Community Visitors
Annual Report 2020–2021

Office of the Public Advocate

Safeguarding the rights and interests of people with disability

Disability Services | Mental Health | Residential Services

Ted More
The Magical Garden of Wisdom
Paint, pen and ink

About the cover image

The cover art by Ted More entitled ‘The Magical Garden of Wisdom’ is a metaphor for the collation of lived experience of disability and mental illness — the wisdom of the profound experience of Victorians with disability and mental illness that volunteer Community Visitors capture in their reports across the disability, mental health and Supported Residential Services sectors.

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 2020–2021

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
2021
No 273 Session 2018–21

Letter of transmittal

29 September 2021

The Hon. James Merlino
Deputy Premier
Minister for Education
Minister for Mental Health
Level 22, 50 Lonsdale Street
Melbourne VIC 3000

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

Level 22, 50 Lonsdale Street
Melbourne VIC 3000

Dear Ministers

RE: Community Visitors Annual Report 2020-2021

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 2020-2021*.

This year, the findings have been drawn from 3718 visits by 337 active 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 continuing abuse, assaults and violence, particularly resident-on-resident and patient-on-patient, as well as concerning issues relating to Community Visitors being frustrated in their work with facilities, denied access to incident reports, vulnerable people still failing to access or benefit from the NDIS, insufficient accommodation for people with a mental illness and a failure of regulation in the SRS sector, resulting in the troubling neglect of residents.

The report also details Community Visitor work during the COVID-19 pandemic including by engaging with remote 'visiting' that created new opportunities to connect with those they visit, and their findings during this time.

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

Yours sincerely

Colleen Pearce
Public Advocate and Chairperson of the Combined Board

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Report from the Public Advocate

Colleen Pearce

Community Visitors are volunteers who play a vital role in safeguarding the rights of people with disability and fostering their inclusion in the community

Safeguarding in a pandemic

This year has been a very challenging and difficult time for the Victorian community.

Notwithstanding the challenges presented by the pandemic and the ensuing lockdowns, our dedicated and committed volunteer Community Visitors continued to play an important role in safeguarding the rights and interests of people with disability. They have been a part of making this difficult time safer for our clients.

They pivoted to providing their services remotely by phone or video when prevented from visiting disability group homes, mental health units and Supported Residential Services (SRS) in person. Community Visitors in metropolitan Melbourne, for example, were only able to attend facilities in person for 65 per cent of the year due to lockdowns.

Remote safeguarding, however, presented some massive logistical challenges as Community Visitors visit over 1400 locations.

Some Community Visitors have not conducted in-person visits this year due to health risks as 74 per cent are in the high-risk age range of 55 to 84 years. Others took extended leave due to their own or family's health concerns; or were worried about potential exposure for those they visited.

It is a testament to the commitment of these stalwart Victorians that, despite all the obstacles, the number of visits only decreased by 10 per cent over last year.

While Community Visitors prefer to conduct visits in person to ensure that they can communicate as effectively as possible with people with disability or mental illness, they have risen to every challenge lockdown posed. They continued to connect online with residents and patients, each other, and service providers. Their technological skills increased enormously, and the vast majority are now able to operate effectively in the new environment.

Community Visitors have continued to be Victoria's human rights warriors"

One innovation was an Easy English mail-out to every consumer that Community Visitors engaged with across all three streams. It encouraged them to answer a short survey and request a personal call-back, if desired. It aimed to assure the 11,500 clients understood they had not been forgotten.

Impressively, 360 responses to the survey were received from residents in the Disability Services stream, with 58 requesting follow-up. Their key concerns were not being able to have visitors or go out in the community.

There were 64 responses in the Mental Health stream with 16 people requesting follow-up. Their key concern was access to secure accommodation post-discharge. While the number of responses from SRS residents was small, there has been a 3.5 per cent increase in calls to OPA's Advice Service over the last two years for Community Visitors from SRS residents, their family, and supporters.

Remote safeguarding has changed the way Community Visitors work. In a relatively short period, they have moved from a totally paper-based practice to utilising electronic reporting. Although still in its infancy, the program hopes to build on these learnings on its road to digitisation.

This process was facilitated by the Disability Services COVID-19 funding which the Community Visitors Program received from the Department of Health and Human Services, as it was then, which enabled the purchase and configuration of tablets as well as internet access for more Community Visitors.

Abuse, neglect and violence

Community Visitors have been advocating for the safety and wellbeing of their clients for 34 years.

Their dogged focus on issues of violence, abuse, neglect and exploitation has resulted in significant system reform—nationwide.

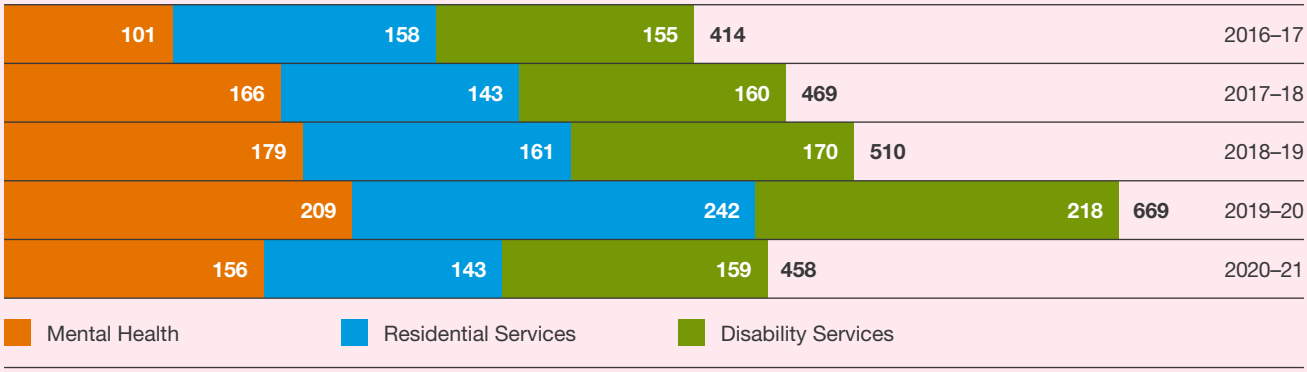
This includes that the most serious of the issues are now referred for investigation to the Disability Services Commissioner (DSC) and the NDIS Quality and Safeguards Commission.

This year, Community Visitors referred 51 serious incidents to the DSC and 36 to the commission in their work to prevent violence, abuse and exploitation of people with disability.

The less serious issues are reported on and dealt with at the facility level.

The abuse statistics this year are substantially reduced compared to last year, as remote forms of safeguarding required by the COVID-19 restrictions do not compare to face-to-face visiting in people's homes.

Figure 1. Community Visitor reports of abuse, neglect and assaults across all streams, 16/17–20/21



Vaccinations for people with disability

Disappointingly, the Australian Government's failure to meet its vaccination commitments for people with disability has left the nation's most clinically vulnerable people at risk of adverse outcomes if they contract COVID-19.

Like many advocacy organisations, Community Visitors reported their continued concern about the slow rollout of COVID-19 vaccinations for the people with disability. Initially, disability care residents were placed in the highest priority cohort. However, as vaccines were redirected to aged care, the rollout to disability care slowed to a trickle.

The failure of the Australian Government to meet its own targets meant some service providers sourced their own vaccines rather than wait for the government program to ramp up. As a consequence, the vaccine rates for people with disability remain far too low.

Community Visitors were also concerned about the access of disability workers to vaccines. They note that it is mandatory for aged care workers to be vaccinated, but this is not the case for disability workers.

Potential legislative change

Community Visitors are empowered to perform their role under three Acts of Parliament pertinent to each stream: the *Disability Act 2006*, the *Mental Health Act 2014* and the *Supported Residential Services (Private Proprietors) Act 2010*.

The Mental Health Royal Commission handed down its final report in March 2021 with one of its key recommendations being the introduction of a new Act. This change will have implications for Community Visitors, consequently, they made a substantial contribution to OPA's submission to the Victorian Government on it.

Change to the regulation of the social services sector in Victoria, which will include SRS, also requires new legislation and this will also affect how Community Visitors work and report.

Finally, the completion of the transfer of the disability sector from the state system to the Commonwealth National Disability Insurance Scheme (NDIS) will lead to further changes to the Victorian Disability Act. Here again, Community Visitors will be affected.

The critical issue for Community Visitors in any legislative change is that they are recognised as part of the safeguarding regime for people with disability, including the protections they provide from abuse, neglect, and exploitation. Any legislative change needs to ensure that their independence is maintained and that appropriate information-sharing provisions are included so that Community Visitors can effectively monitor what is happening in the lives of those they visit.

Finally, these potential legislative changes provide an opportunity to consider whether the powers of Community Visitors can be modernised and enhanced, such as having the right to take photographs to better evidence the conditions they witness and report on.

SRS regulation and the NDIS

Consumer choice is central to the design of the NDIS. There are, however, serious doubts about the ability of the NDIS's marketised system to adequately support the needs of people the market has historically failed.

In Victoria, there are increasing numbers of SRS proprietors setting up NDIS businesses. In some of these businesses there is a lack of transparency and accountability about the use of NDIS funds.

Again, this year, Community Visitors have documented allegations that a growing number of SRS residents are susceptible to exploitation by proprietors who are unable to explain the use of NDIS funds to pay for services previously provided by the SRS. Community Visitors are concerned that some NDIS participants may not be getting the much-needed services funded in their NDIS plan.

There is the need for improved and stronger oversight of SRS. Any regulatory change must ensure that current and prospective SRS proprietors meet a strengthened 'fit and proper' person criteria to ensure they are appropriate service providers for this vulnerable clientele. A stronger regulation and enforcement system tailored to the sector's operations that includes improved mandatory staff qualifications and increased compliance requirements for proprietors is required to meet the increasing resident complexity and the resulting challenges.

There is also an urgent need for greater collaboration between Community Visitors, the state regulatory system and the NDIS Quality and Safeguarding arrangements to address the gaps in the regulatory and oversight frameworks. Each system operates in their own silo and there are impediments to each body sharing information. Appallingly, this gap has resulted in some people with disability being left in situations of neglect, exploitation, and abuse.

Finally, Community Visitors have continued to be Victoria's human rights warriors for the many vulnerable people they visit. In these truly unprecedented times, they have diligently and selflessly continued to provide support and encouragement to isolated and vulnerable members of our community.

Their willingness to go that extra mile through their innovative remote safeguarding approaches is commendable. On behalf of all Victorians, I thank them sincerely for their ongoing, selfless commitment to people with a disability and mental illness.

There is no doubt that their effort has had substantial and positive impacts on the many thousands of Victorians who live in the regulated environments they visit.

Colleen Pearce
Public Advocate and
Chairperson of the Combined Board

CASE STUDY

Conflict of Interest?

Community Visitors were deeply troubled by the violence, drug use, inadequate onsite security, medication errors and a general lack of cleanliness at a west metropolitan pension-level SRS housing 40 residents.

Community Visitors were also concerned that the proprietor of the same SRS was simultaneously operating an NDIS business onsite, raising the potential for a conflict of interest.

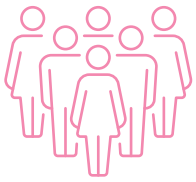
Their concerns were mirrored by NDIS support coordinators who reported feeling pressured to choose the SRS proprietor's NDIS business. A support worker reported to Community Visitors that SRS staff always attended NDIS meetings and that residents felt intimidated into agreeing to their attendance.

These issues were included in seven referrals made by the Public Advocate this year to the NDIS Quality and Safeguards Commission for investigation of potential conflicts of interest by SRS proprietors. Despite these referrals, Community Visitors continue reporting the same issues and fear that the NDIS participants in this SRS are not getting the services they need and are funded to receive.

Community Visitors will persist in documenting and reporting on the lack of transparency regarding the expenditure of resident NDIS funds in SRS that are operating concurrently as SRS under state legislation and with an NDIS business, federally. Where appropriate, these issues are escalated to the SRS Regulator and the NDIS Quality and Safeguards Commission for investigation.

2020–2021 Snapshot

337
active Community Visitors



394
appointed Community Visitors

3718
in person & remote visits

228
requested visits

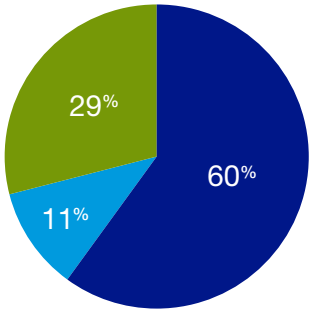
1467
facilities visited

ISSUES
5068 issues identified by Community Visitors

36
abuse referrals to NDIS Quality and Safeguards Commission

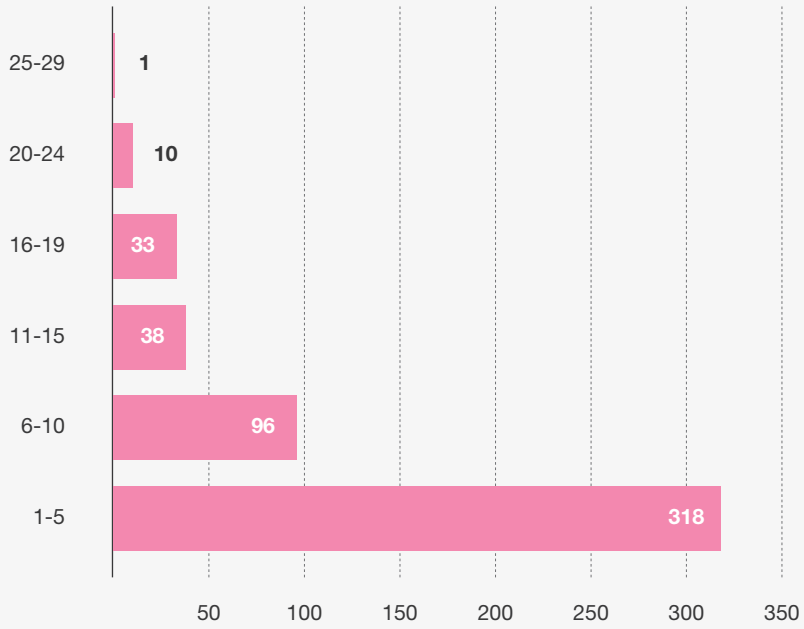
ABUSE
51 referrals to Disability Services Commissioner

Visits by attendance type
20/21



- By Phone 2220
- In Person 1096
- By Video 402

Community Visitors & trainees by years of service
20/21



Select volunteer profiles
20/21

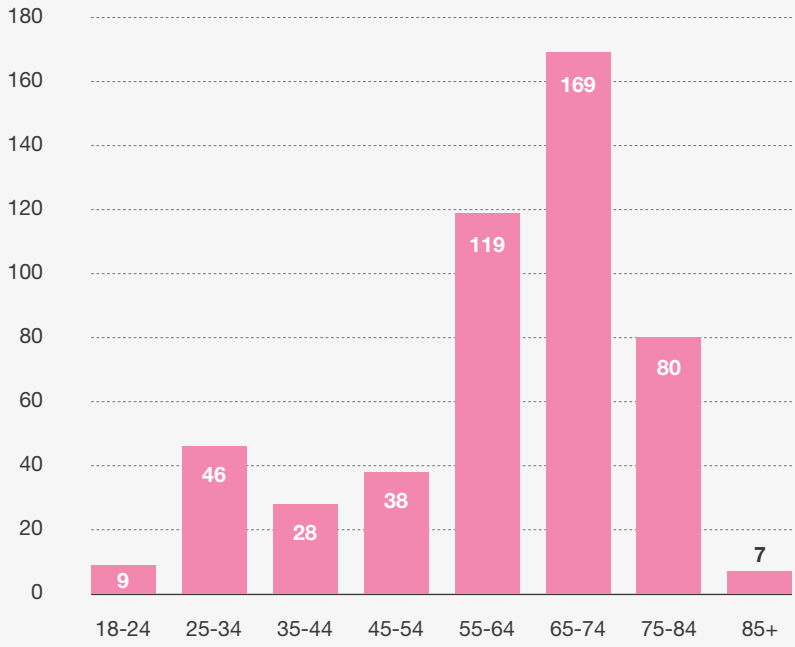
Avril Green, 90, is OPA's oldest volunteer. Although retired now, she volunteered up until October 2020, so she is recorded in this year's statistics

She is followed by Maureen Fontana, 86, then Jo Allen.

The youngest OPA volunteer is Senuri Weliwattege, 19, a trainee with volunteers Ros Thurrowgood and Ron Butler.

The longest-serving volunteer is Dominic Boland with 25 years service, followed by Deanne Ades with 24 years then Lyn Johnson and Susan Harraway each with 23 years service.

Community Visitors & trainees by age
20/21



Introducing the Combined Board

1.

1. Dr Colleen Pearce
Public Advocate and Combined Board Chair

Dr 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 the Community Visitor boards.

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.

Colleen 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.

She is a board member of Connecting Home, an organisation established in response to the recommendations arising from the Stolen Generations Taskforce Report.

Colleen is a proud Yuin woman from southern NSW.

3.

5.

2.

4.

2. Amanda Kunkler
Residential Services Board

Amanda Kunkler was appointed as a Community Visitor in 2015 and was elected to the Residential Services Board in 2019.

She relocated to Melbourne after a professional career in NSW, which included 20 years work as a journalist, two years working with foster carers and eight years in policy and advocacy for regional investment and development.

Ms Kunkler has a Masters Degree in Journalism and postgraduate qualifications in Community Engagement (University of Melbourne). She works as a Community Engagement and Advocacy Officer in the policy team at Council on the Ageing (COTA) Victoria.

Ms Kunkler has deepened her knowledge and understanding of the Community Visitors Program through her Board work.

3. Beverley Devidas
Residential Services Board

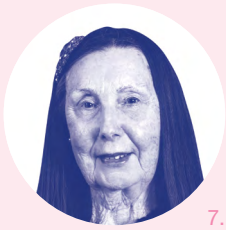
Beverley Devidas was appointed as a Community Visitor in 2018, is a Regional Convenor and this is her first term on the Residential Services Board.

A retired orthoptist, case manager and advocate for people with vision impairment, she has over 40 years experience as a clinical orthoptist, including as a leader in her profession.

She is a member of Zonta Club Melbourne, past president and board member, as well as the current chair of advocacy for her area.

Ms Devidas is keen to support the Residential Services stream volunteers while on the Board.

6.



7.

4. Anne Fahey
Mental Health Board

Anne Fahey was appointed as a Community Visitor in 2019 and this is her first term on the Mental Health Board. She lives in regional Victoria so brings a welcome country perspective to her role.

Ms Fahey has an Honours Degree in history, a Diploma of Education, a Graduate Diploma in Sociology and a Masters of Assessment and Evaluation. Ms Fahey's postgraduate study has been in mental health service delivery.

In addition to teaching experience, she has worked for Bendigo Mental Health Services and managed aged and mental health programs at Golden City Support Services. Ms Fahey is a community representative on the Positive Ageing Advisory Committee, City of Greater Bendigo.

Ms Fahey is looking forward to contributing part of her time to the Mental Health Board and supporting Community Visitors.

5. Sam Haouchar
Mental Health Board

Sam Haouchar was appointed as a Community Visitor in 2016.

She has been a Regional Convenor and was elected to the Mental Health Board in 2019.

Ms Haouchar has an Arts Degree majoring in Psychology and Social Research (Victoria University) and a Master of Business Administration (Deakin University). She is employed as an Asia Pacific Supply Chain Lead.

As an Australian with Lebanese parentage, she has focused on expanding her understanding and awareness of the mental health supports required for diverse communities. She also contributes her operations, systems and governance experiences to data and processes across the mental health system.

Ms Haouchar is enjoying contributing to the Board and supporting her fellow volunteers.

6. David Roche
Disability Services Board

David Roche has served nine years on the Disability Services Board: four successive terms and one year in 2009–2010. 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.

Mr Roche lives in Inverloch and has a history of active involvement in local and regional community-based organisations in South Gippsland. He has thus brought a rural perspective to his role which has been invaluable in ensuring that the program was responsive to the challenges related to rural and regional Victoria.

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

He has been a staunch advocate for the rights of people with disability and has highlighted the importance of the program at countless statewide Disability Liaison meetings, in his appearance before a Victorian parliamentary committee, chairing the Australian Government's Community Visitor review consultation meeting and before the Disability Royal Commission. Mr Roche 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.

7. Daisy Ellery
Disability Services Board

Ms Daisy Ellery was appointed as a Community Visitor in 2020 and elected this year to fill a casual Disability Board vacancy.

She has a Bachelor of Arts (La Trobe University) and a Graduate Diploma in Gender Studies (University of Melbourne).

Prior to retiring, she worked as a hospital administrator responsible for managing staff and ensuring adequate patient care between departments.

Ms Ellery now volunteers with homeless services for the disadvantaged as well as being a peer researcher for 'A Social Innovation Thinkpiece' on the implications of ageing in Australia, with a particular focus on women. She is a past Chairperson of the Housing for the Aged Action Group.

She is looking forward to learning more about Community Visitors in this role.

About Community Visitors

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

- Disability Services – visits are conducted to community-based facilities for people with disability
- Mental Health – 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 – visits are made to people who reside in supported residential services (SRS) and require additional support.

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. These boards 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.

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 but from February 2021, it became two departments—Departments of Health and Families, Fairness and Housing. 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 is at the discretion of the Community Visitors.

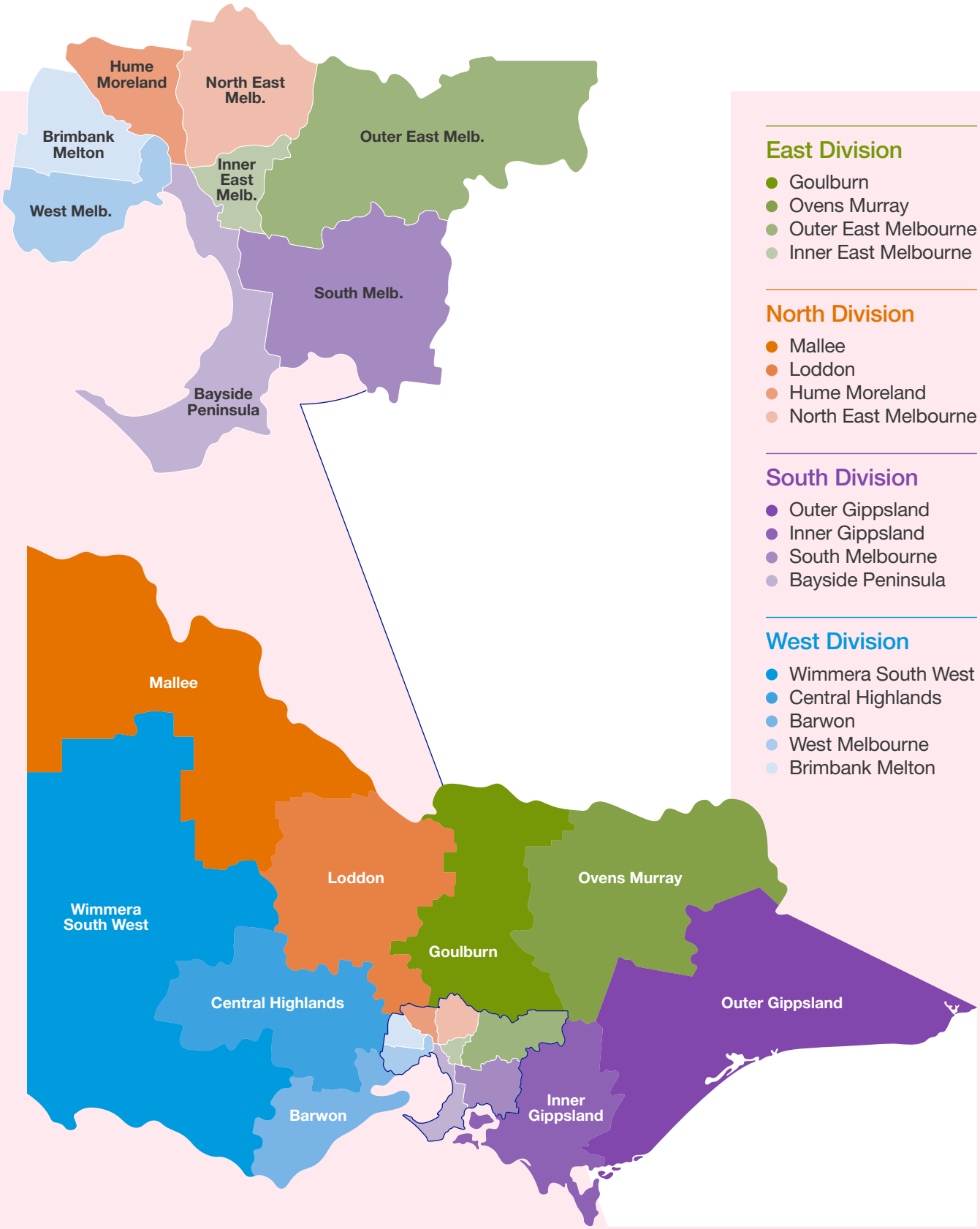
The ongoing support, training and recruitment of the Community Visitors and the boards is the responsibility of staff in the Safeguarding, Inclusion and Volunteer Programs Unit.

Table 1. Number of active Community Visitors and number of visits, 20/21

Stream	Active Community Visitors	Visits
Disability Services	205	2124
Mental Health	66	834
Residential Services	66	760
Total	**337**	**3718**

Reporting Divisions

From 1 February, the Department of Health and Human Services became the Department of Health and the Department of Families, Fairness and Housing.



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

01

Disability Services

Program Stream

DS

Recommendations

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

DS

1. ensure that a percentage of the Big Build social housing program is allocated to people with disability including those with complex and high support needs
2. improve the behaviour support skill levels across the disability sector including direct care staff by continuing the development and maintenance of initiatives in this area
3. simplify the Specialist Disability Accommodation registration process to ensure that providers understand and can meet their compliance obligations as well as clarifying eligible properties for Community Visitor visits
4. work with the National Disability Insurance Agency to ensure that all Specialist Disability Accommodation and Supported Independent Living house residents have internet access
5. lobby the Australian Government to amend legislation to improve information sharing between the National Disability Insurance Agency, the National Disability Insurance Scheme Quality and Safeguarding Commission, and Community Visitors
6. lobby the Australian Government to amend legislation to include Community Visitors as a key component of the safeguarding arrangements for National Disability Insurance Scheme-funded services
7. ensure that Community Visitors have the power to take photographs to support the documentation of issues, amending legislation, if necessary
8. commit to an annual timeline to respond to the recommendations in Community Visitors annual reports
9. provide additional funding to assist with implementation of the changes from the *Residential Tenancies Act 1997* and the National Disability Insurance Scheme to ensure that the Community Visitors Program has the technology and resources required to effectively fulfil its important safeguarding role.

Statewide Report

Introduction

Community Visitors have a critical safeguarding role for Victorians living in disability accommodation. They work to improve the lives of residents and their home environment, their choices, and their opportunities.

Community Visitors have continued their safeguarding role this year shifting between face-to-face visiting and remote contact. Nevertheless, they have continued their important work in identifying issues to be addressed by disability service providers. Increasingly issues related to the National Disability Insurance Scheme (NDIS) including service or system shortfalls were a common theme this year.

Community Visitors visited 1168 group homes during the reporting period. They undertook 2124 visits in person, when care directives allowed, as well as phone and video conference calls to meet with residents and staff.

This year, 81 requests for Community Visitors were made by telephone or email to the OPA Advice Service. Depending on the nature and urgency of the request they were treated as either a special visit or absorbed into the regular visiting cycle.

The requests came from the residents themselves, concerned family, friends and community members, staff directly supporting the resident or service providers and from anonymous callers.

Residents in group home settings remain vulnerable to violence and abuse. Community Visitors seek to identify these serious issues, referring the most serious to the Office of the Disability Services Commission or the NDIS Quality and Safeguards Commission for investigation and action.

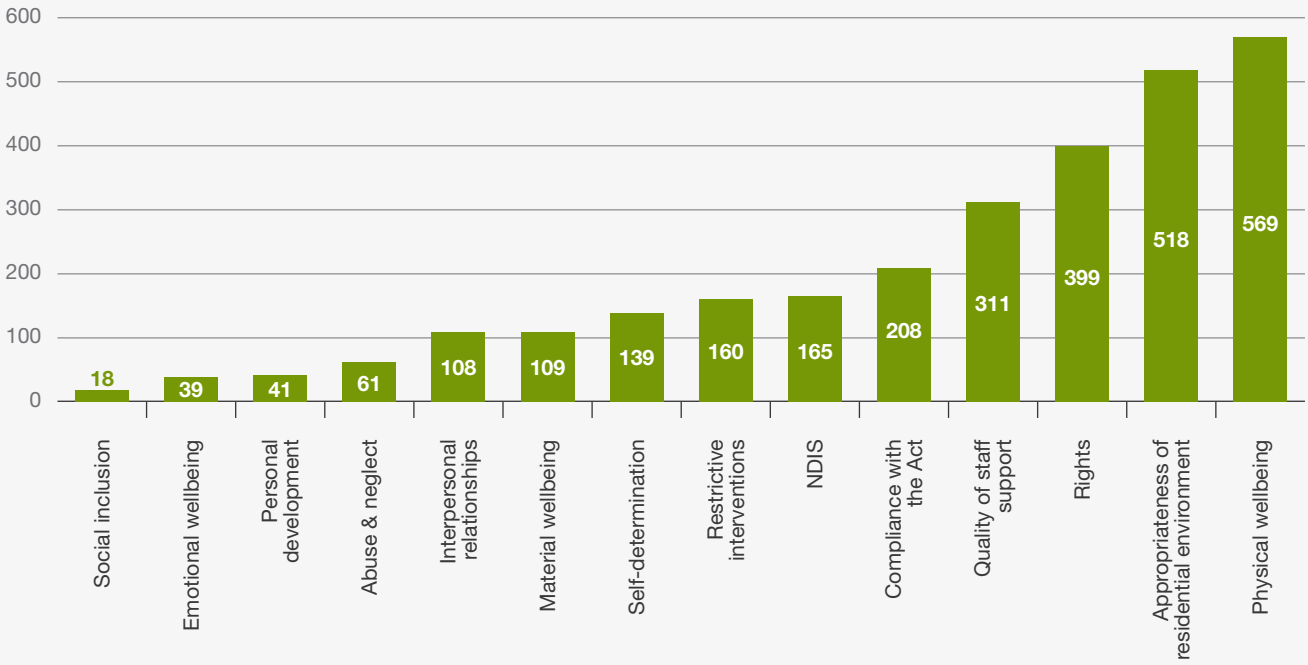
Remote safeguarding has its unique challenges. One of the most significant of these is the difficulty Community Visitors have in accessing documentation in the homes they visit. They have, however, continued to ask for and report on serious concerns about inadequate care and support as well as areas of good practice. Incident reporting and access to these documents was a focus for Community Visitors, particularly for people with complex needs.

