Community Visitors

Annual Report 2021–22

Office of the Public Advocate

Safeguarding the rights and interests of people with disability

Mental Health • Residential Services • Disability Services

Hannah Bozik
The Neurodiverse Peacock, 2019
Pen, ink and watercolour

About the cover image

"All the other peacocks are blue but this peacock was born green with rainbow feathers and is the odd one out. It hopes to find some new friends who are also the odd ones out. The picture celebrates Neurodiversity Week. I am very creative and visual because I have autism. Being different can be good."

About the examples and stories

All names and some identifying features have been changed in the examples and stories used throughout this report.

Content warning

Please be advised that this report refers to abuse, neglect, and death and may be distressing.

Safeguarding the rights and interests of people with disability

Community Visitors Annual Report 2021–2022

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OF THE PARLIAMENT OF VICTORIA, 2023

Letter of transmittal

24 March 2023

The Hon. Gabrielle Williams MP
Minister for Mental Health
Minister for Treaty and First Peoples
Minister for Ambulance Services
Level 22, 50 Lonsdale Street
Melbourne VIC 3000

The Hon. Lizzie Blandthorn MP
Minister for Disability, Ageing and Carers
Minister for Child Protection and Family Services
Deputy Leader of the Government (Legislative Council)
Level 22, 50 Lonsdale Street
Melbourne VIC 3000

Dear Ministers

RE: Community Visitors Annual Report 2021–2022

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 2021–2022*.

This year, the report is based on information gathered during 3411 visits by 383 active volunteer Community Visitors across Victoria. The report identifies issues that are critical to the human rights, safety and treatment of Victoria's most at-risk citizens who, due to disability and mental health issues, require 24-hour support.

Most concerningly, the report reveals unacceptable levels of abuse, neglect and violence in the places people live and receive treatment or support, in both government and non-government services. It also provides an important insight into the enduring impact of COVID-19 on people with disability and mental health issues; on the benefits and frustrations of the NDIS; and on the dire lack of affordable and accessible housing which holds people in living situations that would shock most Victorians.

Community Visitors are also pleased to report on the good practice they saw during their visits, and present to you their recommendations for reform. The Community Visitor boards commend this report to you and look forward to receiving your response.

Yours sincerely

Colleen Pearce
Public Advocate & Chairperson of the Community Visitor boards

Contents

Report from the Public Advocate

Dr Colleen Pearce

Introduction

It has been another challenging year for Victorians as the impact of the COVID-19 pandemic continued. Community Visitors have again dedicated themselves to their vital safeguarding role, visiting throughout the year remotely when they had to, and in-person whenever they could.

Community Visitors are Victorian Governor in Council appointees who have powers to make unannounced visits to prescribed facilities. They monitor and report on the quality of life and standard of services provided to people with disability and mental health issues.

This year, 334 appointed Community Visitors and 102 trainees conducted 3411 visits at 1246 facilities. They identified 5472 issues requiring action from services. Community Visitors also responded to an increase in calls to OPA's Advice Service from people requesting a visit, particularly during COVID-19 lockdowns.

COVID-19

As the lockdowns and restrictions came and went, Community Visitors switched from remote visiting to in-person visiting and back again to meet the needs of the people they visit.

People living in Supported Residential Services (SRS) faced periods of isolation as whole facilities were required to quarantine. Consumers in mental health units told Community Visitors about the effect of visitor bans, boredom, and extended stays. Community Visitors reported that people living in disability accommodation were often confused about why they were locked down again. Staffing shortages were perpetual across all services creating serious risks for people and workers and are continuing now.

> *95 per cent of Community Visitors told us that they intend to be in the program in 12 months from now."*
>
> *— Colleen Pearce, Public Advocate*

