefing following every conflict would be ensured.

Facility management

High standards of maintenance, hygiene, and cleanliness were observed across all units. Some errors occurred in Bendigo regarding the supply of specialist meals to address allergies and dietary preferences. Bendigo Health followed these up with the supplier to improve consumer safety. Renovations are proceeding at the Mildura Base Hospital acute unit, including the creation of a new intensive care area.

Activities and programs

Patients often say they are bored or unaware of activities organised. While acute unit patients are often unwell or disinterested, inadequate notification of daily programs and the lack of activity materials have been observed.

Patients in the Mildura acute unit have requested access to exercise equipment.

NDIS

Despite ongoing challenges and barriers, access to NDIS processes for consumers in the Extended Care and CCUs has been facilitated. Bendigo Health appointed an NDIS coordinator to support work on NDIS related issues. Consumers who do not have NDIS support are now without pre-NDIS community supported activities that have ceased.

Service provider responsiveness

Bendigo Health quarterly liaison meetings are well-attended and supported by management. Action items from the meetings and visit report requests receive appropriate attention. Mildura Base Hospital has unreservedly participated in discussions with the OPA staff present. Community Visitors were invited and participated in the first year anniversary celebrations for the Mildura PARC.

Northern Metropolitan Melbourne

Introduction

Three health networks provide mental health services in this region:

- Austin Health manages the following units: parent infant, acute, SECU, statewide child, adolescents, brain disorder (BD), psychological traumatic recovery, community recovery, a PARC, TSU and an ED with co-located PAPU.
- North West Mental Health (NWMH) provides the North West Area Mental Health Service and Northern Area Mental Health Service (NAMHS) and has a PARC, CCU, two adult acute units, an aged acute inpatient unit and four mental health beds in the Northern Hospital ED.
- Forensicare manages Thomas Embling Hospital (TEH), an eight-unit forensic mental health hospital. This year, its capacity increased from 116 to 134 beds.

Serious incidents, assaults and safety

Serious incidents have been reported in various units.

Case study

Last year, a consumer at Northern CCU died from multiple stab wounds allegedly inflicted by another consumer. The matter is still progressing through the justice system.

NAMHS reviewed the operation of the CCU in detail and implemented changes in response to the incident and the general rise in acuity of CCU patients. These include model-of-care changes, increased clinical staff, the engagement of three peer support workers and security improvements.

Acute units continue to experience a high level of aggression including assaults on staff and patient-on-patient. This is accentuated by the high churn in units where short stays (14 days average) and a continual influx of highly agitated and unwell patients, challenges the recovery of patients who have stabilised.

A difficult treatment dynamic also exists in 25-bed units where a mix of male and female patients have a complex blend of mental health issues, eating disorders and drug and alcohol addictions.

Case study

NAMHS reported the accidental overdose and subsequent death of a consumer while home on leave from a PARC.

Attempts to contact the consumer for welfare checks failed and police follow-up discovered the death.

Support was provided to the family and appropriate follow-up arranged. The incident report was provided to Community Visitors and a detailed review of the incident completed.

A copy of that review has been promised to Community Visitors.

The opening of the Apsley unit at TEH has enabled the separation of seriously ill and agitated prisoner patients from other acutely unwell forensic patients in the acute units where they were formerly treated.

Seclusion statistics in the two acute forensic units have plummeted as a result but the patient behaviour remains challenging. The more settled atmosphere in the acute units has enabled nurses to employ better patient management practices, reducing the need for seclusion.

Last year, Community Visitors reported an incident of patient harassment by a contract cleaner. That matter was promptly handled by the Austin. This year, Community Visitors reported repeated complaints of rudeness by a cleaner towards patients at a NAMHS acute unit. Because of the complex contract arrangements between the health network and the cleaning provider, this matter remains unresolved. Outsourced service arrangements that do not permit prompt remedial action are flawed and present an unacceptable risk to vulnerable patients.

Treatment and care

Community Visitors observed a generally high standard of treatment and care. Treatment issues raised by Community Visitors were promptly responded to, including concerns raised about medication, restraint, ECT treatments, staff behaviours, requests for second opinions, security of belongings, and access to leave.

Despite this, there were occasional lapses or miscommunication in support, impacting on patient care. At NAMHS, issues raised include consideration of LGBTQI patients on admission, overflowing bins, only two psychologists for 50 patients, and a wheelchair user still not showered at 12:10 pm after overnight urinary incontinence. Despite behavioural complications, that is not acceptable.

Seclusion and restraint

TEH has several patients with treatment-resistant illnesses and persistent outbursts of violence leading to episodes of seclusion. A female patient has been predominately managed in seclusion for more than two years because of volatility and frequent violence. Her seclusion episodes are documented and advised to the Chief Psychiatrist.

The commissioning of the Apsley unit, and the separation of acutely unwell prisoner patients from forensic patients, has assisted staff to work with two male patients with persistent behavioural issues and seclusion episodes have reduced as a result. A Seclusion and Restraint Committee at TEH reviews every episode of seclusion and restraint and their recommendations impact on patient behavioural management.

NDIS issues

Patients and staff report concern and frustration at the time it takes to engage with and receive appropriate support from the NDIS. Patients at the brain disorders unit experienced difficulty in communicating with the scheme and receiving support including the provision of an NDIS-funded carer and wheelchair. Hospitals advocating for NDIS support on behalf of patients experience confusion and delay over the funding

responsibility for patients living in hospital facilities, despite the long-term and ongoing nature of their disabilities.

Facility management - Works at TEH

Construction of the eight-bed Secure Psychiatric Intensive Care Unit (SPICU), Apsley, is now complete. The unit commenced operations in March and is fully occupied. The unit provides short-term intensive treatment of prisoners admitted from the general prison system and is directed towards their early return and mental health care there provided by Forensicare.

Construction of four additional, two-bedroom units and one four-bedroom unit (10 beds in total), expanded dining rooms, updated laundry, and shower facilities, and additional interview and counselling rooms were completed during the year.

There are plans to remove the sunken lounges and activity areas in the main common rooms of six TEH units. These original design features of the hospital present falls risks and barriers to the access of common room areas by mobility-restricted patients and wheelchair users.

Staffing difficulties

Staffing has proved a major challenge for Forensicare this year with the multiple challenges of the increased capacity, the specialised needs of the Apsley unit, and the increasing need to provide prison-based services for a growing number of mentally ill prisoners. There is insufficient capacity to transfer all mentally-ill prisoners promptly to TEH. Despite recruiting more than 70 mental health nursing and clinical staff, Forensicare has been unable to staff and open six of the new beds.

Service provider responsiveness

Quarterly liaison meetings between mental health hospital managers and Community Visitors continue to be effective and informative.

Access to incident reports and their summaries are treated differently by various providers. NAMHS and TEH provide written copies of reports and summaries requested by the Regional Convenor. The Austin Hospital has agreed to make printed copies of these materials accessible to Community Visitors during visits but they have not always been available. Austin Health has a firm position about not allowing copies of incident reports to be removed from facilities, but action is planned to make copies available for viewing.

Community Visitors have long-recommended that these reports be provided for review and inspection, and in practical terms, this means that copies should be provided for Community Visitors to take away and examine at length under appropriate security and privacy arrangements. It does appear that specific legislative directions will be necessary to achieve this and it is recommended that Government amend the *Mental Health Act 2014*, accordingly.

Clinical governance

The Community Visitor Regional Convenor attends the Forensicare monthly Safety, Quality and Risk Committee (SQARC) as an observer. The SQARC is the senior clinical review authority for all Forensicare facilities.

Attendance at the SQARC has enabled observation of the rigorous incident notification, review, classification, investigation and response, supported by the provision of detailed written materials.

The Austin has a similar arrangement for the Regional Convenor to attend its monthly SQARC.

South Division

South Division includes Southern Metropolitan Melbourne, comprising the DHHS areas of Bayside Peninsula and Southern Melbourne, and the regional area of Gippsland, comprising Inner and Outer Gippsland.

Gippsland

Introduction

The Latrobe Regional Hospital manages mental health services in the Gippsland Region. Community Visitors visit an acute inpatient unit at the hospital that includes an HDU, SECU, child and adolescent beds, an acute aged persons inpatient unit, ED, and a parent-baby unit. A CCU is in Traralgon and a PARC in Bairnsdale.

Serious incidents, assaults and safety

At the CCU, police used pepper spray and attempted to taser a consumer who was making threats to kill. He had been known to gradually reduce his medications and was taken to HDU. Other consumers were given support and counselling following the incident.

At the aged persons inpatient unit, two patients raised concerns regarding the aggressive behaviour of a male patient who allegedly assaulted an elderly female patient and "sent her flying". Queries were raised about the staff and their capacity to manage the male patient.

Two fires in HDU were caused by interference with power points, which have now been covered to prevent future incidents.

Treatment and care

> ***Case Study***
>
> Funding for the Agnes Parent and Infant Unit at the La Trobe Regional Hospital has recently increased to allow the unit to operate as a seven-day a week facility. Patients report that the flexibility means more supported time for themselves and their partners who are employed.

Legal rights and information provision

Privacy and security issues arose in the women's wing at the acute inpatient unit due to the corridor security door mechanism failing. Swipe cards have proven unsuitable for patient use, so wristbands are being sourced to replace them.

Facility management

The HDU kitchenette damaged by vandalism was rebuilt over the last year to more robust specifications, however, this meant that patients could not access the space to make hot drinks. This resulted in long-term inconvenience for patients and staff. One bedroom in HDU was also out of action due to fire and vandalism for months and subsequent building works were noisy.

Anti-ligature curtains are now in place in the acute inpatient unit, though they are still removed if a patient is assessed to be at risk of self-harm.

Community Visitors are concerned at the continued lack of appropriate outdoor seating in both the women's wing and Macalister aged acute courtyards.

Having raised the issue for a long time, Community Visitors were pleased that driveway entrance signage for the Agnes Parent and Infant Unit will soon be erected.

The CRU refurbishment is another positive development. This has nearly been completed with landscaping to come.

Activities and programs

Mutual help meetings are run regularly by consumer consultants and other support staff.

Service provider responsiveness

Quarterly liaison meetings take place, however, Community Visitors are only given access to monthly summaries of de-identified incident reports to review. Written response times to issues raised by Community Visitors are variable due to a range of factors including ongoing or incomplete investigations and patients being discharged.

Southern Metropolitan Melbourne

Introduction

Three health networks (Alfred Health, Monash Health and Peninsula Health) provide seven adult and four aged persons acute inpatient units, four aged persons residential units, four CCUs, three child and adolescent inpatient units, one eating disorders unit, one mother and baby unit, one SECU, one TSU and seven PARCs.

Serious incidents, assaults and safety

At the Alfred Health's aged persons acute inpatient unit, Community Visitors were approached by a female patient who reported feeling unsafe due to the unpredictable behaviour of some male patients, including some walking around naked and masturbating. One male had also entered her room, which was shared with another female at night. She also reported fears about a specific patient who she said had made threats to kill her. The patient said that she wanted males and females to be separated so that she could feel safer. At another Alfred Health inpatient unit, a female patient reported that she was reluctant to use the bathroom at night due to the presence of male patients in the corridor.

Community Visitors were alerted to numerous incidents where patients and/or staff were assaulted. These included alleged sexual assaults of patients. At a Monash Health inpatient unit, one patient physically assaulted three staff members, with one sent to ED with a skin-tear injury.

At a Monash Health aged persons facility, a consumer grabbed a chair with the intention of assaulting a nurse. Although the nurse was able to direct the patient to let go of the chair, the staff member was physically assaulted and required assessment in ED. A similar incident occurred at another Monash Heath aged persons residential unit when a consumer attempted to throw a chair at another consumer. In that incident, no residents or staff received injuries.

Case study

A patient in a wheelchair at a Monash Health inpatient unit complained to Community Visitors that he was subjected to rough handling by staff after he kicked a door when he was being transferred to HDU. The patient alleged that he was dragged from his wheelchair (pointing to bruising on his left forearm) and verbally abused. Community Visitors also observed a staff member talking to the patient in a harsh tone. A query was raised with management regarding staff treatment of the patient.

Monash Health advised that the patient had been verbally and physically aggressive during the transfer to HDU and staff had experienced difficulty in directing him there. They advised that the NUM would follow-up with the staff regarding the technique and the amount of pressure used for restraining him.

Feedback was also provided to the staff member who spoke to the patient in a harsh tone, reminding them of obligations regarding professional standards.

A service review found no corroboration of the patient's claims.

Treatment and care

Concerns regarding discharge planning continue to be highlighted by Community Visitors, particularly with regards to the limited accommodation options available. During liaison with Alfred Health, discussion focussed on readmission rates. Alfred Health management indicated that it was interested in using its emergency funding more effectively to facilitate discharge.

At a Monash Health aged persons residential unit, one long-term consumer is only 45 years old. Staff say there is no other facility that can appropriately meet her mental health needs. At another Monash Health aged persons inpatient unit, two patients have been admitted for over 12 months, due to the lack of appropriate accommodation options.

Community Visitors have sought feedback from the Alfred Health's adult acute inpatient units regarding the time spent with patients relative to time spent in the nurses' station. Management advised that the introduction of a new electronic information management system will impact on workflow and enable staff to be more mobile, thus improving patient care. Their ground and first floor acute units have also introduced a concierge role at the entry to reduce the time devoted by nursing staff to managing entry and exit at these units.

At a Monash Health inpatient unit, Community Visitors expressed concern that both adults and adolescents were being admitted. During one visit, almost half the patients were over 25 years of age. Community Visitors had understood that the facility was a designated youth inpatient unit (18 to 26 years), however, Monash Health advised that this was not the case. During times of high bed requests, adult patients (26 years or older) are admitted with the service. Despite this, Community Visitors have observed an increased number of incidents and presence of security staff on the unit and queried whether adult patients were impacting on safety in the unit.