Behaviour support needs and compatibility issues between residents were frequently reported as reasons for an unsettled or even a dangerous home. Community Visitors continued to advocate for greater opportunities and the best quality of life possible so individuals can live in a calm and safe environment.

Table 2. Total visits Disability Services stream, 20/21

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	338	62	29	531	**560**
North Division	287	36	15	421	**436**
South Division	273	57	20	437	**457**
West Division	270	50	17	654	**671**
Total	**1168**	**205**	**81**	**2043**	**2124**

Figure 2. **Issues reported by Community Visitors, 20/21**



The COVID-19 pandemic resulted in Community Visitors observing many changes in the lives of the people they visit. Like other Victorians, the lockdown presented opportunities for some residents to undertake new hobbies, explore interests, connect with their local community, and embrace technology for social, leisure and medical needs. Some residents took the opportunity to review their lives and how they use their time, resulting in it being very different to pre-COVID times.

The NDIS continues to be a changing and complex environment for participants to navigate, which lead to 165 issues reported by Community Visitors this year. NDIS issues ranged from questions about funding, support coordination, aids and equipment to communication between agencies.

A key NDIS issue is the separation between Specialist Disability Accommodation (SDA) and Supported Independent Living (SIL) providers. The SIL service provider delivers the in-home support, however, they do it in the environment dictated by the facility fabric which is the purview of the SDA provider. Consequently, issues reported included on-going maintenance problems, residents living in homes unsuitable for their needs as well as living with those with similar care needs but totally incompatible with each other and where the physical space does not enable them to be properly separated.

The Board notes with disappointment that a response was not received from the State Government to the recommendations in the *Community Visitors Annual Report 2019-202*0. This year's annual report has been prepared without the recognition and feedback of that work by Community Visitors.

Abuse, neglect, and violence

Community Visitors identified 159 issues relating to abuse and violence, many of which were resident-to-resident assaults. Incompatibility in group homes between residents is a common reason for this violence.

Serious abuse and neglect incidents reported by Community Visitors were referred to the NDIS Quality and Safeguards Commission or the Disability Services Commissioner (DSC). There were 51 referrals to the DSC over the year and 36 to the NDIS Commission.

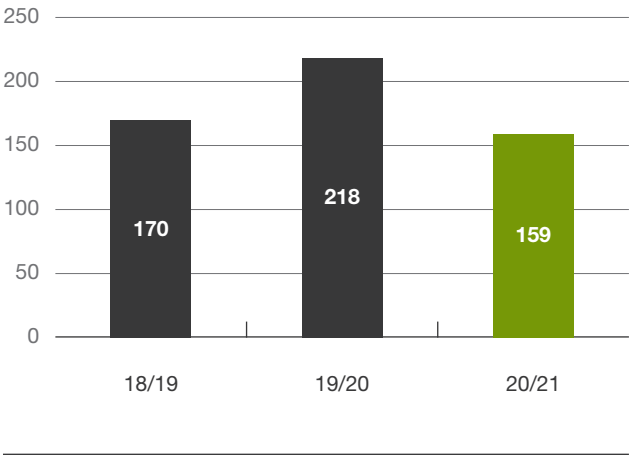
Abuse referrals to the NDIS Quality and Safeguards Commission

Abuse matters are referred to the NDIS Quality and Safeguards Commission when the resident is an NDIS participant. The Commission will only accept those matters rated as high risk. One of the key challenges related to these referrals has been the information sharing provisions which have meant that there has been little or no feedback to Community Visitors on them.

The high-risk referrals to the commission related to:

- resident-to-resident abuse
- resident-to-staff abuse
- staff-to-resident abuse
- self-harm and the impact on the person and co-residents
- incompatibility
- neglect or lack of adequate care.

Figure 3. Issues of abuse, neglect and violence identified in Disability Services stream, 18/19–20/21



In some cases, it appears that the Commission was aware of the situation because the service provider had reported it appropriately. In others, it is unclear if the Commission knew of the matter before the Community Visitor referral. However, invariably the referrals can add additional information and insights about what is happening to individuals and in the homes where they reside.

Resident-to-resident abuse was the most common referral type with instances of long-term physical and verbal abuse as well as threats and intimidation, the destruction of residents' belongings or damage to the home. Community Visitors also provided detailed accounts of conflict in homes reported by residents and staff, described in incident reports or even, in some cases, witnessed by Community Visitors.

Typically, residents tell Community Visitors they want a co-resident to move out because they are afraid, feel threatened, or have suffered from the disruptive behaviour of another resident. In a home where Community Visitors are well-known, the residents openly expressed their enjoyment of a calm home environment while another aggressive resident spent time in hospital.

Community Visitors submitted high-risk referrals where abuse was exacerbated by the inadequacies of the individual's NDIS plan, poor health management, inaction on their expressed preference to move homes, and a lack of adequate support staff. One example was while a staff member was supporting a resident to prepare dinner, the resident stabbed them in the cheek with a knife. The home has three residents, all with very complex needs, significant behaviours of concern and a long history of resident-to-resident and resident-to-staff violence as well as self-harm. After unsuccessfully working with families and the residents' support coordinators to find alternative accommodation over an extended period, the provider gave the residents more than 12 months' notice that they would cease services. They did not believe the residents could live safely together and none of the carers seemed prepared to accept any alternative accommodation on offer and there was an ongoing unacceptable health and safety risk to staff.

An anonymous caller to the OPA Advice Service reported that a resident assaulted co-residents as well as staff in their home. Community members including two minors were also assaulted; the alleged perpetrator was also sexually inappropriate with minors. At a subsequent visit, Community Visitors were informed the resident had been admitted to an acute mental health unit however they remained very concerned about the safety and wellbeing of the resident, staff, other residents, and members of the public.

Several serious incidents prompted Community Visitors concern about safety and the quality of care provided at two homes. Community Visitors met with the service provider to explore what had been implemented to address the incidents and possible physiological trauma residents were exposed to. However, they remained concerned about the perceived absence of proactive strategies for residents with complex care needs or who were exposed to trauma.

Resident attacks on staff members sometimes appear to target specific individuals. Not surprisingly, such incidents can greatly distress residents observing them. In one case, Community Visitors reported that repeated attacks led to a resident being issued with a Temporary Notice to Vacate for endangering the safety of residents and staff.

Staff-to-resident abuse often occurs in complex situations. On occasion, Community Visitors sighted unauthorised restrictive practices, poor-quality care along with physical and sexual assault. An external investigation substantiated the allegations, and the staff member was terminated as well as being reported to the Victorian Disability Worker Commission.

Community Visitors also submitted referrals about residents who self-harmed and the impact this had on co-residents. In one instance, the service provider managing the home engaged additional staff, external health supports and the individual's care team to overcome the problems created.

As the medium and low-risk referrals are not accepted by the Commission, they are now made directly to the service provider for a formal response. The provider response dictates any follow-up action. If Community Visitors feel issues have not been taken seriously or appropriately addressed or there is no response, then the matter is likely to be escalated to the Commission as a high-risk referral.

Abuse referrals to the Office of the Disability Services Commission (DSC)

There were 51 referrals made to the DSC during the year, 25 of which were categorised as high-risk situations.

The three key issues were:

- resident-to-resident violence
- staff-to-resident abuse and neglect
- systemic inadequacies.

Community Visitors reported long-term violence in homes. In situations where there was one main perpetrator, other residents frequently withdrew from communal areas, often at the direction of staff. Many incidents appeared unprovoked with the victim often having little ability to protect themselves. Sometimes the resident injured themselves and then escalated to assaulting others. On other occasions, there was no warning or apparent trigger for an attack. Violent incidents included punching, kicking, hair-pulling, yelling, and screaming.

A caller to the OPA Advice Service reported an incident witnessed by two residents where a staff member allegedly hit another resident over the head. Community Visitors were concerned for the residents in this high-needs home as they have very challenging behaviours, exacerbated by delays in accessing behaviour support assessments.

Community Visitors noted in a resident's Behaviour Support Plan that they had made concerning accusations about staff. The house supervisor made a request for a communication assessment to strengthen opportunities for positive engagement and engaged a counsellor. All abuse allegations were taken seriously and reported to Victoria Police for investigation.

The causes and impacts of abuse

Community Visitors remain concerned about the impact of a violent home environment on the residents who live in these homes and the staff who work in them. Some issues are long-running and are carried over from previous years but remain unresolved due to the continuing lack of appropriate accommodation that supports individuals with complex needs. Consequently, all too frequently residents are living daily with physical or verbal aggression, violence, or repeated threats.

A knowledgeable and proactive care team is a critical factor in supporting residents with challenging behaviours. Community Visitors find some house staff and providers work diligently in collaboration with behavioural support practitioners to address aggression and violence. Their role is to develop and review support plans as well as provide strategies that staff can use to address the problems. In one case, the disruptive behaviour of a resident impacted severely on other residents, staff, and the resident themselves. This troubling situation was resolved when the service provider engaged with all stakeholders to relocate the resident to a more suitable setting. The resident is much happier, as are their former co-residents. Consistent strategies, clear team messages and multiple supports for the resident contribute to a stable environment, even when there are staffing changes.

CASE STUDY

Julia, a resident in a home in a country region, frequently communicated her desire to move because she was fearful of a co-resident who displayed heightened and aggressive behaviours. Eventually Julia's physical health was impacted to such a degree that she required hospitalisation.

Community Visitors strongly advocated for Julia's SIL provider to contact her NDIS planner and support coordinator to ensure her wishes to find alternative accommodation were known.

After ten months of continuous advocacy, including regular visits and liaison meetings with the SIL provider, Julia successfully moved to a new home. She is happier and now feels safe.

Resident-to-resident abuse

With regular attendance, Community Visitors can monitor resident wellbeing in their homes. They regularly observe staff endeavours to redirect aggressive or challenging residents, support residents' mental health and deal with physical injuries. During, and after violent incidents, staff provide support and reassurance to residents, including in some instances encouraging them to go to their bedrooms for their safety. Family members are generally informed of incidents impacting their loved ones.

Community Visitors seek to form a thorough picture of a home's operation and identify concerns about aggressive behaviour between residents. In these circumstances, they request an explanation of what is being done to address the situation and spend time to understand the complete picture. For example, in one home, a resident showing signs of early dementia, was unable to protect himself from threats of violence. Community Visitors were informed that the resident would eventually move out when his care needs were beyond the capacity of the house staff. The service provider and staff appeared to be doing all they could, but Community Visitors felt this was an intolerable situation. They were informed that a behavioural specialist had spent considerable time in the home observing the situation and speaking with staff to ensure a detailed plan was prepared. They continue to monitor this situation.

During a remote visit, staff informed Community Visitors of several incidents of a resident assaulting another resident. The staff reported that this was because the victim was deemed to be in the other person's 'space'. Behaviours were documented and a behavioural specialist recommended restraint be considered. Eventually, a meeting of the resident's care team decided that a different type of accommodation should be found.

A family member contacted the OPA Advice Service seeking the assistance of Community Visitors because their relative had been allegedly physically and verbally assaulted by a co-resident and then sexually assaulted by another. The person relocated to the family home temporarily before moving to another group home in the same town. The caller reported that both their relative and the alleged perpetrator were interviewed by Victoria Police.

Over a ten-day period, one group home had six incidents of aggression and violence targeted at both co-residents and a staff member, as well as property damage. Community Visitors observed that staff were supportive and dedicated and did their best to care for residents in this difficult situation. The service provider undertook a review of the actions, strategies, and medication administration to prevent similar numbers of incidents occurring in the future.

Community Visitors reported about two particularly disturbing, unprovoked attacks on a resident who was hit, kicked, and verbally abused by another resident during dinner time. The residents were moved from the area to finish their meal and then to the safety of their bedrooms. Community Visitors acknowledged the staff strategies and actions to minimise friction between residents, however, they remained concerned about the ongoing stress in the home.

Staff reported a serious incident of a resident assaulting a co-resident and staff. This incident was one of several similar incidents that appeared to occur when the resident became heightened which often led to violence. Support strategies were implemented, and staff followed de-escalation guidelines and met afterwards to debrief. The resident was waiting on a new Behaviour Support Plan and had recently had a medication change.

Community Visitors reported a violent outburst by a resident which resulted in staff locking themselves in a separate room while residents were left on their own. The incident report stated the resident was only targeting staff, however, Community Visitors questioned how that could be known when staff were not in the same room as the residents. The service provider responded by stating that staff knew the residents well and co-residents had been monitored to ensure they were not directly impacted.

CASE STUDY

Juliette and Trevor moved into the same home in 2017 and Community Visitors have documented long-standing and escalating issues of incompatibility. Verbal abuse was normal and constant, lasting for several hours. Staff found it difficult to maintain physical distance between residents as assaults from one to the other were mostly unprovoked.

Despite modifications to the house to keep them physically separated, medical assessments and behaviour support strategies, the situation deteriorated. This impacted on both residents' mental health.

Four notifications were made to the DSC and two referrals to the NDIS Quality and Safeguards Commission. In April 2021, Trevor moved into temporary accommodation in an empty house.

Both residents were well supported and happier living by themselves and they continue to be monitored for their physical and mental health needs. Community Visitors were pleased a temporary solution was found but were concerned it took over four years to occur.

Staff-to-resident abuse

During a visit, Community Visitors observe, read, and receive information about staff violence towards residents in homes they visit. These incidents ranged from staff punching, slapping, and pushing residents to frequently yelling at residents and treating them disrespectfully. In some cases, the allegations were investigated, and staff were subject to disciplinary action including termination of employment and reporting to the Victorian Disability Worker Commission.

At the conclusion of one visit, an acting house supervisor disclosed an incident report he submitted about a senior staff member shouting and pushing a resident. It was reported that the staff member was known to shout at residents and call them names when he became upset. The provider informed Community Visitors that the staff member had been immediately stood down pending an investigation. At a subsequent visit, the resident who had been subjected to the most abuse was more settled and happier. The allegations were later substantiated so the staff member did not return to the home.

At another home, three allegations of staff-to-resident abuse led to staff being stood down pending an investigation. When a resident witnessed a staff member strike a co-resident, the service provider undertook an internal investigation but was unable to substantiate the allegation. In a further matter, a resident was hit with a pair of wet pants and reported feeling intimidated, nervous and unsafe in the presence of the carer.

All three matters were investigated and reported to Victoria Police yet only two allegations were substantiated. Community Visitors were concerned for the residents as some displayed very challenging behaviours exacerbated by delays in accessing behavioural support practitioner assessments.

The OPA Advice Service received a call alleging several staff at a group home had been mentally, verbally, and physically abusive towards residents, some who were non-verbal. Community Visitors undertook a visit but were unable to determine if there was any abuse occurring. They did note there were many different staff working at the home and this appeared to make it challenging for them to be abreast of resident needs and provide continuity of care.

Restrictive practice

Community Visitors vigilantly identify and monitor restrictive practices they observe in homes, reporting 20 issues this year. They routinely sought explanations why particular practices were in place, their impact on the resident and their housemates.

One example involved two non-ambulant residents who were confined to a bedroom when a staff member used a visually impaired and frail resident in a wheelchair to block the doorway. The staff member sat in the lounge-room and used their mobile phone. When questioned, the staff member said: "I have been in the game a long time and I know what I am doing". In response to the Community Visitors report, the provider advised that it was investigated internally.

In some cases, restrictive practices are so normalised that they become part of the daily living arrangements and accepted work practices. This can mean these practices are overlooked and not deemed restrictive or impinging on a person's human rights. Community Visitors use their skills to observe and objectively question and comment on their use. Frequently, they see restrictive practices in place for one resident that negatively impact on others. For example, a family member placed their relative on a restricted diet which the resident did not like. In response to Community Visitors' questions, staff consulted a dietician who deemed the tests to ascertain the necessity for such restrictions too invasive. A gastroenterologist subsequently approved a normal diet as there was no supporting evidence for such restrictions.

Community Visitors noted a welcoming courtyard at a property between separate units. However, the residents of the front unit were only able to access the courtyard with staff supervision. The property is owned by DFFH and there have been repeated requests over the past three years to modify access to ensure all residents have unrestricted use of the courtyard, not just the unit two occupant.

Behaviour support

The preparation of behaviour support plans can be delayed for a range of reasons including an inadequate NDIS plan with no funding for behaviour support, long waiting lists due to a shortage of or difficulty finding suitable practitioners, particularly in rural and regional areas.

Enquiries were made about how the behavioural support practitioner approached the situation at one two-person home where there were complex needs. The service provided informed Community Visitors that the house supervisor reported at monthly meetings with the practitioner. This assisted the support staff to work successfully with the person, and the practitioner was able to provide tailored, hands-on training.

Community Visitor reports show a correlation between existence of high-quality behaviour support plans and a reduction in incidents. This demonstrates that when a resident is appropriately supported both they, and their co-residents can have a much better quality of life.

In one home, staff use a QR code to connect with a behavioural support practitioner. This approach enabled them to update the practitioner as issues unfolded so effective strategies could then be developed and shared immediately. The specialised guidance was used to support the resident in real-time.

Over three months there were eight incidents where a resident threatened, swore at and exhibited disruptive behaviour towards other residents and staff. Despite staff following the detailed Behaviour Support Plan, the behaviours continued, impacting on the other residents who were fearful and stayed in their own rooms. Community Visitors continued to enquire about the actions taken to keep the other residents safe and were pleased when the staff commenced weekly meetings with the psychologist for the resident with challenging behaviours.

During two consecutive visits, Community Visitors enquired about a resident's out-of-date Behaviour Support Plan. The resident was known to push other residents, have verbal outbursts and damage property. The service provider advised that the Behaviour Support Plan had been authorised. Community Visitors continued to monitor the home remotely and look forward to being able to visit in person to verify whether the situation had resolved for everyone in the home.

Community Visitors were concerned the recommended behaviour intervention strategies did not address the elevated behaviours of one resident. One-to-one staffing, particularly during the COVID-19 restrictions, led to a reduction in the number of incidents. Despite this, the resident's behaviours were regularly problematic. Following a formal complaint by another resident, the service provider requested a reassessment of their Behaviour Support Plan. However, this was delayed because the resident was ineligible for a NDIS plan to fund the assessment and their treating psychiatrist had retired. This is an example of where the shortage of suitable practitioners adversely affected the wellbeing of the residents of this home.

The triggers for assaults by one resident of co-residents were unclear. To alleviate these risks one resident had a medication change which made them a little drowsy, but the assaults stopped. Community Visitors will continue to monitor this situation particularly in relation to whether a further medication review may be required.

One resident's long-overdue speech therapy sessions and Behaviour Support Plan were reported by Community Visitors. It was hoped that speech therapy would improve the individual's communication skills and, therefore, lessen their frustration. The house supervisor worked diligently to address the situation and get supports needed.

Community Visitors requested information about plans and strategies to eliminate abusive behaviour between two residents. It was reported that although, sometimes, the residents got along very well, on other occasions, it was very dangerous for everyone present. A medication review was to be undertaken, but Community Visitors remained concerned about ongoing safety in the home.

Incompatibility

For many years, incompatibility issues have been reported by Community Visitors. Frequently, it plays out as violence or the threat of violence in the home for one or more residents. Sometimes, the attack is targeted at a particular person and other times, the resident might lash out at any resident in range. The need for more housing options and the space to live as individuals wish are critical systemic issues that need to be addressed.

A resident's behaviour and abuse of other residents was of great concern to Community Visitors as co-residents lacked self-protective skills, so constantly felt unsafe in their home. Staff reported the resident's challenging behaviours were relatively

predictable, which enabled them to manage the situation. Professionals were engaged to develop proactive strategies for staff and an environmental assessment was planned.

Community Visitors noted an altercation between two residents where Victoria Police were called. One resident was upset by the other's noisy behaviour, with staff suspecting that they were losing their hearing. Staff explained further tests as well as assessments for both mental and physical health had been arranged.

Community Visitors noted an incident involving one resident being abusive and threatening two others which resulted in a physical assault. Communication assessments were planned for all residents with a focus on the skills required to cohabit as a group. Community Visitors will continue to monitor the safety in the home.

Residents were being intimidated in their own home by another much younger resident. There appeared to be no obvious triggers and the recommended strategies were not working so a behavioural support practitioner was engaged to work with residents and staff.

Community Visitors reported instances of verbal abuse and self-harm. Staff worked hard to support one resident whose behaviour impacted co-residents, particularly during the lockdown periods. A new house supervisor was appointed, changes made to behaviour management strategies, medication adjusted and the staffing roster stabilised. Consequently, Community Visitors were pleased to hear on the following visit that there had been no aggressive incidents for four months following these changes.

One very isolated resident was incompatible with their housemates. Their goal was to move to a home with others of a similar age, interests, and skill levels. Eleven incidents of self-harm were reported over three months related to this resident. The service provider supported the resident with activities and outings of interest and continues to seek more appropriate alternative accommodation, but Community Visitors remain concerned about the resident's mental and emotional wellbeing.

Frequent incidents of physical assault, verbal abuse, and disruptive behaviours were reported in a small house with two residents. They have lived together for four years but there were increased behavioural issues throughout the COVID-19 restrictions. The confines of the space and the residents being at home all the time, intensified their incompatibility.

The pandemic and resulting lockdowns have intensified some compatibility issues. Community Visitors report that, in one home, incidents occurred mostly around mealtimes, staff transitions and when unfamiliar staff were working. Each incident needed to be reviewed by staff and management to improve future practice and ensure all residents felt safe in their own home.

Physical wellbeing

COVID-19 response

Community Visitors reported over 200 COVID-19 issues, the majority relating to metropolitan Melbourne houses.

Community Visitors were made aware of a few disability accommodation sites across the four Melbourne metropolitan divisions where either residents or staff members tested positive for COVID-19. Most were in the western metropolitan area.

A resident who tested positive, spent two weeks in hospital isolation before returning a negative test and being allowed to return home. All staff and other residents of the home were tested but their results were negative.

Another home was in lockdown for almost three months as a precaution after three staff members tested positive. All residents tested negative and coped well with the situation as no major incidents were reported.

There were 23 staff from one home self-isolating after a household contact tested positive. The remaining staff did double shifts as the provider did not want to engage casual staff as the residents have medical needs that require staff with specialist training. All residents were tested, and the service provider revised the roster, so staff only worked at one home. The home also had two deep cleans and Community Visitors reported the residents were well-supported.

A home in the same area managed three active COVID-19 cases among six residents. One resident, who refused to be tested, was treated as if they were positive as a precaution. All regular staff were required to self-isolate and were not allowed to return to work until they and their household contacts tested negative. Another house supervisor was deployed to take charge with the support of casuals and agency staff.

A household implemented strict isolation measures after a staff member tested positive. All regular staff were quarantined, and casual staff took over after a deep clean of the home. The residents all tested negative on the eleventh day. A house supervisor who had previously worked at the home kept it operating smoothly, following regular contact with the usual house supervisor.

Four residents and a staff member tested positive in a group home. The service provider acted swiftly to move the residents from the home and put them in pairs in untenanted houses it operated. The residents only returned to their home after they tested negative. Community Visitors were advised all residents had mild symptoms and COVIDSafe procedures were followed to protect residents and staff. Following a request for further information about contact tracing the service provider advised that this commenced immediately for all their homes and they had identified the source of the initial contact. Consequently, 12 staff were furloughed within 12 hours. Community Visitors commend the staff who provided care for residents enabling them to remain at home during this crisis.

A staff member had a false positive COVID-19 test result so was required to be tested three more times. This impacted staffing levels and the roster in the home as other staff were close contacts and in isolation. The home followed the recommended precautions such as temperature checks, hand sanitising as well as health and travel declarations.

In regional Victoria, a resident's family member tested positive for COVID-19. The resident was visiting her family at the time, though the infected family member was not at home. After the staff were informed of the contact, the resident was immediately isolated in her unit, causing her great distress. She stopped eating and house staff checked on her every 15 minutes. She was in constant phone contact with family during this time. After 36 hours of isolation, she and other family members tested negative, so the resident could return to her regular routine.

Two residents were diagnosed with COVID-19 and, following a brief hospital stay, were moved to another home for three weeks. All contact staff self-isolated resulting in a temporary staff team who did their best to care for the remaining residents. However, the staffing change caused some stress and anxiety for the remaining residents.

During lockdowns, programs and activities were severely impacted. Many service providers took the initiative and arranged alternative programs for residents. Activities included games, music, movies, craft, cooking, special meals and local walks. Community Visitors enquired if NDIS activity funding could be redirected to these new in-house activities. In many homes, there was a small increase in staffing hours, however, in many cases it was insufficient to provide residents with the engagement and stimulation required in the absence of other external activities. In most homes, staff supported residents to connect regularly by phone, mail or video calls with their family and friends.

GOOD PRACTICE

Residents told Community Visitors of excellent activities initiated during restrictions including a terrarium sale at the front of the home which was very popular in the neighbourhood. Residents and staff were very imaginative in identifying ways to keep life interesting and stimulating. During one visit, Community Visitors encountered residents from three different homes meeting up on a video call to play a word game.

At another home, a resident became friendly with a neighbour and their dog, they saw regularly while walking around the area. With staff support, the resident assisted with walking the dog. When restrictions eased, the neighbour and their dog visited the home for afternoon tea, much to everyone's enjoyment.

Some service providers encouraged flexible staffing arrangements allowing residents to be accompanied on special outings. Residents with behaviour support needs were often able to obtain permission to access community spaces outside their permitted area when added to their Behaviour Support Plan.

Community Visitors repeatedly reported residents enjoying the slowing down of activities and when day programs re-opened, some took the opportunity to reconsider their participation. Some chose to retire, reduce their hours or to have a later start to the day.

However, Community Visitors were alarmed to hear of day programs closing for a variety of reasons and residents having difficulty finding a suitable replacement. In many cases, this added pressure in the home with staff required to provide activities and support as life changed post-lockdowns.

Throughout the year, as Community Visitors undertook remote safeguarding visits, they saw how comfortable many residents were with the use of a tablet to communicate. Community Visitors frequently connected with residents and toured the home virtually. Staff supported residents to speak privately with Community Visitors if they wished.

A staff member informed Community Visitors on a phone visit that one of the residents had been verbally abusing housemates and staff and, at times, there was also physical abuse. Staff believed the cause of the behaviour was frustration and feeling disconnected from others during COVID-19 restrictions. They adopted de-escalation strategies and facilitated more contact with family and friends. The resident was supported to go out for a walk or a coffee, and to have one-to-one time with staff. Following these changes, the resident became more settled with improved harmony in the home.

One resident became assaultive to other residents during a COVID-19 lockdown because he was used to staff only being in the home with him during the day. Consequently, his frustration became overwhelming. Staff responded by taking the other residents for a drive and working with the individual to implement coping techniques. When restrictions eased, one-to-one NDIS workers were able to provide their supports and attendance at day programs resumed so the level of frustration decreased.

During a phone visit Community Visitors were told of several assaults over recent months. There had also been some self-harm in the household. Residents with Autism Spectrum Disorder found changes to their routine and environment very difficult to cope with, exacerbated by being unable to attend day programs or other activities. The service provider helped the residents by ensuring a consistent staff team during this time which reduced their anxiety and confusion.

GOOD PRACTICE

One service provider undertook to review each resident's capacity to provide informed consent for a COVID-19 vaccination. Where required, it worked in consultation with families, doctors, and guardians. A forum was established to consult with individuals in relation to the vaccine rollout and any concerns they might have. Advice on how to support residents in group homes who refused the vaccine was provided as some residents had declined. In cases where a poor past response to vaccinations was an issue, clinical assessments were explored.

A service provider in regional Victoria arranged for vaccinations at a special local clinic. For those who were unable to attend the clinic, a doctor visited their home. Residents under 50 years of age received the Pfizer vaccine and those over 50, AstraZeneca. The staff vaccination program was planned to commence the following week.

Healthcare

Community Visitors continue to monitor healthcare provided to residents.

A resident with perceived cognitive decline was reviewed by their doctor who recommended a geriatric assessment. An occupational therapist was engaged and recommended purchasing a large cup with a straw to make drinking easier. After a review by a speech pathologist and a medication adjustment, the resident was able to eat and drink more easily, was more alert and had improved quality of life. The resident began interacting with others and their prior interest in football was rekindled.

Community Visitors reported residents having difficulty obtaining timely and adequate dental care. In one instance, where there was more than a two-year wait to attend a special needs dental clinic, local private options were explored. In another case, routine dental checks were problematic as they required the person to undergo a general anaesthetic. As a preventative measure and to avoid this procedure, staff concentrated on dental care and were on alert for mouth pain, swelling or other changes.

A flu vaccination program took account of the COVID-19 vaccination rollout. Generally, those who had AstraZeneca had their flu vaccination between the two doses, and those who received Pfizer had their flu vaccine after both doses if they had not had it earlier.

A resident died after a serious manual-handling incident from a fall. Community Visitors checked if the service provider had notified the relevant authorities, and their response to the incident, including whether additional staff support, and training was needed. At the time of writing, no response to Community Visitor enquiries had been received.

Three allegations were received by OPA regarding multiple instances of ongoing neglect of a resident, possible physical abuse, inappropriate use of aids and equipment, as well as poor communication and handover information between staff. There were also reports of staff not following COVIDSafe practices in the facility. Subsequently, there was a further request for Community Visitors to check on the situation.

Community Visitors responded to a call to the OPA Advice Service regarding a resident with high support needs and several behavioural issues. It was alleged that the resident had suffered many instances of unauthorised chemical restraint and a fall which led to an injury that required hospitalisation.

Medications

Medication errors and the need for ongoing staff training continues to feature in Community Visitor reports. In one home, there were ten medication errors over 12 months which included medications missed or incorrectly administered medication. The service provider noted most errors occurred when new staff were on duty. Medication charts are now reviewed regularly to ensure staff do not forget to give medication at the prescribed time. At another home, new procedures were implemented to prevent medication errors.

Ageing

Community Visitors reported a prompt referral of an older resident to a geriatrician when there were concerns about their decline. Continuity of staff played an important part in identification of, and support to address, ageing issues.

A staff member informed Community Visitors about a resident whose health was deteriorating with a move to aged care likely. The resident's family disagreed so staff worked hard to continue to provide high-quality care to meet the resident's changing needs.

Rights

Technology

Like all members of the community, residents have increasingly relied on the use of the internet to remain connected to family and friends, and social and recreational groups as well as for healthcare. More residents now have access to their own personal device, but a reliable internet connection is essential for this to be useful.