Abuse, neglect, and violence

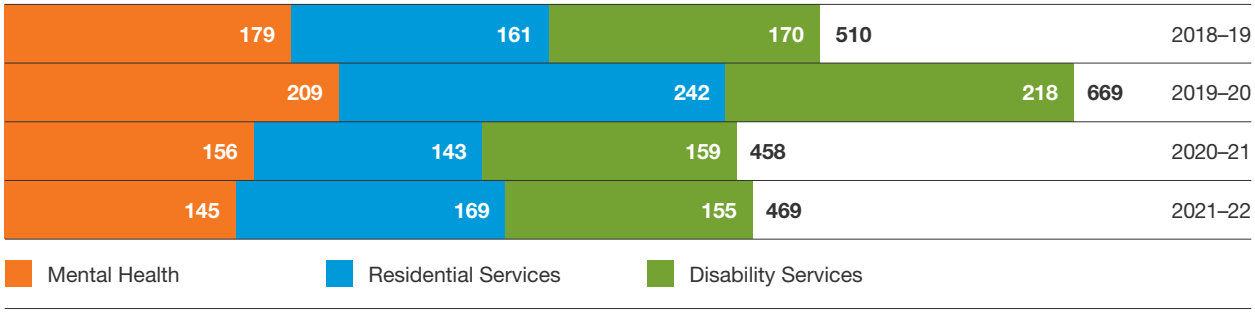
Community Visitors have been reporting on the unacceptable abuse, neglect and violence experienced by people with disability and mental health issues for 35 years. Community Visitors reported on the terrible conditions of people living in large institutions in their very first annual report in 1988. We rightfully expected that after more than three decades of sustained advocacy that the places where people live and receive support could be free from abuse, neglect, and violence. But Community Visitors consistently report that they are not.

Community Visitors have again reported this year on abuse and neglect in Supported Residential Services (SRS). SRS were designed for people with low support needs but are increasingly used as a last resort placement for people who need much more support than the SRS can provide. Community Visitors see violence between residents and the neglect of people with complex support needs, with hospitals and mental health services discharging people to SRS without the supports in place that people need. This creates a cycle of admissions in and out of acute care for some of Victoria's most at-risk people.

In disability accommodation, resident incompatibility is the reason most often recited for why people are being hurt. Governments are doing little to create the quantum of affordable and accessible housing that is needed for the people Community Visitors visit. Neither is the National Disability Insurance Agency (NDIA). It is negligent to have evidence that at-risk people are living with violence and do nothing.

Community Visitors want to see more action taken on the causes of the problems they have reported on over and over. People with disability and mental health issues deserve much better.

Figure 1. Community Visitor reports of abuse, neglect and assaults across all streams, 18/19–21/22



Reforms we need

Residential Services Community Visitors noticed a significant improvement in the responsiveness of the new Human Services Regulator's notification system this year. They were pleased to see SRS' deregistered where there were repeated and major breaches of legislated standards and expect to see similar regulatory action under the new Social Services Regulator.

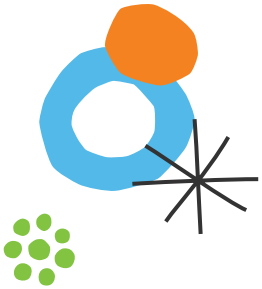
The Mental Health Board advocated for Community Visitors to have more powers under a new Mental Health and Wellbeing Act including conducting remote visits, taking photographs, and the power to view incident reports. Mental Health Community Visitors are also anticipating the positive impact of the state government's $868.8 million investment in the expansion of mental health services across the state. It is long overdue.

Disability Services Community Visitors have witnessed incredible change over the last 9 years as people with disability began to benefit from the National Disability Insurance Scheme (NDIS). However, they remain frustrated that they are not yet receiving information from the NDIA about the location of new visitable properties, resulting in significant safeguarding gaps for at-risk people.

Thank you

This year, we surveyed Community Visitors about their volunteering experience, and while the Australian volunteering sector has seen a sharp decline in people returning since the start of the pandemic, 95 per cent of Community Visitors told us that they intend to be in the program in 12 months from now. It's a testament to the dedication and commitment of the Community Visitors that they continue on year after year ensuring that their valuable safeguarding role is always available to people who need it.

On behalf of all Victorians, I thank each and every Community Visitor for their outstanding contribution this year to the people they visit, particularly in hard times, to safeguard their rights in the places they live and receive services. Their impact made a difficult year safer, better and fairer.



PUBLIC ADVOCATE STORY : SRS DEREGISTRATION

This year, the Human Services Regulator (HSR) took action against two Supported Residential Services – Sydenham Grace and Grace Manor. Investigations undertaken by the HSR found serious contraventions of the Supported Residential Services (Private Proprietors) Act 2010. Signed affidavits were produced by residents and their families, current and former employees, and allied health workers about the conditions at both facilities.