During a visit to a Monash Health PARC in October 2018, Community Visitors were concerned about an incident where a person self-harmed in the front garden in staff presence and was transported to Casey Hospital ED. Staff informed Community Visitors that they had already had 97 acute admissions that year. The

incident report indicated that a review of their treatment plan would take place.

Consumers in a range of settings have found it challenging to adjust to more stringent smoking restrictions applied by health services. Patients at two inpatient units at Dandenong Hospital expressed concern that their leave had been cancelled as a punishment for smoking within hospital grounds. Monash Health responded that decisions to cancel leave were always based on clinical considerations.

Legal rights and information provision

Case study

A patient at a Monash Health facility expressed concerns about the security of possessions, as staff searched his room and removed cigarettes without his knowledge or consent.

The patient also noted that his mobile phone had been confiscated and he had been locked out of his room for a period. Community Visitors queried this apparent intrusion on privacy by the staff.

Monash Health management confirmed that staff had searched the patient's room without his consent. The NUM met with the patient, apologised for what had occurred and provided reassurance that he would be notified in future of such checks and encouraged to be present.

Facility management

Cleanliness and tidiness are ongoing issues with Community Visitors to Alfred Health inpatient units particularly concerned by the state of the bathrooms. Management has liaised with the cleaning contractors and plans to revise working schedules and ensure improvements in this area.

Renovations to facilities at Monash Health were welcomed by Community Visitors. These include works completed at Monash Medical Centre P Block and Casey Hospital Ward E. Refurbishments at Alfred Health facilities have also continued.

The TSU managed by Monash Health began taking patients in December 2018. It is described by Community Visitors as a clean, friendly and inviting environment. However, its ten beds for people with dual disabilities are yet to be fully occupied.

Activities and programs

Community Visitors raised concerns regarding the lack of activities for patients at the Alfred Health aged persons acute inpatient unit. Similar issues were raised at Dandenong Hospital as activities were not available when staff were on leave. At the Monash Health Biala aged persons acute unit, Community Visitors raised issues about a staff shortage that placed limitations on patients accessing outdoor areas. Monash Health has said it is trying to manage this within resources.

Service provider responsiveness

The relationship between Monash Health management and Community Visitors is a productive one, as facilitated by regular liaison meetings and discussion. Community Visitors have also conducted information sessions at different Monash Health facilities, which have been warmly received, and educated staff about the role of Community Visitors.

At Peninsula Health, Community Visitors report that good relationships have been forged with management across the service to address issues effectively, while the timeliness of responses to issues raised has also improved.

Access to incident reports remains a contentious issue. During the year, Monash Health reviewed the provision of incident reports to Community Visitors. Following the review, Monash Health Community Visitors were advised that they are only able to view detailed incident reports when visiting facilities, and they are not entitled to request or receive a copy of the documentation for later follow-up.

At Peninsula Health, Community Visitors have had difficulty accessing incident reports during visits, as well as being unable to obtain copies of detailed incident reports. Both Monash Health and Peninsula Health have agreed to provide Community Visitors with a periodic summary of incident reports which is welcomed. These summaries are de-identified, limiting a more thorough analysis of the data to determine what occurred, who was involved, and what follow-up took place following incidents.

Community Visitors believe that service providers must facilitate ready access to detailed incident report to enable them to fulfil their functions within the meaning of the Act. The lack of access to full incident report information has been raised with the Chief Psychiatrist for follow-up.

West Division

West Division includes Western Metropolitan Melbourne, comprising the DHHS areas of Brimbank Melton and Western Melbourne, and the regional Victorian areas of Barwon, Central Highlands and Wimmera South West.

Barwon and Wimmera South West

Introduction

The Barwon South-Western Region spans from Geelong to the South Australian border.

There are two major providers: Barwon Health in Geelong and South West Healthcare in Warrnambool which, between them, manage two acute inpatient units, two EDs, two PARCs, one aged persons unit, one extended care unit (ECU) and one community rehabilitation facility (CRF). Two nursing home providers, Lyndoch Living and Western District Health Service, manage some psychogeriatric beds in Warrnambool and Hamilton.

Serious incidents, assaults and safety

Community Visitors asked for more information concerning seven claims of assault or aggression and one of self-harm. In all cases, the service provider had investigated and reported the incidents as required by the Chief Psychiatrist. They had counselled as necessary and no further action was required.

Treatment and care

Shortage of suitable accommodation for discharge, either to another facility or to the community, is an issue at all adult facilities in Geelong and Warrnambool.

The Swanston Centre Acute Unit had a high rate of seclusion. The lack of an HDU does mean Barwon Health has fewer options, which may have an impact on its seclusion rate. The majority were very brief seclusions as a precaution for volatile people when they receive injections. After administration, they were returned to the ward. This procedure has been developed in the absence of an HDU.

The Safewards program has introduced daily mutual help meetings, new activities and equipment at the centre. Unfortunately, iPads are being withdrawn as several went missing.

Aggressive behaviour has been effectively managed at Blakiston.

Psychogeriatric patients in Lyndoch do not have scheduled psychiatric reviews as there are no psychiatrists on site. However, they are provided on request.

At Barwon ED, it is not unusual for mental health patients to wait three hours. The new PROMPT Project to assess emergency mental health incidents at home may reduce the number of patients arriving through ED.

Legal rights and information provision

Security of possessions has been an issue at the Swanston Centre Acute Unit, for example, two mobile phones have gone missing.

Facility management

Blakiston Lodge has initiated staff training in clinical systems as well as reviewing all treatment plans because of an audit in January. McKellar Centre aged care, including Blakiston, had accreditation visits. It failed four standards: medication management, lifestyle, complex care and information management. Community Visitors requested and received copies of the report.

Service provider responsiveness

All service providers are now providing regular access to incident report summaries. Barwon Health emails monthly summaries covering all facilities.

Both EDs in the region questioned right of access for Community Visitors. The right of Community Visitors to visit unannounced is now

understood and accepted following the provision of information sheets and the organising of future information sessions for ED staff.

Both major service providers have regular and productive liaison meetings but responses to report questions are sometimes slow.

Grampians

Introduction

There are nine units in the Grampians area providing mental health care through Ballarat Health Services. These include adult acute aged care, SECU, CCU, aged residential unit, an ED, plus a mother and family unit. There are also six funded psychogeriatric beds at Nhill and Stawell.

Serious incidents, assaults and safety

The management report many challenges in recruiting staff and demand for beds is very high in both acute units.

Incident reports indicate that staff and patients have been assaulted, sometimes violently, in the adult acute unit and, to a lesser extent, in the SECU. Hospital security are called to assist when necessary, sometimes restraining patients while medication is administered.

Community Visitors are pleased to see that the Safewards program has been rolled out with positive feedback from patients and staff.

The hospital's non-smoking policy appears difficult to enforce. Incident reports have included staff finding hidden matches or lighters in bedrooms.

Treatment and care

The majority of SECU patients are male with only one or two females at any given time and there is no space for a female lounge. Community Visitors have reported on this for many years. There are current plans to renovate a disused bathroom as a sensory space which Community Visitors report as a "very good initiative!"

Community Visitors commend staff in the aged care unit for support shown and the variety of activities provided, including an innovative 'bird week' complete with a bird circus.

A temporary CCU accommodates three to five consumers while a new 12-bed PARC is being built. The PARC is expected to be completed in December 2019. An issue with sound-proofing at the CCU has limited the number of available beds. There are no plans to address the costly sound-proofing so the numbers will remain below capacity.

Housing has been a real issue and discharge is often dependent on the availability of suitable accommodation. It was complex to locate accommodation for one consumer who had been in the CCU for over 18 months. The mother and family unit is funded for only five days a week and is not occupied over the weekend which can be disruptive to their recovery. The Gippsland unit, which was similarly only funded for five days a week, recently received additional money to expand to seven days.

Service provider responsiveness

Community Visitors meet quarterly with unit managers and address any outstanding issues raised. There is a positive relationship with good discussion and information sharing.

Western Metropolitan Melbourne

Introduction

Western Metropolitan Melbourne consists of NorthWestern Mental Health Service (NWMH), Inner West Area Mental Health Service, Mid-West Area Mental Health Service, Orygen Youth Health, Mercy Health Services and the Royal Children's Hospital mental health services. These services consist of eight adult acute inpatient units (including the first women-only adult acute unit in Victoria), two aged acute inpatient units, one aged residential unit, one adult rehabilitation unit, four CCUs, one eating disorders unit, one neuropsychiatric unit, one mother-baby unit, two adolescent acute units, four PARCs and three EDs.

Serious incidents, assaults and safety

> ***Case study***
>
> A male at Ursula Frayne Centre's adult acute unit awoke in the early hours of the morning to find a male standing over his bed.
>
> It was reported that the second male had no top on and was allegedly committing a sexual act. The victim immediately reported

the incident to staff and required extra medication to re-settle and return to sleep.

The alleged perpetrator was stopped from entering another bedroom by staff who redirected him to his own room. The incident took place in the vulnerable persons' corridor of the unit.

Community Visitors became aware of the situation during a routine monthly visit. The patient expressed his shock and anger to Community Visitors when it became apparent information about the alleged assault had not been handed over from night staff to day staff. The nurse in charge was not aware of any incidents overnight.

When notified, staff immediately completed all risk assessment processes and promptly followed sexual safety procedures. Community Visitors gained permission from the patient to access nursing entries and incident reports. Staff were followed up by the Mercy Hospital management.

One staff member subsequently resigned.

Mercy Health manages the first women-only adult acute unit in the state. There has been praise and positive feedback from patients who report feeling safe and well-supported compared to being in a mixed-gender unit.

Mercy Health management conducted a full systemic and practice review following the death of a patient who had received highly traumatic personal information without hospital staff knowledge. New procedures require people to speak with staff on entry to the unit and a formal handover process is required of all professionals who continue to work with the consumers while in hospital.

There are ongoing security issues involving illicit drug use at a CCU. This was reported last year. Concerns range from used syringes found on the property to a drug overdose resulting in a death. CCTV was installed, however, the proposed security fencing has taken an inordinate amount of time to be funded and approved by council. The current fencing provides opportunity for easy access to the grounds, units, and staffing areas. The CCU provides regular dog and police checks, ongoing education, counselling and support for consumers to help address concerns.

In an incident at Broadmeadows Adult Acute Unit, a patient slashed a couch, cut a TV cable and stuck a knife into a wall. Six months later, the couch had still not been repaired. Fortunately, there were no injuries to patients or staff.

Community Visitors were notified of a suicide in an aged acute unit during staff handover. The patient had been on observations at 15-minute intervals but, during the staff handover, visual observation only occurred at 30 minutes. Tragically, the patient took their life during this time. This highlights the need for greater staffing levels where clients require intense observation to keep them safe.

Treatment and care

Case Study

Patients at the Ursula Frayne Centre have expressed dismay that meals are microwaved.

Food has been described as "tasteless, microwave food" and that the meals are small and served "half cold". There are numerous complaints to staff about being hungry and requesting further food. Staff report they cannot meet these requests due to limited supply.

Food is pre-packaged into small white containers, separated into soup, main, vegetables and desert. A Patient Service Assistant (assigned to the general cleaning of the unit) is allocated a very small amount of time using three microwaves to heat the food. Once heated, the food is transferred to the plates. The portions are quite small and are the same for everyone, regardless of personal needs.

Staff expressed concern that diabetic and halal meals are not always provided in a timely manner. Staff acknowledged that the service and communication from the food company is poor. On one occasion, sandwiches were not delivered all week despite active follow-up from staff.

The plan is for meals to be provided by Western Health as the inpatient unit is located on a Western Health facility. The contract between Western Health and Mercy Health includes meal provision as well as many other matters, and it is still being finalised.

Community Visitors feel that this situation is unacceptable for consumers and staff and urgently requires Mercy Health and Western Health to resolve this longstanding issue.

Legal rights and information provision

The rights of patients to their preferred food can be complex.

In an eating disorders unit, a lactose intolerant patient indicated a preference for soy milk. Community Visitors were informed that, while patient preferences are always considered when developing meal plans, sometimes a person's choice may be related to their eating disorder, rather than medical or cultural requirements. The dietician considers all aspects and works with the consumer, however, preferences may not always be able to be accommodated.

Mercy Health provides monthly incident report summaries. This has given Community Visitors a better insight into challenges in their mental health units and enabled more effective follow-up of issues. NWMH is open to providing monthly reports and Community Visitors are working with it on this process but it is yet to occur. The process for accessing incident reports has not improved at the Royal Children's Hospital Banksia ward.

Facility management

The relaxation room in Orygen Youth Health is uninviting, unkempt and not in line with a professional modern service. There is a large streak of blue paint and writing on the wall and cupboard. The furniture is badly stained. This has been evident for months and Community Visitors have witnessed doctors consulting with clients and family members in the room. Community Visitors were informed management was unwilling to complete basic maintenance as there are plans to demolish the room in the current building works proposal.

Offensive graffiti scratched into two bedroom doors has been reported on many occasions.

Community Visitors have reported potential ligature points in the Broadmeadows Adult Acute Unit. These range from handles on kitchen pantry doors, the fire hose-reel, occupational therapy cupboard and sensory room, to magnetic door holders on fire doors. These door stops are fixed to the walls about 1.7 metres above the floor and protrude from the wall about 15cm. Community Visitors were informed by management that these potential ligature points were noted in the unit's 2018 Ligature Risk Audit as being of low risk as the doors are within four metres and in direct line-of-sight to the nurses' base that is occupied around the clock. In addition, there is CCTV in the women's corridor. Community Visitors noted on their reports that the other handles would be removed but, to date, this has not occurred.