Community Visitors advocated strongly with one service provider for its residents to have access to Wi-Fi. Staff were using their own devices to provide a hot spot for residents to access the internet, or residents had to use the house device in a communal area for online medical appointments or for calls to family and friends. The service provider advised that residents needed to purchase their own individual internet plan as they were unable to use the house Wi-Fi because it was part of the service provider's secure network. Almost 12 months later, the service provider reported it would not be providing secure internet access for their residents and the residents would still be required to make their own arrangements.

Another service provider supplied internet access to residents as the NDIS funded the purchase of tablets, but nothing for an internet plan. A further provider paid for two separate Wi-Fi networks for the home: one for themselves as the SIL provider and one for residents.

Access to the internet in one's own home is a basic need, particularly to keep connected with family and friends and link with health practitioners. Community Visitors remain alert to residents having restricted internet access in their own home and will continue to advocate for better connectivity for residents.

Independence and choice

Community Visitors are conscious of the need for a homely environment where residents feel comfortable to say and do as they wish. A place where they can express themselves freely and have privacy when needed.

When Community Visitors asked a resident if he had any issues he would like to discuss with them, he indicated he did, but would speak to them at another time because there was nowhere private to talk. Later, staff confirmed residents knew how to contact Community Visitors and were able to use the

cordless phone, if needed. Community Visitors were impressed in another home where residents were involved in interviewing and selecting new staff.

Community Visitors observed situations where NDIS plans provided more choice and control for residents, often leading to opportunities for a more fulfilling life. Equally, however, Community Visitors reported instances where residents had little or limited freedom of choice.

CASE STUDY

Community Visitors were concerned about a family member's strong opinions on what they thought Peter was able to do. This was having an impact on what the service and care staff were able to provide to him. Community Visitors asked if the matter could be discussed with Peter's family.

The house supervisor arranged a meeting to discuss Peter's needs and desired community activities. Peter was included in the discussion so a plan could be formulated to enable him to achieve his goals.

Substitute decision-making

Where residents have other's making decisions for them, Community Visitors look for evidence of their wishes being considered. When this does not appear to be occurring, Community Visitors request an explanation and reflection on what could be done differently.

A resident told Community Visitors he would like more personal choices in his day. He wanted his NDIS plan, which was organised by his family, to reflect more of what he wanted. Staff and Community Visitors continued to strongly advocate for a review of his activities to enable this to occur. At his last review meeting, staff supported the resident to refer to a prepared list of desired activities to explain his wishes.

Financial management

Resident access to their own personal funds is an issue Community Visitors continue to enquire and report on. Their aim is always to promote greater opportunity for self-determination.

Some family members maintain tight control of a resident's finances when they are the appointed administrator. Community Visitors report that this can impact greatly on the person's daily life. In some cases, the administrator may have unrealistic expectations of the amount of money the person needs or be slow to release money.

Access to incident reports

The regular provision of electronic incident report summaries by service providers is seen as best practice as it enables Community Visitors to be prepared and better-informed during visits. Regular access to incident reports is important so they can request further information, explanations about what occurred, and the follow-up actions taken. This year, Community Visitors have worked hard with service providers to develop processes for this access. They have made frequent requests during visits, at service provider liaison meetings and via phone calls and emails to the organisation. It is pleasing to report that some providers have been very responsive. However, the practice varies widely and continues to be an ongoing issue.

One service provider stores all incident reports centrally at their head office so Community Visitors are only able to view daily notes and references to incident reports during visits. Community Visitors asked for summaries to be available at the home before they visit and the service provider eventually agreed to this. When Community Visitors attempted to log onto the system at the home, they were unable to view the reports because the documents were too slow to download.

Remote safeguarding has required Community Visitors to rely more on the information detailed in incident reports. During a phone visit, Community Visitors requested copies of incident report summaries. Since COVID-19 restrictions began, there appeared to be a noticeable increase in serious incidents, particularly related to one resident. Incidents included self-harm, property damage, threatening gestures, and aggression towards other residents and staff. Specific information requests to the provider about the situation were met with details of staff and their training as well as advice about an external investigation.

Several resident-to-resident physical assaults and instances of disruptive behaviour were listed in the incident report summary. Community Visitors raised concerns about the residents' Behaviour Support Plan and the level of support being provided after being able to review the incident reports.

GOOD PRACTICE

Community Visitors have consistently received regular electronic incident report summaries from one large service provider. The reports contained detailed information which resulted in Community Visitors being able to ask informed and relevant questions about residents when they visit. Having access to incident report information has been particularly helpful with remote safeguarding because Community Visitors have been able to review this important information without needing to be at the home.

Community Visitors will continue to request access to incident reports at each visit and, where necessary, work with service providers to ensure it occurs.

Quality of staff support

Recruitment and training

Community Visitors meet many staff working in homes and frequently report on supportive and well-trained staff making a difference in the lives of the people they care for. There are also instances of poor staff practice often resulting from a lack of suitable training.

A service provider was asked about an incident involving a casual staff member refusing to transfer a resident using a hoist because they felt they had inadequate training and were unfamiliar with manual-handling plans. There was an investigation following the incident and recommendation for further training. The resident was pleased that the staff member would not be returning to their home.

Community Visitors reported occasional cases where casual staff were unaware of the expectations and duties to support high-needs residents. When this comes to Community Visitors' attention, they request details about the steps to be taken to recruit and train suitably qualified staff to perform such duties.

New staff at one service provider are required to complete compulsory NDIS modules prior to starting work. They undertake a two-stage induction, including general information and expectations of a disability support worker. There is also mandatory on-line training, including manual handling, abuse prevention in disability services, diversity and culture in healthcare, food safety as well as infection control. They have 'buddy shifts' with experienced staff, are given feedback on their competency by a trainer and additional training is available on request. Several 'shadow' shifts are completed prior to commencing overnight shifts. Service providers must consider staff experience, study completed and their suitability for the role in staff recruitment or placement decisions.

Most service providers are experiencing staff shortages. There are alarming reports of some permanent staff having to double-up on shifts and agency staff having to be sourced from either Melbourne or regional towns. The staff shortage is exacerbated by the considerable delay in the appointment of new staff due to new NDIS-screening requirements. This is particularly concerning in rural and regional areas.

Community Visitors made a referral to the DSC when they were concerned about frequent reports of unexplained bruising and abrasions on a resident in a home and the deaths of two residents in the same home within 12 months. They also requested further information from the service provider about training and support of staff in the home. A liaison meeting discussed the issues around the appointment of an external investigator to review resident injuries and Community Visitors were told additional training and support would be provided to the staff during the pandemic.

While undertaking a visit, Community Visitors encountered a family member who expressed many concerns about the care provided, individual support offered by staff and upkeep of the home. This followed an earlier request to monitor some allegations of neglect. Community Visitors were informed that a new house supervisor was developing new processes to address the family member's concerns.

Staff as advocates

Community Visitors were heartened to hear of staff going above and beyond their required duties to ensure residents lives were better. This has been evident this year, in pandemic-related activities, events and in renewing or building new connections.

In one home, a resident who had not had family contact for many years was supported by dedicated staff to attend a family reunion and recently reconnected with her parents. To the delight of the resident, photographs of the reunion were displayed in her room.

Residents in another home were looking forward to visiting a local club for a celebration. After purchasing their tickets, the club told them they would need to bring additional staff to support the

residents. Staff felt the club was being unreasonable and discriminatory as they often visited and were well-known there. The issue was escalated to the club management and resolved, thus, enabling the group to enjoy a night out with their friends.

Community Visitors requested an update on whether a doorbell was impacting on a resident's seizures. The house supervisor explored alternate options to a chiming doorbell. A light-activated doorbell was suggested as this would also be helpful for residents with hearing impairments.

An OPA Advice Service request about a resident not seeing their family often was followed up by Community Visitors. Initially, it appeared the house supervisor was not allowing a visit, however, it was found the resident received a minor injury from a family member while on a visit, so the service provider was attempting to manage the situation.

Another call to the OPA Advice Service reported that a resident with a dual disability was not receiving letters from family. The caller also alleged the resident was experiencing an increased number of seizures. The service provider explained to Community Visitors that the resident had requested to have limited contact with family and that their seizure activity had decreased following this change. The provider was exploring options for a third party to provide communication support.

Quality of care

Community Visitors made a report after reading six serious incidents of assault, aggression, and intimidation by a resident towards their housemates over three months. In addition, there were 11 separate days where there were difficulties with the resident taking their medication and occasional property damage. The staffing levels in the home appeared adequate if the resident participated in activities. If not, then all residents had to stay home, as the resident needed to have two staff members for support and there were not always enough rostered on. The home appeared to revolve around this resident's behaviours on any given day. Community Visitors were concerned about the need for a stable and calm environment with appropriate staffing to meet everyone's needs.

There were significant tensions between one resident and the other residents with 17 incidents reported over a month. The individual did not attend a day program but had one-to-one funded support six days a week, however, staff shortages meant that the resident only received support four days a week. This home often runs with less than the full staff complement.

A resident was taken to the incorrect address by taxi after a medical procedure and was left on the street. A member of the public called another taxi for the resident. Staff made a complaint to the taxi company which was unable to contact the driver and, subsequently, removed him from their system. The resident is now taken and picked up by staff for medical appointments.

OPA received a call to its Advice Service detailing poor care of a resident with complex needs. It was alleged the house supervisor was not following through with aspects of the Behaviour Support Plan or follow-up appointments. When Community Visitors enquired about the care, they were told that there was involvement of behavioural practitioners and allied health, personal doctors, family, and house staff. Staff appeared aware of the importance of meeting support needs and were implementing strategies accordingly. Progress was being recorded so it could be reported and discussed at care team meetings.

Community Visitors sought more information about the operation of a home where they believed the number of staff on duty was inadequate to meet resident needs. Most residents required behaviour support due to the possibility of assault by one resident. During the pandemic, the behavioural support practitioner closed their business, and another specialist was engaged. The new practitioner completed observational assessments and wrote reports detailing what was required when NDIS plans were reviewed as well as coaching the staff. At the same time, the service provider attempted to stabilise the staff team through a recruitment drive.

Community Visitors were unable to ascertain information about an alleged assault and unexplained bruising. The house supervisor appeared unfamiliar with all the incidents that had occurred. Community Visitors were concerned that a resident with complex needs and deteriorating health was not being adequately supported by the model of care in the home. A written response was requested from the service provider and, when that was not forthcoming, an abuse referral was sent to the DSC.

Community Visitors have been reporting for a few years about many bruises and unexplained injuries of residents at one home. This year, Community Visitors continued to see similar reports. The service provider reported staff had received additional manual handling and active support training as well as extensive discussions about the physical care of residents at team meetings. However, Community Visitors were unable to locate evidence of this at their later visit nevertheless it was raised again with the service provider.

All residents in one home require physical support, with additional care for some residents' communication needs including hearing impairment, use of gestures and interpretation of other non-verbal communication. Some residents have high medical needs including for epilepsy and PEG feeding tube management and some use wheelchairs. Incident reports showed medication errors, poor quality of care and unsafe manual transfer of residents. There were also a few long-term staff vacancies, including the house supervisor position. The service provider engaged regular casual staff to work in the home who also received training tailored to the care needs of the residents.

GOOD PRACTICE

A service provider had arranged for a mobile coffee van to attend its homes in the Geelong area two or three times a week during the COVID-19 lockdown. The initiative provided residents with an opportunity to connect with a local vendor and increased social engagement opportunities while they enjoyed a barista-made coffee. The coffee vendor had not previously had much contact with people with a disability, so it also served to breakdown these social barriers and change perceptions.

NDIS

This year, the impact of the NDIS at group homes was a common theme raised by Community Visitors. There were 165 individual issues raised relating to the scheme. In addition, there were many ongoing NDIS matters from previous years that Community Visitors continue to advocate for. The numbers utilised in this section include both new and previously unresolved issues on NDIS matters, including:

- aids and equipment
- access to programs and activities
- plans and reviews
- support coordination
- funding
- service provision, staffing and interagency liaison
- accommodation and SDA.

CASE STUDY

Over the last 18 months, Ali's condition declined. She appeared depressed, anxious, and aggressive which had a detrimental impact on both other residents and her regular carers. Ali was prescribed anti-depressants and mood stabiliser medications but, over the long-term, little improvement was evident.

Last year, Ali declined to attend day program, so her NDIS plan now provides seven hours a day of one-to-one support from Monday to Friday and six hours on a Saturday. She rarely goes out of her home despite encouragement and when she does, her behaviour is unpredictable. She showed little interest in communicating with others of a similar age.

Ali receives a PEG feed four times a day. Some food 'testing' occurred but was stopped when Ali had difficulty swallowing and was very reluctant to continue. Carers were affected by Ali's behaviour and were at a loss to find ways to improve her wellbeing.

Efforts were made to improve opportunities for Ali to communicate with the purchase and delivery of the tablet, having apps installed that met her needs and interests. This took 12 months to be provided and Ali showed little interest in using it when it arrived.

When Community Visitors first met Ali, she used an electric wheelchair, however, when she became upset, it was used as a weapon to attack other residents and staff. She was provided with a manual wheelchair to slow her down. This chair was ill-fitting and uncomfortable, so her electric wheelchair was modified to be safer. By the time this occurred Ali no longer wanted to use an electric wheelchair.

Ali has repeatedly expressed her desire to move to another home and, for some time, her family have supported this idea as did her care team. However, recently nothing further has been done to explore more suitable housing options. Meanwhile, she spends much time in her bedroom.

The SIL provider delivers good care to Ali but her physical and emotional needs have become increasingly more complex. Since December 2019, Ali has self-harmed. Staff do their best to pre-empt this and redirect her behaviour but are often unsuccessful. There was a month where PRN (as needed) medication was used six times to alleviate Ali's self-injurious behaviour.

The management team met with the Community Visitors to provide updates and discuss concerns but appeared unable to progress much without direction from Ali's family and her support coordinator. It seemed to Community Visitors that the NDIS framework was too cumbersome and slow to respond to Ali's complex needs and there is little hope that she will move to a more suitable home.

Aids and equipment

Community Visitors raised issues about inappropriate or inadequate aids and equipment in 129 matters over the year. In one home, Community Visitors were shocked to see a resident's bath in a living area next to the kitchen. Equipment had to be moved daily in this small house so other residents could shower. Another resident at the same home had a large shower chair that did not fit in the bathroom when the bath was in there. The bathroom was inspected by the property owner, but no decision had been made about a renovation.

A resident waited for over six months for a specific, seat-belt harness so they could go out in the bus. During this time, they were unable to leave their home, contributing to increased behaviours of concern. Staff did their best to provide adequate support and stimulating, home-based indoor and outdoor activities while they waited for the seatbelt.

Community Visitors were told of a resident waiting on a special mattress for 18 months. After questioning the delay, it was reported the resident had insufficient funds in their plan for it. In the interim, an occupational therapist investigated hiring a suitable mattress while additional reports were prepared for the NDIS.

Community Visitors were frustrated to hear of long waits for occupational therapist assessments before an equipment order could be placed as well as delays in equipment production. When there are delays at both stages, the wait time is exacerbated.

CASE STUDY

Community Visitors were shocked to hear about the extended wait for a specialised wheelchair for Alice. The reason for the delay was attributed to a lack of funding even though it was identified in her NDIS plan. OPA advocated with State Trustees for Alice as house staff and her support coordinator had not had any success. State Trustees released the substantial funds for the purchase of the wheelchair. Both Community Visitors and State Trustees were concerned that Alice's quality of life would continue to be deteriorate if the purchase waited until the NDIS arrangements were finalised. Two months later Community Visitors were informed that Alice had died before her wheelchair was delivered.

Access to programs and activities

Community Visitors are always interested to hear about the activities and events the people they visit experience. However, frequently they are told about situations when plans and funding do not meet an individual's needs. This year, there were over 20 issues reported about access to programs, activities and transport.

CASE STUDY

John resides in regional Victoria and has NDIS funding to visit his mother in a nearby town. As the local taxi service was not an accredited NDIS provider they could not bill the scheme for his trips. So, John has been unable to visit his mother for over six months, although they speak regularly on the phone. Community Visitors understand that NDIS is undertaking a 'light touch' review of the taxi company at the request of his support coordinator and, hopefully, he will be able to resume visits to his mother soon.

Community Visitors attended a home where a resident with complex support needs was yet to access any one-to-one support, despite this being in their plan. Staff suggested the resident required more stimulation and some new activities other than what they could provide. Several options for support were suggested and the support coordinator continues to explore what suitable options are available.

Community Visitors were very disappointed to learn a resident had not returned to his day placement when the COVID-19 restrictions lifted with no reason given to his house support staff. This situation, combined with slow implementation of his NDIS plan, meant he was only able to access the community with house staff support. The day program eventually offered him two days a week with a plan to increase the number of days later.

Community Visitors were told of day programs closing or offering fewer hours of attendance. While this provided many residents with an opportunity to review what they would like to do, for others who require more support, it has increased challenging behaviours, and reduced opportunities for weekly activities. Community Visitors see a strong correlation between residents not attending regular activities outside their home and an increase in behaviours of concern.

Plans and reviews

Community Visitors were alarmed to hear all residents in a home had their one-to-one support funding significantly reduced at their last plan review. Staff were unsure of the rationale for the decisions and spoke about the impact it was having on the services and activities previously provided to residents. Many of the 54 issues raised this year about plans were complex and long-running.

A successful trial of an electric commode chair was reported as being more hygienic, dignified, and safer for a resident. A recommendation to purchase the chair by the occupational therapist and support coordinator was declined by NDIS. Community Visitors questioned if the NDIS planner involved was suitably qualified to assess and reject the recommendations of professionals. An additional review was undertaken, and Community Visitors were told that the item was then approved for purchase.

A family member set up social media accounts on an individual's mobile phone. The individual misused the accounts to post and text personal photos of themselves and access other's photos and repost them on their account. Staff assisted the resident to delete the accounts, but the family member then helped the person, at their request, to set up new accounts. The resident now has no internet access on their phone, so uses the house tablet and phone. Their mobile phone can only be used to send texts and make phone calls. The resident's NDIS plan was subsequently reviewed to include behaviour support.

Support coordination

Community Visitors raised 21 issues about the effectiveness of support coordinators. These included lack of understanding of complex needs, time taken to source appropriate staff and general inaction. Responses to these questions varied from barriers outside their control to the SIL provider being unable to influence support coordinator actions.

A request was received to visit a complex resident who appeared to have no one in their life providing oversight. Direction from the support coordinator was inconsistent while the resident continued to wait on behaviour support intervention, one-to-one support workers and a new wheelchair. The house staff also raised concerns about quality of care with allegations of shifts being cancelled, verbal abuse of residents and racist comments.

Community Visitors referred where appropriate, complex, systemic NDIS-related issues, particularly where residents appeared to be disadvantaged when negotiating their plans. Examples included inadequate support coordination resulting in goals not being achieved, and a case where there was no family supports or plan nominee, leading to a lack of oversight of the quality of services.

Complex needs

Increasingly, Community Visitors identify inadequacies of the NDIS in meeting the needs of individuals with very complex needs. These complexities are in relation to:

- behaviour support needs
- ongoing health issues
- ineffective support coordination
- family and support network dynamics
- incompatibility with co-residents
- lack of suitable housing options.

Community Visitors have been advocating for a household of residents with complex needs for several years. The house has many maintenance issues in need of urgent attention, however, the last issue raised was a lack of adequate staffing supports due to NDIS-funding shortfalls for one-to-one workers.

CASE STUDY

Alex, a group home resident, refused to return home following a visit to his elderly mother. Later, it was reported to OPA that he had not showered in many months and was refusing supports and services. His family were extremely concerned about his health and wellbeing.

At a visit to his group home, Community Visitors asked for an update about Alex as it had been over two years since he had left the home, Although the staff no longer saw him as part of the household, rent was still being paid for his room and some of his possessions remained there.

Staff said they had initially attempted to re-engage with Alex and return him to the group home, but he made it clear he did not want to return and refused to get onto the bus sent for him. The lockdown restrictions made it more difficult to engage with Alex and his family, and staff said they struggled to communicate with the family.

There was a lack of information and documentation around Alex's residential status which has implications for the rent he has paid and his future entitlements. Community Visitors are concerned that he seems to have fallen through the gaps in terms of where he will reside, his eligibility for SDA funding, and how he will receive the level of support he requires.

Funding

The pandemic has left many residents with unused NDIS funds. Community Visitors asked if surplus funds could be rolled over or used for other unmet needs. In some cases, funding was able to be reallocated and participants received more one-to-one supports. In other cases, funding was simply reduced. In a few instances, the SIL provider supported residents to raise the matter successfully with their support coordinator.

During the year, Community Visitors raised 106 issues related to funding and NDIS plans.

A staff member informed Community Visitors of insufficient NDIS funds resulting in residents being unable to attend their day program. Consequently, residents were at home for longer periods which appeared to escalate their behaviour to concerning levels.

Service provision

Community Visitors have frequently reported inadequate numbers of suitable workers to provide NDIS services, particularly outside Melbourne or larger regional towns.

This year, Community Visitors have reported 30 significant instances of shortfalls in service provision. In one case, house staff were unsure about the content of an individual's plan and felt unable to provide adequate care. Eventually, a modified plan, with financial details omitted, was provided to the staff team. Other examples of inefficiencies include funding delays or inaction on agreed services.

A person's NDIS plan may not provide the required services for a number of reasons including a lack of funding, poor coordination of the services, changed or complex needs, delays in access to services or as previously mentioned, lack of suitable staff.

Unregistered service providers

Self-managing NDIS participants can access services from registered or unregistered providers, depending on the services. To be registered, a provider must have an in-house incident management system, and notify the NDIS Quality and Safeguards Commission should a reportable incident occur.

Community Visitors reported an incident in which a male resident with complex behaviours regularly stayed with his family on the weekend. The man's family engaged two unregistered NDIS support workers for weekend care. When the workers brought the man home at the end of one weekend, they reported to house staff that they had witnessed the resident being assaulted by his father. The house staff assumed the workers, or their supervisor would report this to the NDIS, however, it was later discovered they had no obligation to make such a report. This highlights a system oversight in view of there being no requirement for unregistered providers to report incidents, which in this case led to six months of inaction for this vulnerable resident.

Upkeep of buildings and fittings

Under the NDIS, there is a separation between SIL in-home service provision to residents versus SDA providers responsible for property fabric. Generally, the SIL and SDA are separate organisations though sometimes the latter is a separate division of the overall disability organisation. The SIL receiving the Community Visitors report is usually aware of the maintenance issues being raised and, in some cases, has also requested that they be addressed.

It is pleasing to report that, where DFFH is the SDA provider, there have been significant improvements in the responsiveness to maintenance requests. However, SIL staff have required ongoing education about the process to escalate maintenance issues to the DFFH call centre to have them addressed. On occasion, the house supervisor has been required to follow-up the request more than once before the work is completed.

CASE STUDY

For several years, Community Visitors reported maintenance issues at a home. The most important issue is in the main bathroom where water from the shower pools on the concrete floor. This is a safety issue for the residents. There is also dampness throughout the home with mildew on the blinds in the bedrooms and office.

The SDA provider assessed the situation, however, as the bathroom floor slope meets building code requirements, it is unclear what further action is possible.

Community Visitors were aware of a very unsuitable property where one resident resides alone. The house is rundown, the kitchen in disrepair and unusable while the bathroom is filthy and very difficult to clean. Despite DFFH assessment of the property in late 2020, they are yet to determine its eligibility for SDA funding. Meanwhile, the resident is living in a dirty and rundown home, with no repairs or improvements planned.

Community Visitors also reported building maintenance issues which were delayed due to COVID-19 lockdowns in both metropolitan and regional Victoria. Service providers were careful to ensure residents remained safe as only essential maintenance works could be carried out in group homes.

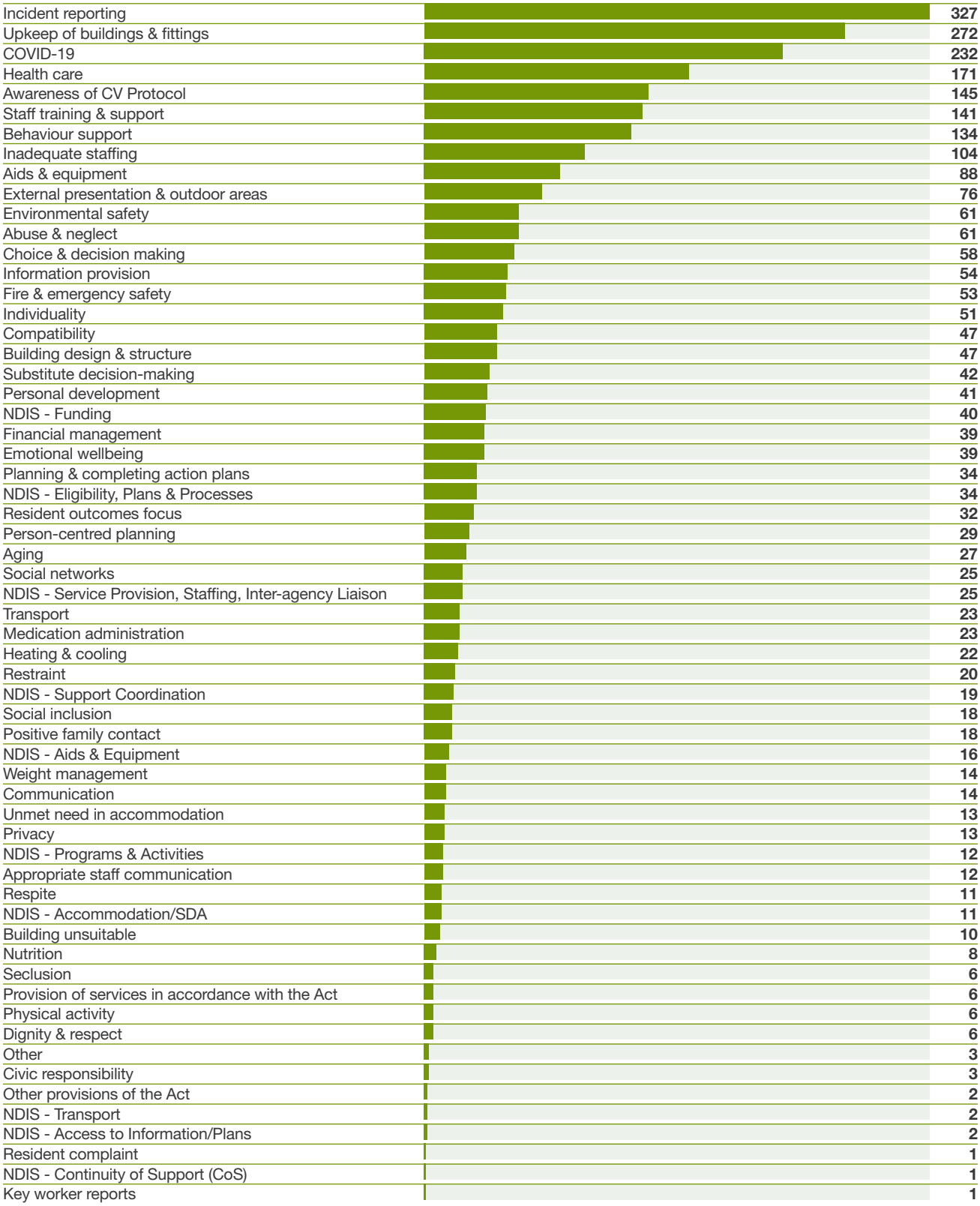
Over three months, several incidents were reported in relation to an assault and a health and safety risk due to a resident's access to the kitchen. The design of the small swing door and the lock between the kitchen and the dining area, as well as the kitchen bench all contributed to the situation. Redesign of the area is needed as a matter of priority.

In addition, residents' easy access to the kitchen and pantry led to some overeating incidents causing critical medical conditions and hospital admission. Community Visitors remain concerned about the risk to residents posed by the kitchen configuration and the burden of care it places on staff. Community Visitors will continue to advocate for this situation to be addressed.

Thank you

The Disability Board would like to thank Sylvia Walton AO who was elected to the Board and took up her role on 1 July, 2020. However, she had to resign in March 2021 due to ill health. Sylvia made an important contribution to the Board during her time as an elected member.

Figure 4. **Disaggregation of issues reported by Community Visitors, 20/21**



02

Mental Health

Program Stream

MH

Recommendations

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

MH

1. substantially increase the number of acute beds for adolescents in all areas to improve access to treatment and care, particularly for regional consumers
2. develop a statewide strategy to address gaps and improve access to eating disorder services, irrespective of where people live in Victoria
3. review the experience of mental health consumers in hospital-based extended care units, and particularly, long-stay consumers during the COVID-19 lockdowns, and recommend practices for future lockdowns that will support consumers' ability to develop daily living skills, as well as improved quality of life
4. enshrine the functions and powers of Community Visitors in the new Mental Health and Wellbeing Act, recognising their right to inspect a range of records including incident reports kept by mental health services
5. ensure that the new Act is accompanied by guidelines that require open air access is available to all mental health consumers for a minimum of two hours daily and any failure to do so be reported to the Chief Psychiatrist
6. operationalise the objective of reducing and eliminating the use of seclusion and restraint and ensure that this purpose of the Act is echoed in its second reading speech
7. make publicly available the data collected in response to the Mental Health Royal Commission's recommendations and ensure that the data set is organised by mental health and wellbeing provider and identify which services need specific attention
8. ensure that the Mental Health and Wellbeing Commission monitors and publishes data on long-stay consumers and incidences of consumers' discharged from mental health facilities into homelessness
9. provide therapeutic activities seven days a week as a minimum standard in all Victorian mental health facilities
10. provide additional funding to the Community Visitors Program to assist with the implementation of the Mental Health Royal Commission's recommendations and ensure that the program has the technology and resources required to effectively fulfil its important safeguarding role.

Statewide Report

Introduction

Multiple lockdowns in Victoria and the COVID-19 pandemic have impacted on both the work of mental health services in Victoria and that undertaken by Mental Health Community Visitors, this year.

Many experienced Community Visitors took leave or resigned from the Community Visitors Program and others suspended their visiting for some months. While this is the case for all streams of the Community Visitors Program, the lockdowns in Victoria appear to have had a greater impact on mental health visiting. The number of visits to mental health facilities decreased from 1236 in 2019-2020 to 834 in 2020-2021; the total number of issues reported by Mental Health Community Visitors decreased from 1927 last year to 1177 this year.

Many of the volunteers who visit in the Mental Health stream do so because they have a particular interest in mental health. This is sometimes a consequence of their own lived experience or their connection to a family member or friend living with mental health issues. During the pandemic, the normal routines and activities of most people were disrupted, and new economic and psychosocial stresses were widely reported. As a result, many volunteers understandably made taking care of themselves and their loved ones their priority during this time.