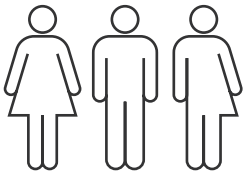
The investigations found evidence of:

- bullying, intimidation, coercion and abuse of residents
- unsafe, unhygienic and uninhabitable living conditions
- insufficient quality and quantity of food
- inadequate provision of personal and health care
- improper storage and provision of medications
- hindering access to NDIS and health services
- opening private mail and forging resident's signatures
- failing to keep and falsifying records and incident reports
- insufficient staffing
- obstructing communications between residents, their family members and appointed guardians
- admitting residents who were unsuited to live in an SRS, resulting in an inappropriate and unsafe mix of residents
- that the services were not financially viable.

In June 2022, both Sydenham Grace and Grace Manor were deregistered by the HSR. The facilities had the same person listed as sole director.

Community Visitors had repeatedly raised concerns about the situation for residents at Sydenham Grace and Grace Manor. They are to be congratulated on their tireless efforts to make the problems known to the HSR and the Department of Families, Fairness and Housing. Community Visitors worked hard to see that the HSR was established and are pleased to see that action has been taken in these two cases.

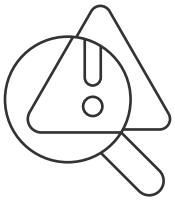
2021–2022 Snapshot



383

Community Visitors

↑ 12% from 20–21



5472

issues identified

↑ 7% from 20–21

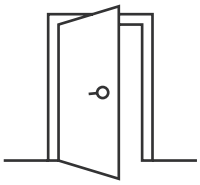
118

new trainees

153

visits requested*

↓ 33% from 20–21



1246

facilities visited

↓ 15% from 20–21

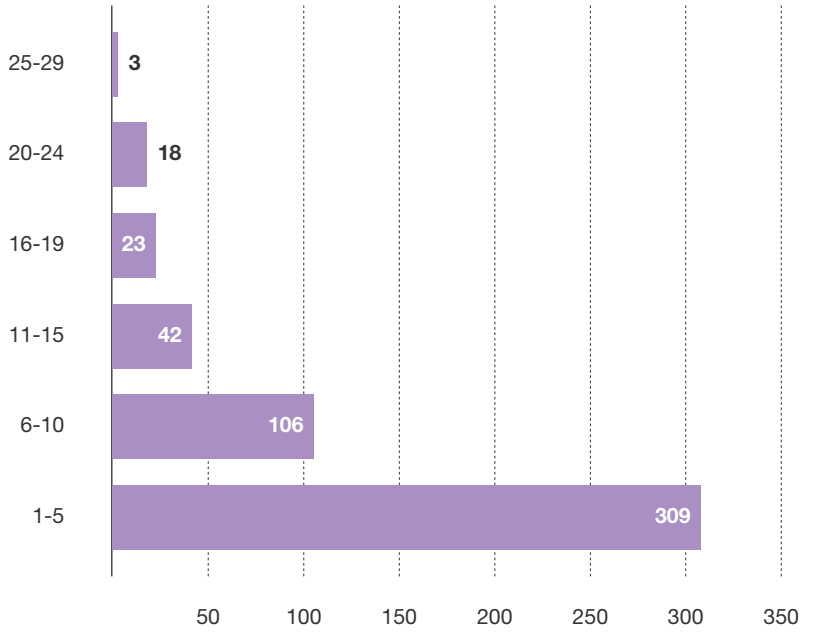
3411

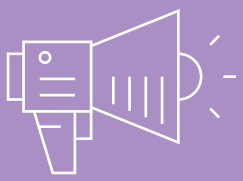
in person & remote visits

↓ 8% from 20–21

*Community members who have contacted OPA to request an urgent visit

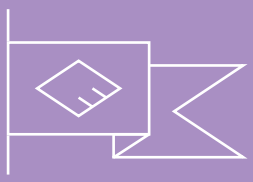
Community Visitors & trainees by years of service
21/22