In the John Cade unit at the Royal Melbourne Hospital, a patient told Community Visitors that he had been bitten by a mouse. There have been issues with mice in the past that management attribute to extensive structural rebuilding over recent years.

Community Visitors were pleased to note that the balcony in the neuropsychiatric unit at Royal Melbourne Hospital is now able to be safely used. It needed urgent attention as pigeons had taken up residence creating a potential health risk. Community Visitors reported the balcony has been cleaned, refurbished, and repainted.

Activities and programs

On numerous occasions, Community Visitors have noted out-of-date program boards in Werribee adult acute units. The appearance of the program boards was substandard and not in keeping with a professional, educative service. Group programs were not listed, staffing contact information was missing, or there was no current information at all. Patients expressed their disappointment at the lack of attention to this matter.

Community Visitors were informed that it was the program nurse's responsibility to update the boards. When the nurse was unavailable, no one else attended to it. When Community Visitors followed up with management, assurances were given that the nurse in charge of the shift was responsible for all daily updates and information.

The situation was not resolved until the NUM formally assigned the duty to night staff in all acute areas. Community Visitors observed a vast improvement and praised efforts to see up-to-date program boards and new activities such as "bread making" now listed.

Community Visitors have reported comments concerning a lack of activities in other areas such as the Royal Melbourne Hospital's eating disorders unit and Broadmeadows Hospital's aged persons acute inpatient unit. Patients in the eating disorders unit gave positive feedback about the art therapy sessions but expressed an interest in having diet and nutrition sessions made available.

Patients have provided positive feedback around activities in Broadmeadows Adult Acute Inpatient Unit with good reports about the staff and facility. Activities include a self-directed art station, guitar for client use, information sessions, regular group meetings, meditation sessions and walking groups.

3

Residential Services

> Issues concerning abuse of various kinds have unfortunately been a constant theme this year.

Recommendations

The Community Visitors Residential Services Board recommends that the State Government:

1. urgently act on the recommendations of the KPMG review of the Supporting Accommodation for Vulnerable Victorians Initiative and the Pension-Level Supported Residential Services Project
2. reopen the Pension-Level Supported Residential Services Project funding of $10,000 a year for pension-level SRS not currently receiving funding through the project or the Supporting Accommodation for Vulnerable Victorians Initiative until the review of the initiative is finalised
3. clarify regulatory responsibilities for fire safety in SRS to ensure there is no gap in the regulatory framework
4. ensure mental health facilities use key performance indicators to monitor the usage and effectiveness of the mental health referral form for discharge and follow-up of patients to Supported Residential Services
5. audit Supported Residential Services staff attendance at mental health training against the potential staff attendance pool
6. establish a Supported Residential Services health project in collaboration with VicHealth to develop strategies to improve the health outcomes of SRS residents
7. fund a partnership with QUIT to reduce smoking levels in Supported Residential Services
8. ensure Supported Residential Services staff have English language skills and competencies to provide a safe environment for residents in matters such as dispensing medications, safety and emergency procedures
9. actively encourage Supported Residential Services proprietors to increase linkages with local support services and model best practice to meet complex resident needs
10. require all funded workers entering Supported Residential Services to display visible identification including the organisation name
11. respond to all Community Visitor annual reports in a prompt and timely manner
12. fund the Community Visitors Program to enable it to recruit and support adequate numbers of volunteers and use technology to efficiently and effectively carry out its critical safeguarding role.

Statewide Report

Introduction

For a second consecutive year, the board is disappointed to report that, at the time of writing, it had not received a response from the State Government to the recommendations in the *Community Visitors Annual Report 2017-2018*.

This years' recommendations have, therefore, been prepared without the benefit of this feedback. The board remains ever-hopeful that future responses include accountable actions and time frames reflective of the Department of Health and Human Services (DHHS) core mission to enhance the health and wellbeing of vulnerable Victorians.

Supported Residential Services (SRS) are private, for-profit businesses, that typically provide accommodation to about 30 residents and some personal support services for people who need assistance with daily living. They either charge 85 to 95 per cent of the cost of a pension ('pension-level') or whatever rate they choose ('pension-plus').

Following the closure of one pension-plus facility in the inner east, there are now 127 SRS in Victoria with fewer pension-plus SRS than five years ago.

A SRS Census has been conducted every five years since 1993. The 2018 Census identified that residents of pension-level SRS are younger and have more mental health needs compared with the previous census. This has significant consequences for SRS proprietors and staff as SRS are not clinical environments, have one staff member to every 30 residents and only one staff member required to have a Certificate III qualification, the Personal Care Coordinator.

Few staff in the sector have formal qualifications and attendance at DHHS-endorsed skills training is patchy even for the mandatory mental health training. The provision of quality care for a more diverse and complex resident population comes at a financial cost which is largely borne by SRS proprietors.

SRS proprietors are generally caring, committed and hardworking but increasingly challenged to meet the needs of their diverse and complex residents. Community Visitor report lower occupancy rates in SRS that are threatening the financial viability of the business model.

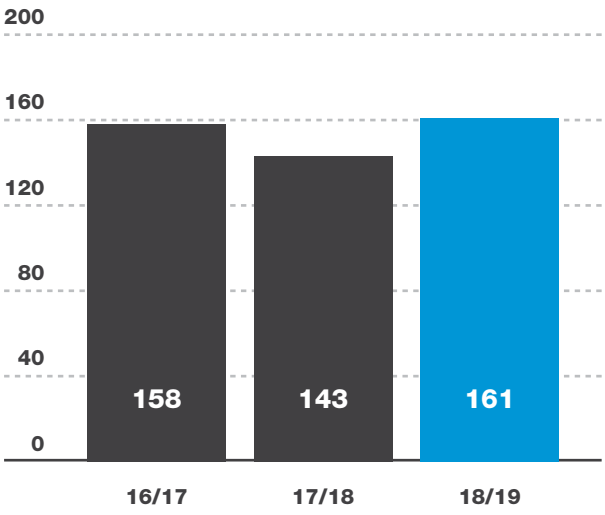
This year, Community Visitors continued to find SRS where they considered the care was inadequate and the residents' living conditions substandard. Several SRS, one of which is in receipt of substantial State Government funding, had continuous bed-bug infestations with multiple residents experiencing bites on their arms and legs. Community Visitors believe the infestations were directly related to the hygiene standards in the facility. In circumstances where resident wellbeing is significantly compromised over an extended period, Community Visitors expect timely and comprehensive responses from both the proprietor and the regulator but that is yet to occur in this situation.

Throughout the year, Community Visitors have raised ongoing issues with the quality, consistency and timeliness of the DHHS response to their notifications. The board was particularly concerned about the adequacy and timeliness of the response to a situation where Community

Table 5. Total visits Residential Services stream, 18/19

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	39	20	22	197	**219**
North Division	21	13	11	162	**173**
South Division	51	21	20	275	**295**
West Division	17	24	13	205	**218**
Total	**128**	**78**	**66**	**839**	**905**

Figure 11. Issues of abuse, neglect and violence identified in Residential Services stream, 16/17–18/19



Visitors were subjected to ongoing abuse and intimidation by a proprietor. Community Visitors are volunteers who freely give their private time to support and protect the human rights of vulnerable Victorians. The board expects DHHS to support them in this role and to take strong and timely action to reinforce and protect their legislated role.

Abuse, neglect and violence

Community Visitors conducted 905 visits this financial year and reported 623 issues of concern, of which 161 related to abuse.

In pension-level SRS, Community Visitors frequently reported the use of cannabis, and other drugs such as ice, alcohol and indoor smoking by residents. Often, drug and alcohol addiction and/or complex mental illness were key factors in episodes of violence, followed by the formal eviction of residents or pressure to leave the SRS.

Abuse issues documented by Community Visitors over the year include:

- an alleged sexual assault of a vulnerable resident by a staff member at night
- a resident who “wanted” an apology after being hit and thrown against a wall
- a resident intoxicated from drinking vanilla essence evicted by police after he hit a staff member with a vacuum cleaner
- a resident who threatened assault and was returned to hospital after three hours when the proprietor alerted his case worker and police
- financial abuse of several residents by an allied health practitioner
- a resident shouting and behaving aggressively instructed by the manager to go to their room, subsequently self-harmed and taken to a hospital emergency department.

In 2019, the Community Visitors Program initiated an Abuse Referrals Project to detail abuse issues reported by Community Visitors and forward them to the Division responsible and to the DHHS SRS Program for action. The project is a result of department advice to the Board that it received a significantly lower number of abuse issues than were reported in the Community Visitors Annual Report.

The project will provide quarterly referrals to assist DHHS in identifying high risk SRS. This financial year, 80 detailed referrals were sent to the DHHS about abuse, assault and neglect incidents that occurred between July 2018 and March 2019. The project has highlighted that some serious issues documented by Community Visitors were not reported as Prescribed Reportable incidents (PRIs). The board has raised its concerns about this issue at its liaison meetings with the department.

This year, DHHS undertook a compliance audit for SRS that had reported no or few PRIs since the legislation came into effect in 2012. The board noted a 77 per cent increase in PRIs in the quarter following the audit and a further 44 per cent increase in the next quarter. There is still under

reporting of PRIs. A recent visit to SRS revealed two serious assaults on residents in the incident book but neither reported to the department.

The Community Visitors Program expects to see a higher level of responsiveness to these serious abuse issues next year.

Health

This year, Community Visitors found 104 issues related to healthcare, which was the second highest issue category documented by them.

Most pension-level residents have complex health needs, have been adversely affected by poverty and lack of access to health services including prevention initiatives. Unexpected and premature deaths at pension-level SRS, including some related to drug overdose, are high in comparison with pension-plus SRS. Accordingly, Community Visitors sought the establishment of an SRS health project in collaboration with VicHealth to monitor general resident health and develop strategies to improve overall health outcomes.

Smoking is an ongoing and critical issue for SRS residents as 54 per cent are smokers compared with the general population rate of 12.8 per cent. This is responsible for, or exacerbates, many of the health conditions residents suffer and impacts on their financial wellbeing. Community Visitors also recommended to the State Government a partnership with QUIT to dramatically reduce smoking and address the resulting health effects of this addiction.

> ***Case study***
>
> Community Visitors met a resident who was about to be evicted because the SRS could not provide him with accommodation on his Newstart allowance.
>
> He had been in prison for 17 years, had a serious mental health condition, very poor physical health and only his eye teeth left.
>
> He had no family contact or friends on the outside, so relied on his Mind Australia case worker who was assisting him to access a pension and temporary housing.

Mental health issues

Despite the launch of referral guidelines in 2018 between mental health services and SRS, there continues to be a lack of advice and accountability when discharging patients from mental health facilities with an informed support plan and timely post-discharge follow-up.

Proprietors frequently report that patients are sent to SRS with no notice, limited or no referral paperwork or community case management support in place.

The 2018 Census data reinforces the disturbing feedback gathered by Community Visitors that there are increasing number of younger pension-level residents with mental health issues, including some who are undiagnosed or untreated. Staff have limited capacity to engage and support these residents or to manage how they impact other residents due to them having little or no training in this area.

Such training assists proprietors and staff to effectively engage and manage residents with these complex health presentations. The referral guidelines recommend proprietors employ a range of staff with mental health skills, reinforcing a 2015 coronial inquiry recommendation, accepted by DHHS, that all SRS staff have mental health training.

Despite DHHS efforts to promote and monitor the SRS mental health training program across the sector, the workforce response remains inadequate. The latest figures provided to Community Visitors showed that 723 SRS staff booked into the training but only 500 attended. DHHS does not have figures on the pool of staff who should attend such training.

Fire safety

The *Supported Residential Services Private Providers Act 2010* (the Act) sets out 15 accommodation and personal support standards that SRS are required to meet, one of which is a safe environment.

In response to resident concerns, Community Visitors made three notifications about frequently activated and then disabled fire alarm alert tones in one SRS, DHHS advised that the focus of its work is emergency management, with local government responsible for building and fire safety.

Community Visitors have identified this as a gap in the fire regulatory framework that requires immediate attention. There is no system of ensuring that building and fire safety issues identified by local government are relayed to DHHS, the department responsible for ensuring the safety and wellbeing of SRS residents.

Meetings between the DHHS and the board have not satisfied the board that, in the short-term, the regulatory gap has been adequately addressed. The board is acutely aware of the vulnerability of SRS residents, many who require support with daily living, and are extremely concerned

for the safety of residents while the regulatory gap remains. The inquest into the fire at Kew Residential Services led to many fire safety changes for people with disabilities. The salutary lessons from that inquest could well be applied to the SRS sector.

The regulator's initiative to engage with the Municipal Association of Victoria (MAV) about the co-regulatory responsibilities is welcomed but the board notes this is a long-term strategy.

SAVVI and PLP funding

In 2016, KPMG commenced a review of the Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) and the Pension-Level Supported Residential Services Project (PLP) funding which is worth in excess of $10 million annually. The review recommendations were finalised two years ago, but nothing has happened to implement them.

In March 2019, the board wrote to the DHHS Secretary to request an update on the review and recommended only short-term extensions of the SAVVI contracts pending a final decision of the review recommendations.

In addition, the board sought the re-opening of the PLP funding to all new eligible SRS. The limited availability of this funding has now created four categories of pension-level SRS: those under the SAVVI program; those funded under PLP; one group, Dependable Care, which has refused both SAVVI and PLP funding; and new pension-level SRS that are ineligible to receive any additional funding.

Community Visitors are supportive of the review recommendation to combine the SAVVI and PLP programs and for these programs to be spread across all pension-level SRS. Any findings of this review should require that SRS receiving State Government funding must meet robust performance measures that ensure it is used to benefit residents.

The board welcomes the meeting with the departmental area responsible for implementing the review recommendations that came about as a result of its letter.