The work of a Mental Health Community Visitors can be rewarding but it can also be taxing: listening to and responding to people who are distressed and reading incident reports about people who have tried to harm themselves or others can take a toll.

The shift to remote safeguarding practices required Community Visitors to undertake visits to units via phone or video link. Mixed results were experienced. Community Visitors worked out the best way to conduct a meaningful visit via phone call or video link appropriate to the type of services they visited. However, some services did not answer calls, while others did well with remote safeguarding arrangements. Community Visitors said the remote visits had been positive for regional and remote areas, with less travel required to visit the services physically.

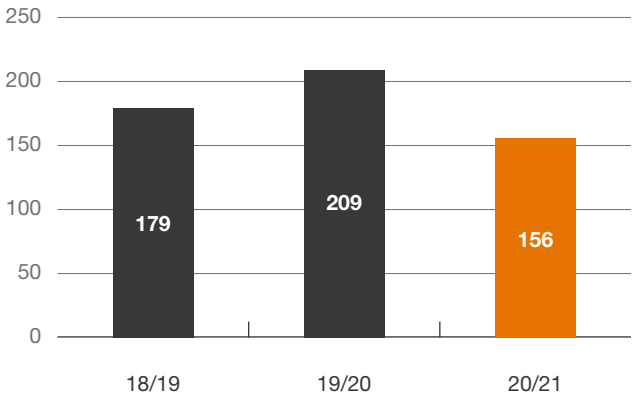
Some Community Visitors disliked the process of organising remote visits and some expressed scepticism about the value of remote visits compared to the unannounced face-to-face visits normally conducted. It was often harder to connect with consumers using remote means and the main source of information was frequently the unit manager.

Some health networks were also reluctant to allow Community Visitors to return to face-to-face visiting in hospital and aged care settings after restrictions eased. However, difficulties were usually resolved

Table 3. Total visits Mental Health stream, 20/21

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	33	13	12	141	**153**
North Division	33	13	16	144	**160**
South Division	49	14	21	155	**176**
West Division	59	26	20	325	**345**
Total	**174**	**66**	**69**	**765**	**834**

Figure 5. Mental Health stream assaults and violence, 18/19–20/21



once the program provided OPA's legal advice clarifying that Community Visitors have the status of workers, not visitors, under Department of Health Care Facilities Directions.

Units visited

A total of 158 of the 174 mental health units eligible for visits were visited. The units which were not visited were almost all emergency departments (ED) and Psychiatric Assessment and Planning Units (PAPU) which many Community Visitors deemed not appropriate to visit in a COVID-19 environment. PAPUs provide short-term (up to 72-hour) inpatient care and they are normally located next to an ED.

Despite the reduction in the number of visits this year, the reports from Community Visitors provide a unique and valuable insight into the experiences of consumers and staff within mental health services during an incredibly challenging year.

Mental Health Community Visitors visit state-funded mental health facilities providing 24-hour care prescribed under the *Mental Health Act 2014*. They inquire into the adequacy of services and facilities provided to people receiving treatment in these facilities.

Under the Mental Health Act, Community Visitors have considerable functions and powers and they can speak with anyone who is receiving mental health services who wishes to communicate with them and view any documents required to be kept under the Act.

Community Visitors visit a wide range of mental health units in the public system including:

- Hospital inpatient units
- Prevention and Recovery Care Services (PARCs)
- Community Care Units (CCU)
- Parent and infant units
- Child and adolescent units
- Aged persons assessment and residential care units
- Extended care units (ECU)
- Forensic units
- Other specialist units prescribed under the Mental Health Act.

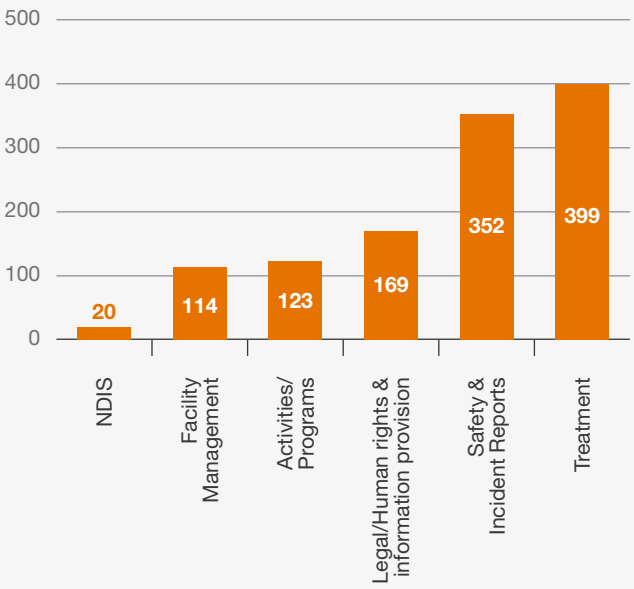
In addition to advocating on individual issues which they identify, Community Visitors report on, and alert service providers and government to, systemic issues in Victoria's mental health system. Examples of both individual and systemic advocacy by Community Visitors and the Mental Health Board are included throughout this report.

When the Mental Health Royal Commission released its report in March 2021, Commission chair, Penny Armytage, was reported on the ABC news as saying the state's mental health system "had been failing for decades…It has catastrophically failed to live up to expectations and is woefully unprepared for current and future challenges."

Community Visitors have reported, over many years, a multitude of concerns about treatment practices in Victorian mental health facilities and the often-traumatising impact of some acute environments. There is much to be improved. However, again this year, Community Visitors have also commented positively on the efforts of many dedicated staff within the system who have demonstrated creativity, compassion, and care despite the demands and challenges of working in an acutely under-resourced and poorly designed service system.

The Board hopes that the commitment of the Victorian Government to substantially increase expenditure on mental health and to create a new Act and structures, built on not only the Royal Commissions' findings but also the voices of people with lived experience and their carers, will completely transform the service system. The Board is hopeful that the traumas experienced by many mental health consumers entering the mental health system will soon be a tragedy of the past. If this vision is to be achieved, the ongoing independent enquiry and advocacy of Community Visitors, as well as the scrutiny of other safeguarding and advocacy bodies, will remain critical.

Figure 6. **Issues reported by Community Visitors, 20/21**



Serious incidents, assaults, and safety

This year, Community Visitors reported 352 safety issues, compared to 452 last year. This is the second year in which issues related to incident reports (195) were included in the safety category. The number of issues related to incident reports decreased last year, indicating a net increase in safety issues.

Safety issues identified by Community Visitors included assaults including sexual assaults (25); suicides and attempted suicides (19); self-harm (16); hazards/safety issues (35); aggression, intimidation, harassment (45); dignity (9); security of possessions (7); and environmental hazards (10).

Assaults including sexual assaults

Serious assault of both consumers and staff in Victorian mental health care continues to be concerning, especially with some units reporting repeated assaults leading to distress to other consumers and detrimental effects on staff morale.

Assaults and abuse were both consumer-to-consumer and consumer-to-staff. There were reports of broken bones to consumers; staff members punched and their hair pulled; broken teeth; soft tissue injuries; and threats to rape or kill.

At one of Melbourne Health's acute inpatient units, incident reports noted numerous assaults by consumers on staff, other consumers, and security personnel. Additional security measures were introduced to protect both staff and a consumer after the consumer's partner allegedly made threats to rape.

Sexual assaults ranged from sexual safety breaches involving consensual acts to inappropriate serious contact/behaviour, and allegations of sexual assault. All instances appeared to be treated as serious matters, with units following protocols, involving police where required, undertaking investigations and reporting to the Chief Psychiatrist as required.

CASE STUDY

A sexual assault incident between consumers occurred at a metropolitan acute inpatient unit. Protocol was followed, and police were brought on to the unit to manage the situation. The alleged perpetrator was transferred to an alternative unit. The victim was supported on the unit and assisted with connection to appropriate community services when discharged.

At the same unit, in the same month, a consumer was reported to have committed two assaults, one on a staff member. Police were involved and the consumer was taken to a remand centre.

GOOD PRACTICE

In the Loddon Mallee region, Bendigo Health reconfigured an acute inpatient unit to introduce secure female bedroom corridors and a separate female lounge.

This has resulted in a decrease in instances of sexual assaults and inappropriate behaviour.

Aggression, intimidation, and harassment

At several units, Community Visitors reported a small number of consumers, including some with a forensic background, were responsible for many of the incidents of aggression, intimidation and harassment.

In one month, at Eastern Health CCU, nearly half of the 22 incidents involved aggression or threatened aggression towards staff. In one instance, a staff member had coffee thrown at them and they were punched in the face by a consumer. At this time, there was one or two very unwell consumers who were aggressive and responsible for many of these incidents.

Bendigo Health's aged mental health units also experienced repeated incidents of aggression and assaults of staff and co-consumers by consumers. Pleasingly, a residential unit employs the Dementia Behaviour Management Advisory Service (DBMAS) for consumers who are unresponsive to unit strategies and, when needed, arranges a 'step-up' admission to the Older Persons Acute Inpatient Unit.

At St Vincent's Acute Aged Psychiatry Unit, Community Visitors reported an increasing number of consumers with behavioural and psychological symptoms of dementia. Due to levels of aggression, some consumers required psychogeriatric nursing home care, however, staff reported long waiting times for it.

At one Dandenong Hospital unit, Community Visitors reported some serious behaviour issues, which the nurse unit manager told Community Visitors could be a result of the cumulative effects of lockdowns, including missing activities and outings.

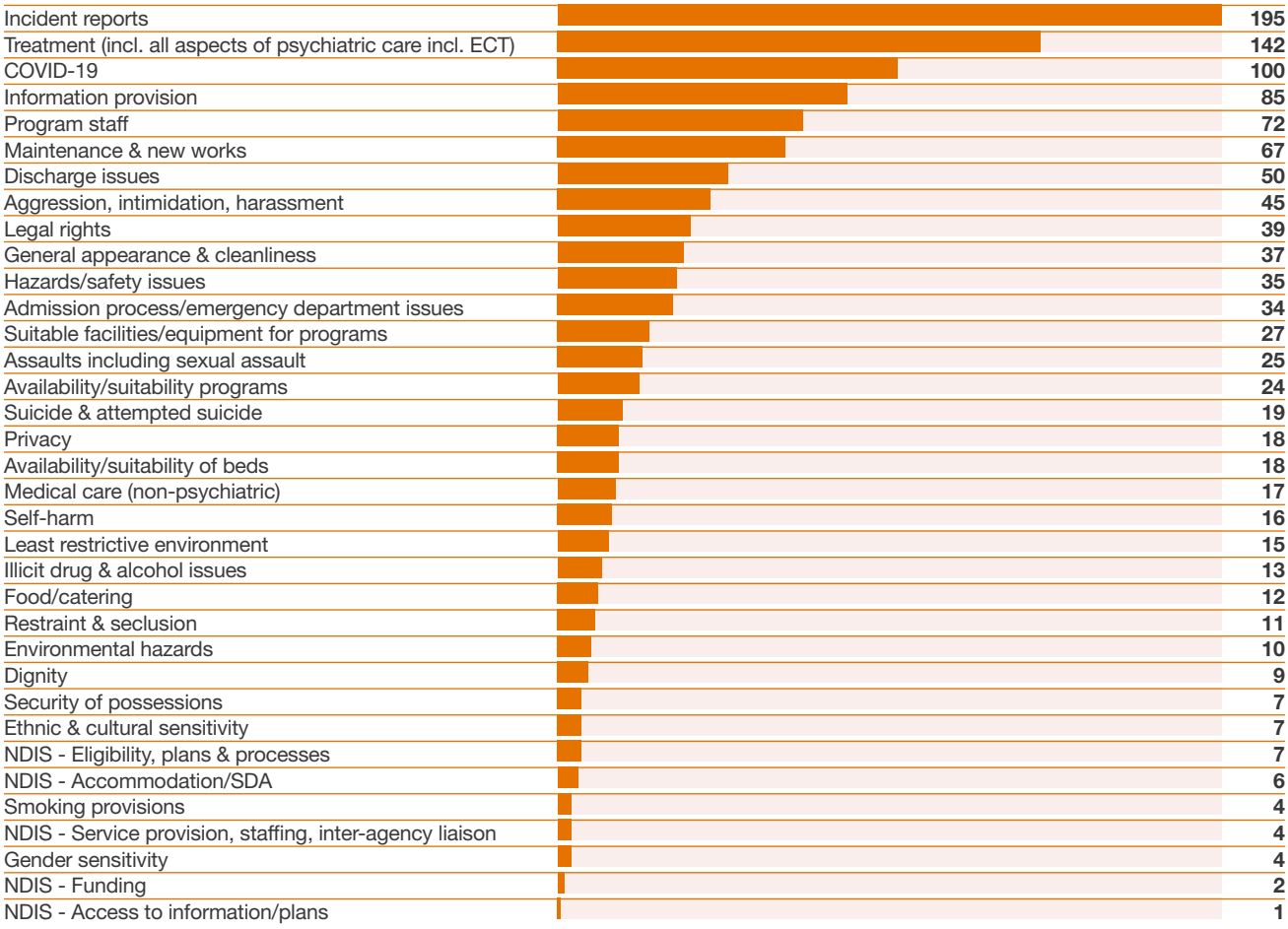
These incidents included a fire allegedly lit by a consumer, which resulted in police and arson unit involvement, and the evacuation of the unit for 48 hours. Goulburn Valley Health reported in June 2021 that they had experienced increases in acuity in their acute units leading to aggression and assaults.

CASE STUDY

Lauren, a PARC consumer, contacted OPA and the Mental Health Complaints Commissioner with concerns about another PARC consumer's behaviours.

She claimed the consumer who she shared a bathroom with, screamed, spoke loudly on her phone, and played loud music and that she felt vulnerable as a result.

Figure 7. Disaggregation of issues reported by Community Visitors, 20/21



Community Visitors raised Lauren's concerns with the service manager who said staff had briefed all residents on the house rules about respectful behaviour and the importance of consideration towards co-consumers. A move was also planned so that the two consumers would not have to continue to share a bathroom. Community Visitors concluded that Lauren had been listened to and her concerns addressed.

The Safewards Program continues to be of value, equipping staff with skills to promote peaceful environments and create safer mental health services. Community Visitors reported good practices because of the Safewards Program, with refresher training documented as having been completed. As the acuity of consumers increases, training staff in de-escalation processes is important to limit the use of restrictive interventions, support staff morale and reduce the impact of aggressive behaviours on other consumers.

St Vincent's Auburn House, a residential aged care facility, has established a project recording the physical aggression of consumers each month, related to their contact with family/significant others. The intention is to examine if there could be a causal relationship between family contact and consumer behaviour.

Illicit drug and alcohol issues

Community Visitors reported a noticeable difference in the prevalence of incidents involving illicit drugs. During the COVID-19 lockdowns, illegal substances in units decreased, and with no outside visitors and no consumer leave, there were reportedly fewer problems with illicit substances, noncompliance with smoking restrictions, and consumers were more engaged with activities offered.

After lockdowns in the first half of the financial year, there were increased admissions of drug-affected consumers when access to drug supplies seemed to increase.

In regional areas, increased acuity was reported in some facilities, because of increased levels of amphetamine use, leading to aggressive incidents by consumers. Staff applied de-escalation skills to prevent and reduce the impact of aggression as much as possible. In the Hume region, Community Visitors reported staff receiving training in managing drug-affected consumers. There was concern at the Shepparton adult acute inpatient unit that the impact of drugs on mental health consumers was escalating.

Changes to physical spaces can help address illicit substance issues. At Alfred Health's Adult Inpatient Units, a reception area staffed by a security officer was introduced and furnished with secure lockers for visitors to leave their belongings. This reduced the number of contraband items, such as drugs, being brought into the unit and given to consumers.

Smoking

By law, smoking is prohibited within all enclosed workplaces and within four metres of the entrance to Victorian public hospitals. However, many mental health consumers are smokers. This policy and practice can sometimes cause tensions with staff or other consumers at services. The COVID-19 pandemic raised new challenges with normal leave for consumers reduced during lockdown. Community Visitors reported the introduction of programs to address smoking; either supporting consumers to smoke safely or to transition to a smoke-free environment.

Goulburn Valley Health located a safe area for smokers in the lead-up to becoming a smoke- free environment. There was a phased approach over two-weeks at the Wanyarra Acute Unit, at the end of which the cigarette lighter provided by the service was removed from the courtyard. Relevant policies and procedures are in place as well as nicotine replacement products. Staff also completed QUIT education and training.

A different approach was taken at a Melbourne Health CCU. Consumers were issued with black plastic containers to dispose of cigarette butts safely after a small fire in the garden was started by a stray butt on a windy day.

Safety

Adoption of technology or changes to physical layout of units have been the key to addressing safety issues across mental health services.

Community Visitors reported units introducing or adding extra CCTV to address blind spots and extending monitoring of areas as well as reconfiguring spaces to establish female-only bedroom corridors or separate female lounges. Adding lockers in reception areas has also helped to prevent unwanted items being brought into units.

CASE STUDY

In December 2020, at Eastern Health Maroondah, there were several incidents of aggression in and around the CCU including an intruder, attempting to force an entry, kicked in doors and windows. The police were called in response. Community Visitors asked whether more CCTV cameras would be installed as a deterrent.

A security review with a focus on the CCU staffing area took place. This was conducted by the Eastern Health Security Manager; the Mental Health Program Occupational Health and Safety Advisor and the Rehabilitation Service Manager responsible for the CCU. The plan included recommendations for increasing CCTV coverage, adding alarms to certain CCTV cameras to alert staff to movement afterhours, improving the safety of afterhours access to the office and general security improvements.

In April 2021, Community Visitors reported there had been more cameras installed and staff had noticed a reduction of blind spots around the CCU.

Suicide and attempted suicide

Concerningly, consumers have self-harmed and attempted suicide using many different means while in facilities, on leave, or shortly after discharge.

Risk assessments and safety audits are undertaken but staff highlight that not all risks can be eliminated. Community Visitors noted that one consumer at an acute unit had attempted suicide six times in three weeks. After the first incident, a designated nurse was allocated to stay within arms-length of the consumer until her mental health was assessed to improve.

In two rural areas, three deaths occurred that appeared to have been suicides: two at inpatient units and one when the consumer was on short-term leave from a CCU. These were reported to the Coroner for investigation. Two critical incidents also occurred at a metropolitan hospital, with one person suiciding by asphyxiation.

Another incident involved a member of the public pushing past a doctor in an airlock and pouring petrol over himself, and then unsuccessfully attempting to set himself alight. Staff promptly intervened and he was removed by police.

Three deaths were noted at another metropolitan adult acute inpatient unit: one occurred after a consumer was discharged; another after a consumer climbed over a fence to leave the unit; and the third was investigated by the Coroner and found to be due to natural causes.

Suicides are traumatic incidents for all involved, with staff sometimes having to perform CPR when they find someone who has tried to take their own life. Staff sometimes take sick leave following such traumatic events.

At Latrobe Regional Hospital in Gippsland, curtains were removed from most rooms due to the high risk of destructive and suicidal behaviour. A risk assessment determined fittings could be used for self-harm.

CASE STUDY

At one regional hospital, two consumers who met in an acute unit needed to be separated as they were supporting each other to self-harm.

This was difficult to do as the hospital only has limited adolescent beds and those at other facilities were difficult to access.

Such self-harm instances require extraordinary risk assessments and they can cause stress to staff and other consumers.

This very complex situation required Chief Psychiatrist assistance to find a solution to the matter.

Incident reports

Incident reports are an extremely important source of information for Community Visitors.

For the last two years, Community Visitors have documented access to incident reports at the time of their visits. However, as many of the visits have had to occur by phone or video link, access to reports was not always possible. Many good practices were reported with Albury Wodonga Health, Eastern Health, Bendigo Health, Goulburn Valley Health, LaTrobe Hospital, St Vincent's, Werribee Mercy and most Melbourne Health facilities, emailing incident report summaries to Regional Convenors each month. There were some initial issues with Ballarat Health but, after discussion, monthly summaries were supplied.

In the North West and Northern regions, Community Visitors reported access issues at some units run by the Royal Children's Hospital and Austin Health, with some difficulties accessing incident reports at the time of the visit, and summaries not being provided electronically.

Austin Health suggested that a staff member go through the reports with the Community Visitors rather than providing them in their entirety because they view the content of reports as potentially disturbing and triggering reading.

Community Visitors who visit a unit at the Royal Children's Hospital have been told they can only view incident records in the presence of a manager. This not only uses staff time, it also complicates access if the manager is not free at the time of the visit. Having a manager or staff member present, also prevents free discussion between the Community Visitors while they process the information recorded.

Treatment

This year, the greatest number of issues reported in any category was about treatment (142). Consumer complaints related to all aspects of treatment including admissions, mental and medical care, discharge bed availability, food, and restrictive practices. COVID-19 restrictions was the category with the next highest number of issues. These restrictions created a complex and challenging service delivery environment for consumers, families, and services.

Admissions

There were 34 issues reported by Community Visitors in relation to 'admission processes' and ED. The following examples are indicative of issues related to consumer experiences in ED. Consumers making multiple presentations to ED that do not result in transfers to acute care units is a concern with instances cited at two health services.

In one instance, a consumer made multiple presentations to ED, with issues of substance abuse and self-harm. In another, Community Visitors were concerned that a lack of service coordination between ED, the acute inpatient unit and the youth team resulted in multiple presentations to ED by one young consumer.

One consumer raised issues about possible discrimination by triage staff related to their religious beliefs. Community Visitors followed this up with the hospital concerned.

Another issue raised by Community Visitors was a consumer not being checked for dangerous items during admission to the Wanyarra Acute Inpatient Unit. This is a challenging issue. Searches on consumers or their belongings are not done as a matter of routine as they may be intrusive and impinge on consumer privacy. This needs to be weighed up against the risks to consumers, visitors and staff if dangerous items are not detected. Guidelines from the Office of the Chief Psychiatrist make it clear that consumer consent must be sought before a search.

CASE STUDY

Following Community Visitors raising concerns about multiple presentations and the discharge of consumers from Mildura Base Public Hospital ED, the service and Community Visitors engaged in discussions about out-of-hours assessment procedures and the treatment of alcohol or drug affected consumers. This led to an information session on ED admission and referral procedures. Training for ED staff was also reviewed and a commitment to additional online training and a new education program to be delivered by an interstate provider was made.

At times, consumers were held in ED due to the unavailability of psychiatrists or beds. Community Visitors were advised that consumers could be held for up to eight hours, though never more than 24 hours in ED, and that they were adequately cared for in the interim.

Community Visitors were also advised that delays in transfers to acute care were occurring. During COVID-19 outbreaks, health services were required to monitor physical distancing and this sometimes affected consumer and staff numbers. Staffing shortages also affected service admissions and the availability of beds as in the following example.

CASE STUDY

Over many months, Community Visitors reported that the number of beds available at the Albury Wodonga Health PARC was reduced from ten to eight because of staff shortages. Eight consumers was judged to be a full load for the staff available and to maintain physical distancing of consumers and staff within the COVID-19 guidelines. During this time, peer worker support was essential. The service advertised for more staff without success.

GOOD PRACTICE

Community Visitors were advised that the Bendigo Health Service had initiated a first response arrangement. This involved a clinician joining a PACER (Police, Ambulance, Clinical Early Response) team to assist Victoria Police in responding to the mental health needs of the community. It operates from 2.30pm to 11pm.

An outcome of this initiative has been that referrals are being made more frequently to case management and community support, rather than the consumer having to be admitted to ED.

As a consequence, the number of ED admissions dropped substantially.

Bed shortages

Acute inpatient beds were reported to be in high demand in many parts of the state.

Of particular concern is the shortage of child and adolescent beds in metropolitan areas and the lack of such beds in rural and regional areas.

In July 2020, Community Visitors reported that the 12-bed adolescent unit at Box Hill was fully occupied with two consumers being discharged on the day of the visit. A 40 per cent increase in demand had been reported. The strain of social isolation and no school was reported to be impacting on mental health and included more self-harm. Families were also needing respite. Admissions at the unit were a brief four to five days because of the demand for services, and many inpatients were said to be reluctant to go home, preferring the human contact in hospital to isolation at home.

There are only two child and adolescent, acute inpatient beds in Gippsland. Other rural areas such as Bendigo, Barwon and the North East do not have any so consumers need to access child and adolescent beds in Melbourne.

The Bendigo Health clinical director advised that paediatric/youth acute beds are not included in the established accommodation for a mental health facility but said that no one is turned away. Bendigo Health management agreed with Community Visitors that adult acute units were often not appropriate for vulnerable adolescents and, at times, adolescent consumers are accommodated in a children's medical unit instead for their safety. The director of nursing agreed to advise Community Visitors when the transfer of adolescents from the ED to a metropolitan unit was not possible and adolescents had to be accommodated in medical units instead.

COVID-19 NSW/VIC border closures have made access to services for some children and adolescents challenging.

Consumers in NSW border towns such as Albury can no longer access Victorian youth mental health facilities and must go to Sydney, a much greater distance for the adolescent consumers and their families.

There was also pressure on adult beds. In October, Community Visitors reported that the adult acute inpatient unit at Bendigo Health had been operating at full capacity (35 beds) for a month with consumer acuity at very high levels. Four consumers were in the process of being discharged while six were in ED awaiting admission to the acute unit.

Despite the "bed pressure", the nurse unit manager did not believe that consumers were being discharged prematurely, reporting that discharge planning was always very thorough.

Food

Consumer comments about food were mixed. Community Visitors logged 12 complaints about insufficient food and variety.

At one aged acute psychiatric assessment unit, consumers with specific cultural needs expressed some initial dissatisfaction with the food provided but greater choice and satisfaction was later reported.

At another acute unit, consumers from culturally diverse backgrounds and a vegan consumer were pleased with the quality and range of meals available.

There were also examples of food intolerances not being catered for. A consumer with a lactose intolerance received inappropriate food. Another consumer had difficulty ingesting food and Community Visitors requested a dietician consultation for them.

GOOD PRACTICE

Plated meals are not provided at the Austin Health's ward 17. Instead, consumers can choose their own meal size and types of food from a bain marie and a salad bar.

ECT, restraint and seclusion

Eleven issues related to restraint and seclusion were reported, a decrease from 42 last year.

Reports cited training, policies and practice being used to reduce rates of restraint and seclusion. Several services mentioned that the Safewards program has helped to reduce the use of restraint and seclusion. However, Community Visitors continue to note the use of physical and mechanical restraints in incident reports, including the use of all-in-one 'dignity suits' (a one piece clothing suit with a zip down the back) in some aged care units.

At Thomas Embling Hospital, a secure forensic facility, one consumer has spent a large part of the year in seclusion because of aggression and their complex needs. One metropolitan acute inpatient unit has also used restraint to manage some aggressive consumers with a forensic background. Community Visitors were told that if restraint is used then staff try to minimise the time of the restraint and ensure debriefing after each episode as well as follow-up with consumers to try and maintain a therapeutic relationship with them.

Due to age-related frailties and conditions such as dementia, older persons services faced dilemmas in reducing the use of restraint. One report noted a specialist chair with a chair-tray being used to manage a consumer's behaviour. This mechanical restraint allowed the consumer to still be in the lunchroom and see other people while remaining under close nursing supervision. The nurse unit manager reported that they would prefer to use this type of restraint as opposed to seclusion due to the consumer's unsteadiness on his feet and risk of falling. This example highlights the challenge in getting the balance between safety and restrictions for this age group and the difficulties for residential aged care facilities in complying with the requirements of the Mental Health Act and Australian Government regulations on restrictive practices.

Community Visitors have reported that often small things can make a difference. In one regional hospital, an elderly woman diagnosed with Borderline Personality Disorder was reported to be self-harming. The management plan included specific 20-30 minutes of individual attention and chatting per shift and when this was implemented, the behaviour ceased.

CASE STUDY

Rita, a long-stay consumer with complex needs who has an Acquired Brain Injury, low IQ, mental health issues and a debilitating neurological condition has spent extended time in many mental health units and community-based accommodation.

When Community Visitors visited, she was in the high dependency unit and had spent time in seclusion.

The consumer's violent and unpredictable behaviour had resulted in numerous staff injuries and there had been some staff anxiety around providing support to her.

Staff showed tenacity and skill in trying new strategies with her, reducing the instances and length of time in seclusion. The consumer had an extensive NDIS plan, however, due to her many behaviours of concern, the unit had become her accommodation of last resort.

An extensive support team is exploring options for her future.

GOOD PRACTICE

At Wanyarra Adult Acute Inpatient Unit, the work reducing restrictive interventions is paying off with a notable decrease in the use of seclusion.

Strategies like weekly meetings, experienced staff modelling management of distressed consumers, and mutual-help sessions, all contributed to the decrease.

ECT

One metropolitan aged care service noted there was an increased demand for electro-convulsive therapy (ECT) related to depression triggered by COVID isolation. This put pressure on the service to engage anaesthetic services, including private anaesthetists and a new internal partnership for these services. Not all consumers agree to receive ECT and permission is not always granted to administer it.

Medication

Community Visitors spoke with many consumers who said they lacked an understanding of their treatment, medication changes and diagnoses. Consumers complained of medications not working and said that they did not understand or have information on their treatment. Consumers also complained of medication mistakes. One consumer said she was given a double dose of medication which upset her digestion. She was concerned that the high doses of medication would cause harm to her liver which had a pre-existing impairment. Community Visitors also often frequently noted medicated errors in incident report summaries.

Consumers at PARCs have to take responsibility for their own medication. On occasion, they may miss doses or mismanage their medication. Staff reported that this is monitored and information passed on to community-based services to better support consumers in developing strategies to manage their medication.

GOOD PRACTICE

At Wanyarra Acute Inpatient Unit, Shepparton, a pharmacist has been employed to review medications including on commencement of new medication.

At Bendigo Health's ECU, a medication "workstation" was introduced in conjunction with an electronic consumer record system for medication administration. Medication errors in the facility have decreased significantly.

Access to medical treatment

Community Visitors observed that access to the right medical care (non mental health) can be difficult.

Seventeen issues were logged regarding medical care.

A consumer who had been admitted to an adult acute inpatient unit, in a very distressed state, told Community Visitors that he had not received necessary attention for a medical condition. Community Visitors tried to convey the extent of the patient's anxiety to the nursing staff and were advised that staff believed it was a priority to stabilise the consumer's mental health prior to transferring him for treatment of an injury. He was put on the usual waiting list for surgery and the hospital communicated that he would be attended to when his turn came.

Another consumer in an acute unit had continuing pain after a hernia operation in 2019. While a mental health inpatient, a range of tests was organised for him and he was referred for pain management therapy.

Community Visitors also noted issues to do with medical decision-making and advanced care planning.