469

issues raised with services on abuse, neglect, and violence



87

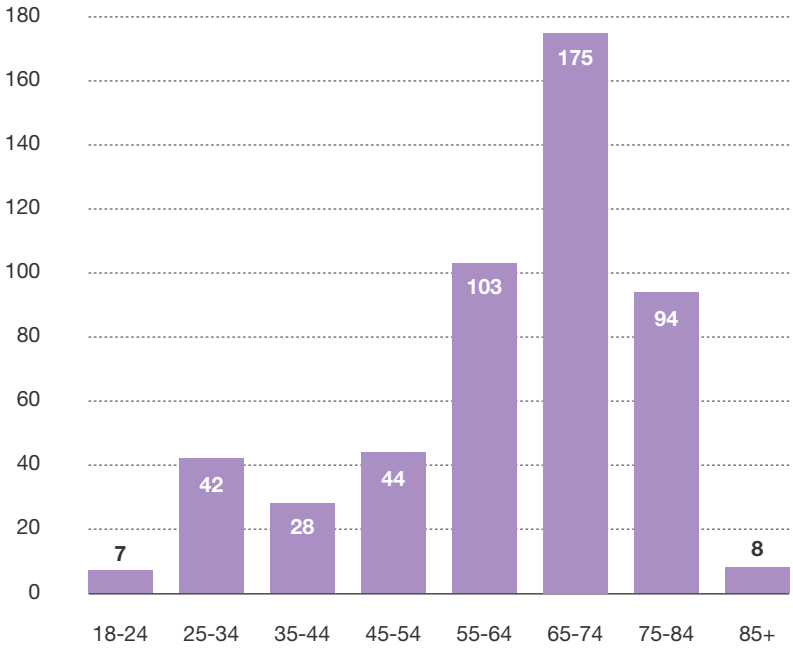
years young

Maureen Fontana is OPA's oldest volunteer. Followed by Audrey Grace and Ian Alexander who are both 86.

20 years of age, makes Senuri Weliwattege, OPA's youngest volunteer.

26 years of service, means Dominic Boland is OPA's longest serving volunteer.

Community Visitors & trainees by age
21/22



1.

Introducing the Combined Board

Public Advocate and Board Chair

1. Dr Colleen Pearce

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 disability in Victoria and the chair of all Community Visitor boards. Colleen fearlessly advocates for the human rights of people with disability and mental health issues, and is outspoken on the abuse, neglect, and exploitation of at-risk and marginalised people.

Colleen has more than 40 years' experience managing community and health services in both the government and non-government sectors. Her 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.

2.

3.

Residential Services Board

2. Lynn Wallace-Clancy

Lynn started as a Community Visitor in the Disability Services stream in 2010 and was appointed into the Residential Services stream in 2012. She has been a Regional Convenor since 2015 and visits in regional Victoria in the western division.

Lynn has a Master of Arts (Communications) and has more than 20 years' experience working with culturally diverse and refugee communities in Adult Multicultural Education Services. Since retiring she has also volunteered in Timor Leste training local teachers. Lynn has experience on boards including as a member of the Adult and Community Education Board.

Lynn is pleased that the outcome of the tragedy that was Hambleton House has been better regulation and is proud to be part of the team of Community Visitors that achieved it.

3. Beverley Devidas

Beverley Devidas was appointed as a Community Visitor in 2018 and is a Regional Convenor. This is her second year of 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.

Beverley has made an outstanding contribution to the Residential Services Board, including providing leadership in advocacy for the introduction of the Human Services Regulator and the development of its new protocol with Community Visitors.

4.

5.

6.

7.

Mental Health Board

4. Anne Fahey

Anne Fahey was appointed as a Community Visitor in 2019. This is her second term on the Mental Health Board. Anne lives in Bendigo and has a keen interest in issues that affect people living in rural and regional Victoria.

Anne has an Honours Degree in History, a Diploma of Education, a Graduate Diploma in Sociology and a Masters of Assessment & Evaluation. Anne's postgraduate study has been in mental health service delivery. In addition to her teaching experience, Anne has managed psychosocial support services as well as disability and aged care services. Anne is also a member of the Positive Ageing Advisory Committee for the City of Greater Bendigo.

Anne considers it to have been a privilege to serve on the board to support the Community Visitors in their response to the challenges of safeguarding during the pandemic and the lockdowns. Anne is impressed by the resilience of Community Visitors in continuing to advocate for consumer rights, their commitment to collaboration, and their responsiveness to change.