Changes to the DHHS regulatory role

A 2015 Victorian Auditor-General's report into DHHS regulation found the lack of a systematic, risk-based approach to its obligations and that it could not demonstrate regulatory outcomes were achieved.

In mid-2018, the significant changes made to align and centralise regulatory functions across DHHS aimed to improve compliance and enforcement under the leadership of the Human Services Regulator. Regulatory Officers now have a broader range of responsibilities including SRS, child, youth, families and out-of-home care.

The purpose of SRS regulation is to protect the safety and wellbeing of SRS residents and ensure minimum standards. The role of Community Visitors is to protect the human rights of SRS residents, ensuring they are free from abuse, have choice and control in their lives and are accorded dignity and respect. Given these different roles, it is not surprising that, from time to time, there

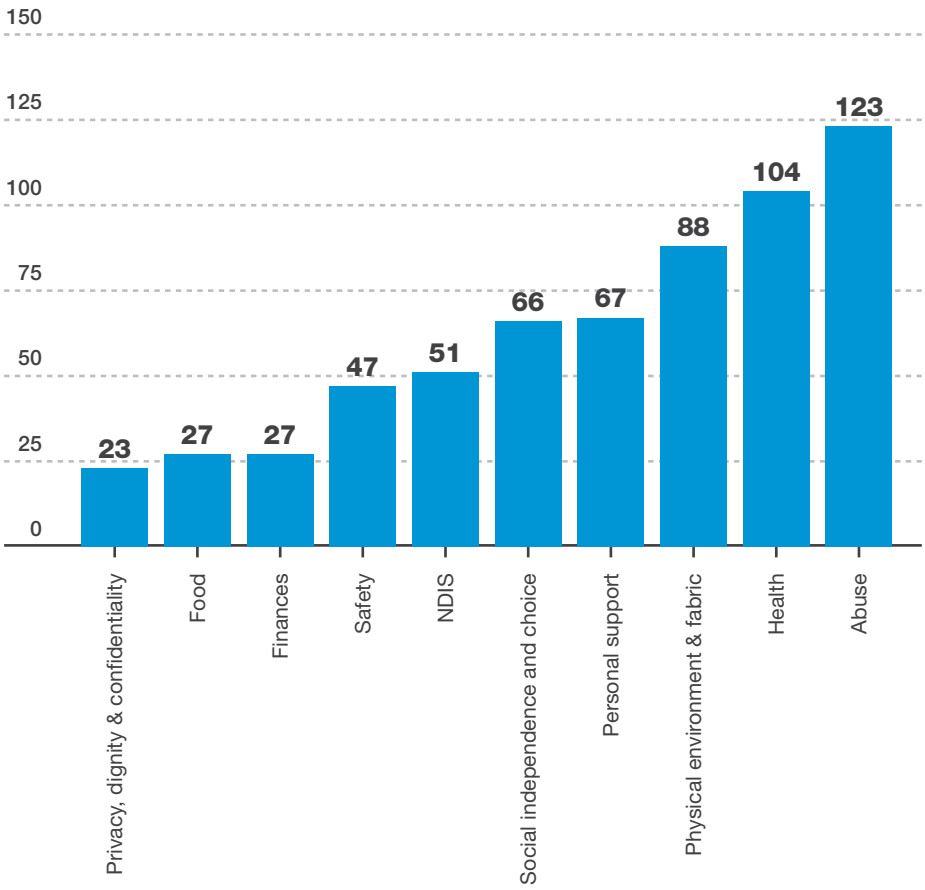
What makes a good SRS?*

- a clean, well-maintained and homelike environment
- adequate staffing to meet resident needs
- consistent, well-trained and caring staff who understand their role. Staff with adequate language skills to communicate with residents.
- organised and capable managers with access to detailed referral information from health services
- managers who make informed decisions about resident mix
- SRS that model good practice
- residents who are meaningfully occupied and encouraged by staff to participate in local community activities
- referrals and access to community resources and services

= a profitable and stable business for the future with high occupancy rates

** prepared by Residential Services Regional Convenors*

Figure 12. Issue groups and number of issues identified in each, 18/19



can be considerable tension between DHHS staff and Community Visitors. This year proved to be exceptionally challenging, particularly as departmental staff transitioned to new roles which heralded a very different approach to, and understanding of both their role, and that of Community Visitors.

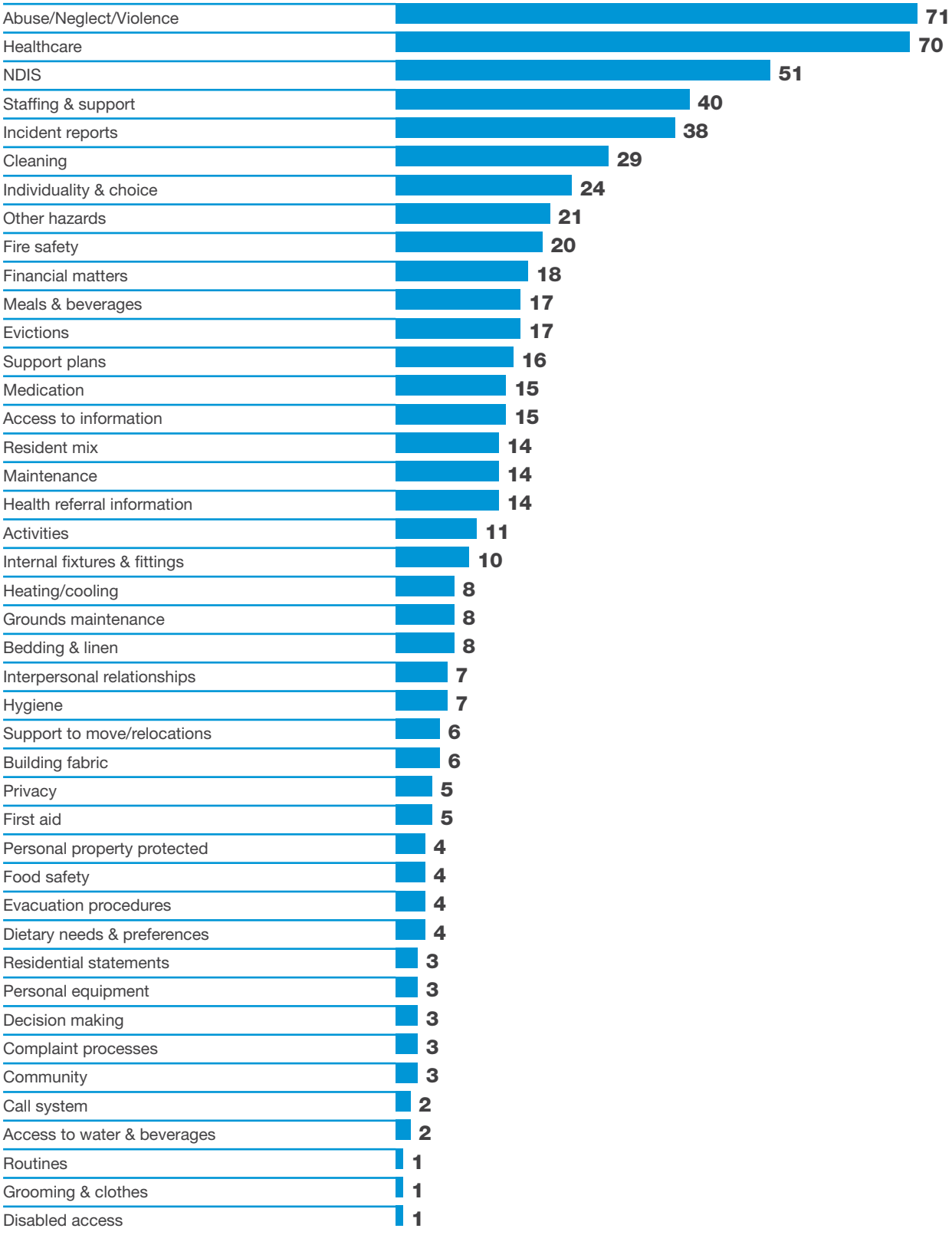
Community Visitor concerns about the response to several adverse events and communication issues led to the establishment of a working group between the board and DHHS. Its aim is to improve the ongoing working relationship and communication and revise the protocol for responding to issues and informing Community Visitors about compliance actions.

Proprietors are also confused about the changes in the regulatory approach. Community Visitors continue to receive proprietor feedback that they still see DHHS's role being to assist them and their residents navigate an increasingly complex and challenging social care system. A proprietor forum held in April 2019 sought to clarify the regulatory landscape changes but, at the end of it, proprietors still seemed unclear about these changes or the implications for them. Regular forums such as this and improved stakeholder engagement will better equip SRS proprietors and their staff to deal with change.

The following example illustrates the impact of the changed regulatory approach in one SRS.

An SRS resident with a Residential Tenancy Agreement signed on her behalf by a homelessness service rather than the Residential and Service Agreement as required under the Act, proved very difficult to evict. Over several months, the resident assaulted and abused residents and staff. The intervention order she took out against the proprietor prevented staff from entering and cleaning her room. This added pressure to an already untenable living situation for other SRS residents, many who were frightened vulnerable older people who were at immediate and high risk of abuse.

Figure 13. Issue types identified and number for each, 18/19



The experience of Community Visitors is that, under the previous regulatory regime, the proprietor would have received significant support from DHHS to assist them deal with this challenging situation. Under the new regime, the proprietor was advised they were responsible for managing the situation, should seek legal advice, report matters to the police and review their security arrangements. While perhaps a technically correct approach, the outcome was a proprietor struggling to manage, SRS residents at high risk of assault and abuse for an extended period, and increasingly concerned Community Visitors who felt their notifications were not adequately addressed in a timely manner.

Demountables at an SRS

Dependable Care Limited runs a group of three SRS, including Reservoir Lodge (RL) with 49 beds. Community Visitors have been visiting this SRS since 9 October 2009.

Twenty-eight used demountable units (DUs) were delivered to the RL site in early 2014. Darebin Council was alerted to the situation and discovered that RL had been operating as an SRS without a permit. The Council later approved a retrospective permit for the SRS and simultaneously one for the DUs.

The DUs have subsequently been fitted out as mostly two-bedroom accommodation options, with plumbed bathrooms but without food preparation facilities, save that some have a small bar fridge and microwave. There is very little floor space with no living, dining or lounge areas. The DU residents have no option but to access the existing SRS facilities for meals, to do laundry, living and socialising.

Community Visitors reported that the DUs were being used as an accommodation option by the proprietor as if they were part of the SRS. However, the proprietor and staff repeatedly and continually blocked Community Visitors' access to them on the basis that they were "not part of the SRS" as they were "independent living" units. Signage was observed out the front of the SRS and online that invited the public to take up residence in the DUs as 'independent living units'.

A subsequent review of Council's Planning Minutes showed that they issued a permit to RL for the DUs strictly on the basis that they formed part of SRS.

In March 2019, the Public Advocate wrote to Council in relation to the permit conditions versus the proprietor's contrary claims. A letter was also sent to the DHHS Secretary about the existence of the DUs and related concerns of the impact on existing SRS residents. The DHHS responded in writing to indicate that *"...the department will be requesting an application for variation of the registration of the SRS to accommodate...the demountable units..."*.

An RL site visit was arranged by the Council, accompanied by representatives from the Office of the Public Advocate, DHHS SRS regulatory branch and Consumer Affairs Victoria.

Several fire safety issues were observed on the visit. It appeared that the DUs, (some of which were occupied) did not comply with the regulations specifying an automatic fire suppression system (i.e. fire-sprinkler systems) be in place. This issue was brought to the attention of the DHHS and the Council, so the latter conducted a fire safety inspection and reported to the Public Advocate that the fire hydrants on-site were blocked by the DUs.

At the time of writing, the RL fire safety issues have not been resolved. The Public Advocate continues to press for this urgent fire safety risk to be promptly remedied by both the proprietor and DHHS.

Community Visitors remain concerned that the occupancy of the DUs doubles the number of residents on-site without any additional dining, laundry, lounge or recreational facilities. Further, if the DUs are not classified as part of the SRS then resident safeguards are uncertain, the fire protection is lower and the required staffing unclear.

NDIS and My Aged Care staff support

For the second consecutive year, board undertook a project to assess the level of implementation of the National Disability Insurance Scheme (NDIS) across Victoria. Of 128 SRS, 82 participated in a verbal survey. The 2018 SRS Census records 48 per cent of residents are under 65 years of age, so could potentially be eligible for NDIS.

The survey identified that, on average, 51 per cent of residents under 65 years of age living in SRS have an approved NDIS plan. The East Division was the best performer with 69 per cent of eligible residents having NDIS supports, highlighting the positive impact of the 2018 Resident Opportunities After Reform (ROAR) project.

Community Visitors report that residents accessing funded services are better supported, have increased social engagement and fewer behaviours of concern.

NDIS applications were declined for 29 residents and the project identified that the knowledge and support of the SRS proprietors was a key factor in the approval and successful implementation of a NDIS plan. The survey indicated proprietors' response to engaging with the funded reforms varies. Some have provided welcome support to residents that has resulted in them accessing services, while others lack the skill, knowledge and time to assist residents to navigate NDIS access.

A proportion of proprietors have registered as an NDIS service provider, in some cases, even employing their SRS staff as NDIS support workers to provide additional services for residents. While there are benefits to residents of being supported by staff who they already have a relationship with, the arrangement also creates the possibility of conflict of interest which can negatively affect residents.

Monitoring and reporting on potential conflicts of interest will continue to be a priority for Community Visitors.

In response to Community Visitors identifying this issue, DHHS initiated a Targeted Compliance Review (TCR) to ensure that services provided as part of a Residential Services Agreement remain separate to those funded by an NDIS plan. The Community Visitors Program is waiting for the results of this TCR.