Breakdowns in communication can sometimes affect consumer access to medical care or appropriate support. Supported Residential Service (SRS) proprietors sometimes report a lack of information when mental health consumers are discharged from mental health facilities to SRS.

CASE STUDY

Mario reportedly arrived at an Supported Residential Services (SRS) in a taxi on a Friday after being evicted from a PARC for alleged inappropriate behaviour towards other consumers.

The SRS manager said he received no discharge summary regarding the consumer's needs so he contacted the PARC and told it he could not accommodate the consumer until the following Monday.

The SRS manager claimed the PARC had failed to notify the SRS that the consumer had had an amputation and was now a wheelchair user with different support needs from when he previously lived at the SRS.

Community Visitors contacted the PARC manager who said that Mario had come to the PARC from an acute unit, but the SRS was listed as Mario's home address. Mario had been given the option of returning to the acute inpatient unit but he did not want to go there.

Delays of 30 minutes in ambulance attendance occurred for medical emergencies at a PARC and YPARC in Bendigo. Community Visitors were concerned that there could be life-threatening consequences of the delays. They were advised that the PARCs could provide a first response but they did not have oxygen or resuscitation equipment, and, as residential facilities, they were not legally required to have staff trained in advanced emergency response skills and the administration of oxygen. All staff have Basic Life Support mandatory training and an ambulance is to be called in an emergency.

Consumers with eating disorders often need mental health and medical treatment. They can present with medical instability and complex issues. The Royal Melbourne Hospital Specialist Eating Disorders Unit received $250,000 in funding to support eating disorder patients on the medical wards. This will employ a specialist senior nurse and a number of other part-time staff to improve care to eating disorder consumers, carers and medical staff working with them.

GOOD PRACTICE

A consumer with a 16-day-old baby in care was found by staff to be using a breast pump incorrectly and providing milk that was potentially contaminated.

When the maternity section of the hospital was called in, it became apparent that the unit did not have correct procedures and policies in place for consumers after they had given birth.

In response, staff from the maternity unit provided education to Swanston staff. Some mental health staff volunteered to take responsibility for this care and a maternity ward contact agreed to liaise with the mental health unit in future.

Discharge

Community Visitors logged 50 significant concerns related to consumers' discharge. Bendigo Health, Ballarat Health, South West Healthcare and St Vincent's Hospital all had matters related to discharge.

One consumer was not able to be discharged because there was an absence of positive discharge options available. Another was unable to be discharged because there was no positive therapeutic environment available. The consumer could return to the family home, however, this was not the best therapeutic option and all attempts to connect the consumer to community-based supports failed.

At St Vincent's Hospital, acute unit staff and community staff meet weekly to look at readmissions which occur less than 28 days post-discharge and those with three admissions in a year. A post-discharge Diversity in Lived Experience support group and peer workers were to start meeting face-to-face again after lockdown as well as phone contact being made with consumers. The service aims to provide three contacts in the 28-days post-discharge and try to link people in with community groups to promote community connection. Prior to January 2021, the readmission rates were high but since January 2021 the rate has been below the state target except for May 2021 when it was just above – this is a pleasing improvement, signifying better outcomes for consumers and families.

CASE STUDY

Community Visitors had advocated for over two years for Van who has a brain injury. Van has lived in an aged care mental health unit for five years but he is considerably younger than most of the other consumers at the unit and he wants to move to supported accommodation in the community. He has no family or regular visitors other than NDIS support workers.

Community Visitors had received updates that planning was in progress to assist Van to relocate but progress seemed very slow.

OPA arranged a referral to the DFFH Intensive Support Team as there seemed to be a lack of clarity about the consumer's NDIS transition process which had been ongoing for several years. Despite supportive assessments from health practitioners, his NDIS application for SDA funding had been declined resulting in him missing out on an identified vacancy. This matter still remained unresolved at 30 June.

One metropolitan acute inpatient unit recently had four long-stay consumers. In May 2021, two of them were reported to have been at the unit for over 400 days. At another hospital, in March 2021, Community Visitors reported that a consumer had been in an acute unit for 106 days.

COVID-19 restrictions did lead to some innovative practices around discharge. Consumers who left for a home stay prior to discharge, were reviewed over a video-link platform and did not need to return if the transition was deemed successful.

At one ECU, senior staff have recently taken greater responsibility for small groups of residents and are sharing responsibility for resident discharge planning rather than it being the sole responsibility of the nurse unit manager. This should result in better patient outcomes.

GOOD PRACTICE

In Barwon, a Hospital in the Home initiative which commenced in March 2021 is helping relieve bed pressure by providing intensive support to consumers on discharge. A similar program operated by South West Healthcare has funding until October 2021.

Accommodation

Alfred Health, Albury Wodonga Health, Ballarat Health, Bendigo Health, and North Western Health all reported discharge delays, partly due to a lack of accommodation. This was reported to have resulted in some return admissions.

In North East Victoria, caravan parks are one of very few options for accommodation after discharge. Housing issues are being exacerbated by an increase in people moving to the regions to escape metropolitan COVID-19 lockdowns. Two people with long-stays were further prolonged due to a lack of accommodation options in one case and a delay in the availability of a suitable residential aged care bed in the other.

To address discharge and accommodation issues in the Wangaratta and Wodonga region, Albury Wodonga Health is trying to engage with Wangaratta City Council to address the homelessness issue.

Finding suitable accommodation for people with dual disabilities, such as an intellectual disability as well as a mental health diagnosis, can be particularly challenging.

CASE STUDY

Sophia was discharged from a rural, acute inpatient unit to a disability services group home in September 2020 and then readmitted six days later.

She was admitted with escalating behaviours and unexplained bruising, which was reported to police and the Department of Human Services. They are investigating, and more supportive accommodation is being sought for her.

Sophia was still in the acute unit at the end of June 2021, ten months later.

COVID-19 pandemic

During the year, consumers in residential and inpatient services responded to the COVID-19 restrictions very impressively.

The nurse unit manager at another unit for older people commented, “The aged consumer cohort has proven to be, overall, fairly resilient during this period and mostly adherent to all the requests for distancing and isolating during the pandemic.”

The work of mental health staff in facilities coping with the additional demands placed on them by COVID-19 restrictions is also acknowledged.

Community Visitors at one acute inpatient unit reported in March that changes in nursing procedures took “time, patience and perseverance” as staff were required to wear goggles or face shields and masks if there was any possibility of contact with others.

Restrictions

COVID-19 protocols and restrictions had an impact on all mental health units, although the application of restrictions varied from service to service and unit to unit at different time points.

Consumers in hospital and residential facilities were generally under the same restrictions as other hospital inpatients.

Community Visitors commented on the strict application of restrictions including those relating to visitors and the supply and use of PPE.

Units limited visitors during lockdowns and many adopted a cautious approach to their easing with the changing of restrictions. Consumers were not given any leave other than for attending medical appointments.

Services were particularly challenged when staff tested positive to COVID-19. At one facility, because two members of staff tested positive, all consumers were confined to their bedrooms and no discharges or admissions were allowed. Community Visitors found it extremely difficult to speak with consumers at the time. As the restrictions eased, short visits were allowed with visitors for up to one hour, rostered between 10.30am and 6.30pm. A total of two visitors were allowed in the unit at any time.

Community Visitors received a call from OPA's Advice Service related to the provision of food from home. In accordance with a hygiene practice guideline, possible community transmission of the virus via food required that only sealed and packaged food that did not require re-heating and could be sanitised was allowed in the unit. All other deliveries had to be disposed of.

Programs and activities were significantly affected by restrictions. Consumers in some extended care units complained of a lack of access to sunlight, fresh air and exercise in the community.

Programs in all units were affected by staff shortages and restrictions such as social distancing. Consumers reported being quite bored. Planning for more weekend activities at some units was put on hold.

No external providers or volunteers were allowed to visit during some lockdown periods.

Admissions

Restrictions also affected admissions.

Specialist units such as parent-infant units reduced bed numbers. Travencore PARC was unable to be fully utilised due to a shared bathroom. Several high dependency unit beds were closed from general use and reserved for patients who needed to isolate after COVID-19 testing.

At the same time, some services reported an increase in admissions. One said re-admissions within 28 days of discharge increased and another reported a 40 per cent increase in admissions in recent months compared to the same time the previous year. Another service noted mid and post-lockdown increases in admissions, especially in young people under 18 years of age which caused serious pressure on ED and other mental health beds. Bed blockages had a flow-on effect to other units.

Some services also experienced increased admissions of people from different cultural backgrounds. To quote from one Community Visitor report, "Many clients are from overseas: South Africa, New Zealand, Colombia, Afghanistan. Manager felt that, if there is an underlying mental health issue, this is exacerbated by a lack of community support due to the stressors of COVID."

Innovative responses

Community Visitors noted innovative responses to the COVID-19 restrictions:

- An older persons unit missed the regular in-person input of a geriatrician in developing and reviewing consumer treatment plans. The unit arranged for consultations to occur twice a week via video-link.
- With no visitors allowed and no leave for a period, consumers in an adult acute inpatient unit without a smart phone (to contact family and friends) were compensated by being given iPads. Telehealth was also available.
- The local cafe closed so the unit bought a coffee machine. The Coffee Group is popular.
- The Eastern Health Foundation organised visits from animals for consumers to interact with.

GOOD PRACTICE

The kitchen at a PARC was initially closed due to COVID-19 restrictions. This was a negative for consumers, as taking responsibility and sharing the cooking of dinner is part of recovery.

The manager found a solution by limiting the amount of time that could be spent in the kitchen, the number of people in it and ensuring masks and gloves were worn.

Staff

The COVID-19 pandemic had quite an impact on staffing levels.

Agency staff required training in internal processes such as electronic medical records. One service reported: "Staffing levels have suffered due to many factors: no recruitment of staff from overseas, illness and burnout among staff due to the increased level of unwellness of patients, exposure to COVID-19 and the need to quarantine, and the availability of well-paid easier work for nurses in the community such as quarantine and vaccination hubs."

Legal rights and information provision

This year, Community Visitors reported 169 issues specific to legal and human rights and information provision, a decrease from 209 reported last year. This decrease may reflect the reduced number of visits conducted this year.

Issues identified by Community Visitors included information provision (85), legal rights (39), privacy (18), dignity (9), ethnic and cultural sensitivity (7) and gender sensitivity (4).

Unfortunately, cyber-attacks on health systems continue to cause havoc, with staff having to resort to paper records with no access to electronic medical records. This added significantly to the normal challenges of managing inpatient units.

GOOD PRACTICE

Bendigo Health demonstrated good practice in communication through pandemic lockdowns. Consumers, staff, and relatives were made aware that OPA and Community Visitors were taking calls for referrals of Community Visitors to remotely visit during the pandemic crisis. Staff were continually updated on the evolving pandemic directly via the service's executive communications and by the nurse unit manager.

At the Bendigo Health's Older Persons Unit (OPU), COVID-19 rules and restrictions were communicated to consumers and discussed in the Mutual Help Meeting held three times a week. The nurse unit manager also regularly addressed consumers and staff during lunchtime in the dining room to pass on relevant information. Additionally, each week after completing unit rounds, a member of the OPU team contacted the families of each consumer to update them on their family member's progress/condition.

Legal rights

During pandemic restrictions, Mental Health Tribunal (MHT) in-person hearings shifted to Telehealth hearings.

In some units, during lockdowns, consumers did not have access to peer-support workers or legal advocates. At Barwon Health's acute inpatient unit, this led to confusion about whether consumer wishes had been taken into consideration. Staff were also not able to readily access information to answer questions by Community Visitors on behalf of consumers.

In the initial outbreaks and lockdown of 2020, Barwon Health said it reduced the number of staff attending the Swanston Centre, including peer workers. They reviewed this and, in subsequent lockdowns, actively encouraged the peer workforce to attend the unit and provide therapeutic support through lived experience engagement. In-person MHT hearings were also re-introduced.

Elsewhere, there were reports of consumers not being able to exercise or access fresh air (apart from within hospital courtyards or on exercise equipment) due to lockdown restrictions. Consumers were also not permitted to go to hospital cafes.

Community Visitors in Hume region remain concerned about the room used for MHT hearings in Shepparton. As reported in previous Community Visitors annual reports, consumers right to privacy is compromised due to poor soundproofing in the tribunal room. Although DH approved $1800 to obtain a quote from relevant specialists, there has been little progress in the soundproofing of the tribunal room. Plans indicate this issue is to be addressed as part of a substantial renovation.

Gender sensitivity

Physical space issues and lack of female staff to support female consumers were reported. Community Visitors were pleased to note that staff training in relation to LGBTIQ+ consumers was delivered at a Melbourne Health facility.

At Ballarat's Sovereign House, an extended care unit, Community Visitors have reported for several years concern about the lack of a female lounge/ space. This is considered a priority for the unit given there are one-to-two female consumers in the unit and ten male . Community Visitors were advised funding was available in September 2020, yet no works had begun by 30 June 2021.

Community Visitors in the Loddon Mallee region also raised the concerns of female consumers in a Bendigo dual diagnosis unit who were not able to discuss gender-specific matters when only male staff were rostered on. The unit has since changed the rostering of staff to take gender issues into account.

Programs and activities

Meaningful programs and activities are important to consumers in developing the skills that they need for recovery. Some units reported that consumers actively committed to shared tasks and activities at regular weekly meetings and very rarely have any complaints. Community Visitors noted a variety of programs and activities that are good practice, and these occurred both prior to COVID-19 restrictions and in a modified form during restriction periods at some units. While consumers frequently reported gaps in activities and frustration at the limited type of activities available, particularly on weekends, COVID-19 restrictions also led to some innovative programs and activities (See previous section on the COVID-19 pandemic).

At one metropolitan PARC, activities were reported to be varied and well-attended. These included a peer worker (two days a week), a Healthy Habits Program (anti-addiction) and an exercise class. A newly built pavilion fitted with weatherproof bean bags in the backyard at one PARC has been good for groups, for getting people outside (sensory benefits), and for recovery programs delivered in a more COVID-Safe way. NDIS-funded workers were actively involved with two residents who have long-term disabilities, for example, assisting them to go shopping.

Barwon Health's Blakiston Lodge for older people with dementia and mental health issues has been granted funding to employ three additional therapists. In addition to providing quality programs, activities have been able to be run in the early evenings, which have improved staff-to-consumer ratios at a time of the day when it is generally difficult to have staff available.

GOOD PRACTICE

In Bendigo, an exercise physiologist was engaged to provide services to consumers across all mental health units.

Consumers advised Community Visitors that they enjoyed the sessions which added a lift to their day. Also, mutual help meetings are held each weekday morning. These provide an opportunity to give information, discuss issues, and make suggestions.

After the mutual help sessions, various activities are offered, for example, art and origami on Mondays; courtyard games on Wednesdays; Yoga, card games and relaxation group on Thursdays plus exercise physiology twice a week, and colouring, Sudoku and Coffee Club.

At Bendigo Health's Parent-infant Unit, consumers continue to participate in the Mother Goose program delivered by Baptcare via video-link. Four staff are trained in the Circle of Security Parenting program and one staff member is doing the training via video-link. This continues to be the method for this program's delivery.

Another beneficial care service is delivered by child and maternal/midwife trained staff providing a valuable source of advice for mothers.

Gaps in programs and activities

During the year, consumers frequently told Community Visitors they were bored due to a lack of interactive or physical activities and they sometimes requested better exercise or other equipment.

In one older persons' unit, Community Visitors noted that consumers often had little to engage in other than TV. It was regularly reported that a lack of staff limited the activity programs that consumers could participate in. At an eating disorders unit, Community Visitors reported that consumers have not had the benefit of an occupational therapist for several years. The unit, however, reports that it intends employing a psychologist, occupational therapist and a senior social worker.

The activities program at Geelong's Swanston Centre has had severe staff shortages, seriously impinging on the quality and range of activities offered. The multi-disciplinary team needs the equivalent of 1.4 social workers, 1.4 occupational therapists and a 0.5 nurse. Furthermore, since the first COVID-19 lockdown, volunteers who assisted with the weekly Open Lunch have not been attending.

In other cases, it was a lack of equipment that restricted programs. During the 2020 lockdown, Blakiston Lodge's bus was sold by Barwon Health. Once outings could be resumed, the unit had limited access to a shared bus – one afternoon a week. Staff noted that bus trips had a significant impact on mood in the unit. The new arrangement means a cap on the number of consumers who can go out each week, with no flexibility in the length or duration of the trip. The unit does not have a pool car, so taking a resident shopping for clothes, for example, is not possible.

CASE STUDY

Ian, an older person with an ABI, was to transfer from a rural service to a specialist ABI unit in Melbourne.

The team recognised that the ambulance trip and arrival was going to be challenging for him. An iPad was loaded with music which Ian enjoyed and it included video clips that he was interested in.

An experienced staff member well-known to Ian accompanied him on the ambulance trip and helped him settle into the ABI unit. The staff member demonstrated to unit staff strategies for working with Ian. NDIS funding was used to support Ian's transition to the new setting and to purchase equipment for him.

This demonstrates how activities can be used to prevent behaviours of concern and the value of collaborative work between services and the NDIS.

GOOD PRACTICE

At a specialist unit for veterans and emergency services personnel run by Austin Health, consumers spoke highly of the range of activities and genuine care shown by staff.

One consumer who had stayed in several other mental health services, described the service at the unit as "world's best practice" and he said it was a humbling, hopeful experience to spend time there.

Activities include group discussions, relaxation, and coffee mornings. The staff were reported to be amazingly caring genuine people, and local shops very supportive and caring, providing items free-of-charge.

Facility management

Community Visitors reported 114 issues ranging from graffiti, tripping hazards, broken and ageing equipment or furniture, to major renovations or repairs needed across Victorian mental health facilities.

At a Shepparton PARC, an internal phone service was not working for some time, resulting in no contact between the office and units. Community Visitors were advised the matter was being given high priority.

At the same PARC, in July and again in September and November, Community Visitors reported a heating/cooling unit in the communal area was broken. Several months later, Community Visitors reported that new heating/cooling had been installed. At one metropolitan PARC, Community Visitors reported a stovetop not working for a prolonged period.

Community Visitors reported units were successful in increasing cleaning schedules for the management of infection control. However, there appeared to be long delays in facilities arranging consumer access to Wi-Fi. Structural issues in existing buildings were a barrier which required additional funding to address.

Several services were able to complete renovations during COVID-19 lockdowns. While reports indicated that outcomes were positive, staff and consumers experienced strain in the process due to less usable space. Routines were readapted temporarily in the sharing of common spaces. For example, in Gippsland, the old kitchen became the staff office and interview room for a while.

Locating furnishings and equipment suitable for mental health settings is a challenge. The replacement of curtains with blinds at a South West Health acute unit was ongoing. Finding blinds that were safe, that could not be dismantled or did not create a safety issue was difficult. In one Alfred Health unit, a hot water tap was installed but later removed for consumer safety when it was apparent that the temperature of the water was too high.

GOOD PRACTICE

A Bendigo older persons unit has completed extensive renovations with carpeting, painting, and light fittings achieving a brighter and more aesthetically pleasing environment.

A new lifestyle area has been installed with a hairdressing fit-out, although a professional hairdresser has not been employed. In the meantime, staff with the competency are attending to consumers' hairdressing needs.

NDIS

Two groups of issues reported by Community Visitors this year related directly to the NDIS: eligibility, plans and processes (7) and accommodation/SDA (6).

Community Visitors reported some NDIS success stories. NDIS has enabled the transfer of consumers from acute care to more suitable accommodation.

Blakiston Lodge staff in Geelong organised an NDIS package for a younger resident who uses a wheelchair. He is now due to move from the aged care unit where he was admitted two years ago, to shared accommodation with a support worker. In Warrnambool, PARC and ECU staff have been able to organise comprehensive NDIS packages for long-term residents. However, a lack of affordable accommodation means consumers continue to remain in secure environments and packages cannot be activated.

Community Visitors noted instances of delays with applications for SIL/SDA funding for post-discharge accommodation, leading to consumers having to stay longer in mental health facilities. The difficulties in placing consumers who need special care post-discharge has been raised at the statewide mental health liaison meetings with the Department of Health. Other services reported lengthy delays in accessing NDIS accommodation support for CCU consumers. Similar comments were made about difficulties in accessing nursing home care.

When a consumer does get NDIS accommodation funding, a lack of suitable accommodation can make it very difficult to actually use it. It is very hard to find accommodation in an extremely tight regional rental market. Supported accommodation for people with complex needs is even harder to find. Families often need to take in consumers in situations that are not ideal.

Some services raised concerns about NDIS refusing to accept reports from allied health staff. Negotiations are continuously difficult and slow, with the NDIA failing to accept reports from professionals working in the mental health unit, for example, occupational therapists can complete a professional functional assessment but the NDIS often demands another assessment by an independent occupational therapist, arguing there may be a conflict of interest.

Stakeholder relationships

Regional

Many Regional Convenors (volunteer team leaders) reported that the Community Visitors in their region have had very positive interactions and cooperative working relationships with their local health networks and the managers and staff at facilities.

Some Community Visitors continued to have well-attended quarterly liaison meetings with service managers throughout the year, despite the challenges presented by the COVID-19 pandemic with most meetings held via video-link. Community Visitors also report management responds well to their email or phone enquiries.

In other areas, contact between Community Visitors and services was less frequent this year because of significant changes in either the Community Visitor team or management personnel at the health service.

Reduced contact with service providers often mirrored a decrease in visits. This was a particular issue in metropolitan Melbourne this year where the Community Visitors Program has been without Regional Convenors in several areas for a significant part of the year, largely due to the impact of COVID-19 pandemic.

Regional Convenors play a key leadership and training role in the program and the small number of paid staff in the Community Visitors Program cannot replace the work of Regional Convenors.

Traditionally, Community Visitors attempt to view incident reports as part of their scheduled visits to mental health services, but this has often been a challenge because of the large volume of incidents at some services and the preference of most Community Visitors to prioritise interacting with consumers and following-up their issues at the time of the visit.

On-site viewing of incident reports has not been possible for Community Visitors undertaking remote rather than face-to-face visits. As mentioned under 'Safety', some services were willing to provide monthly electronic summaries of incidents to Community Visitors via a secure email or with password protection, but others were not. There continues to be inconsistency in the nature and formatting of the information that is provided to Community Visitors and this has led to considerable frustration.

The Board hopes that an outcome of the recent Royal Commission will be an improvement in the coordinated collation and analysis of data between Safer Victoria and the Department of Health and that will lead to Community Visitors having unfettered access to data related to their functions.

Statewide

The Community Visitors Mental Health Board has continued to engage in informative discussions with the Department of Health and the Office of the Chief Psychiatrist. All liaison meetings were held via video link this year.

Issues discussed at liaison meetings this year included:

- The impact of COVID-19 upon service consumers and service responses
- The MH Royal Commission's interim report and final report recommendations
- Ongoing difficulties in Community Visitors accessing incident reports and the analysis and categorisation of data
- The varied quality of activities and programs
- The shortage of acute adolescent beds
- Transition Support Units and the needs of people with a dual disability not being adequately met
- Parent-infant units
- Workforce issues
- Discharge and accommodation issues
- Peer-support initiatives
- NDIS.

The Community Visitors Program provided statistical reports to the Department of Health on a quarterly basis with examples of good and poor practice where relevant. The program also sent the details of some consumer matters to the Office of the Chief Psychiatrist, expressing Community Visitor concern about service gaps and NDIS-related issues that either prevented consumers from being discharged or led to them being discharged to places that were clearly unsuitable.

The Board notes that no formal response was received to last year's Community Visitors annual report or its recommendations, and the response by government to the prior year's report was only tabled in Parliament just prior to last year's annual report being tabled.

The Victorian Government has committed to spend $868.8 million on mental health as a consequence of the Royal Commission. Many preventative, community-based and outreach services are to be established to relieve the pressure on emergency departments and support people before they reach crisis.

Further, the Government has committed to funding 100 new acute beds and new acute mental health facilities in Greater Melbourne and Geelong and an additional 107 forensic beds at the Thomas Embling Hospital. The Board commends the Victorian Government for their commitment to implement all the Royal Commission recommendations and for their increased investment in social housing, some of which is to be targeted to people with a mental illness.

However, the Board notes the need for additional, acute adolescent beds does not seem to have been included in the Royal Commission's recommendations. The Board recommends that this need be recognised and addressed.

The State is to be divided into eight regions with new regional boards and a new Mental Health and Wellbeing Commission established. The Board looks forward to engaging with these new bodies and hopes that the role of Mental Health Community Visitors will be endorsed and strengthened in any resulting legislation from the Royal Commission recommendations.

03

Residential Services

Program Stream

RS

Recommendations

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

RS

1. require that regulatory reform includes
   - an assessment of Supported Residential Services proprietors against a strengthened 'fit and proper person' criteria
   - a requirement that proprietors meet a tougher registration process within two years
   - a minimum qualification standard for all personal support staff to meet residents' personal hygiene, medication management, care, and activity requirements
   - minimum standards for meaningful activities that facilitate social connections
2. consolidate the Supporting Accommodation for Vulnerable Victorians Initiative and Pension-Level Project funding into one funding program that applies to every pension-level SRS
3. request Homes Victoria assess the suitability and risks of existing Supported Residential Services buildings and report to government over a three-year period as to whether they are fit for purpose
4. require all proprietors to complete an annual compliance report on the status of their staff to meet the 90 per cent mandatory attendance at mental health training
5. fund staff training in Supported Residential Services to manage the de-escalation of violence and delivery of Mental Health First Aid
6. 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
7. require all workers entering Supported Residential Services to display visible identification including the organisation name
8. ensure that Community Visitors have the power to take photos to support the documentation of issues, amending legislation, if necessary
9. provide additional funding to ensure that the Community Visitors Program has the technology and resources required to effectively fulfil its important safeguarding role.

Statewide Report

Introduction

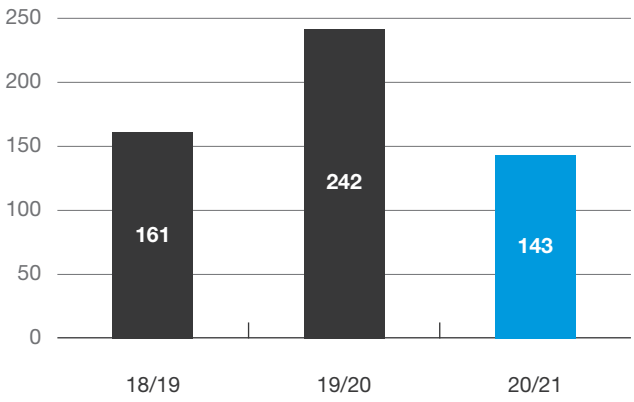
This report focuses on the work of Community Visitors in the Supported Residential Services (SRS) sector, which provides supported accommodation for about 4000 vulnerable Victorians.

SRS are almost all privately operated and offer variety in the services they provide and the fees they charge, with some accommodating as few as two residents and others up to 80, with the average being 30 residents. Many residents have complex needs and are well-supported while others receive sub-standard support and care— and some even live in squalor.

SRS can be broadly divided into two categories: 'pension-level' facilities where residents are charged 85-95 per cent of the disability or aged pension, plus rent assistance, or 'pension-plus' facilities where resident's may pay more than $1000 a week for their room, meals, care and support.

Community Visitors have reported long-standing concerns about regulation of the sector, and about services and supports provided by some SRS which charge almost the full cost of a pension. Indeed, for more than 30 years, OPA and the Community Visitors Program have highlighted the difficulties

Figure 8. Issues of abuse, neglect and violence identified in Residential Services stream, 18/19–20/21



these 'pension-level' SRS have had meeting minimum regulatory requirements or providing a standard of living that meets basic community expectations.

In 2010, in the second reading speech of the SRS Bill, the purpose of the SRS legislation was described by the-then Minister for Community

Table 4. Total visits Residential Services stream, 20/21

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	39	13	18	159	**177**
North Division	23	11	11	169	**180**
South Division	42	20	42	187	**229**
West Division	21	22	7	167	**174**
Total	**125**	**66**	**78**	**682**	**760**

Services, Lisa Neville MP. She said that it was to protect the wellbeing of SRS residents. Further, the Minister recognised that:

- SRS residents are vulnerable but have the same rights and responsibilities as other members of the community and should be empowered to exercise them
- they rely on SRS private proprietors to provide them with both accommodation and support
- the Bill aims to ensure that people living in SRS are protected from neglect or abuse and cared for properly
- this would be done by establishing a registration system and imposing minimum standards on service providers.

In a letter sent to SRS proprietors in December, Minister Donnellan recognised the vulnerability of people living in SRS remained a key concern for the Victorian Government. He reinforced proprietors' legal requirement to support the critical role of Community Visitors in safeguarding residents and providing valuable information that residents may not directly share with proprietors regarding their safety and wellbeing.

SRS proprietors must comply with the 15 prescribed accommodation and personal support standards set out in the SRS Regulations across four key aspects of a resident's life: lifestyle, food and nutrition, health and wellbeing, and physical environment.

This year, Community Visitors reported on these aspects as they found them at 125 SRS which operated in Victoria.

During a year defined by the COVID-19 pandemic and government issued Public Health Directions, including care facility visitor restrictions, 66 Community Visitors completed 760 visits to SRS either in person or remotely via phone or video.

Remote visits placed limits on the ability of Community Visitors to properly monitor and interact with residents and view facilities, however, many staff and proprietors provided detailed information to Community Visitors who reported 1046 issues this year. Figure 9 shows the number of issues by category. Figure 10 at the end of the report provides a further disaggregation of these issues.

During the year, seven SRS closed. They comprised three pension-level and one pension-plus SRS in the southern metropolitan area, two pension-level SRS in the Central Highlands, and one pension-plus SRS in the Loddon Mallee area. One of these, Hambleton House, had its registration revoked pursuant to section 168(1)(a) of the *Supported Residential Services (Private Proprietors) Act 2010* (the Act), one closed voluntarily, with five due to the landlord not renewing the SRS lease.

As there is a recognised shortage of affordable accommodation options for vulnerable people, Community Visitors are alarmed that 118 pension-level beds were lost to the sector during the year without an alternative option being made available.