5. Nicole Smyth

Nicole Smyth was appointed as a Community Visitor in 2019 and was elected to the Mental Health Board in 2021. Her experience living and working in Malaysia, UK, Germany, and The Netherlands has given her a unique perspective and a deep appreciation for cultural diversity. She currently works as a Community Liaison Officer for a digital start-up company where she leverages her skills to connect with stakeholders and build strong relationships.

With a degree in Business Information Systems and postgraduate qualifications in Community Development and Mental Health, Nicole is committed to addressing the challenges that have arisen as a result of the COVID-19 pandemic.

Disability Services Board

6. Daisy Ellery

Daisy Ellery was appointed as a Community Visitor in 2020 and visits in the east division in the Disability Services stream. She has a Bachelor of Arts from La Trobe University and a Melbourne University Graduate Diploma in Gender Studies.

Before retiring, Daisy worked as a Hospital Administrator managing staff and ensuring adequate patient care between departments. Daisy volunteers with homelessness services and is a peer researcher on aging in Australia, with a particular focus on women. She is also a past Chairperson of the Housing for the Aged Action Group.

Daisy has enjoyed her time on the Disability Services Board and made an important contribution to supporting Disability Services Community Visitors in remote visiting during COVID-19 restrictions.

7. Craig Ng

Craig Ng was appointed as a Community Visitor in 2014. He visits disability group homes in the Eastern Metropolitan Region (Inner East) and served as a Regional Convenor from 2015 to 2018.

Craig is a lawyer by training, with degrees in Law and Economics. He has been practicing law for over 30 years and was a partner at national law firm Maddocks before retiring from full-time legal practice in 2010. He currently advises international Internet bodies on governance and stakeholder-engagement issues.

Craig feels privileged to be in a position to engage with his local community, particularly meeting community members with disability, and to advocate for issues that matter to them.

About Community Visitors

Kay Gregory, Disability Services Community Visitor, 10 years of service certificate, with Anthony Carbines (left), Minister for Disability, Ageing and Carers and Dr Colleen Pearce (right), Public Advocate - June 2022

Community Visitors are volunteers that visit people with disability and/or mental health issues in facilities across Victoria. They are independent statutory appointees who are formally appointed for 3-year terms by the Governor in Council after completing training with other Community Visitors and by the Office of the Public Advocate. In 2021-2022, there were around 500 Community Visitors and their trainees conducting visits across Victoria.

Community Visitors have powers under 3 Acts of Parliament:

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

Each Act establishes a board and each board is comprised of 2 elected Community Visitors and the Public Advocate. The boards are responsible for representing Community Visitors, reporting the activities of Community Visitors to government, supervising the training of Community Visitors, and escalating serious issues from their visits to the Public Advocate, Ministers, and to any complaints, regulatory or oversight body they choose.

Disability Community Visitors visit people who live in disability supported accommodation, such as group homes, Specialist Disability Accommodation and Short Term Accommodation. Mental Health Community Visitors visit people in mental health units and services that provide 24-hour care. Residential Services Community Visitors visit people in Supported Residential Services where up to 80 people live together.

Community Visitors make regular unannounced visits in groups of two or more. They make enquiries about the support people receive and their living conditions. They examine documents about the services people receive. At the end of each visit, Community Visitors write a report summarising their observations and listing items where action is required from services. A copy of the report is provided to a senior staff member at the service. Legislation requires that services respond in writing within a prescribed timeframe to any concerns Community Visitors have raised.