Community Visitors are equally concerned about the poorly regulated coordination and delivery of NDIS services to SRS residents. Proprietors are often not involved and describe situations where NDIS participants receive a poor-quality service, inconsistent with their plan goals such as a disinterested worker playing with their mobile phone while the resident supposed to be having a coffee with them as part of their social inclusion goal and workers who turn up late or not at all.

It has been widely observed that support workers arrive unannounced, often make no contact with SRS staff and provide no information about their activities with residents. There is an urgent need for better protocols associated with NDIS service provision for SRS residents.

Community Visitors have observed a reduction in group activities and report a growing disparity between those eligible for funded supports, such as through NDIS or My Aged Care, compared to those who are ineligible.

Divisional Reports

East Division

East Division includes Eastern Metropolitan Melbourne, comprising the DHHS areas of Inner Eastern and Outer Eastern Melbourne, and the regional area of Hume, which, in turn, comprises the DHHS areas of Ovens Murray and Goulburn.

Eastern Metropolitan Melbourne

Introduction

In the Eastern Metropolitan area, there are 18 pension-level SRS where residents pay over 85 per cent percent of their aged or disability pension for accommodation, food and support. There are also 19 pension-plus SRS following the closure of Camberwell Manor in September 2018.

Abuse

Case study

A major conflict developed in an SRS when a woman living in a van was referred by a homelessness service who signed a Residential Tenancy Agreement on her behalf rather than a Residential and Services Agreement, as required by the Act.

The resident made physical and emotional threats and physically assaulted residents and staff; she pushed a woman on a walking frame to the ground, rode her wheelchair into a staff member; and kicked an older woman who suffers from multiple sclerosis in the stomach until another resident stepped in.

The police were contacted on multiple occasions but took no further action.

DHHS advised the proprietor it would be advantageous to ensure that security cameras were functioning, report incidents and obtain legal advice to apply to VCAT for a Notice to Vacate. The aggressive resident sought assistance from Tenants Victoria and obtained a restraining order against the proprietor. The resident came and went over several weeks, her unpredictable behaviour frightening residents.

After receiving legal advice, the proprietor finally made a successful application to VCAT for her to vacate.

Arguments take place between residents and, on rare occasions, erupt into violence due to disputes over cigarettes or other drugs when experiencing substance withdrawal, boredom or simple differences of opinion.

Community Visitors have noted that some proprietors choose not to interfere to resolve a dispute or educate and counsel residents, rather they evict them. In one SRS, in response to a resident's aggressive behaviour, a worker allegedly threatened that her husband would hire someone to "chop" the resident's hands off.

An ongoing concern is where an individual cannot or is no longer able to live with others. Consequently, Community Visitors observe some residents moving frequently between facilities. One resident moved three times this year.

In SRS where frequent conflict is reported, Community Visitors observe a lack of activities. A noticeable decrease of conflict is present where the proprietor engages residents in the different aspects of running their home and where residents have responsibility for clearing the tables, maintaining the garden, emptying cigarette bins and sometimes assisting with shopping and meal preparation.

Health

The physical health of residents is usually well-supported with health practitioners such as the GP, physiotherapist, optometrist, and podiatrist regularly visiting SRS. Community Visitors are generally more concerned for the mental health of residents who deny their need for counselling, medication, assessment or need continual support to engage with an integrated treatment cycle such as depot (slow release) injections.

Staff and other residents may not always understand that a person's behaviours and mood can be changeable.

Community Visitors reported proprietors' dissatisfaction with the discharge process from acute mental health units. Residents are disadvantaged when incomplete referrals impede a proprietor's ability to assess a person's appropriateness for a facility or prepare a support plan to care for a resident to optimum levels. A man sent to an outer eastern SRS with incomplete paperwork quickly became abusive to other residents. The proprietor kept careful note of his behaviours and he was evicted and referred to a men's shelter in the city, leaving in a taxi at the facility's expense, threatening "I'll see you in court".

> ***Case study***
>
> A resident was discharged from a mental health acute unit to the SRS without referral documentation.
>
> Days later, the DHHS Communicable Diseases Prevention and Control Unit advised that she had hepatitis A and that residents and staff would require vaccination and a full clean of the facility.

There are instances where the actions of well-meaning family members are harmful to the mental health of a resident. One resident's parent repeatedly moves her from one facility to another and cancels medical appointments, disrupting continuity of care. Another resident's parent cancels psychiatric appointments for her son whose behaviour is abusive and, sometimes, physically aggressive. Other residents report that they fear him.

Community Visitors have noted that animals in facilities often lead to a greater social interaction and better health.

Physical environment and fabric

In May 2018, Community Visitors were alerted to a complaint about a leaking roof in a pension-level SRS. They found filthy cooking equipment, water damage to walls, and broken doors. Cobwebs were noticeable and, in one bathroom, the shower tiles were black from mould.

Regulatory officers inspected and required the immediate replacement of pots and pans and proprietor undertakings to address the concerns. Monitoring was undertaken by DHHS to ensure cleaning works were completed and mould removed. Negotiations between the proprietor and building owner are in progress to maintain facilities and complete building works.

Personal support

Community Visitors observe that residents in most facilities are happy and well-supported. However, there is ongoing disquiet and conflict in a small number of facilities which has ranged from heating only being switched on when the proprietor is at the facility to carelessness with medications.

> ***Case study***
>
> A young woman given the medications of an elderly man for a heart condition and a psychological disorder spent a week and a half in hospital recovering from this serious medication error.

Community Visitors discovered that residents in one SRS are charged different amounts for rent, causing consternation among them. In the same facility, a resident referred from an acute mental health unit was given a bed in a shared room with a male. She left and her whereabouts were unknown at the time of writing.

Community Visitors meet pension-level SRS residents who require support beyond that which can be reasonably provided by the facility. In some cases, proprietors lack the skills and resources to support people with mental health conditions, thereby increasing their risk of homelessness. Professional assistance is needed to support residents to apply for NDIS or to arrange timely and accurate referrals for community care.

Case study

Community Visitors notified DHHS about a female resident who reported an alleged sexual assault to police and complained of complex health issues. Over several months, the resident rarely left her room. The proprietor provided increased care and encouraged the resident to seek medical assistance and find more suitable accommodation. The resident was resistant to support and refused food and assistance to keep the room clean. After several months, the proprietors could no longer meet the health and care needs of the resident and were supported by DHHS to access support from a social worker and other health practitioners. DHHS advised the proprietor to seek legal advice to apply to VCAT to issue a notice to vacate. Consequently, the resident was given a deadline to vacate the SRS.

Social independence and choice

Community Visitors notice a change to the occupancy profile of several SRS. For example, a well-run and settled facility of 45 beds of older residents was activity filled and welcoming. Now, residents vary in age, life experience and abilities, many referred by mental health acute units and paying fees at pension-level rates. Needs are more complex, behaviours less predictable and activities almost non-existent due to reduced staffing from the minimum regulated at 1:30.

Long-standing residents who remember what it was like when they first chose to live there are increasingly disturbed. The job of proprietors is not made easier when hospitals and other referring agencies do not send timely and accurate information about complex resident needs, such as a newly referred resident with hepatitis A and a resident with a history of attempted arson who lit a fire in his room.

Community Visitors accept that proprietors develop their own business model, decide who to accept, under what circumstance, at what price and they acknowledge the cost of running facilities is substantial. However, there is a need to regulate more effectively to ensure SRS regulations are always enforced so the personal support requirements of each resident are fully met in a timely manner in accordance with the residents' support plans.

NDIS

Following the success of the State Government-funded ROAR project in 2018, several proprietors are confident to proactively work with service providers such as EACH and Salvo Care to support residents to access NDIS or to prepare for a review. Where proprietors have chosen or have been permitted to be involved, the impact for residents has been overwhelmingly positive.

While many residents are delighted to go out one-to-one to shop, walk or for a social outing, Community Visitors question the accountability of support workers who do not sign the SRS Visitors' book or decline to share information about the resident's activities. Frequently, Community Visitors are told that a resident "went out for coffee" with a support worker and wonder how this specifically builds the capacity of the resident. Proprietors comment on the attitude of some funded support workers, who appear disinterested in client needs, such as dealing with incontinence, medication needs, or how to manage stress triggers and responses.

Often, residents need support to align the NDIS service with their schedule. For example, support workers from one agency arrived to bath a resident at lunch time. The manager intervened and arranged for the support worker to arrive at a suitable time for the resident. The proprietor was unhappy with NDIS and My Aged Care support workers arriving unannounced and going to residents' rooms, so they used SAVVI funding to install a key-pad entry lock and requested visitors inform the manager on duty when visiting.

Residents hopeful of receiving much-needed equipment such as a wheelchair, can become disillusioned and resentful with delays in the approval process for NDIS and My Aged Care packages.

Good practice

Community Visitors met a parent who was able to come from Tasmania to be with her daughter who had just received an NDIS package. They are now living happily together in the SRS.

Hume

Introduction

One pension-level SRS in northern Victoria close to the New South Wales border is a 30-bed residence, which is occupied by 25 residents for most of the year.

Abuse

Persistent verbal abuse instigated by a resident with a severe, unstable mental health condition toward another resident, led to a physical altercation. The victim reported the abuse but refused further intervention. Each resident now has their own room and improved support.

Health

A resident with a chronic skin condition is very reluctant to treat it or let staff minister to it. Some residents were referred to hospital for treatment following falls and acute mental health episodes. One resident undergoing cancer treatment, is unlikely to return to the SRS as staff will be unable to provide appropriate support.

Physical environment and fabric

Furniture in the lounge area was smelly, dirty and in a poor state. The SRS secured SAVVI funding to replace recliners, couches and chairs which has been appreciated by residents. A main passageway exit door that was difficult to open was promptly repaired. The undercover gazebo adjacent to the residence is well-used by residents who smoke.

Social independence and choice

One resident keeps a keen eye on the indoor plants in the lounge area and tends an outdoor vegetable garden. Leisure activities include, tablets, jigsaws, drawing, painting and bingo and a regular group travel 66 kilometres to Shepparton for ten pin bowling.

NDIS

All residents eligible for NDIS support have been offered plans. The roll-out in this area has just started so, in many cases, the additional support has not yet commenced.

North Division

North Division includes Northern Metropolitan Melbourne, comprising the DHHS areas of Hume Moreland and North Eastern Melbourne, and the regional areas of Loddon and Mallee.

Loddon Mallee

Introduction

There are four pension-level and one pension-plus SRS in the Loddon Mallee area.

Abuse

Instances of abuse, including physical aggression and sexual abuse, occurred at some pension-level SRS.

Actions such as the prompt attention by a proprietor and a visit by the DHHS Regulatory Officer resolved these issues. Some long-term disharmony between residents at one pension-level SRS has been effectively settled.

Health

Many residents in pension-level facilities have mental health issues. One resident repeatedly told Community Visitors that an extended ECT program was not beneficial for him. It has since stopped.

The death of a resident who took large amounts of medication was referred to the Coroner.

The increasing health needs of elderly SRS residents has been observed. Community Visitors questioned if a frail resident in his eighties needed a higher level of care following hospitalisation. A resident at another SRS had multiple health

conditions which were neglected. Community Visitors advocated for attention to these needs and care is now being provided.

Physical environment and fabric

Maintenance and cleaning issues included subsidence in a floor section in a common area and stained flooring in an SRS bathroom. At another SRS, residents complained of being cold for three months. A later visit by Community Visitors found the SRS temperature comfortable.

Personal support

Instances of support plans being outdated or with missing information were reported. Attention to hygiene issues with incontinent residents and not showering were raised with SRS management with improvements noted at subsequent visits.

Social independence and choice

The cessation of community support programs has impacted residents without NDIS support. Some residents reported feeling discriminated against.

NDIS

Most SRS residents who qualify for NDIS now have plans, however, some individuals were ruled ineligible. Community Visitors referred one resident's case to a DHHS Regulatory Officer who confirmed that a service provider would assist the resident to appeal the NDIS decision.

Service provider responsiveness

SRS staff and management have been cooperative with only a few delays in addressing Community Visitors' concerns.

Northern Metropolitan Melbourne

Introduction

There are 17 SRS operating in the area, 13 pension-level and four pension-plus facilities.

Abuse

Community Visitors reported incidents of violent and aggressive behaviour by residents towards other residents or staff at five pension-level SRS.

At one facility, a fight between residents led to the calling of the ambulance and police. At another, police were notified when a resident threatened assault with a knife. Instances of self-harm and property damage were also reported.

Several allegations of theft were reported at one SRS. Police were informed and residents told to keep their rooms locked. A resident at another SRS believed she had been unfairly charged several thousand dollars in back rent. The issue was escalated to State Trustees who advised the charges seemed justified.

Health

There are many people with mental health issues who may experience homelessness if they were not living in pension-level SRS. Staff from mental health services have an active presence at some SRS but usually only on weekdays.

Many residents have physical health problems. Few complaints regarding care were recorded. Falls were noted in several reports. One resident broke her nose and was taken to hospital as the result of her fall. Another fall resulted in the hospitalisation of a resident for three days. Community Visitors reported to DHHS that there was no record of this matter in the SRS incident report book. A response to this notification is yet to be received.

One resident who had chronic fatigue, diabetes and mobility problems complained to Community Visitors that the SRS where he lived was not providing the gluten-free food he needed and his insulin was not correctly stored in the fridge. He also complained he was bullied by the proprietor and that the SRS wanted to charge him extra to provide gluten-free bread. The resident moved to live with a friend soon after.

On a positive note, dental care is provided on site at one SRS.

Physical environment and fabric

OPA's advice service was contacted several times by different parties regarding bed bugs at one pension-level SRS. Community Visitors who raised the issue with the SRS manager, were told that the issues were confined to one room and it had been sprayed.