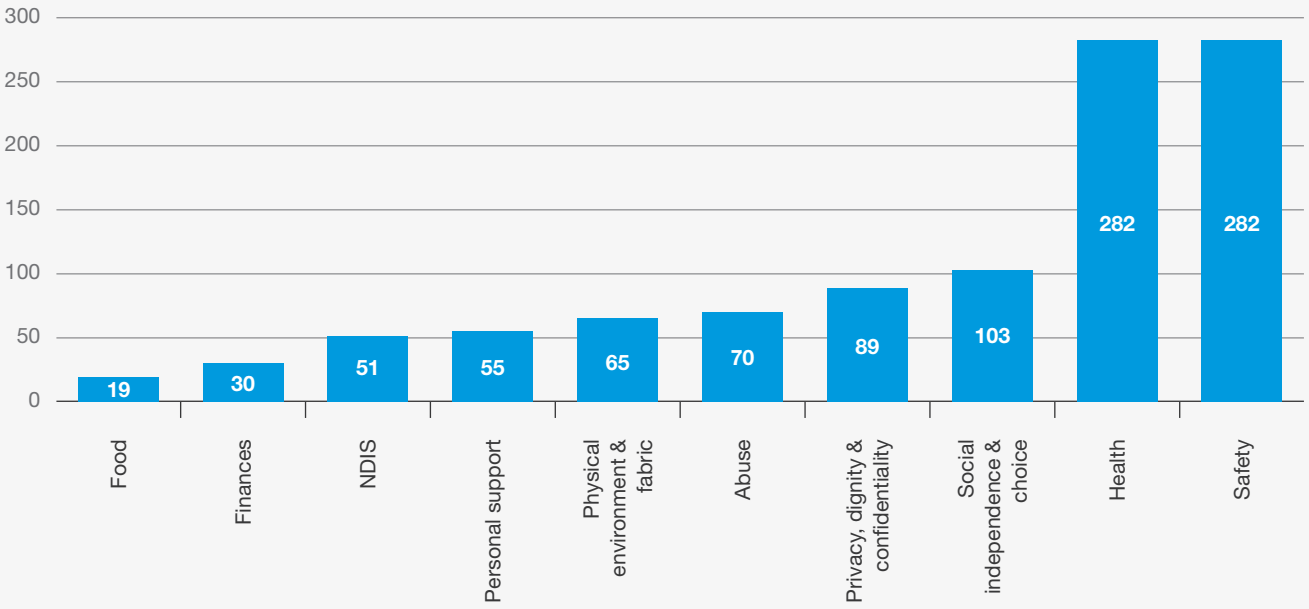
Increasingly, SRS are housing residents with diverse health needs related to ageing, disability, complex mental health conditions and addiction. Often residents have been adversely affected by poverty and a lack of access to health and preventative services. The complexity of the issues confronting the sector has been exacerbated by the introduction of NDIS and aged care reforms.

The Board is concerned that the sector's long-term financial viability is threatened by the challenge of operating an SRS to an acceptable community standard in this complex environment. The full support of government is required to maintain the long-term wellbeing and security of residents, so it was a concern that the Victorian Government Response to the *Community Visitors Annual Report 2018-19* received in September 2020 did not accept six of the 12 recommendations. Five of the remaining six were accepted in principle only and it is unclear to Community Visitors what action will emanate from them.

Community Visitors identified areas of good practice and highlighted opportunities for improvements at both a local and systemic level. Consistent with the Government's intentions as stated in 2010, Community Visitors are alert to the sector being at risk of regression and calls on government to prioritise immediate and direct action to address shortfalls in the quality and viability of SRS services. This is needed to support residents to live as independently as possible, to choose their service providers, and to be safe in supported care.

Community Visitors did not receive a response from the State Government to the recommendations in the *Community Visitors Annual Report 2019–2020*, so this year's recommendations have been prepared without that feedback.

Figure 9. **Issues reported by Community Visitors, 20/21**



Abuse, neglect, and violence

This year, Community Visitors reported 143 new issues of abuse, neglect, and violence.

The COVID-19 pandemic had a significant impact on the ability of Community Visitors to conduct face-to-face unannounced visits. As more visits were conducted remotely, Community Visitors relied on the information shared by SRS staff, were often unable to speak to residents, or to examine written documentation, such as incident reports which is the highest issue type recorded this year with 255 issues. Refer to Figure 10.

Community Visitors reported five allegations of sexual assault, three involving the same alleged perpetrator and victim, and two allegations of sexual threats. Police informed the SRS management about the allegations of multiple assaults because the resident didn't want the information shared with SRS staff and residents. In response, Community Visitors were pleased that the SRS manager relocated a female resident to another part of the SRS and arranged different mealtimes.

Community Visitors followed up information provided by a caller to the OPA Advice Service who was alarmed that a female SRS resident feared for her safety due to the likelihood of an assault. She was told by the manager that she may have to move from the SRS because of them.

Community Visitors noted that, in some SRS, verbal and physical aggression had become more normalised during the pandemic, with some assaults not accurately reflected in the incident reports nor shared with Community Visitors, despite police attending the SRS. Community Visitors are always anxious to follow up with any victims. In other instances, residents with challenging behaviours move from one SRS to another until they find the support they need to live with others. This included one man who resided at four facilities before he could find an SRS that suited his needs and circumstances.

Community Visitors documented many incidents of resident-on-resident assault, resident-on-staff assault, verbal aggression and intimidation of staff and residents by other residents, as well as property damage. Often these incidents occurred when residents experienced a mental health episode. Multiple incidents of violence were often reported at the same SRS by different residents, making some SRS high risk for abuse, neglect, and violence.

Community Visitors noted many instances where there was a lack of appropriate information shared by clinical mental health services to SRS as part of the discharge and referral process. The failure to share critical information did not promote safe discharge and, in many cases, meant consumers failed to receive appropriate supports vital to their recovery. This is despite the 2018 publication of

'A guideline to promote the collaborative support of residents' distributed to all SRS and health services. It was published by the Office of the Chief Psychiatrist and Community Visitors helped to develop it.

Some examples of abuse, neglect, and violence reported by Community Visitors this year include:

- an allegation of a resident attacking a sleeping resident with a brick, resulting in the evacuation of the SRS while the police investigated, and the victim needing long-term intensive care support for their substantial injuries. Other residents needed counselling support and assurance that they were safe in their home

- numerous knife threats and stabbings, such as a resident fight about cigarettes that resulted in one resident allegedly stabbing the other. A separate incident at another SRS, where a physical fight resulted in an attempted stabbing and property damage, with the police arresting the alleged offender. In another knife threat, the resident threatened to harm the resident in the next room, but police said they were unable to act unless an actual offence occurred

- the assault of a staff member and pulling of a fire extinguisher off the wall. The proprietor refused to allow the woman to continue to live at the SRS due to concern for the welfare of other residents

- five incidents over a two-day period by a resident who went to hospital three times. This included, over this period, the resident threatened hospital staff with crutches and was escorted back to the SRS; verbally abused and threatened to kick and scratch SRS staff; and smashed a window before police were called to restrain them prior to being taken to a mental health facility

- a verbal fight between two residents escalated after one resident left then returned to threaten the other with a meat cleaver. Staff were able to disarm the resident, and they were arrested by police

- a fight between two female residents resulted in one woman pushing the head of the other resident into a wall, which was recorded on CCTV

- multiple incidents of abuse and aggression towards co-residents over a two-month period in a regional SRS. On one occasion residents were isolated for their safety until police and ambulance arrived. This resident had complex mental health issues so his NDIS support worker sought more appropriate accommodation

- a resident who verbally abused and threatened other residents with a knife, also played music loudly at unreasonable times, removed doors and wall tiles from inside his room, and tried to destroy the air conditioning unit. Police attended on several occasions, so the resident was issued written warnings and a Notice to Vacate but initially refused to leave the SRS

- former residents who returned to an SRS and threatened residents and staff. In one example, a former resident arrived naked. On another occasion he was painted black, and the manager put the SRS in lock-down until emergency services arrived

- a resident who threatened a staff member who was forced to hide for his safety. The resident was evicted but later returned to threaten the staff member, who called police

- an ex-resident who returned to sell drugs, trying to enter the SRS by breaking a window before threatening staff and residents

- deteriorating behaviour of a resident led to him verbally abusing staff and threatening them with a cricket bat

CASE STUDY

A sleeping resident in a pension-level SRS was the victim of an unprovoked and vicious attack by a co-resident wielding a brick.

A frightened resident who heard the assault did not want to alert the perpetrator, so called an off-duty staff member to the SRS. The staff member on sleep-over was woken only after the off-duty staff member arrived.

The victim sustained serious injuries and was rushed to intensive care. Other residents were evacuated while the police investigated the assault.

The initial response from emergency services and DFFH was very positive. Community Visitors, however, were deeply concerned about the lack of subsequent follow-up and reported that some residents remained traumatised weeks after the attack.

A delay in accessing counselling services left staff and residents who experienced trauma inadequately supported. Community Visitors felt that the risks for people living with mental health conditions and a history of trauma were not properly considered.

A significant number of SRS residents, particularly those in pension-level facilities, have serious mental health issues and find it challenging to live with others. COVID-19 visitor restrictions placed pressure on residents and SRS staff to maintain a harmonious environment and staff capacity and skills were tested in the lengthy lockdowns during the year.

For the period June 2020 to March 2021, 44 SRS residents were issued a Notice to Vacate.

Community Visitors reported proprietors' concerns about the financial viability of SRS due to reduced occupancy. This placed some managers under pressure to consider referrals which were not aligned to their resident demographic profile and to accept residents with complex needs who displayed aggressive behaviours. In many cases, these residents disrupted the calm environment within the SRS and were eventually issued a Notice to Vacate.

Emerging issues

A significant concern for Community Visitors were reports of vulnerable residents who relocated from some SRS to what is usually described as private rental accommodation.

In some cases, residents are relocated to a house operated by the SRS proprietor. Community Visitors have reported, residents being allegedly moved despite not wanting to leave the SRS and felt that some other vulnerable residents may not understand the implications of the move or the financial arrangements of it. Many of the residents had NDIS packages and Community Visitors expressed concerns about the transparency of the use of their funds.

Furthermore, there are also concerns that other SRS residents are being offered cash or other incentives to relocate to housing in the community. Community Visitors are concerned that this accommodation may, in some cases, be an unregulated SRS disguised as private rental. Community Visitors are unable to visit such accommodation. They are gravely concerned that residents are being exploited by unscrupulous people and taken advantage of so that their NDIS package can be misused.

Safeguarding provisions for other forms of accommodation other than SRS are minimal and do not include Community Visitors. Further, Community Visitors are not entitled to know the addresses or the names of residents residing in these forms of accommodation as they fall outside of their responsibilities under the Act. Community Visitors remain concerned about the human rights of, and safeguards for, these vulnerable people in the community.

Incident reporting

Community Visitors encouraged SRS staff to record every incident as this helps to identify issues of concern and patterns of behaviour which may prevent issues escalating while improving resident support.

Despite this, Community Visitors observed that some SRS do not regularly record serious incidents that threaten the safety of residents and staff. Such incidents affect the feeling of safety and security for all residents and detract from staff efforts to create a home-like environment.

Community Visitors were also concerned about the decrease in the number of incident reports this year. From experience, Community Visitors have observed that where there are reduced reported abuse incidents they often escalate to alarming reports of violence, and this has been more prevalent at times of lockdown during the pandemic.

SRS have reported some residents displaying particularly challenging behaviours during lockdowns but did not report them as incidents. Community Visitors observed that these behaviours were increasingly noted by staff as 'normal', and the underlying causes not addressed.

In last year's annual report, Community Visitors reported that DFFH investigated the serious assault of a female resident by a co-resident. Community Visitors challenged the outcome of the investigation as they believed the matter should have been categorised as a prescribed reportable incident.

The Public Advocate requested a further review of the CCTV footage of the incident, which led to the proprietor being requested to record and report this as a Prescribed Reportable Incident under Section 77(1) of the Act. The proprietor complied with the request, and Victoria Police were provided with the CCTV footage of the incident.

Community Visitors were pleased that, in May 2021, DFFH wrote to all SRS proprietors outlining the reasons for compliance requirements in relation to incidents. It is hoped that staff will be better trained to record incidents, thus, providing greater reporting consistency.

Compliance with the Act

Community Visitors were concerned that DFFH did not adequately address some allegations of abuse and neglect in a timely manner or provide adequate responses to serious assaults. However, Community Visitors were mindful that Authorised Officers were required to assist in the COVID-19 response at various times across the year which may have reduced their capacity to act on SRS issues.

Community Visitor requests of DFFH for copies of publicly displayed compliance notices were declined, however, the issue is the subject of dialogue between the Community Visitors Program and DFFH. The program understands there are future plans for Community Visitors to gain access to this information.

CASE STUDY

In last year's annual report, Community Visitors reported on abuse and neglect in an inner-south SRS.

The issues were well-documented in 18 Community Visitor reports and eight Notifications for Investigation over three years to DHHS (now DFFH).

While performing their duties, Community Visitors were threatened and abused. This combined with the perceived lack of effective action on the part of the department, and the appalling living conditions of the residents, left the Community Visitors and the Board angry, dispirited, and troubled by what they saw as infringements on the rights of vulnerable residents.

The Board took the view that no volunteer should be subjected to intimidation and abuse and that immediate action should have been taken to protect them.

Constraints on reporting in the Community Visitors annual report led to the preparation of a report which was sent to the relevant minister, Minister Donnellan, about the situation at the SRS. Subsequently, the Minister met with the Community Visitors Residential Services Board to discuss the report and ongoing safeguarding issues, such as the protection of vulnerable residents and the treatment of Community Visitors.

The Board felt the meeting with the Minister was very productive. It welcomed his strong support for the program and his acknowledgement of the important role of volunteers. They appreciated the letter he sent to SRS proprietors which highlighted the important role of Community Visitors as part of the safeguarding system and emphasised the requirement that proprietors respond truthfully and in an open manner to them.

The Board also discussed what they considered to be a failure in the SRS regulatory system and their support for systemic change to regulation and safeguarding. The Minister committed to communicating his expectation that DFFH would be more responsive to issues raised by Community Visitors and to consider OPA's recommendation that government assess the need for an independent safeguarding body for SRS complaints.

The Board is pleased to note that the social services regulation reform has been progressed. They hope that this reform will strengthen the SRS regulatory system and the failures they saw at this SRS will not occur again.

In early 2021, an improved SRS risk-based regulatory approach was adopted by the regulator. In March, the department also wrote to proprietors to provide them with further clarity about their legal requirements and that compliance with them would be monitored.

Community Visitors welcomed an increase in collaboration and engagement by DFFH Authorised Officers at regional liaison meetings where they discussed the safety and wellbeing of residents.

The Board is pleased the SRS Protocol between the Community Visitors Program and the Human Services Regulator, which expired four years ago on 30 June 2017, is being renegotiated as it will clarify information sharing and escalation pathways between the two areas.

Demountables at an SRS

For many years, Community Visitors have reported concerns about a large number of demountables placed on the Reservoir Lodge (RL) SRS site that were refurbished to accommodate residents.

Each demountable contains a small bedroom and an ensuite. Other services such as meals, recreation and laundry were provided in the SRS building proper and by the same staff. While the demountables doubled the number of residents on the site, the proprietor denied that they were part of the registered SRS and refused Community Visitors entry or to speak to people residing in them.

Community Visitors documented the issue and notified DFFH about potential breaches of the Act that required investigation.

In February 2020, a Compliance Notice was issued against RL that:

- the number of beds at the SRS was greater than its registration allowed
- the SRS was providing services to the residents in the additional beds
- the proprietor made changes to the SRS without the approval of the departmental Secretary, as required under the Act.

RL appealed the Compliance Notice to VCAT, and the matter ran until early June 2021 with the file holding over 2900 pages of statements and documents.

The VCAT Member upheld the first two points of the Compliance Notice and the proprietor had 30 days from the decision to decide whether to:

- close the Hub (the SRS name for the demountables) and move the existing residents out permanently within three months or apply to vary her SRS registration to include the Hub as part of the SRS.

The SRS was also required to publicly display the Compliance Notice, with penalties for non-compliance. This outcome demonstrated the persistence of Community Visitors in reporting issues of concern to keep residents safe and support good outcomes for this vulnerable cohort.

Health

Community Visitors reported 282 health-related issues including concerns for residents who were bed bound, required mobility assistance, continence support or had regular falls. Several residents required ambulance transport and one resident died in hospital due to a chronic health condition. In one case, SRS staff attempted CPR for 20 minutes while waiting for an ambulance and the resident recovered.

Self-harm, drug use, medical conditions such as recurrent urinary tract infections, falls, broken bones, or other injuries such as cuts or severe burns were reported as critical factors in the subsequent hospitalisation of residents. One resident fell and was diagnosed in hospital with fluid on the lungs, which required intubation, while another was diagnosed with a complex communicable disease.

Community Visitors advocated on behalf of a resident who relied on a co-resident's support to shop for personal items and whose reading glasses had been broken for over three months. Community Visitors also assisted a resident who required a wheelchair following a motor vehicle accident as well as regular hospital appointments.

The efforts of managers and staff to support residents in coordinating and attending medical appointments or providing support to transition back from rehabilitation following an injury or planned surgery is recognised by Community Visitors. Some SRS helped residents receiving palliative care. Others worked closely with general practitioners who regularly visited the SRS for injections including the influenza vaccine and to check on resident wellbeing.

Impact of COVID-19 pandemic

Community Visitors commend the efforts of the SRS proprietors and staff who demonstrated exceptional commitment and resilience in their support of residents during the 112-day, COVID-19 lockdown. This included severe stay-at-home rules and a curfew across metropolitan Melbourne from July to October 2020.

Community Visitors reported 107 coronavirus related issues in 101 SRS including 71 at pension-level facilities and 30 at pension-plus SRS. Eight SRS reported positive COVID-19 cases, five of them pension-level and three pension-plus. Four outbreaks occurred in East Metropolitan Melbourne, one in North Metropolitan, one in West Metropolitan and two in South Metropolitan Melbourne.

Three SRS reported COVID-19 close contacts: one in each of the East, North and West metropolitan Melbourne areas.

The two case studies below illustrate how two different SRS responded to a COVID-19 outbreak; one responded poorly and the other did all they could to support the residents and staff through the process.

CASE STUDY

At a pension-level SRS in Melbourne's south-east, Community Visitors enquired over the phone about COVID-19 precaution measures and residents' health. They were assured that the SRS was fully compliant with Public Health Directions.

The manager reported all residents were well, that staff worked exclusively at the SRS and only two NDIS support workers entered the SRS to undertake cleaning. Some residents were supported to access local shops or go out for coffee and shopping. Many residents were frightened about being fined and stayed at the SRS. Staff ensured social distancing by arranging different sittings for meals. Community Visitors were informed that DFFH checked in regularly, and the SRS received a small supply of PPE in addition to purchasing their own.

Four days later, it was reported that a number of residents who had tested positive for COVID-19 were breaching quarantine, out in the community without face masks, and entering businesses. The residents were returned to the SRS by police.

Community Visitors were concerned they had been given inaccurate or limited information in response to their questions, so they notified DFFH to investigate the matters.

CASE STUDY

In July 2020, a staff member at a pension-plus SRS tested positive for COVID-19.

Three staff in close contact were sent home to test and isolate. All residents were isolated in their rooms for 14 days and ate their meals there. The activities coordinator encouraged residents to exercise in their rooms and checked on them regularly. Residents used video chat to contact family and friends as they understood that no one could enter or exit the SRS during the quarantine period.

The manager reported that, at that time, there was minimal government funding to meet the cost of employing the extra staff needed to comply with the regulations. To ensure new staff were trained and able to meet residents' needs, the manager worked extended hours, seven days a week and was concerned about the substantial financial impact and future viability of the facility. Subsequently additional supports were provided to the SRS sector and the expense of replacement staff was reimbursed.

To protect the safety of residents against contracting COVID-19, many SRS staff lived on site during the extended lockdown to maintain the 'no-one in, no-one out' safety bubble.

Some SRS offered in-house accommodation, so their workers did not access public transport, or paid for a taxi to and from shifts. Many SRS were cautious to employ staff who worked exclusively at that SRS including personal support staff, cleaners, chefs, and support workers. This approach led to SRS staff being in conflict with NDIS workers as well as staff who worked across several workplaces.

Staff in some SRS were encouraged to talk more with residents and debrief with the manager or other staff during lockdown periods.

Over time, with assistance from the service provider EACH and other regional Community Health Centres, all SRS developed their own COVIDSafe Plan, and visiting protocols.

Some residents had surgery postponed, alcohol and drug programs were suspended, and irregular depot and insulin injections were modified due to the pandemic. Access to allied health was impeded even in regional areas which had not experienced COVID-19 cases. Residents in hospital who were discharged back to SRS required COVID-19 testing before and after hospital admission and to isolate at their SRS.

To minimise the spread of infection, some SRS visitors, including Community Visitors, were only allowed to visit one area, such as the front lounge of an SRS, and given a time limit.

Many SRS were challenged to access and maintain adequate supplies of PPE and incorporate improvements to hygiene standards. In some cases, SRS managers were required to source their own PPE, as DFFH advised, there was a prioritised waiting list due to widespread shortages. One proprietor expressed frustration that such equipment was not available earlier prior to when a resident tested positive. Later, proprietors welcomed the support of DFFH who arranged for two nurses to visit each SRS to develop protocols and assist in securing PPE.

Residents required constant reminders about hygiene practices, and not all were compliant with mask-wearing when leaving the facility. The ongoing cost of PPE and additional cleaning impacted on SRS running costs. An SRS in a border region employed a cleaner who lived across the border so services were reduced during the lockdown. When activities resumed Community Visitors queried if support workers disinfected cars between clients however some SRS staff were unsure about the protocols of other service providers who took residents out.

Activities such as outings and entertainers to the SRS were curtailed even when restrictions eased. Many SRS tried to increase inhouse activities and changed menus for variety; one had a food truck visit to the delight of residents. Another planned to celebrate when all residents were vaccinated. Staggered mealtimes were well-received by residents and will continue in some SRS as they offer more social independence and choice.

GOOD PRACTICE

The COVIDSafe plan at a pension-plus facility required all residents to be retested for COVID-19 every two weeks. It was difficult to organise as a referral from a doctor was required and the results could take four to five days, during which time staff needed to isolate. It was demanding for the staff do the right thing for the residents and their families, including not working at other facilities during this time.

Changes were made to the activities to ensure social distancing. These activities included quizzes, word games, exercises, listening to music and a talking book club. Family visits were 'contactless' through a window and only permitted when a resident was feeling depressed or anxious.

Following an outbreak of COVID-19 at one SRS, Community Visitors were concerned that staff did not always appear to receive or understand information provided from DFFH. They observed that several SRS did not have adequate COVID-19 emergency plans and required the DFFH COVID Response team to audit and improve plans to meet their needs.

CASE STUDY

Community Visitors received a report from an SRS about the challenges and what they felt was inadequate support from DFFH (then DHHS) during the early stage of a COVID-19 outbreak in the facility.

When the SRS manager and a key staff member tested positive and were required to isolate, there were no replacement staff to support 19 residents.

DFFH reminded staff who remained on site that, if they failed to meet their obligations to isolate, they would be in breach of regulations and may incur serious penalties. Distressed staff explained to Community Visitors that they had been waiting for relief support for several days and they were concerned that, if they stood down and isolated, there would be no one to assist residents, and the result would be chaos.

Over several days, departmental divisions of Public Health, Regulation and Disability Outbreak Response as well as Eastern Health teams engaged with the SRS on the risks and supports required including monitoring of test results for all residents and staff, isolation requirements, staff backfill, provision of PPE and food supplies.

Community Visitors, however, observed significant challenges in coordination, timing, and delivery of these supports attributed to the significant demand on the department's Public Health team.

Eastern Health stood up a clinical response on site. When replacement agency support staff arrived, they had limited knowledge, nor was there a handover or opportunity for training on resident needs. Residents complained that some staff had insufficient English and did not appear to understand how to work with them while replacement staff complained that residents refused to co-operate.

Residents who were required to remain in their rooms were distressed when Victoria Police and Australian Government defence services arrived to check that those who had tested positive were isolating on the premises. This was addressed once DFFH notified these agencies that there was constant surveillance by the nursing staff onsite.

A member of the Disability Outbreak Response team delivered fresh food items to the SRS. However, Community Visitors were informed that at one point food ran out and no one from the SRS was permitted to shop. Local council volunteer services supplied 140 meals within two hours, however, they were frozen, so the meals were returned, and alternative, fresh meals arrived an hour and a half later.

A deep clean of all communal rooms was completed, residents received a GP review, and a kitchen hand was employed to cook, rather than the SRS having to continue to pay for expensive takeaway food.

Nursing staff told Community Visitors they were unable to access resident's health files and support plans to assess individual needs, as they appeared to have been removed.

During this outbreak, the SRS sector received more comprehensive advice from the COVID-19 Public Health Division regarding optimal infection control and prevention measures. COVID-19 site assessments were conducted and DFFH provided an infection prevention and control resource pack created specifically for the sector.

Going forward, this case study shows that a proactive emergency response plan and access to support is required for all SRS in the event of a COVID-19 outbreak.

Vaccinations

While some SRS reported that all eligible staff and residents had both influenza and COVID-19 vaccinations, other SRS reported inadequate support resulting in little uptake of the COVID-19 vaccination among staff and residents.

One rural SRS reported that no staff or residents had received access to vaccination and complained to DFFH that SRS were not receiving priority attention like aged care facilities and metropolitan SRS. Despite health messaging, proprietors reported that some staff were reluctant to be vaccinated.

Some SRS managers described a smooth COVID-19 vaccination process while others felt that they received inadequate support from the Australian Government. Time was scheduled to complete all consent forms, however, some residents, or their next of kin and staff, refused the vaccination. In many SRS, there was limited consideration about the timing of flu and COVID-19 vaccination.

Managers expressed concern about their capacity to support residents with a positive diagnosis of COVID-19, or even to support a resident who became unwell after having a vaccination.

Mental health issues

The 2013 census of SRS reported that mental illness and psychiatric disability affected over 59 per cent of SRS residents with mood and psychotic disorders most common in residents residing at pension-level facilities rather than pension-plus facilities.

Community Visitors observed the impact of residents' poor mental health in a congregate environment and are concerned that the skills and competencies of staff are, at times, insufficient.

Many staff have a first-aid certificate and about a half have a Certificate III in Aged Care. Personal support coordinators are required to complete a minimum of 40 hours training every three years in priority training areas. Mental health training is mandated for SRS staff as a result of a key recommendation of the 2016 coronial inquest into the violent death of a resident at Bellden Lodge SRS, but DFFH does not monitor this for compliance.

This year, only 126 SRS staff attended mental health training with an average of 21 staff in each online training session. Community Visitors are concerned about the low attendance level, particularly in a year when COVID-19 lockdowns increased pressure on staff to support residents to live harmoniously in a congregate environment. DFFH promote this training, yet Community Visitors believe a higher standard of compliance monitoring is needed to address this critical skills gap. An audit of staff attendance at mental health training, staff with existing relevant qualifications, or who have attended other appropriate training that meets the requirement should be measured against the potential staff attendance pool. This would give an accurate picture of staff skills and future training needs in mental health in this sector, however it is not centrally monitored.

Community Visitors reported that many residents were anxious about the increasing number of COVID-19 cases. Community Visitors recognised the work of SRS staff in talking to the residents regularly to allay their fears.

In one SRS, Community Visitors reported increased levels of resident paranoia due to their difficulty in understanding why they could not access the community. Many residents were concerned that they may have COVID-19 due to excessive coughing but later tested negative. At a pension-level SRS in the Barwon and Wimmera South West region, some residents with mental health issues and dementia did not understand restrictions and continued to go out.

Community Visitors received feedback from proprietors that referrals from health services and agencies were most often for residents who had multiple disabilities but also complex mental health presentations, including behavioural issues. This was beyond the training and skill set of most SRS staff.

Despite the Office of the Chief Psychiatrist 2018 guideline 'Mental health services and Supported Residential Services: A guideline to promote the collaborative support of residents', Community Visitors continue to report that it is underutilised and there are few documented referrals between mental health services and SRS.

A proprietor told Community Visitors that the mental health discharge summaries from two services did not arrive before or with the residents on arrival at the SRS. When queried, the concerns of the SRS were dismissed as neither prior service seemed to understand the nature of an SRS.

A proprietor in the Barwon and Wimmera South West region reported a resident returning from a mental health facility without discharge notes. They also reported examples of residents returning from hospital with no information on the basis that this could not be provided as the SRS were not their next of kin.

Community Visitors were informed about the benefits of a detailed referral by a manager in regular contact with local hospitals and case managers regarding potential resident referrals. The manager confirmed the SRS could accommodate short-term residents for respite but could not take residents for permanent accommodation who displayed aggression as they need to maintain a calm environment for all residents.

Drug and alcohol issues

The consumption of excessive alcohol and drugs by some residents endangers their own health and often results in abusive behaviours towards staff and other residents.

Proprietors regularly informed Community Visitors about the lack of support services available for residents with drug and alcohol issues. One SRS manager was challenged to maintain a safe facility when residents were intoxicated and displayed poor behaviour towards staff and other residents yet explained that, if they asked residents to leave, they would become homeless.

Medication management

A resident refusing his mental health medication disturbed other residents so relocated to his mother's house before going to hospital. The SRS later advised his case manager that he was not welcome to return.

Community Visitors were concerned that these issues were not recorded in the incident report book. It is a requirement to record incidents so managers, staff, Authorised Officers and Community Visitors can investigate and identify risks, observe patterns or ascertain common characteristics and then, possible solutions should the incident occur again. In this case, identifying the common characteristic of medication refusal via an incident report may have led to the root cause being addressed. This may have allowed the resident to remain at the SRS and the proprietor to meet their statutory obligations of incident reporting.

Community Visitors identified multiple examples of incorrect medication given to residents by staff including a nicotine patch instead of pain relief. In some instances, this resulted in aggressive behaviour by residents and caused other residents to become distressed.

In most cases, however, the SRS identified the need to provide further training in medication management for staff, and review handover routines.

Some residents were non-compliant with medication which led to self-harm, suicide ideation and re-admittance to mental health facilities. Some SRS were not willing to accept the residents back as their care needs were beyond the capability of SRS staff to manage. In other cases, a review of medication, or change from oral administration to injection, led to the resident being stable and able to return to the SRS.

Community Visitors advocated that all personal support staff employed in an SRS should have a qualification to meet the residents' daily living needs such as dispensing medications, managing personal hygiene, grooming, toileting, oral, skin and nail care.

Personal support

Residents with complex mental health needs rely on the support of skilled staff. This year, Community Visitors were informed by one SRS that mental health training for staff was very effective and validated what many staff were already doing. Another SRS supported staff to participate in a thorough range of training modules including the COVID-19 training courses; Mental Health, CPR, First Aid and Working with Difficult Clients.

Community Visitors advised DFFH that some SRS do not readily support new staff to attend training. They were also concerned about the quality as well as the paucity of attendance at mental health training particularly for regional SRS staff, where community mental health services are often less accessible.