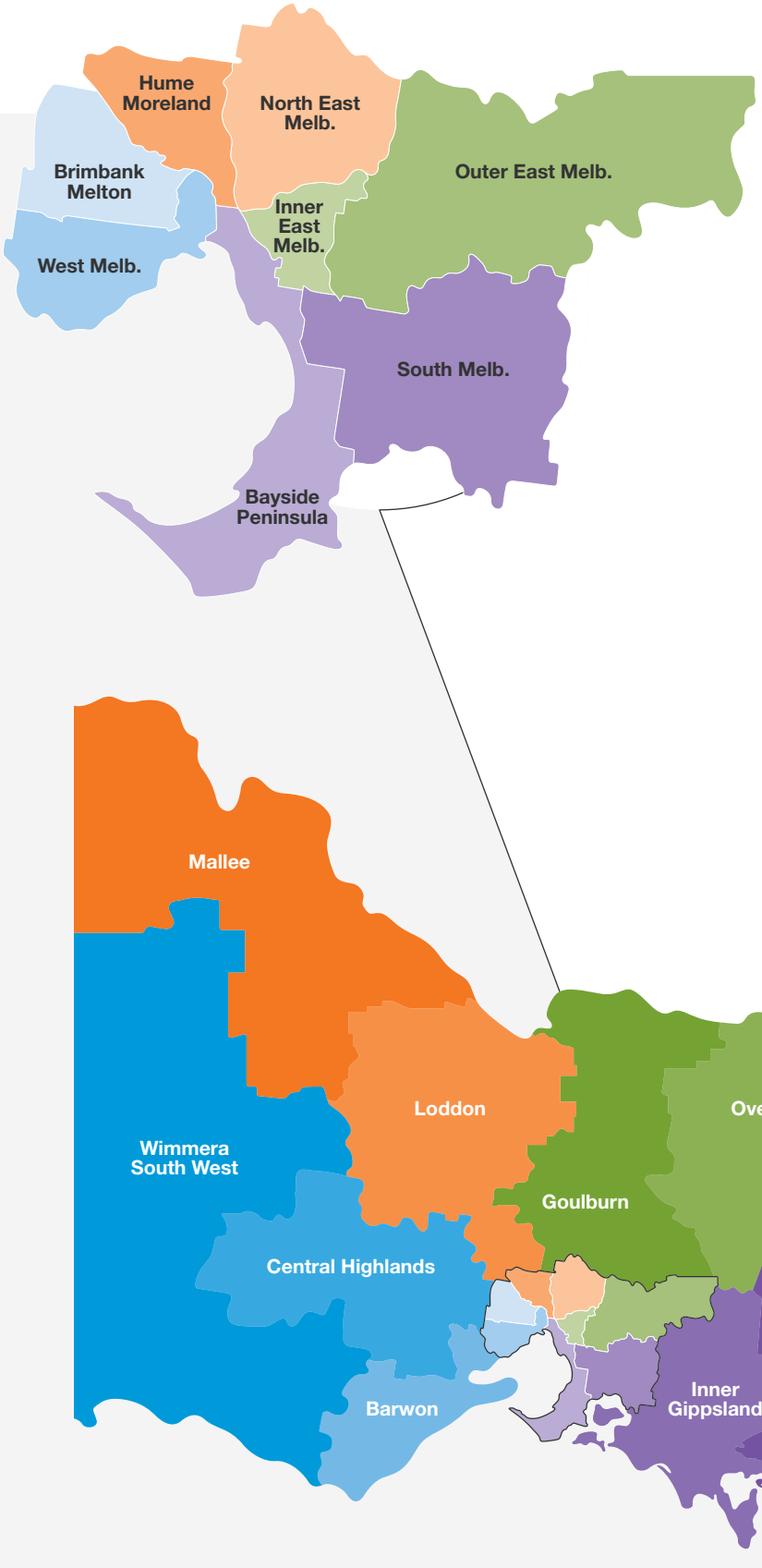
If Community Visitors are not satisfied with the response of a service, or if they don't receive one, they will escalate their concerns to senior management, or to the relevant government department or funding body. Serious abuse and neglect is referred via the boards to other responsible bodies for action, including the NDIS Quality and Safeguards Commission, Office of the Chief Psychiatrist and the Human Services Regulator.

The Office of the Public Advocate provides support to Community Visitors to undertake their role, including with recruitment, administrative support, training, advice, data analysis, the preparation of reports to government, and assistance with advocacy.

Table 1. Number of active Community Visitors and number of visits, 21/22

Stream	Active Community Visitors	Visits
Mental Health	57	716
Residential Services	67	743
Disability Services	210	1952
Total	**334**	**3411**

Reporting Divisions



East Division

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

North Division

- Mallee
- Loddon
- Hume Moreland
- North East Melbourne

South Division

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

West Division

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

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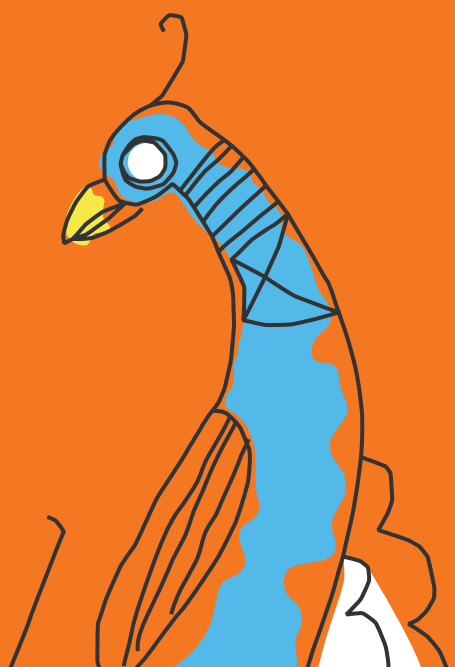
Mental Health