A wide range of other maintenance and cleaning issues were reported across the sector,

including filthy toilets and toilets without soap, a broken toilet seat, damaged doors, mould on mattresses, dirty tables, chairs and floors, flies, untidy cigarette butts, and lights and heating not working. In some instances, action was taken once issues were reported. In others, issues continued over many months. Cockroaches in a small fridge in an SRS dining room were reported on two consecutive visits. The SRS manager said the fridge was no longer used, however it was not removed or cleaned.

At the same SRS, there is only one washing machine and two dryers for 43 residents, which Community Visitors consider totally inadequate.

Personal support

Support plans have been reported as missing or lacking at several facilities and residential statements were out-of-date at one facility. Several instances of dirty clothes and matted hair, as well as other issues indicating inadequate care, were reported.

> ***Case study***
>
> A diabetic resident who used a wheelchair was discharged from a mental health unit to one SRS then moved to another.
>
> The wheelchair from the hospital did not have an effective harness or headrest and, when Community Visitors first met the resident, he said he had fallen out of the wheelchair three times. The toilet and dining-room tables at the SRS were too low to fit his wheelchair under, also presenting an injury risk.
>
> The Community Visitors Program coordinator contacted the resident's case manager who arranged an urgent occupational therapist assessment and for the Royal District Nursing Service to attend the SRS as staff were unable to assist with insulin injections. The resident also had a home care package for a worker to assist him with showering and clothes washing but this was only one hour a week. There was only one washing machine for residents to use and this could be in use when the worker went to the SRS.
>
> When Community Visitors met the resident he was very downhearted. Eventually he moved to a facility with a higher level of care and was reportedly happy there.

Social independence and choice

While it is not true of all SRS in the area, residents of some SRS have limited choices at some facilities.

> ***Case study***
>
> At one pension-level SRS, residents are issued with a cup and are expected to bring it to all meals and tea breaks.
>
> Some residents misplace or break their cups and arrive to meals and refreshment breaks with an assortment of bottles and cups that they are expected to wash in their rooms.
>
> At morning tea, Community Visitors noted that there was one pot of coffee and one pot of tea brought out on a trolley with no separate milk or sugar as it is made in the pots with milk and sugar included. Residents rushed to obtain a slice of bun as there was only one plate provided for up to 49 residents.
>
> At lunchtime there were jugs of water provided but no glasses or cups.

At the same SRS, there is a pay phone in the foyer for incoming calls, but it is reportedly locked at 8pm and residents cannot ring out.

NDIS

There continues to be confusion regarding the NDIS and discussion about its benefits. While some residents access more support for individual activities since its introduction, there appears to be fewer group activities across the sector. One SRS proprietor told Community Visitors that a resident has a package that allows four hours of support each week-day, but it appears to involve the client and carer sitting together while the carer uses their laptop.

Community Visitors have expressed concerns about a potential conflict of interest when companies are registered to provide both SRS (state regulated) and NDIS (federally funded) care at their facilities. At one SRS, some residents have received NDIS funding for additional support with laundry or frequent cleaning of their rooms. NDIS funding is intended to provide supports in addition to the services included in the SRS Residential and Services Agreement. Community Visitors observe inconsistencies in the basic service provided to residents and query if SRS are upholding their responsibilities to provide support services as specified under the Act while simultaneously charging for the same services under the individual's NDIS plan.

South Division

South Division includes Southern Metropolitan Melbourne, comprising the DHHS areas of Bayside Peninsula and Southern Melbourne, and the regional area of Gippsland, comprising Inner and Outer Gippsland.

Gippsland

Introduction

The Gippsland area has five SRS, including one pension-level and four pension-plus facilities. There have been changes of management/ ownership in three of the SRS during the year.

Health

Community Visitors are concerned at the quality of support and lack of communication between health and mental health services with the SRS. The outcomes are often inadequate services and supports for residents and management alike.

A patient was referred to a pension-plus SRS for respite but her health rapidly deteriorated and she passed away the following day despite the efforts of ambulance officers. SRS management complained to the hospital as they were provided with little information regarding the seriousness of her health issues prior to admission.

> ***Case study***
>
> A resident at a pension-level SRS intentionally set fire to her nightgown with a cigarette lighter while in a shared smoking area. The alarm was raised by another resident to staff and emergency services responded quickly. The resident incurred critical injuries and died in hospital a few days later.
>
> She had been a resident for only 11 days when the incident occurred.
>
> Prior to the incident, the resident had been admitted to hospital twice due to overdosing on insulin and complaining of chest pains. The resident was discharged back to the SRS in both instances with the chest pains, assessed as "attention seeking" behaviour.
>
> Management at the SRS were concerned about their ability to support the resident and manage her behaviours as they received very little information about her clinical presentation on referral.
>
> The resident had a history of mental health issues and behavioural difficulties, including self-harming behaviours as well as unstable accommodation, including recent stays in two other SRS and a hotel in Melbourne.

Physical environment and fabric

One SRS in the area has been extensively refurbished but this is the exception rather than the rule. Continual prompting is often required regarding maintenance, especially with bathrooms and toilets, where missing tiles, water damage and mould are frequently observed. One SRS, with longstanding water leakage issues, needed to replace the entire shower floor including underlying timbers.

Personal support

The location of an SRS can often dictate the availability of free or meaningful activities. A lack of public transport compounds the problem so residents spend significant hours sitting in their rooms or in the smoking area. Personal plans are developed but implementation is often inconsistent with agency staff not showing up at appointed times or an activity being cancelled.

NDIS

Some SRS are experiencing problems with NDIS implementation including some support workers failing to arrive for appointments, while others do little other than sit with residents and watch television. Progress with NDIS applications has been slow for some residents.

Southern Metropolitan Melbourne

Introduction

There are 37 SRS in the Southern Metropolitan Melbourne area, 28 pension-level and 13 pension-plus.

Abuse

Ensuring adequate clinical care and support for residents with mental health issues continues to be a challenge for proprietors. Where this is lacking, SRS staff and resources are put under strain, and other residents may be significantly impacted.

An individual given a two-week trial at a pension-level SRS following her discharge from an acute mental health facility, caused extensive property damage over two days breaking windows, tearing curtains and emptying residents' flower pots. The residents experienced an uncomfortable and fearful weekend before she left the SRS.

A resident with chronic mental health issues at a pension-level SRS became aggressive, physically threatening staff and other residents. Frightened staff locked themselves in the kitchen before help arrived and the resident was hospitalised.

Loud and threatening arguments between residents with complex needs can be upsetting for other residents and for Community Visitors when they witness them. As an incident of this sort unfolded at a pension-level SRS, Community Visitors were extremely concerned that the residents' argument would escalate into a physical fight. They were impressed with the proprietor's ability to calmly engage with the residents involved and defused the situation.

A resident who was pushed up against a wall by another resident during an argument over cigarettes required hospitalisation for a serious head wound. The perpetrator of the assault was on a community treatment order following previous violent episodes and did not return to the SRS.

At a pension-level SRS, a resident assaulted a proprietor who was attempting to defuse an argument between residents. The resident was given immediate notice to vacate due to the risk that he posed to staff and residents. His current whereabouts are unknown.

Health

Community Visitors were disconcerted to see an offensive 'No blowing snot' notice on the front door of a pension-level SRS. It was reported that some residents blow their noses directly onto the ground and even onto the tables in the dining room at meal times. Staff are attempting to curb this unhygienic practice that poses a health risk to residents. Community Visitors suggested that the provision of hand sanitiser rubs on the tables and other communal areas of the home might augment staff educational efforts to improve resident hygiene.

An elderly resident at a pension-plus SRS was admitted to hospital to treat infected ulcers. Her support plans documented a significant deterioration in her health over many months, and a subsequent increase in her care needs including regular turning in her bed, as she was bed-bound and needed assistance with eating and drinking due to her need for pureed food. Her pressure sores became infected and her sons were unable to pay for the specialist dressings requested by the GP. Community Visitors queried why the SRS continued to manage the resident despite her increasingly high-care needs. DHHS continue to investigate this matter.

Staff at a pension-level SRS reported inconsistencies in the information provided to residents discharged from hospital, particularly mental health services. There is a documented process with the local health service, however, the extent to which this is followed varies greatly depending on the hospital staff involved.

Physical environment and fabric

A bathroom shared by four residents at a pension-level SRS was found to be unhygienic with a filthy floor and toilet pan, together with swarms of insects in the area and a strong smell of urine. Following a Community Visitors notification, Regulatory Officers promptly visited and worked to ensure adequate cleaning occurred.

While improvements were noted in the bathroom on a subsequent visit, the adjoining bedroom was found to be infested with at least four types of crawling and flying insects. Community Visitors noted the need for urgent action to combat the pest invasion. These issues highlighted the need for the proprietor to maintain appropriate oversight of the cleaning services he paid for.

An SRS with persistent complaints about bed bugs conducts weekly spraying of rooms to control the infestations. Community Visitors are concerned it is not effective as the general cleanliness of the whole facility is poor.

The central heating system at one pension-level SRS is broken and the reportedly prohibitive cost of a replacement has left the corridors and residents' rooms without heat. Residents have been given small oil heaters, which only have limited effectiveness, especially on cold winter days and nights. One resident informed Community Visitors that he sleeps in his clothes because it is so cold when he leaves his room to go to the bathroom during the night.

Lack of responsiveness from landlords to maintenance issues can impact on the living environment and lead to safety issues. At one pension-plus SRS, the external fabric of the building is deteriorating rapidly. Community Visitors observed a broken fence, cracking bricks, rotting window frames, two electrical outlets with loose wires, and a very overgrown garden that is a tripping hazard. There are also many areas of frayed carpet in the facility.

Case study

One SAVVI-funded, pension-level SRS has consistently failed to meet acceptable standards of care. The SRS provides accommodation to residents with highly complex health and psychosocial needs.

Community Visitors have been subjected to bullying and harassment by the proprietor and have been advised of bullying and intimidation towards residents. One elderly resident is reportedly fearful for her tenancy.

Significant concerns regarding food preparation and hygiene have arisen. Community Visitors have regularly observed an unclean kitchen, perishing food items and cats in the kitchen. They have also observed the handling of the cats while food is being prepared.

There is little fresh fruit provided and residents have complained that baked beans, two-minute noodles and frankfurts are regularly served for meals.

Cleaning of the SRS does not appear to be regularly done. Bedroom floors were observed with cigarette ash, bed linen was soiled, and mould was observed in one bedroom. The lounge room reeks of urine. There is also broken furniture that requires replacement throughout the SRS. Rubbish bins are overflowing on occasions, while toilets are smelly, dirty and in a state of disrepair.

There is an ongoing issue with bed bugs in the facility with many residents presenting with bites on their arms and legs.

The SRS is very cold in winter, when heating is only turned on for two hours in the morning and night. In one instance, a resident has purchased her own doona; another resident wears her clothes to bed.

The residents are in the main dishevelled, their clothes torn and dirty and many do not appear to have had a shower for some time. Community Visitors observed one resident with diabetes whose room was littered with dozens of soft drink cans and bottles and food wrappers.

Community Visitors have made multiple notifications to DHHS regarding the concerns and expect timely and comprehensive responses from both the proprietor and DHHS as the regulator but that is yet to occur.

NDIS

Good practice

The NDIS has created many challenges for proprietors and residents, however, two SRS, Alma House and Crosbie Lodge, have provided exemplary leadership in actively supporting all residents under 65 years of age to apply for funding packages.

Each SRS engaged Local Area Coordinators in preparing applications and arranged for GPs to provide medical reports. At Crosbie Lodge some residents now have funded gym, hydrotherapy and swimming lessons.

Safety

Some residents continue to smoke in their rooms despite the best efforts of staff to curb the behaviour.

Case study

At a pension-level SRS, two residents told Community Visitors that they didn't feel safe because they believed staff switched off the fire alarm when it was activated after a resident smoked in their room.

They were concerned about what might happen if a fire occurred in another part of the SRS while the alarm was switched off.

The frequency of unnecessary call outs resulted in substantial fines from the Country Fire Authority. After discussion between local fire services and the SRS, the proprietor decided to disable the automatic callout to Fire Services.

> Following notifications to DHHS, Community Visitors were informed the alarm would remain operational and alert the CFA at all times, even if the facility-wide alarm was switched off. While an automatic call to the fire services does not occur when smoke is detected, activation of the sprinkler system by heat, or by staff breaking the fire alarm glass would result in the fire services attending immediately.
>
> On subsequent visits, residents again mentioned the frequent activation of the fire alarm and the distress this causes them, especially if they are woken from sleep.

Staff report that one resident continues to smoke in his room. They have attempted to manage his smoking by restricting his supply of cigarettes but he merely asks other residents to lend him a cigarette. Community Visitors have repeatedly highlighted the need for the proprietor to actively engage all possible mental health and QUIT supports for this resident whose behaviour is having a detrimental effect on the life of his fellow residents.

Inquiries at two other SRS regarding fire alarms revealed similar situations where the facility-wide siren is switched off when the Fire Indicator Panel is triggered by smoke. Following notifications to DHHS, Local Government Authorities (LGAs), which have key responsibility for fire safety, were requested to provide an assessment of the buildings and their fire protection systems. These reports are provided to the owner of the building who is then responsible for any rectification works to bring the building and its fire systems up to the appropriate standard. These works are likely to involve substantial costs to the building owners.

SRS proprietors, LGAs and DHHS are all obliged to ensure a safe environment for residents. Community Visitors strongly believe that DHHS Regulatory Officers must play the main role in assessing the impact of SRS proprietors' and building owners' non-compliance that pose immediate risks to residents. It is not sufficient for DHHS to refer concerns to LGAs to take primary responsibility as DHHS is clearly obliged to monitor and enforce SRS standards of accommodation and care to ensure the wellbeing of vulnerable residents.