At several SRS, personal support plans were incomplete and only updated after Community Visitors' intervention. For example, a resident was hospitalised following a fall at the SRS and returned with his care needs documented and specialist support equipment to aid his recovery. While

progress notes had been made concerning the incident and subsequent discharge from hospital, the resident's SRS support plan had not been updated to reflect the change in personal care needs.

Some SRS attempted to care for several high-needs and frail residents, while another SRS tried to find suitable accommodation for one resident in an accredited residential aged care facility that employed a registered nurse on site. Community Visitors reported their concerns about some frail residents to DFFH Authorised Officers, who subsequently investigated. Monitoring of these residents will continue to ensure they receive appropriate care.

GOOD PRACTICE

A large not-for-profit, pension-plus SRS in a regional area is managed by a local board.

The board identified that the practice of holding large resident meetings was intimidating for some as they were afraid to speak up. Instead, a designated board member now meets regularly with SRS residents in small groups to hear their concerns. An expert in communication with those suffering from dementia is invited to participate, when required. Regular meetings via video conferencing are also arranged for the family members of residents with the board to hear about residents' concerns.

A resident at another SRS is hearing-impaired and cannot speak. The SRS manager downloaded an app on their phone, so they can now communicate and address his daily needs as well as build rapport with other residents.

One SRS employed a receptionist to free up the manager to attend to residents and staff.

SRS staff have put up a message on dining room wall thanking all residents for their support and congratulating them on their compliance with COVID-19 restrictions.

Community Visitors commend the efforts of committed staff to provide personal support and create a home-like environment for residents. Notably, staff in one SRS in the outer east region, assisted residents to farewell a much-loved cat, which belonged to a former resident. This left eight dogs and two cats which continue to have a positive impact on the daily life of the residents. A resident who lived unsuccessfully in several SRS was given responsibility for one of the dogs which now sleeps in her room. Staff report positive behaviour changes since this began.

Cleanliness and hygiene

Community Visitors followed up an anonymous call to the OPA Advice Service about the cleanliness and lack of staff in an SRS. On their visit, they observed food mess left on tables and chairs, unplanned meals, and general untidiness. The SRS manager explained that regular staff were away but agreed to review cleaning schedules and improve living conditions.

Safety

Over a three-months, five residents were reported missing from an SRS and there were frequent callouts to police to report drug use. Mental health services were supporting the SRS and local police proposed to have a meal regularly with residents and work proactively with the SRS to address issues and improve safety. Unfortunately, due to COVID-19 restrictions, this positive and proactive initiative has not occurred.

Social independence and choice

A positive aspect of the Act is the emphasis on the residents' right to social independence and choice. Community Visitors are concerned when residents' choices are not considered, sometimes to the detriment of an individual. It is also an issue when a resident's preference impacts the harmony of the whole facility affecting all residents.

There are many aspects about group-living arrangements that can affect personal choice, such as what food to eat and when meal-times occur, individuals choosing whether to make positive or poor health decisions, or even how loud to play music or the volume of the TV. This year, this perennial issue was exacerbated by COVID-19 restrictions which impeded the ability of SRS residents to exercise social independence and choice.

GOOD PRACTICE

An SRS reported that most residents engage in their own activities with their NDIS-funded support workers. Despite this, the SRS continued to run special events such as a Halloween party, bingo, and football nights. Some residents attended planned activity groups and an art group run by a local provider.

During the extended lockdown, the SRS acquired a pinball and 'Space Invaders' arcade machine and residents started a competition recording their scores on a newly purchased white board.

At a weekly residents' meeting, it was decided the Pension-Level Projects funding for the coming year would be used to convert the unused spa room into a multipurpose games and relaxation room as it was difficult for residents to watch TV while others were playing arcade games.

Community Visitors were concerned that some SRS facilities enforced harsher lockdown measures than required by law, including locking their facility to visitors. When a resident complained, he was told he could move out anytime, but that lockdown was likely to be the same in any other SRS. It was the manager's view that their anxieties were linked to cognitive and mental health issues, but Community Visitors advocated for greater understanding and support of residents already living restricted lives.

All residents should be entitled to access life-enriching activities, however, this requires SRS staff to understand what a good program would look like. It could include part-time work opportunities, volunteering, theatre, art, community connections, like attending the football, or engaging in home-based projects such as making a vegetable garden, or craft.

Activities in the pandemic

Community Visitors transitioned to a long period of remote visiting and sometimes had to verify what staff told them by speaking to residents and reading support plans. For example, Community Visitors were told a particular resident was going well despite their knowledge that this person used to go out four days a week, relying on regular routines and social contact for their mental wellbeing.

In some regions, community activities for residents were completely withdrawn, with the SRS providing no alternative stimulation or activity to promote social interaction among residents. In one SRS, Community Visitors suggested the manager survey residents at the facility, which he did, and discovered that they would like to do more exercise.

Residents' independence and choice to access online activities or to maintain personal connections were impacted by a lack of Wi-Fi at various facilities. At pension-level facilities, only a minority of residents have money to pay for data and their own devices so, with cafes and libraries closed, some were unable to independently access information and healthcare.

When Community Visitors returned to face-to-face visits, they were concerned that some facilities offered few options to engage residents in meaningful activities as an alternative to reduced or non-existent community activities.

At one SRS with 29 residents, many with high care needs that restricted their independence, there were no activities to engage them such as newspapers, magazines, board or card games, or exercise equipment. This was despite numerous SRS staff and NDIS workers on site who could have helped residents with activities.

Community Visitors were alarmed to learn that, in some facilities, NDIS day-support activities were sporadic, cancelled or altered without prior notice, even when there were no COVID-19 restrictions.

However, other SRS arranged additional in-house activities, including:

- a Men's Shed and jewellery production on site
- support for residents to paint a wall mural, that was proudly displayed to Community Visitors
- daily games, craft, and music
- after consulting residents, the purchase of a games table, basketball ring, access to a video streaming service and arranged walks to a nearby lake.

Health and wellbeing outcomes

SRS are challenged to support the complex health and lifestyle choices of residents and adopt a variety of strategies to assist them. In one SRS, a resident consumed excessive alcohol and refused medical intervention. The proprietor struggled to provide care and sought advice from family, but they had struggled in the past to provide support and no longer wanted to engage.

At another facility, a resident died from medical complications linked to alcoholism despite ongoing support from his GP, psychiatrist and NDIS worker. In another SRS, a harm minimisation approach to alcohol consumption saw a resident provided with an alcohol beverage at lunch and dinner with this privilege being rescinded if she attempted to obtain alcohol via a home delivery phone app.

An SRS relayed concerns about addiction-support service gaps for the residents who were often disruptive, yet they feared giving them a Notice to Vacate the SRS would lead to homelessness.

Community Visitors are concerned for the wellbeing of residents who choose to leave SRS for alternative accommodation. They believe these vulnerable people could be isolated, and not receive the needed services and supports in other unsupported accommodation. In one case, an SRS resident with mental health issues and an intellectual disability who had episodes of self-harm and distress moved out of the SRS to live in the community without a case worker and few supports.

At another SRS, Community Visitors reported a resident moved out with someone he claimed was his sister, despite having no next of kin listed and who the manager had never met. The manager was concerned for the former resident's wellbeing after learning that his State Trustee payments were subsequently supporting the woman and her family.

In one facility, a resident with diabetes refused to eat properly or seek medical help which led the proprietor to issue a Notice to Vacate as he could no longer provide the necessary care and supervision. Following a conversation about the Notice, the resident agreed to seek medical assistance.

In a regional facility, a heavy smoker with a lung condition refused medical advice to help cut down or quit. While in hospital, smoking was not permitted. However, when he returned to the SRS he resumed smoking and died not long after from a smoking-related condition.

Facilities often struggle with residents smoking inside, despite being in breach of SRS house rules, and a condition of the residential and services agreement. An SRS tried to penalise offenders $30 each time the alarm went off, but residents were unconcerned, so the facility returned to just appealing daily to residents not to smoke inside.

In another facility, an obese resident was placed on a diet supported and maintained by the SRS. Despite this, the resident chose to regularly order takeaway food.

Financial rights

Community Visitors are concerned that many SRS residents cannot read or understand documentation such as a residential and services agreement. Community Visitors would welcome a person-centred, transparent, and accountable approach to the management of residents' money by SRS proprietors.

A State Trustees information session for Community Visitors clarified arrangements for supporting clients including the process for escalating matters of concern. Community Visitors were advised that State Trustees was leading a cultural change from a 'best interests' to a 'supported decision-making' model and so they now meet clients at the SRS to assist them with budgeting and financial planning.

Community Visitors welcomed State Trustee's approach to prioritise person-centred support and to increase the capacity of residents to make financial decisions.

Privacy, dignity, and confidentiality

Residents living in an SRS often have their personal privacy and confidentiality compromised. In one case, residents felt uncomfortable about a co-resident with dementia regularly using a toilet adjacent to the meals area with the door open. Community Visitors discussed installing a curtain or screening for privacy.

In another SRS, residents were denied basic privacy and security as they were not provided with a key to lock their bedroom door. In another SRS, Community Visitors reported the disability toilets had no locks.

The confidentiality of a resident's complaint was reported as an issue as a resident thought he could only raise concerns directly with the proprietor or face retribution for complaining to an external person. Subsequently, several residents at this SRS, asked not to be named when complaining to Community Visitors about the quality of food, lack of activities and a fellow resident who regularly appeared naked in the doorway of another.

Community Visitors were alarmed to hear that a regional SRS introduced random, mandatory urine testing for drugs and alcohol as a condition of tenure. It had been agreed to by some residents when signing their residential and services agreement. Community Visitors notified DFFH that this was not consistent with the provisions of the SRS Act and violated resident's right to privacy and dignity. Following the notification, the proprietor

discontinued random drug testing and removed this clause from the agreement. It was understood that matters of concern covered by the condition would be referred appropriately, if required.

Death and dying

DFFH received reports this year of 29 unexpected deaths in SRS across the State. Concerningly, Community Visitors, however, recorded 32 unexpected deaths so three were allegedly not reported to DFFH as required. There were no deaths reported due to COVID-19 at any Victorian SRS.

The Community Visitors Program and DFFH are liaising to improve communication around deaths in SRS. The program is striving to improve the data capture process and there is an agreement to share more information between it and DFFH in the future.

Deaths were sometimes mentioned in incident reports, sometimes not. Even when they were mandatory Prescribed Reportable Incidents, they were not always shared with Community Visitors at the visit. Better information sharing around deaths would assist Community Visitors to respond more sensitively to residents and staff on their next visit, pay proper respect and enquire about adequate grief support.

Community Visitors reported that the support for grieving residents varied between SRS. Although unexpected deaths are likely to be investigated by the coroner, there is no requirement for proprietors to offer counselling to residents. Unfortunately, when this is required in traumatic circumstances, there are often delays in accessing the services.

Community Visitors acknowledge the efforts of staff to provide palliative care for residents, some in their late 90s, enabling them to remain at home for as long as possible, sometimes until they pass.

Community Visitors observed a lack of shared knowledge between SRS, DFFH, and residents on the diverse cultural needs around death, or grief support for staff and residents.

Some deaths seem to pass unnoticed, but at other SRS a death is commemorated with staff and residents attending a funeral, or meeting to share memories.

Unfortunately, some residents died in hospital, but the SRS was not informed until they called to enquire about the health of their resident.

GOOD PRACTICE

An SRS proprietor phoned Community Visitors to inform them that Alex had died the previous night.

The manager and residents were upset as Alex was well-liked.

The proprietor arranged grief counselling and ensured everyone was given a chance to speak about Alex.

NDIS

In many cases, the NDIS is delivering real benefits to people with disability. However, many people with complex and challenging support needs are not seeing the benefits that the scheme was intended to deliver.

During the year, Community Visitors reported 51 issues of concern about the implementation of the NDIS. Of these, 18 issues identified concerns with service provision, staffing, inter-agency liaison and 11 related to NDIS eligibility, plans and processes.

Eligibility, plans and processes

Community Visitors reported a wide range of outcomes linked to the plan review process and the quality of assessments and information provided to the NDIS Planner.

SRS staff often supported residents in the preparation of an NDIS plan or at plan review meetings which they attended along with family members, and allied health practitioners such as occupational therapists and physiotherapists. While one SRS manger said his presence would not help, Community Visitors were pleased that another SRS manager sat in on most NDIS planning sessions as he thought he could provide information that verified residents' needs.

An SRS manager reported that one resident's NDIS package reduced from four hours a week to four hours a month during the review process, thereby reducing his personal care supports considerably. Another resident's NDIS plan package was reduced by 60 per cent after the review; the reason why is being investigated by his mother.

When a resident's health needs changed due to stroke, there was a significant time lag to re-assess the additional assistance required to improve their circumstances.

A manager commented to Community Visitors that SRS staff were not consulted for a resident's NDIS plan review and cited examples of over-supply of services. For example, one resident who regularly visited the shops by bus now had a worker who drove them once a week. Another resident requested a mobility scooter, so now never walked, and had gained a substantial amount of weight.

Services, staffing and interagency liaison

Some SRS staff advised Community Visitors of the number of residents who had an NDIS plan and others said they are unaware of any information about NDIS plans.

Some SRS staff reported excellent rapport with NDIS service providers and other staff were dismissive of providers; there were allegations of disrespect towards SRS staff.

Community Visitors observed that some SRS were challenged by the complex support arrangements associated with residents on NDIS plans. For example, one SRS with 20 residents liaises with a large range of different support workers, many who change regularly. It is challenging and time-consuming for SRS staff to keep up to date with clients' needs and difficult for residents to build a rapport with changing support workers.

During the second extended lockdown, support workers contacted their clients by phone, or visited an SRS using an 'access' window. Some SRS did not allow support workers to enter during lockdowns while others seeking to maintain critical supports for residents imposed a time limit or requested they wait in the carpark to meet their client.

A serious incident was referred to the NDIS Quality and Safeguarding Commission by DFFH. Initially raised by Community Visitors, it involved the role of the 24-hour, NDIS support worker rostered overnight.

NDIS workers did not always demonstrate an understanding of client needs which potentially placed them at risk. In one instance, a worker brought inappropriate food to clients such as chocolate to a diabetic or alcohol for a resident with addiction issues. Another was dismissed due to being found drunk at the SRS.

Clients were placed at risk by support workers who entered SRS without checking in with COVID-19 protocols including temperature checks.

CASE STUDY

A proprietor told Community Visitors they refuted suggestions made by an NDIS support worker that Sam moved out of the SRS due to mistreatment.

Sam moved to another SRS where the proprietor also expressed frustration about the NDIS worker who did not abide by the COVID-19 protocols. Community Visitors were concerned that Sam designated the support worker as their nominated next of kin, despite her having contact with a family member.

The proprietor reported that Sam cried when leaving the second SRS without notice in the company of the support worker, allegedly relocating to a motel.

A staff member informed Community Visitors he wanted to become an NDIS provider partly due to the frustration of having to tolerate support workers who sat around smoking and drinking coffee with residents instead of taking them out, weren't punctual for their clients' medical appointments and were absent without notification. He felt he could offer a better-quality service and eliminate frustration for residents and staff.

SRS as NDIS businesses

Community Visitors have become increasingly concerned about the number of SRS proprietors registering and running NDIS businesses.

Their apprehension intensified in cases where they rated the SRS as poor or very poor in their current services to residents.

Community Visitors were reassured when one SRS proprietor acknowledged they operated a registered NDIS service, employing separate staff to provide different supports to what was offered by the SRS. Another SRS proprietor recognised the distinct and separate regulatory requirements for each business and was considering the practical impact of renewing their NDIS service provider registration.

Proprietors should be clearly able to demonstrate that they understand the framework and expectations of running their own NDIS business alongside an SRS.

While on visits, Community Visitors requested information to identify potential conflicts of interest where an SRS runs an NDIS business, and to document allegations of abuse that involve NDIS services. Many SRS proprietors would not reveal to Community Visitors if they ran an NDIS business, the name of that business, or which residents had signed contracts for their NDIS services.

Although Community Visitors are entitled to view NDIS plans held by the SRS, many managers were reluctant to share this information. This was further exacerbated by repeated lockdowns and remote visiting which prevented the inspection of documents onsite.

Community Visitors rarely observed that residents were offered choice and could exercise their preference in selection of their NDIS Support Coordinator and services if the SRS ran their own NDIS business. Furthermore, a resident's ability to communicate if their needs were being met was not monitored or assessed.

In some SRS, Community Visitors observed that residents on an NDIS package linked to an SRS proprietor received a higher level of service than those residents just paying for SRS services.

Residents receiving NDIS services should have an SRS Support Plan, and an NDIS Plan. A key concern raised by Community Visitors is that residents are a captive market and their NDIS packages could be being used to cross subsidise the SRS.

These concerns, together with the lack of transparency, have been raised with DFFH, the NDIS Quality and Safeguarding Commission and included in Community Visitor annual reports since the introduction of the NDIS in Victoria. The complex web of jurisdictional roles and responsibilities often make it difficult to understand who is responsible for what. In the meantime, Community Visitors are concerned that this leaves vulnerable residents exposed to exploitation, neglect, and abuse because it is unclear who is ultimately responsible for addressing these issues.

The DFFH is aware of the issues related to the co-structuring of NDIS and SRS businesses and is working closely with the commission, however, progress is slow. The Community Visitors are keen to see greater interjurisdictional collaboration to address these growing concerns.

In February 2021, the Public Advocate wrote to the commission documenting seven cases of alleged abuse by proprietors of SRS residents identified by Community Visitors. These were:

- refusing entry to or threatening to evict residents who would not sign up to the SRS proprietors' NDIS business
- double dipping of resident funds where the NDIS support worker is allegedly providing individual support services to a particular resident while simultaneously being employed in the SRS serving all the residents
- lack of transparency around the use of NDIS funds as some residents have claimed that their NDIS funds have 'disappeared'
- services previously provided as part of a resident's SRS agreement, such as showering assistance, is now only available to those who can pay separately under their NDIS plan, while SRS residents without plans now only receive 'shower reminders' with no reduction in SRS fees
- charging residents with an NDIS plan separately for services they already pay for in their SRS fees such as cleaning and laundry
- charging for NDIS services such as psychological support, that are not provided
- technological equipment purchased for residents through their NDIS plan disappearing for extended periods of time

At the time of writing, the commission had not responded.

A key issue impeding commission responses is the information sharing provisions in the NDIS Act. This combines with its internal regulations, which make it difficult to share information, even with statutory bodies charged with safeguarding.

Community Visitors will continue to document and raise these issues until the appropriate oversight occurs.

Programs and activities

Community Visitors in a regional area reported residents were often disinterested in the activities provided in their NDIS plan, so refused to participate. Concerns about the lack of resident choice and the billing of residents for these activities was not an appropriate use of their NDIS funds were escalated to the commission.

A responsible SRS manager advocated that the NDIS Support Coordinator should identify activities that met resident needs and interests rather than continue with activities that suited the NDIS service.

At this same SRS, there was only one community access activity enjoyed by all six residents receiving NDIS funding: a weekly drive for a picnic lunch. The SRS provided bus transport and food, so Community Visitors queried why only three staff from the NDIS service attended instead of one staff member for each NDIS participant. They also questioned if this was an appropriate use of funds consistent with the goals of the NDIS.

Physical environment and fabric

Community Visitors had fewer opportunities this year to physically inspect the SRS environment, however, they still observed a wide range of maintenance and fabric issues which negatively impacted residents.

One SRS had a spacious layout, however, several bathrooms needed major repairs, downpipes were rusted and there were several roof leaks, some of which were only partly repaired as the internal ceilings were still mouldy.

In one SRS, Community Visitors reported there was a strong smell of urine and smoke, two toilets soiled, and the toilet lights were not working. They also observed that the ramp next to the dining room exit was slippery and in need of repair. Staff said residents did not use this exit, however, the door was unlocked and easily accessible.

Some repairs were delayed due to COVID-19 restrictions, and SRS managers also shared their frustration about the challenges of negotiating with landlords to make building repairs including heating and cooling systems, rectifying a faulty fire alarm system and entrance doors. At another SRS, during a cold surge in winter, the heating and hot water system were not operating, and some residents were given buckets of warm water for washing.

The lack of security for residents' bedrooms and personal items was a concern raised by several residents who told Community Visitors that they did not have keys to lock their rooms. One resident asked if he could have access to a lockable drawer and another said she would like bedside drawers.

Community Visitors observed the challenges of implementing National Broadband Network upgrades to provide residents with Wi-Fi access. This is becoming essential for residents to access health services and interact in the community.

Food

SRS are required to offer residents varied, balanced, and nutritious meals.

Again, this year, Community Visitors reported residents' concerns about the poor quality of food, and lack of dietary alternatives available at some SRS. This included poor menu planning and rotation to meet the needs of residents, some who live with diabetes or Coeliac disease and need special diets, and ready access to drinking water and other beverages.

In the facilities that offer a nutritious revolving menu which incorporates preferences, residents are generally happier, with fewer behavioural issues or complaints, irrespective of whether they are in pension-level or pension-plus SRS. But in some facilities, food remains a consistent gripe, often dismissed as not a big issue despite the obvious contribution that adequate and good quality food and water makes to all people. It is a basic human right.

Issues reported by Community Visitors included:

- facilities struggling to access food supplies during the COVID-19 lockdown and being refused access to larger quantities of toilet paper and staple groceries despite holding a government permission letter
- ceasing morning tea, with staff not sure of why this was the case
- a lack of food choice, including only serving tea and coffee pots containing milk regardless of resident preference

- seven residents who complained to Community Visitors about food variety and serving size. A resident who was served a hot dog for dinner was required to purchase an alternative suitable meal. Long-term residents said they often complained, but that issues were only fixed temporarily. Community Visitors found the menu on the fridge did not match the meal served and there was no access to fresh water overnight. Following a notification to DFFH, the situation improved
- the cancellation of a regular fruit delivery without notice, limiting residents' access to fresh food
- staff stealing residents' specific food, resulting in angry outbursts by residents when supplies were gone
- a resident unable to easily digest powered milk in a facility where this is the only alternative. The proprietor asked the resident to pay for fresh milk via their State Trustee's administrator
- a freezer full of meals that were unlabelled and undated
- a resident who can only use part of his mouth, complained his dietary needs were not being met, but a staff member said they were addressing it.

In other SRS, good practice included:

- staggered mealtimes to accommodate the needs of social distancing, including the use of home-grown lettuce and coriander cultivated during the pandemic
- two residents who don't like pasta offered alternative meals
- food trucks on site and celebrations for special occasions
- a meal survey to consider the feedback and needs of residents.

Financial viability of SRS

Community Visitors reported low occupancy at many SRS this year.

They attended an emotional meeting of residents about the closure of an SRS in Bendigo. Despite the support provided by DFFH and community health services, residents were distressed at having to leave their comfortable and safe home to find alternate accommodation within 28 days.

Community Visitors recognise that the factors causing SRS closures are complex. The rising value of land across Melbourne metropolitan and regional Victoria can be a trigger for landlords to assess their return on investment and the viability of an SRS tenant where there is an ongoing financial investment required to maintain building and fabric. Many SRS were initially established to provide low-care residential support, particularly for frail aged people prior to needing nursing home care. However, there is now is increasing competition for residents who are eligible for aged Home Care Packages.

Residents with NDIS funding may choose or be assisted to exit SRS to take up other forms of accommodation, however, Community Visitors are alarmed that safeguarding provisions do not extend to the range of accommodation options they might access.

The Residential Services Board alerted DFFH to these concerns and recommended that further examination, intervention, and guidance is required to support SRS proprietors with declining occupancy across the sector. There are examples of well-run SRS which have coped well in the pandemic and maintained good occupancy rates that could be used as models for other SRS.

SRS require additional support to strengthen their long-term financial viability and be a housing option that effectively supports residents to achieve a sustainable quality of life. Most SRS continue to rely on the same channels and methods for securing new residents and could benefit from assistance to help them consider how their business can adapt. Options might include the use of social media platforms for advertising and marketing, providing greater person-centred and quality services and the development of relationships with local NDIS service providers as a means of attracting potential new residents to the sector.

Community Visitors provided feedback to DFFH that training for SRS proprietors and staff is inadequate and needs to be developed and delivered by professionals who have visited a variety of SRS including a pension-level, pension-plus, metropolitan and regional SRS. This would assist trainers to understand what an SRS is and how it operates, enabling them to better target their training.

Low occupancy in SRS has led to the reduction of activities and supports for residents and increased the necessity of proprietors to accept referrals from homelessness and mental health services seeking to find housing for complex clients. Community Visitors report on the challenges for staff, many who have English as a second language to deliver services to a diverse cohort and a changing resident mix.

On 2 July, an SRS Association Incorporation was formed as a sector response to increased pressures and a reduction in DFFH support following the 2018 SRS Regulatory restructure that prioritised compliance over education.

At meetings with DFFH, the Residential Services Board requested DFFH consider offering proprietors additional training to increase their capacity to better meet the market and build their business in response to the challenges of an evolving sector.

SAVVI and PLP funding

Some SRS received funding through the Victorian Government's Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) or the Pension-Level Projects (PLP). However, several pension-level facilities are without any Victorian Government funding or support.

Proprietors without access to SAVVI or PLP funding are struggling to provide effective support to their residents. It remains a critical concern for Community Visitors that the recommendations from a 2016-2017 KPMG review of the SAVVI and PLP funding to extend coverage to all pension-level SRS has not yet been implemented.

The Community Visitors Program was pleased to meet with Homes Victoria which now has responsibility for the strategic policy development and management of SAVVI and PLP funding. Community Visitors reiterated the importance of combining the two funding programs and opening them up to all pension-level SRS.

Community Visitors are anxious that future policy should include robust performance measures that ensure funds are used to benefit residents. The opportunity to share insights with Homes Victoria on the issues and challenges facing the SRS sector was appreciated, however, Community Visitors remain concerned about the time taken to address these issues.

A future use of SAVVI funds could be to assist SRS to acquire Wi-Fi and equipment for internet services that enable residents to access information and healthcare in keeping with community expectations.

Divisional Reports

East Division

East Metropolitan Melbourne

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. In addition, there are 20 pension-plus SRS including Kew Supported Residential Service which opened in October 2020 and has capacity for 51 residents.

Four SRS in this area reported an outbreak of COVID-19 in 2020 yet most proprietors have only recently received assistance for residents, many aged over 70 years, to access the first dose of the vaccine on site.

Abuse

This year, 14 residents were formally issued a Notice to Vacate at the SRS for reasons including causing serious damage to the SRS, endangering the safety of others, or causing serious interruption to quiet and peaceful enjoyment. In one case, police were called after a resident assaulted a staff member and pulled a fire hydrant off a wall.

Community Visitors in the outer-east metropolitan region observed many of these disruptive behaviours but also reported that some residents chose to move out of SRS during the lockdown due to distress, including two men who shared a room and went to live with one of their families.

A resident continues to have alcohol delivered to the SRS contrary to its rules and the agreement between herself and the manager. The resident intimidates some staff and makes it difficult for them to clean her room.

DFFH investigated Notifications from Community Visitors made about frail and aged residents who required more support and agreed to address compliance issues as well as monitor the SRS.

Health

Proprietors expressed gratitude for the nurses from the COVID-19 Emergency Response Team who visited facilities and worked with staff to explain PPE and assist in developing a COVIDSafe plan. However, the check list they provided was not seen as particularly helpful without masks, hand sanitiser and PPE being provided.

Many proprietors in the area support residents from 80 years old to over 100 years old and made extensive efforts to protect the residents from exposure to COVID-19. The Human Services Regulator wrote to all SRS proprietors regarding the balance required to afford residents their rights as any other citizen and the need to protect residents' health. SRS staff were challenged in reviewing each person's needs on a case-by-case basis, facilitate resident requests while not compromising the safety of others and maintain the mental health of residents who had no outside contact with the community during lockdown.

Social independence and choice

While many SRS were innovative and creative in offering activities during the lockdown, Community Visitors reported on facilities where there was a lack of activities for older people such as newspapers, magazines, cards, or board games. In these SRS, when NDIS support workers cannot enter the facility, there is little to gainfully occupy residents.

Hume

One pension-level SRS in northern Victoria, close to the New South Wales border, is a 30-bed residence, however, there were only 20 residents there for most of the year, all males.

Social independence and choice

GOOD PRACTICE

During the COVID-19 pandemic, a 'mini-shop' was set up in the SRS each afternoon for 30 minutes to sell snacks and discourage residents from going into town to buy these items. This continued throughout the year and was popular with residents.

SAVVI funding enabled a staff member to work with interested residents to develop individual exercise programs and create memory books.

NDIS

Several residents received NDIS support but did not like the activities proposed by the service or what could be accessed in the community. Other residents really enjoyed the support activities offered. For example, one NDIS support worker accompanied a resident to the library each week, helping him use his iPad and to download an app to listen to his favourite music.

Community Visitors are concerned that some services expect residents to fit in to the activities offered, rather than customising activities to suit their goals.

Community Visitors discovered that one resident on an NDIS plan chose to spend his mornings in bed, however, his NDIS support worker would come in the mornings to provide community access support. Although SRS staff suggested an afternoon visit instead, this did not occur.

North Division

Loddon Mallee

There are five pension-level SRS in the Loddon Mallee area. Bignold Park, a pension-plus SRS with 30 beds in Bendigo, made the voluntary decision to close on 8 June.

Abuse

Several instances of abuse, including physical aggression, occurred at a pension-level SRS and some were reported to DFFH for investigation.

Health

SRS residents with serious ongoing health conditions are not always referred for treatment or more suitable accommodation until a life-threatening crisis occurs.

An SRS resident, who was largely confined to her bedroom, required emergency hospitalisation after which she was relocated to aged care accommodation. At another SRS, a resident with severe respiratory issues was hospitalised on several occasions and died during one emergency admission.

Community Visitors enquire about the adequacy of support plans when residents' health needs change, however, this been difficult to identify due to phone visiting during COVID-19 lockdowns.

Social independence and choice

Community Visitors report that across the area there is a lack of activities for residents without NDIS packages. COVID-19 lockdowns have aggravated this situation as the agencies facilitating activities using SAVVI or community funding have been unable to visit.

Residents at one SRS who rely on engagement in the community, appreciated additional funding for a pizza night but still complained of being bored despite additional games and items provided for a weekly afternoon activity.

NDIS

Staff at one SRS report that residents are experiencing long delays to access NDIS support and plan reviews. SRS staff are overwhelmed by the need to assist eligible residents to make an application for funding, prepare for NDIS plan reviews, and engage with NDIS Support Coordinators or workers. In a low-care environment like an SRS, Community Visitors consider that more support from the Local Area Coordinator is required to educate and support residents.