Recommendations

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

1. Urgently fund and implement strategies to address the critical workforce shortages in mental health services to enable the expansion in line with the proposed mental health reforms - more nurses, peer workers, allied health practitioners and psychiatrists are all needed in the short and longer term

2. Continue to promote and fund risk prevention and management strategies such as Safewards, trauma-informed care, and gender sensitive practices to improve consumer and staff safety and to minimise the use of restraint and seclusion in mental health facilities

3. Analyse occupancy and demand for Prevention and Recovery Care (PARC) beds and then fund additional beds accordingly as well as alternate rehabilitation and step-up and step-down models

4. Increase the number of beds for children and adolescents who are acutely unwell and/or who have behaviour support needs especially in regional and rural areas

5. Work with the federal government to address the lack of services for people with dementia and neurological conditions under the age of 65 currently in older persons' assessment units or other mental health units that cannot provide the specialist support they need

6. Review the model and staffing requirements of the two Transition Support Units for people with dual disability so that they can effectively support people with behaviour support needs and/or physical disability and determine whether additional units or different models are required to meet demand across Victoria

7. Increase affordable housing options for people with chronic mental health issues who require ongoing and intensive staff support after discharge from acute services

8. 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 consumers to Supported Residential Services

9. Support the Department of Health and Safer Care Victoria to work with health networks and OPA to improve the timely sharing of information to Community Visitors about significant incidents and sentinel events in mental health facilities visited by Community Visitors and to provide the outcomes of investigations and action recommendations related to these events

10. Provide additional funding to ensure that the Community Visitors Program has the resources and technology required to effectively fulfil its important safeguarding role.

Statewide Report

Introduction

It's been a tough year for all Victorians, and the uncertainty created by the COVID-19 pandemic has been particularly difficult for people with mental health issues and their supporters.

Mental Health Community Visitors visit state-funded mental health premises as prescribed under the *Mental Health Act 2014*, including:

- hospital inpatient units
- Prevention and Recovery Care services (PARCs)
- Community Care Units (CCU)
- Extended Care Units (ECU)
- parent and infant units
- child and adolescent units
- aged persons assessment and residential care units
- forensic units
- specialist units such as eating disorders units and units for people with dual disability or dual diagnosis.

This year, Mental Health Community Visitors visited 149 out of 178 eligible units and reported 1131 issues for follow up by services. Some mental health units were converted into COVID-19 wards, making them unvisitable by Community Visitors. The Mental Health Board took the unusual step of suspending visits to emergency departments and psychiatric assessment and planning units (PAPUs), because of the risk of COVID-19 infection and in recognition that staff were already under extreme pressure.

The mental health system in Victoria is being reformed in line with the government's commitment to implement all 65 of the recommendations of the Royal Commission into Victoria's Mental Health System. This will lead to substantial restructuring and expansion of mental health services across the state. Changes have already started and are being observed by Community Visitors. However, there has been a limited impact on frontline services to date and the system remains fundamentally broken.

Community Visitor reports show that in the second and third year of the pandemic, services were stretched beyond their limits. Community Visitors faced their own challenges due to COVID-19 protocols at mental health units across Victoria. In 2021, Community Visitors undertook remote visits by phone or video link wherever possible, resuming face-to-face visiting only in February 2022. Remote visits were challenging to organise, with staff already under pressure with the acute support needs of many consumers.

When restrictions eased, visits took longer than usual due to RAT testing and PPE requirements. Some visits had to be abandoned because a COVID-19 infection was identified after Community Visitors had confirmed it was safe to visit. Despite these challenges, Community Visitors continued in their important safeguarding role, and their reports provide a unique insight into the experiences of mental health service consumers as the pandemic has continued.