West Division

West Division includes Western Metropolitan Melbourne, comprising the DHHS areas of Brimbank Melton and Western Melbourne, and the regional Victorian areas of Barwon Central Highlands and Wimmera South West.

Barwon and Wimmera South West

Introduction

There are three pension-level SRS and three pension-plus SRS in Geelong. A further pension-level SRS is located in Warrnambool and another pension-plus SRS in Portland.

Community Visitors are pleased to have a cooperative working relationship with the Regulatory and Compliance team in the West Division.

Abuse

Three residents made separate allegations of inappropriate sexual remarks and behaviours against the proprietor of one SRS. In two cases, the allegations were reported to Community Visitors or to the Office of the Public Advocate's Advice Service. DHHS investigated the allegations and responded. A compliance notice was issued to the proprietor.

Substance abuse has been linked to an increase in aggression in some SRS. Community Visitors reported 16 incidents in just over a month in one SRS, largely related to drug and alcohol use.

In another SRS, Community Visitors reported a resident affected by ice had caused some distress to fellow residents.

Health

One resident attempted to revive another resident using cardiopulmonary resuscitation (CPR) but was unsuccessful. The resident's death is reportedly the subject of a coronial inquiry.

Personal support

The competence of SRS staff to support vulnerable residents with high needs is an increasing concern.

Residents questioned whether a staff member working alone at night had the English language competence to support their needs and respond in an emergency. The staff member now no longer works at the SRS.

A recent incident highlighted the challenge of managing residents with complex mental health needs. A resident repeatedly refused to allow SRS staff to clean or change sheets. The resident invited Community Visitors into a room which had bloodstained sheets and was very dirty and smelly. When Community Visitors queried this situation with the manager, the SRS organised a meeting with the resident, relevant mental health support workers and SRS staff.

Physical environment and fabric

In one SRS, rotten floorboards on the front verandah and uneven surfaces on garden paths constitute a danger to elderly residents. Over several months, there has been disagreement between the landlord and the proprietor regarding their responsibilities for maintenance.

Residents are not able to access that area of the verandah and despite some modification to the path it remains a hazard until works are completed.

Social independence and choice

In some SRS, residents have regularly complained to Community Visitors about the lack of activities. One resident commented that "even bingo would be good."

Activities and social opportunities for residents can vary depending on their SRS receiving government funding. One pension-level SRS, ineligible for funding, has few activities to engage and support residents. By comparison, a SAVVI-funded pension-level SRS has many activities including Tai Chi, swimming, Boxercise, individual craft, Sunday outings, and participation in the planning and development of a new vegetable garden.

NDIS

A proprietor reported to Community Visitors about NDIS workers regularly failing to turn up for appointments with residents. Sign-in procedures remain inadequate in many SRS, which is a concern with many more NDIS carers entering to work with residents. Community Visitors question how SRS staff can ensure safe emergency management.

One NDIS support worker took a resident for respite at another SRS due to anxiety caused by a co-resident. The proprietor was not informed of the move and Community Visitors reported that the resident was upset by the NDIS workers actions claiming the support worker "talked to him as if he was a child". A complaint was made and subsequently there was a change of service provider.

> ***Good practice***
>
> One SRS has teamed with a volunteer group to organise Trio Bikes where two residents are pedalled by a volunteer on a scenic route to Geelong's waterfront. Residents report they enjoy this very much, especially going with their grandchildren.

Grampians/ Central Highlands

Introduction

There are eight pension-level SRS and one pension-plus in the Grampians/Central Highlands area. Good rapport exists between Community Visitors, SRS proprietors, DHHS and support services in this area.

Abuse

Verbal abuse, including threats to staff and residents, is an issue at some SRS.

In one, Community Visitors reported several residents abusing staff, service providers and other residents. In another SRS, a resident was given a Notice to Vacate after allegedly threatening staff with a shovel, making threats to residents and lighting a grass fire. All these incidents occurred under the influence of alcohol.

The resident subsequently moved to alternative accommodation.

Police and DHHS were informed of an alleged assault when a resident was taken by a relative to another SRS for respite, returned confused and covered in bruises. The resident was unable to provide clear details about what happened. Community Visitors were told the bruises most likely resulted from a seizure the resident experienced while in the community. An application for a guardian was unsuccessful. Concerns remain about the relative's ability to keep the resident safe.

Health

The challenges proprietors have in caring for the health needs of residents vary depending on the cohort of people they support.

There have been large numbers of falls documented at one SRS that caters mainly for older people. These incidents have led to staff being provided additional falls prevention training.

A resident at another SRS, who was unwell and slurring his speech, twice refused an ambulance. On the third call to emergency services he was taken by ambulance to hospital where he later passed away.

Community Visitors reported that a resident required permission for surgery to her hip following a fall. Inquiries from Community Visitors confirmed that correct procedures were followed according to the *Medical Treatment Planning and Decisions Act 2016*. The treating health service received a medical treatment decision in a timely manner and surgery was consented to.

Residents are often affected by serious incidents at their SRS. When a resident was killed in a tragic accident, Community Visitors were concerned for other residents traumatised by the tragedy. They were assured that counselling was offered to residents.

A resident who had a history of chronic illness was taken to hospital following a fall. She was discharged back to the SRS where she collapsed later that day. Staff provided CPR and called Emergency Services but the resident was unable to be revived. Community Visitors were told by staff that residents were shaken by these events. DHHS provided the details for counselling services. Community Visitors suggested to the proprietor that residents could also access counselling through their GP.

NDIS

A goal for some SRS residents is the desire to live independently. A proprietor was uncertain how the NDIS determines the support the person requires to be successful with this goal. They were concerned that a resident may move out of an SRS without the necessary supports or the skills to succeed and could be worse off as a result.

In one situation, there was a lack of clarity around responsibility for funding a resident's supports. A proprietor told Community Visitors that a resident's NDIS plan should be providing additional resources to deal with their faecal incontinence. According to the proprietor, the NDIS refused to fund the supports as they felt the responsibility lay with the SRS.

In another case, Community Visitors were told that a resident's NDIS plan was formulated without consultation with the family, SRS staff, or reviewing the resident's detailed support plan. The proprietor felt the resident concerned may not have been able to give an accurate account of their support needs, resulting in a plan that may not adequately resource their needs.

An NDIS worker supported a resident with a tendency to light fires to buy matches, a cigarette lighter and 'chop chop', an unregulated tobacco product that can lead to a range of adverse health problems. Community Visitors gave the proprietor information on how to escalate concerns about the NDIS worker.

Western Metropolitan Melbourne

Introduction

There are eight SRS in the Western Metropolitan Melbourne area, seven pension-level facilities and one pension-plus.

Community Visitors acknowledge the cooperative and collaborative relationship with DHHS in the area and thank the relevant officers for their timely and respectful responses to Community Visitors' concerns.

Abuse

Issues concerning abuse of various kinds have unfortunately been a constant theme this year. A few residents have alleged sexual abuse by

other residents and some of these matters are under investigation. It is important to note that the SRS contacted the police, DHHS and offered appropriate supports.

There have also been several incidents involving resident aggression towards SRS staff, other residents and a neighbour of the SRS. In one facility, there was a noticeable increase in incidents involving new residents, particularly those with complex mental health issues and a history of homelessness.

Community Visitors are concerned about the level of support residents are given during what must be a difficult time settling into a new environment. Staff have completed basic mental health training. Given the complexity of some residents, Community Visitors are concerned that more training is required for staff to cope with incidents such as aggression, alleged sexual assault, theft and facility damage. Long-term residents often tell Community Visitors they are frightened to be in communal areas, particularly at meal times.

At least one aggressive incident is drug-related and has led to residents being evicted from an SRS. They are now residing in another SRS.

A resident was allegedly abducted from an SRS by people claiming to be family. This was reported to police and the resident was found safe and well in another facility. Community Visitors hold concerns for the resident's future safety due to his vulnerability.

Social independence and choice

Even with the difficulties with some NDIS workers, residents have reported that they do enjoy the interaction and benefits of their support workers. However, Community Visitors noticed a considerable lack of available group activities. Some residents have stated they are bored and frustrated which, in turn, has led to arguments and a generally frightening environment.

When activities do occur, such as with Arts Access, it is wonderful to see residents having the opportunity to be creative and enjoy the company of other residents.

It was pleasing to note the initiative by DHHS in the area to contact proprietors and remind them of their responsibilities, as well as giving them some appropriate suggestions. Subsequently, some proprietors showed Community Visitors refreshed activity schedules.

A significant challenge for one SRS has been the introduction of a Guide Dog to assist a resident. Many residents, who are thrilled to have the dog in their home, are over feeding it and taking it for walks without the owner. The situation has slowly improved with constant reinforcement by staff that this is not in the owner's or dog's best interests.

NDIS

With the rollout of the NDIS in the West this year, Community Visitors are pleased to see that many pension-level SRS residents have been registered and are receiving services. However, with this development has come some concerning practices. One support worker left a resident in his car for 45 minutes while he went and did his own shopping. Community Visitors were advised that the worker no longer supports this resident.

Two proprietors have reported to Community Visitors similar issues with support workers including workers attending the SRS without any identification, not using the sign-in book, spending extensive time on their phone, or watching television, and not informing the SRS when they are taking a resident out or leaving shifts early.

Appendix 1

Community Visitors 2018–19

OPA acknowledges and thanks Community Visitors in all streams who stood up for the rights of people with a disability or a mental illness during the year.

Marta Acton
Daniel Adamson
Deanne Ades
Ian Alexander
David Allen
Jo Allen
David Anderson
Arthur Apostolopoulos
Beth Atkins
Karina Au
Kim Baker
Joyce Ball
Wendy Baneth RC
Christine Barbuto RC
Jan Barker
Judith Barlee
Ricky Bartolo
Cheryl Beatson
Susan Beaumont
John Beggs
Efi Bellchambers
Judy Berry
Judith Bink
Rose Blustein RC
Marion Blythman RC
Dominic Boland
Walinda Bonne
John Bowen
Andrew Boyles
Kathleen Bragge RC
Rebekah Braxton
Fiona Breedon
Sheena Broughton RC
Geoff Brown
Lorraine Bryant
Ian Buckles RC
Ronald Butler RC
Don Cameron
Kevin Campbell
Heather Campbell
Ken Castanelli
Joan Castledine
Pat Cerra
Julie Cesal
Chris Chapman
John Chesterman
Shri Chitale
Belinda Clark
Pamela Clarke
Tania Cleary
Adison Cognian
Jo Cohen
Peta Collett
Terry Collison
Kim Conder RC
Sandra Cooper
Carmelo Corrente
Stefania Cortecci
Jeanette Coulter
Adele Coutts
Joanne Coverdale
Erin Cowley
Vicki Cowling OAM
Bryan Crebbin
Fiona Cromarty RC
Patricia Cross RC
Graeme Crutchfield
John Cull
Jeff Cummins
Robyn Cunningham RC
Philip Dalliston
Doreen Dalrymple RC
Rose Daniels
Linda Dare
Wendy Davies
Pat Davison
Meryl Dawson
Geraldine De La Harpe
Stephanie De Pasquale
Susan Dedes-Bonneau RC
Tracey Denby
Bev Devidas RC
L'Shae Dib
Graham Dickinson RC
Christine Dimer
Di Dixon
Alex Dobes
Kerrie Dobrzynski
Diane Doherty RC
Jenny Donaldson
Diana Donohue RC
Robert Drayton
Blake Drever
Jan Dunbar RC
Ian Dunn
Jennifer Dunn
John Dunn
Megan Edwards
Christine Elliot
Elizabeth Elms
Pam Evans
Eveline Fallshaw RC
Mary Farbrother
Gillian Fawcett
Jennifer Fenwick
David Ferguson RC
Jeanette Findlay
Roger Findlay
Trudy Firth
Max Fletcher RC
Maureen Fontana RC
Dalphne Foo
Debbie Fowler
David Frame
Paulette Fraser
Ian Freeman
Judith Freidin
Anne Freudenberger Kay
Dale Furey
Joanne Garrett
Sandra George
Dylan George
Louisa Gibson
Pamela Giles RC
John Gleeson
Daysie Goldenberg
Karyn Golumbeck
Yan Gorrie
Swati Gossain
Audrey Grace
Jillian Graf
Ruth Graham
Eddie Graham
Brian Granrott
Avril Green
Kay Gregory
Alison Gribble
Alan Grigson
Bill Grint
Gerard Grogan
Henry Grossbard
Susanne Grosser
Alan Gruner RC
Suzanne Gubby
Wendy Guy
Frances Haberle
Michael Hadley RC
Ghassan Haidar
Linda Haller RC
Sam Haouchar
Susan Harraway RC
Lynette Harris
Ian Harrison
Rowena Hart
Lynette Hayes
Barbara Hayes
Carol Haynes RC
Coral Heazlewood
Veronica Henriquez
Jennifer Henry
Clifford Heri
Judy Heron RC
Bill Hickey RC
Robyn Hickey
Glenys Hill
Colin Hinckson
Geoffrey Hoare
Jennifer Hocking
Wendy Holland
Margot Holscher
Pat Horan
Mary Howlett
Nan Hu
Natasha Hunt
Carolyn Hutchens RC
Giordana Ienco
Paul Iles
Kim Inglis
Chris Ingram RC
Dallas Isaacs
Felicity Jack
Beverley Jacob
Thomas Jambrich
Rebekah Jardine
Robert Jeferee
Ray Johnson
Val Johnson
Lyn Johnson
Prue Jolley
Heather Jones RC
Barry Jones
Lynda Judkins
Don Juniper
Ivan Jurisic
Peter Kadar
Anthea Katsaros
Karamjeet Kaur RC
Jenny Kerr
Liam Kershaw-Ryan
Sarah Khor
Brian Kiley
Debbie King
Lisa Kirton
Sandra Knorpp
Alan Kohn
Shiv Kumar
Amanda Kunkler
Justyna Kurzak
Tineke Lagerwey
Loi Lam
Suzanne Lau Gooey
Pauline Lavars
Paul Lavery
David Lawrence
Mervin Lee
Debra Lee