Northern Metropolitan Melbourne

There are 17 SRS operating in the area, 12 pension-level and five pension-plus facilities.

Abuse

Police were called to an SRS when a resident began a physical fight with a co-resident over noise created by doors slamming. The manager installed a soft-close mechanism, and the issue was resolved.

Community Visitors enquired about a report of alleged sexual assault of a female at an SRS. Police were called but no charges were laid. DFFH ordered the proprietor install a new lock on the resident's door and the other resident was moved to another facility.

Health

Community Visitors reported that most residents received the influenza vaccine and the majority of facilities have now received access to a first dose of the COVID-19 vaccine.

Privacy, dignity, and confidentiality

Residents felt uncomfortable about a co-resident with dementia regularly using a toilet adjacent to the meals area with the door open. Community Visitors discussed installing a curtain or screening for privacy.

NDIS

Community Visitors are concerned about the long-term viability of SRS in the northern metropolitan area. Proprietors report local support services are enticing NDIS clients to rent cheaper accommodation rather than refer them to an SRS which offers regulated supported accommodation. However, one resident who moved to independent living showed considerable improvement and had the support of the former SRS manager who advised he could return, if needed.

A resident who moved out of an SRS told a manager she wanted to return to the SRS, her former home of six years, due to isolation, however, the NDIS worker was seeking a different accommodation type to promote independent living. The manager was concerned that the residents who live in independent living do not have the same access to medical facilities that the SRS can provide.

South Division

Gippsland

The Gippsland area has five SRS, including three pension-level and two pension-plus facilities.

Health

Community Visitors received a complaint about mice infestations at an SRS. The manager explained that regular baiting was required as some residents left food in their bedrooms that could not be managed by the regular cleaning. However, he agreed to contact a pest control service and consider other solutions.

Mental health issues

SRS managers complained about the lack of information sharing and proper referrals from health and mental health services. Residents can arrive without warning, in a taxi, without discharge papers or medication schedules. The outcome is that often both residents and management are frustrated and even placed at risk.

GOOD PRACTICE

Community Visitors reported that the mental health training organised for staff at a pension-plus facility was very effective and enjoyed by all participants. It validated the strategies that staff were already implementing.

Southern Metropolitan Melbourne

There are 37 SRS in the Southern Metropolitan Melbourne area, 26 pension-level and 11 pension-plus, however, three pension-level and one pension plus closed during the year.

In August, all residents of Hambleton House were evacuated following the outbreak of COVID-19 at the facility. Subsequently, on 29 September, the registration was revoked, and the SRS closed. Each resident was provided support to relocate to secure alternative accommodation. Community Visitors' increasing concerns, which were escalated to the DFFH over the last three years, regarding resident safety, ongoing risk, lack of adequate support and general cleanliness have now been resolved due to the closure. However, Community Visitors remain concerned that the outcome of a DFFH investigation into the SRS is yet to be completed and follow-up actions taken.

Crosbie Lodge closed in June. Residents were extremely happy with the process of finding a new home and Community Visitors felt the proprietors supported residents to find alternative accommodation which reduced the anxiety about moving.

Abuse

Two callers to OPA's Advice Service, requested Community Visitors visit an SRS to enquire about violence, and assaults as well as drug and alcohol use there. The callers reported the SRS had a 'zero tolerance' approach to violence, however, the alleged perpetrator of the violence remained at the SRS after the incident.

The proprietor did not disclose any incidents of abuse, so Community Visitors referred their concerns to DFFH for further investigation. It troubled Community Visitors that the proprietor subsequently disclosed incidents to the Authorised Officer. Refusing or neglecting to give reasonable assistance to Community Visitors is the duty of all proprietors under the Act.

Community Visitors remain alert to the concerns of residents who continue to be fearful of reporting matters of concern.

CASE STUDY

Community Visitors were deeply concerned about reports that an SRS manager is intimidating residents and threatened them with eviction if they complained about issues such as food, personal safety, poor environment, and support.

Residents told Community Visitors they wanted their complaints kept anonymous for fear of retribution.

DFFH was notified about four separate issues and, while the investigation did not substantiate every allegation raised, it did identify numerous areas of concern and non-compliance that resulted in enforcement action and ongoing review of the SRS.

Social independence and choice

GOOD PRACTICE

An SRS supported two residents to obtain part-time work, one in a motor factory and the other as a gardener.

A young resident with a disability moved to another SRS. Her parents asked that she did not go out alone in the area as it was unfamiliar and, as a result, a staff member started to accompany her on a walk every second day.

Safety

Some residents continue to smoke in their rooms despite the best efforts of staff to curb it.

Privacy, dignity, and confidentiality

Community Visitors were perturbed about the accuracy of a list of residents at one SRS. The list is often updated by hand, with names crossed off and others added, with no clear record of when updates occurred.

NDIS

Community Visitors spoke with an SRS manager about NDIS services' involvement with residents and their right to use external agencies for day trips and outings. One agency refused to give the SRS information about arrival and return times, which created problems with the organisation of residents' needs.

West Division

Barwon and Wimmera South West

There are three pension-level SRS and two pension-plus SRS in Geelong. A further pension-level SRS is in Warrnambool and another pension-plus SRS in Portland.

Abuse

There were multiple allegations of verbal abuse, sexual harassment, and aggression at all pension-level SRS as well as several violent incidents where residents were threatened by co-residents wielding weapons including knives, a fire extinguisher, and a meat cleaver.

An allegation of financial abuse of a resident by a family member was raised by an SRS proprietor. The resident was well-supported by the SRS and another family member is now the person's administrator.

Health

Community Visitors reported that several residents were admitted to acute mental health units while at SRS.

GOOD PRACTICE

At a resident's request, a pension-level SRS proprietor attends mental health case conferences with them as they have no relatives in the state.

Social independence and choice

Meals at one pension-level SRS were not to residents liking, however, this was addressed promptly by management.

All year, Community Visitors advocated for activities at one SRS without SAVVI funding. Although there have been some occasional activities provided, there has been no ongoing sustainable and meaningful activities offered and Community Visitors were advised that residents are too hard to engage.

GOOD PRACTICE

A resident at a pension-level SRS is a member of a theatre group.

Central Highlands

Following the closure of two SRS in the Central Highlands area between May and June, there are now five SRS, four in Ballarat and one in Ararat.

Community Visitors are concerned that four SRS have closed in the Central Highlands area since July 2019 and have been alerted by another proprietor about the viability of others continuing to operate.

Good rapport exists between Community Visitors, SRS proprietors, and support services in this area.

Abuse

Disruptive behaviour can be challenging for staff to manage.

A resident who yelled, swore, and slammed doors caused considerable fear in other residents.

Mental health services attended the pension-level SRS and administered Valium to help calm him. The following day, his behaviour continued so he was issued a Notice to Vacate and left with his support worker to a boarding house in the short-term. Other residents reported feeling calmer after he left.

Community Visitors also reported that many incidents were resolved with the support of staff.

Health

Community Visitors were informed of an incident in which a resident was alleged to have violently attacked a staff member. The incident was investigated and found to be false, yet it was discovered that the same staff member was involved in giving three residents the wrong medication on the same day.

All residents were monitored in line with advice obtained from the Poisons Information Line, and relatives notified. The staff member was the subject of disciplinary action.

Western Metropolitan Melbourne

There are seven pension-level SRS in the Western Metropolitan Melbourne area, including one facility that is not eligible to receive SAVVI or PLP funding.

Abuse

Community Visitors reported multiple allegations of verbal and physical abuse at some SRS.

At one SRS, police were called on several occasions when a resident stabbed a co-resident, another had auditory hallucinations and was aggressive; and a third reported an alleged sexual assault but did not want the SRS to know about the incident.

Following an alleged assault between a male and female resident, the proprietor arranged a meeting which included their next of kin enabling the situation to be managed.

Health

Several residents with poor health were admitted to hospital for treatment including for severe burns, pressure sores, stoma surgery, a kidney infection and self-harm.

Regrettably, a resident who overdosed tragically died at the SRS.

Another resident whose hands and fingers were very swollen responded aggressively to staff efforts to get medical attention and refused to see a doctor.

Safety

Residents reported being harassed by a local drug dealer. The proprietor arranged for CCTV to be installed and an intervention order to protect residents.

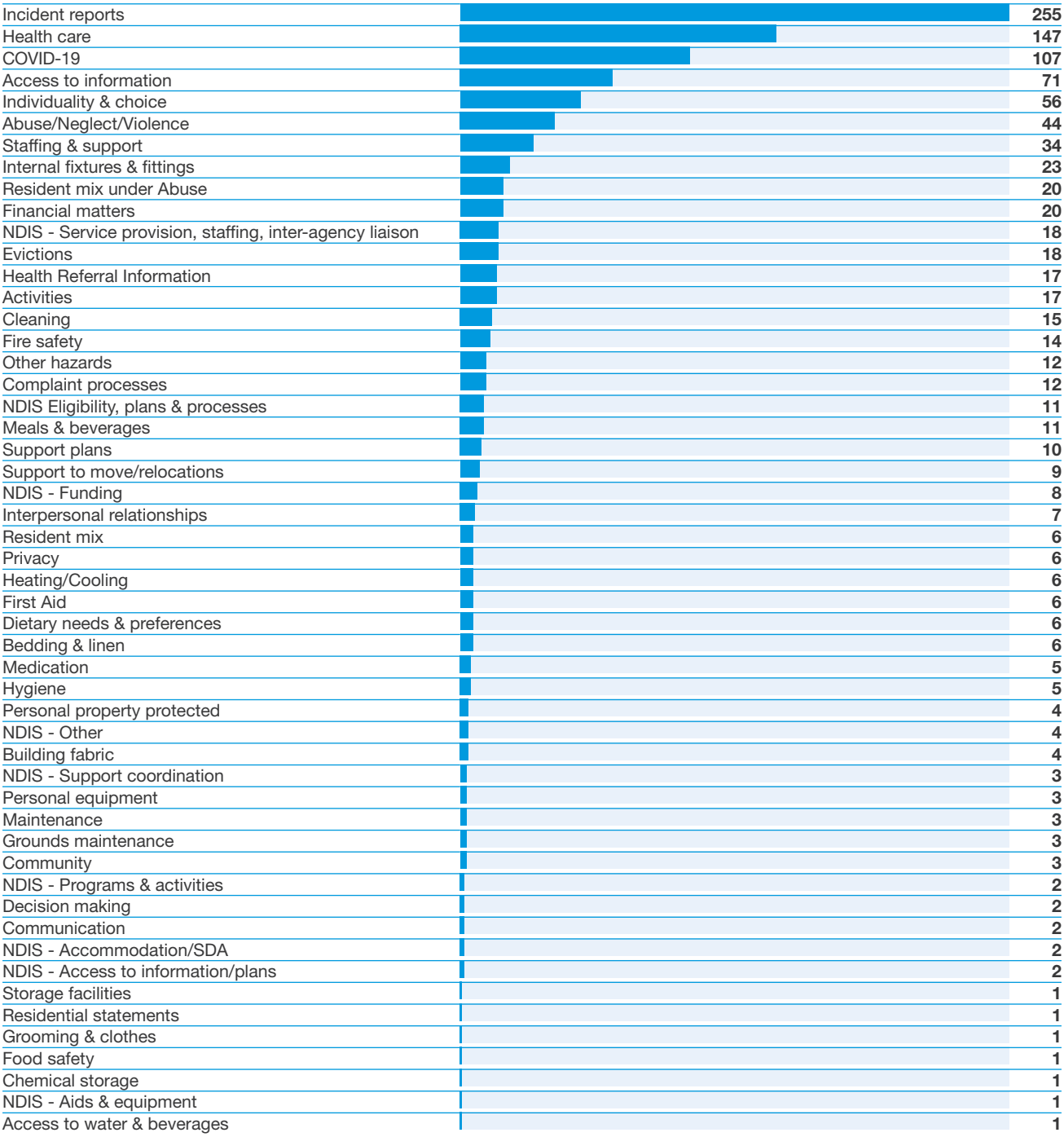
NDIS

Community Visitors investigated concerns reported to OPA by an NDIS Support Coordinator that SRS staff were always present when they met with residents and pressured them to have all their NDIS supports provided through the SRS-affiliated NDIS business, rather than exploring other independent NDIS providers.

Community Visitors discussed with the SRS proprietor the option of SRS staff attending a small part of an NDIS meeting. This was on the condition that, if consent from the resident was provided to convey resident history and support needs, then offering to leave to give the resident and the NDIS support worker privacy to conclude the meeting.

Although the proprietor acknowledged the benefit of this strategy, Community Visitors remained concerned that residents were not being supported to exercise independence and choice in selecting core NDIS supports.

Figure 10. **Disaggregation of issues reported by Community Visitors, 20/21**



Appendix 1: Community Visitors 2020–2021

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.

Deanne Ades
Ian Alexander
David Allen
Jenny Allen
Jo Allen
David Anderson
Arthur Apostolopoulos
Gudrun Argyropoulos
Kim Baker
Joyce Ball
Wendy Baneth RC
Christine Barbuto RC
Ricky Bartolo
Cheryl Beatson
Efi Bellchambers
Judith Berry
Judith Bink
Franciska Blanc
Rose Blustein RC
Marion Blythman RC
Dominic Boland
John Bowen
Kathleen Bragge RC (Deceased)
Rebekah Braxton
Fiona Breedon
Robyn Brewin
Sheena Broughton RC
Deidre Brown
Lorraine Bryant
Ian Buckles RC
Ronald Butler RC
Andrea Cahill
Heather Campbell
Kevin Campbell
Ken Castanelli
Joan Castledine
Pat Cerra
Chris Chapman
Carol Chenco
John Chesterman
Shri Chitale
Coleen Clare
Belinda Clark RC
Toni Clarke
Frances Coffey
Jo Cohen
Terry Collison
Kim Conder RC
Stefania Cortecci
Jeanette Coulter RC
Adele Coutts RC
Georgia Coverdale
Joanne Coverdale
Erin Cowley
Bryan Crebbin RC
Fiona Cromarty RC
Patricia Cross RC
Graeme Crutchfield
John Cull
Robyn Cunningham RC
Philip Dalliston
Wendy Davies
Pat Davison
Meryl Dawson
Melissa Debono
Beverley Devidas RC
L'Shae Dib
Graham Dickinson RC
Christine Dimer
Di Dixon
Alex Dobes
Kerrie Dobrzynski
Jenny Donaldson
Diana Donohue RC
Francine Dudfield
Jan Dunbar
Ian Dunn
Jennifer Dunn
Inez Dussuyer
Anne Eddie
Megan Edwards
Daisy Ellery
Elizabeth Elms
Pam Evans
Anne Fahey
Eveline Fallshaw RC
Mary Farbrother
Isabella Farrugia
Beth Faulkner
Gillian Fawcett
Jennifer Fenwick
David Ferguson RC
Deborah Field
Jeanette Findlay
Roger Findlay RC
Trudy Firth
Judy Fitzgerald
Maureen Fontana RC
Marilyn Forbes
Christopher Forde
Jan Forsyth
Natalie Fourie
Debbie Fowler
David Frame
Paulette Fraser
Ian Freeman
Judith Freidin
Anne Freudenberger-Kay
Emma Frisch
Dale Furey
Jayne Gallo RC
Dylan George
Sandra George
Ken Gibbs
Pam Giles RC
John Gleeson
Yan Gorrie
Swati Gossain
Mark Goy
Audrey Grace
Eddie Graham
Ruth Graham
Brian Granrott
Mandy Gray RC
Avril Green
Kay Gregory
Alan Grigson
Bill Grint
Gerard Grogan
Alan Gruner RC
Sue Gubby
Wendy Guy
Mike Hadley RC
Ghassan Haidar
Gail Haley
Sam Haouchar
Sally Hargrave
Susan Harraway RC
Lynette Harris OAM
Ian Harrison
Vera Hartelt
Barbara Hayes
Lynette Hayes
Carol Haynes
John Heath
Coral Heazlewood
Linda Helal
Neil Henderson
Jennifer Henry
Sue Herbst
Judy Heron
Pradeep Hewavitharana
Bill Hickey RC
Robyn Hickey
Colin Hinckson
Geoff Hoare
Jennifer Hocking
Wendy Holland
Pat Horan
Stephane Howarth
Mary Howlett
Natasha Hunt
Giordana Ienco
Paul Iles
Chris Ingram
Dallas Isaacs
Felicity Jack
Beverley Jacob
Maureen Jacobsen
Thomas Jambrich
Hibba Jamel
Mary James
Robert Jeferee
Lyn Johnson
Raymond Johnson
Valerie Johnson
Prue Jolley
Barry Jones
Heather Jones RC
Lynda Judkins
Don Juniper
Ivan Jurisic
Boudie Katamish
Karamjeet Kaur RC
Julie Kelly
Paul Kent
Jenny Kerr
Liam Kershaw-Ryan
Saima Khan
Brian Kiley
Debbie King
Mary King
Julie Klok
Sandra Knorpp
Alan Kohn
Amanda Kunkler
Francina Lagerwey
Suzanne Lau Gooey
Paul Lavery
Sandra Lawler
David Lawrence
Jayne Lawrence
Susan Lawrence
Debra Lee
Lawrie Leeman OAM RC
Robyn Leeman
George Lefoy
Annie Lenaghan
Lynette Lewis
Mark Lewis
Rob Lewis RC

Beverley Libbis
Nuala Licata
Vashti Lloyd
Louise Long
Jennifer Lush
Virginia Mack
Paul Mackness
Colleen Macqueen
Umberine Madan
Carole Maher RC
Jenny Maiolo
Kaye Manners
Jessica Marie RC
Linda Markowiec
Rohan Marlow
Jenny Martin
Valerie Martin
Brooke Mason
Pam Masters
Cindy Masterson RC
Julian Maugey
Wendy Mayne
Ian McBeath
James McCarthy OAM
Patrice McCarthy
Kaye McClure-Leckie
Carole McElvaney
Stephen McElwee
Paddy McGennisken
Catherine McGowan
Irene McGrath
Pamela McGregor
Deborah McLachlan RC
Heather McLeish
Brenda McMinn RC
Louise McPhee RC
Catherine McRobert
Laurie Messenger
Alex Miller
Frank Miragliotta
Nina Mobach
Joanne Moore
Asher Moses
Rachel Mulder
Marj Munro RC
Alan Murphy RC
Gerald Mutubuki
Phillip Myers
Danielle Neal
Andrew Needham
Craig Ng
Sue O'Brien RC
Kim O'Donoghue
Janine O'Neill
Dave Parker RC
Wendy Patchett
Jim Paterson RC
Judith Pauwels
Cheryl Paxton
Stephen Peterson
Daniel Petrasek
Wendy Pfeifer
Max Pietruschka
Sally Polack
Regina Prakash
Nancy Price
Robert Proudlock
Margaret Purves
Rose Randall
Helen Rawicki
Ann Ray RC
Neil Ray
June Rea
Keren Reeve
Sue Rewell RC
Maureen Rhodes RC
Bryan Richards
Kathy Richards
Dawn Richardson
Julie Ritchie
Dany Roberts
Ryan Robertson (Deceased)
Hugh Robinson
David Roche
Vivienne Roche RC
Jo Roger
Pam Roth
Ainsley Rozario
Linda Rubinstein
Frances Schepisi
Axel Scholz
Diane Seren
Debra Sevastianov RC
Rosemary Shaw OAM
Tracey Shawyer
Daphne Shiek
Awtar Singh
Mohini Singh
Puvana Sivakumar
Jennifer Smith
Nicole Smyth
June Soutar
Helen Sparrow
David Stafford
Glenn Staunton
Ray Steadman RC
Gideon Stein
Gavin Stewart
Graham Stickland RC
Suzanne Straney
Susan Strohfeldt
Sheryl Summons
Bill Swannie
Robert Swiger
Anne Tait RC
Alan Talukdar
Graeme Thornton
Rosslyn Thurrowgood RC
Julia Tivendale
Nam Tran
Meryle Trentini
John Trevillyan
Helen Tribe
Julie Trompf
Demi Tsaroumis
Stephanie Tufft
Merrill Tunstall
Kathy Turcan
Gary Turner
Malcolm Urqhart
Linda van Draanen
Adam Veitch
Antonia Veneracion
Kate Walker
Lynn Wallace-Clancy RC
Sylvia Walton AO
Sebastian Waluk
Betty Waters
Melinda Watt
Jennifer Weber
Christine Weetch
Sally Wellard
Wendy Wereta
Calvin White RC
Michael White
Susan Whitehead
Liz Whyte
Dianne Wilde
Beverley Williams
Carole Williams
John Williams
Joanna Williamson
Ros Williamson
Elaine Wilson
Linda Wilson RC
Sheila Winter RC
Lyn Wood RC
Megan Wood
Tricia Woodcock
Rhonda Woodrow
Ying Yew
Ping Yu
Annie Zahra
Susan Zammit
Ignatius Zanetidis
Alison Zylberberg

Appendix 2:
Facilities eligible to be visited

Community Visitors are Victorian Governor in Council appointees who visit facilities in pairs. They visit group homes, inpatient facilities and Supported Residential Service facilities.

Disability Services Providers

Ability Assist
Ability Hut
Able Australia
Accommodation and Care Solutions
AGAPI Care Inc.
Alkira
Amicus
Annecto Inc.
Araluen Centre
Aruma
Aspect Australia
Asteria Services
Australian Community Support Organisation (ACSO)
Australian Home Care Services
Bayley House
CareChoice
Carinya Society
Colac Otway Disability Accommodation Inc.
Community Living & Respite Services Inc.
ConnectGV
Cooinda Terang Inc.
Department of Families, Fairness and Housing (formally Department of Health and Human Services)
DPV Health Ltd.
Expression Australia
Encompass Community Services
Epworth HealthCare
ERMHA
Focus
Gateways Support Services
Gellibrand Support Services
genU
Golden City Support Services Inc.
Healthscope Independence Services
Home@Scope
IDV Inc.
Independence Australia
Jesuit Social Services
Jewish Care Victoria
Jigsaw Blue
Kirinari
Kyeema Support Services
Life Without Barriers
Mallee Family Care Inc.
Mansfield Autism Statewide Services
McCallum Disability Services Inc.
Melba Support Services
Melbourne City Mission
Merriwa Industries
Mind Australia
Mirridong Services Inc.
MOIRA
Monkami Centre Inc.
Multiple Sclerosis Limited
Nadrasca
Nepean Centre
Nextt Group Pty Ltd.
Northern Support Services
Noweyung Ltd.
OC Connections
ONCALL Group Australia
OzChild
Pinnacle
Possability
Providing All Living Supports (PALS) Inc.
Scope Australia
Southern Stay Disability Services Inc.
St John of God Accord
Statewide Autistic Services (SASI)
Sunraysia Residential Services Inc.
Trio Support Services
Uniting (Victoria & Tasmania) Limited
Villa Maria Catholic Homes (VMCH)
Vivid
Wallara
Woodbine Inc.
Yooralla

Mental Health Providers

Albury Wodonga Health
Alfred Health
Austin Health
Ballarat Health Services
Barwon Health
Bendigo Health
Eastern Health
Forensicare
Goulburn Valley Health
Latrobe Regional Hospital
Melbourne Health
Mercy Health
Mildura Base Public Hospital
Monash Health
Peninsula Health
Royal Children's Hospital
South West Health Care
St Vincent's Hospital Melbourne
Stawell Regional Health

Supported Residential Services

Aaron Lodge (Closed15 May 2021)
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

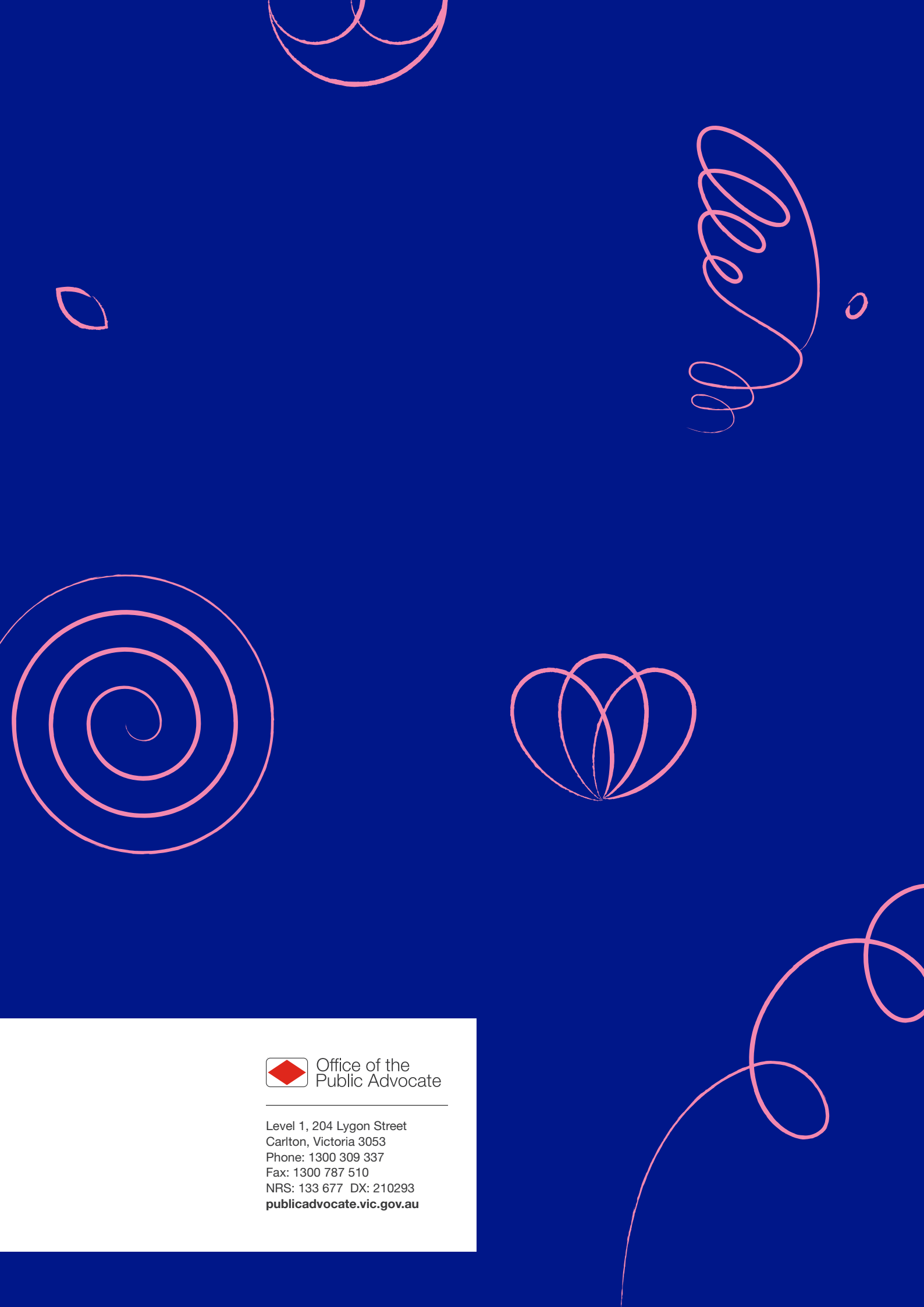
Berwick House
Bignold Park (Closed 8 June 2021)
Blue Bells Crofton House
Blue Willows Residential Aged Care
Brooklea Lodge
Brooklyn House
Browen Lee Home – Ballarat
Browen Lee Lodge – Brown Hill
Brunswick Lodge
Burwood Lodge
Caulfield House
Caulfield Manor
Chatsworth Terrace
Chippendale Lodge
Coorondo Home
Corandirk House
Covenant House
Cranhaven Lodge
Crosbie Lodge (Closed 30 June 2021)
Crystal Manor
Darebin Lodge
Doncaster Manor
Dorset Lodge
Dunelm
Eagle Manor
Edwards Lodge
Elgar Home
Eliza Lodge (Closed 22 Dec. 2020)
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 (Closed 29 Sept. 2020)
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 Care (Bendigo)
Karinya
Kew (Opened 26 Oct. 2020)
Kilara House
Kooralbyn Retirement Lodge
Kyneton Lodge
L'abri
Lilydale Lodge
Manalin House
Maroondah House
Mayfair Lodge
Meadowbrook
Melton Willows
Merriwa Grove
Mont Albert Manor
Mornington House
Mulvra Aged Care (Closed 28 June 2021)
Mulvra Place (Closed 28 May 2021)
Northern Terrace
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
Sydenham Grace
Themar Heights
Trentleigh Lodge
Viewmont Terrace
Warranvale Gardens
Wattle-Brae
Waverley Hill
Westley Garden
Westpeak Residential Services Belmont (Registered 23 July 2020, formerly Belmont Manor)
Westpeak Residential Services Mount Waverley (Registered 23 July 2020, formerly Oakern Lodge)
Westpeak Residential Services Surfcoast (Registered 23 July 2020, formerly Surfcoast Supported Accommodation)
Westpeak Residential Services Vermont (Registered 23 July 2020, formerly Vermont Gardens)
Whitehaven
Waverley Hill
Westley Garden
Whitehaven

Appendix 3: Glossary

This is an alphabetical index that explains the acronyms used in this report.

ABI	Acquired Brain Injury
BD	Brain Disorder
BSP	Behaviour Support Plan
CALD	Culturally and Linguistically Diverse
CCU	Community Care Unit
CDDHV	Centre for Development Disability Health Victoria
CHAPS	Comprehensive Health Assessment Plans
CSO	Community Service Organisation
DFATS	Disability and Forensic Assessment and Treatment Service
DDSO	Disability Development and Support Officer
DH	Department of Health
DFFH	Department of Families, Fairness and Housing
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
HSR	Human Services Regulator
IGUANA	Interagency Guideline for Addressing Violence, Neglect and Abuse
IQ	Intelligence Quotient
ISP	Individual Support Package
LGA	Local Government Area
LGBTIQ	Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex and Queer
MACNI	Multiple and Complex Needs Initiative

MHT	Mental Health Tribunal
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-government organization
OCP	Office of the Chief Psychiatrist
OPA	Office of the Public Advocate
OPP	Office of Professional Practice
OPU	Older Person's Unit
PACER	Police Ambulance Crisis and Emergency Response
PAPU	Psychiatric and Assessment Planning Unit
PARC	Prevention and Recovery Care
PEG	Percutaneous Endoscopic Gastrostomy
PRN	Pro Re Nata (medication provided as needed)
RC	Regional Convenor
SAVVI	Supporting Accommodation for Vulnerable Victorians Initiative
SDA	Specialist Disability Accommodation
SECU	Secure Extended Care Unit
SIL	Supported Independent Living Provider
SOCIT	Sexual Offences and Child Abuse Investigation Team
SRS	Supported Residential Services
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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