Lawrie Leeman OAM RC
Robyn Leeman
George Lefroy
Annie Lenaghan
Mark Lewis
Rob Lewis
Beverley Libbis
Margaret Lippold
Vashti Lloyd
Louise Long
Roger Lount
Jennifer Lush
Virginia Mack
Paul Mackaness
Colleen Macqueen
Umberine Madan
Carole Maher
Jenny Maiolo
Sandra Manitiu
Kaye Manners
Jessica Marie
Linda Markowiec
Rohan Marlow
Jenny Marshall
Sandra Martin RC
Jenny Martin
Brooke Mason
Cindy Masterson RC
Thomas Matthew
Beth Matthews
Julian Maugey
Ian McBeath
Maura McCabe
Debra McCann
James McCarthy OAM
Kaye McClure-Leckie
Desma McDonald
Carole McElvaney
Stephen McElwee
Paddy McGennisken
Irene McGrath
Deborah McLachlan RC
Heather McLeish
Brenda McMinn RC
Romy McNally
Louise McPhee RC
Hilary McVey
Laurie Messenger
Neil Michael
Alex Miller
Sonia Miller-Randle
Frank Miragliotta
Nina Mobach
Joanne Moore
Marj Munro RC
Alan Murphy
Gerald Mutubuki
Danielle Neal
Rodna Nedanoska
Andrew Needham
Craig Ng
Connie Ngu
Edwina Nutt
Sue O'Brien
Judy O'Brien
Kim O'Donoghue
Andrea O'Keefe
Janine O'Neill
Joanne Page
Izabella Pankowska
Gloria Parker
Dave Parker RC
Wendy Patchett
James Paterson RC
Judith Pauwels
Cheryl Paxton
Simon Payne
Betty Pearce
Loes Pearson*
Peter Penry-Williams
Stephen Peterson
Daniel Petrasek
Wendy Pfeifer
Lyn Phelan
Max Pietruschka
Sally Polack
Regina Prakash
Nancy Price
Dame Price
Robert Proudlock
Elyce Pugh
Margaret Purves
Rose Randall
Helen Rawicki
Ann Ray
June Rea RC
Keren Reeve
Pam Remington-Lane
Edith Retemeyer
Sue Rewell RC
Maureen Rhodes RC
Brian Richards
Dawn Richardson
Kiera Riley
Julie Ritchie
Dany Roberts
Sebastian Roberts
Hugh Robinson
David Roche
Vivienne Roche RC
Jo Rodger
Mick Rosier
Pam Roth
Ainsley Rozario
Linda Rubinstein
Lina Schonfeld
Bill Scott
Krystie Sebastian
Diane Seren
Debra Sevastianov RC
Nimit Shah
Gayathari Shastri
Rosemary Shaw OAM
Yvonne Sherlock
Awtar Singh
Mohini Singh
Puvana Sivakumar
Jenni Smith
Rebekah Smith
Mary Smith
Joanne Smout
June Soutar
David Stafford
Glenn Staunton
Nola Stavely
Ray Steadman RC
Gideon Stein
Margaret Stevenson RC
Gavin Stewart
Graham Stickland RC
Suzanne Straney RC
Susan Strofeldt
Bernadette Sullivan
Sheryl Summons
Bill Swannie
Robert Swiger
Anne Tait RC
Suzanne Tatchell
Tanjila Tayeb
Deborah Taylor
Mark Thompson
Graeme Thornton
Rosslyn Thurrowgood RC
Cherie Titman
Julia Tivendale
Rosemary Tomkins
Patricia Tot
Nam Tran Nguyen
Betty Trayling
Meryle Trentini
John Trevillyan
Helen Tribe
Julie Trompf
Merrill Tunstall
Gary Turner
Jordan Turner
Diane Tymms
Gail Upton
Malcolm Urqhart
Helen Vallance
Luke Van Den Dikkenberg
Adam Veitch
Antonia Veneracion
Alexa Viani
Robyn Vote RC
Lynn Wallace-Clancy RC
Sylvia Walton AO
Sebastian Waluk
Betty Waters
Melinda Watt
Jennifer Weber
Christine Weisz
Wendy Wereta
Susan Whitehead
Liz Whyte
Suzanne Wilcox
Dianne Wilde
Carole Williams
John Williams
Lauren Williams
Beverley Williams
Ros Williamson
Linda Wilson RC
Scott Wilson
Elaine Wilson
Sheila Winter RC
Columbia Winterton
Tricia Woodcock
Rhonda Woodrow
Ying Yew
Steven Young
Noel Younger
Ping Yu
Susan Zammit
Ignatius Zanetidis
Allison Zylberberg

** We acknowledge the sad loss of Loes Pearson, a Community Visitor for 15 years, who passed away this year.*

Appendix 2

Facilities eligible to be visited

Disability Services Providers

AAA Nextt Group Pty Ltd
Ability Assist
Able Australia
Accommodation and Care Solutions
AGAPI Care Inc.
Alkira Centre – Box Hill Inc.
Amicus
Annecto Inc.
Araluen
Asteria Services Inc.
Australian Community Support Organisation Limited (ACSO)
Australian Home Care Services
Autism Plus (changed to AAA Nextt January 2019)
Autism Spectrum Australia (Aspect)
Bayley House
CareChoice
Carinya Society
Colac Otway Disability Accommodation Inc.
Community Living & Respite Services Inc.
ConnectGV
Cooinda Terang Inc.
Department of Health and Human Services
DPV Health Ltd.
Expression Australia
Encompass Community Services
Epworth HealthCare
Ermha Ltd.
Focus Individualised Support Services
Gateways Support Services
Gellibrand Support Services
genU
Golden City Support Services Inc.
Healthscope Limited
Home@Scope
House with No Steps and The Tipping foundation
IDV Inc.
Independence Australia
Jesuit Social Services Limited
Jewish Care (Victoria) Inc.
Kirinari Community Services
Kyeema Support Services Inc.
Life Without Barriers
Mallee Family Care Inc.
Mansfield Autism Statewide Services
McCallum Disability Services Inc.
Melba Support Services Inc.
Melbourne City Mission
Merriwa Industries
Mind Australia Limited
Mirridong Services Inc.
MOIRA Inc.
Monkami Centre Inc.
Multiple Sclerosis Limited
Nadrasca
Nepean Centre Inc.
Northern Support Services
Noweyung Ltd.
OC Connections
OzChild
Possability
Providing All Living Supports (PALS) Inc.
Scope (Vic) Ltd.
Southern Way Direct Care Service Inc.
St John of God Accord
Statewide Autistic Services Inc. (SASI)
STAY Residential Services Association Inc.
Sunraysia Residential Services Inc.
The ONCALL Group
Trio Support Services
Uniting (Victoria & Tasmania) Limited
Victorian Deaf Society (Vicdeaf) (changed to Expression Australia August 2018)
Villa Maria Catholic Homes (VMCH)
Wallara Australia Ltd.
We Are Vivid
Woodbine Inc.
Yooralla

Mental Health Providers

Albury Wodonga Health
Alfred Health
Austin Health
Ballarat Health Services
Barwon Health
Bendigo Health
breakthru
cohealth
Eastern Health
Ermha Ltd.
Forensicare
Goulburn Valley Health
Latrobe Regional Hospital
Life Without Barriers
Lyndoch Living
Melbourne Health
Mercy Health
Mind Australia Limited
Monash Health
Neami National
NorthWestern Mental Health
Peninsula Health
Ramsay Health Care
Royal Children's Hospital
South West Health Care
St Vincent's Hospital Melbourne
Stawell Regional Health
Wellways Australia Limited
West Wimmera Health Service
Western District Health Service
within Australia

Supported Residential Services

Aaron Lodge
Absalom
Acacia Gardens
Acacia Place
Achmore Lodge
Acland Grange

Adare Supported Residential Care
Alexandra Gardens
Allbright Manor
Alma House
Angus Martin House
Arnica Lodge
Balmoral
Bamfield Lodge
Belair Gardens
Bella Chara
Belmont Manor
Berwick House
Bignold Park
Blue Willows Residential Aged Care
Brooklea Lodge
Brooklyn House
Browen Lee Home – Ballarat
Browen Lee Lodge – Brown Hill
Brunswick Lodge
Burwood Lodge
Camberwell Manor
(Closed September 2018)
Caulfield House
Caulfield Manor
Chatsworth Terrace
Chesterfield
Chippendale Lodge
Coorondo Home
Corandirk House
Covenant House
Cranhaven Lodge
Crofton House
Crosbie Lodge
Crystal Manor
Darebin Lodge
Doncaster Manor
Dorset Lodge
Dunelm
Eagle Manor
Edwards Lodge
Elgar Home
Eliza Lodge
Eliza Park
Eltham Villa
Fermont Lodge
Ferntree Gardens
Ferntree Manor
Finchley Court
Footscray House
Galilee
Glenhuntly Terrace
Glenville Lodge
Glenwood Assisted Living
Golden Gate Lodge
Gracedale Lodge
Gracevale Grange
Gracevale Lodge
Grand Villa Mentone
Grandel
Greenhaven
Greenslopes
Hamble Court
Hambleton House
Hampton House
Harrier Manor
Hawthorn Grange
Hawthorns Victoria Gardens
Hazelwood Boronia
Heathmont Lodge
Hillview Lodge
Hollydale Lodge
Homebush Hall
Iris Grange
Iris Manor
Jasmine Lodge
Kallara Residential Care
Karinya
Kilara House
Kooralbyn Retirement Lodge
Kyneton Lodge
L'abri
Landora Care
Lilydale Lodge
Manalin House
Maroondah House
Mayfair Lodge
Meadowbrook
Melton Willows
Merriwa Grove
Mont Albert Manor
Mornington House
Mt. Alexander
Mulvra Aged Care
Mulvra Place
Northern Terrace
Oakern Lodge
Parkland Close
Pineview Residential Care
Princes Park Lodge
Queens Lodge
Raynes Park Court
Reservoir Lodge
Rosewood Downs
Rosewood Gardens
Royal Avenue
Sandy Lodge
Seaview House Residential Care
Southcare Lodge
St James Terrace
Stewart Lodge
Strabane Gardens
Sunnyhurst Gardens
Surfcoast Supported Accommodation
Sydenham Grace
Themar Heights
Trentleigh Lodge
Vermont Gardens
Viewmont Terrace
Warranvale Gardens
Wattle-Brae
Waverley Hill
Westley Garden
Whitehaven

Appendix 3

Acronyms

AAU Adult Acute Unit
ABI Acquired Brain Injury
ACSO Australian Community Support Organisation
BD Brain Disorder
BSP Behaviour Support Plan
CAG Consumer Advisory Group
CALD Culturally and Linguistically Diverse
CASA Centres Against Sexual Assault
CAT Crisis Assessment and Treatment
CCU Community Care Unit
CDDHV Centre for Development Disability Health Victoria
CHAPS Comprehensive Health Assessment Plans
CIMS Client Incident Management System
CPAP Continuous Positive Airways Pressure
CRF Community Rehabilitation Facility
CRP Community Recovery Program
CSO Community Service Organisation
DAS Disability Accommodation Service
DCS Disability Client Services
DFATS Disability and Forensic Assessment and Treatment Service
DDSO Disability Development and Support Officer
DHHS Department of Health and Human Services
DSC Disability Services Commissioner
DSR Disability Support Register
DWES Disability Worker Exclusion Scheme
ECT Electroconvulsive Therapy
ECU Extended Care Unit
ED Emergency Department
GP General Practitioner
HCA Housing Choices Australia
HDU High Dependency Unit
IGUANA Interagency Guideline for Addressing Violence, Neglect and Abuse
IHBOS Intensive Home-based Outreach
ISP Individual Support Package
LGA Local Government Area
MACNI Multiple and Complex Needs Initiative
MHRB Mental Health Review Board
NAMHS Northern Area Mental Health Service
NDIA National Disability Insurance Agency
NDIS National Disability Insurance Scheme
NGO Non-government organization
NPU Northern Psychiatric Unit
NUM Nurse Unit Manager
NWMHS North Western Mental Health Service
OCP Office of the Chief Psychiatrist
OPA Office of the Public Advocate
OPP Office of Professional Practice
PACER Police Ambulance Crisis and Emergency Response
PAPU Psychiatric and Assessment Planning Unit
PARC Prevention and Recovery Care
PCP Person-Centred Plan
PDRSS Psychiatric Disability Rehabilitation Support Services
PEG Percutaneous Endoscopic Gastrostomy
PRN Pro Re Nata (medication provided as needed)
PRS Plenty Residential Services
RMH Royal Melbourne Hospital
SAVVI Supporting Accommodation for Vulnerable Victorians Initiative
SDA Specialist Disability Accommodation
SECU Secure Extended Care Unit
SIL Supported Independent Living
SOCIT Sexual Offences and Child Abuse Investigation Team
SRS Supported Residential Services
STO Supervised Treatment Order
SWEP State-Wide Equipment Program
TEH Thomas Embling Hospital
TSU Transition Support Unit
VCAT Victorian Civil and Administrative Tribunal
VDDS Victorian Dual Disability Service
VEOHRC Victorian Equal Opportunity and Human Rights Commission
VIHMS Victorian Incident Health Management System
VSA Victims Support Agency
VSDP Victorian State Disability Plan
YPARC Youth Prevention and Recovery Care

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