Table 2. Total visits Mental Health stream, 21/22

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	31	12	6	170	**176**
North Division	31	12	11	143	**154**
South Division	37	16	13	139	**152**
West Division	50	17	8	226	**234**
Total	**149**	**57**	**38**	**678**	**716**

Due to COVID-19, there were fewer active Community Visitors, and a subsequent reduction in visits from 834 last year to 743 visits this year. The Mental Health Board is grateful to Community Visitors for identifying and escalating concerns particularly given the challenges of pandemic visiting.

Key issues identified this year included:

- mental health consumers who died by suicide
- use of seclusion and restraint
- aggression and assaults in inpatient units
- high demand for inpatient care, specialist units, and forensic services
- a lack of adolescent beds
- a lack of suitable housing and support for people under the age of 65 with dementia
- staff shortages, fatigue and patient transfers due to COVID-19
- delays in building works and the replacement of furniture and equipment.

This year, Community Visitors also reported many examples of good practice, particularly where staff and managers were creative in support provided to consumers as COVID-19 restrictions continued. The Mental Health Board commends their contribution in a very difficult year.

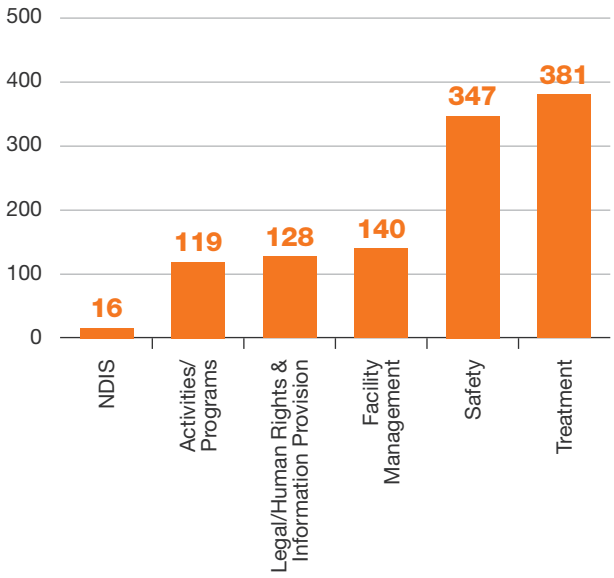
COVID-19

As the COVID-19 pandemic continued this year, the demand for mental health services increased. Further lockdowns led to the reinstatement of visitor and leave restrictions. Consumers continued to be impacted by COVID-related staff shortages and a lack of available mental health beds. In some cases, units were repurposed for COVID-19 patients, for example, PAPUs at Mercy Health Werribee and Austin Hospital. Community Visitors acknowledge the hard work of staff in mental health facilities to keep people safe throughout the pandemic, and their commitment in assisting Community Visitors to visit wherever possible.

GOOD PRACTICE : COVID-19 PROTOCOLS

On arrival at Monash Medical Centre P Block, Community Visitors had their temperatures taken, and vaccination certificates checked. Nursing staff helped Community Visitors into N95 masks and face shields before entry to the unit. Community Visitors reported that staff had excellent compliance with COVID-19 protocols, including the enforcement of PPE requirements for delivery staff.

Figure 2. Issues reported by Community Visitors, 21/22



Restrictions

COVID-19 restrictions impacted all mental health units across the state. However, Community Visitors observed a significant variation between facilities when restrictions eased in the broader community, with some allowing in visitors and leave for consumers, and others continuing with hard-line restrictions.

In September 2021, Community Visitors reported a two-week quarantine for patients when a staff member at the Thomas Embling Hospital tested positive for COVID-19. Consumers were isolated in their rooms and only allowed access to the outside area for two 30-minute blocks per day. They were not allowed visitors or outside leave and maintained contact with family and friends via phone or video link with assistance from staff.

At Bendigo Health's extended care unit in October 2021, Community Visitors also noted that it was over two months since visitors had been allowed at the unit. Community Visitors themselves were not allowed to resume visiting at St Vincent's Hospital until 28 February 2022, even though COVID-19 restrictions eased across the state 4 months earlier. When Community Visitors attended Casey Hospital in March 2022, they found there was no planned date for when visitors would be permitted and leave restrictions lifted for consumers. Monash Health later clarified that they had based decisions on visiting and leave restrictions on community transmission rates.

On 6 May 2022, Community Visitors reported that NDIS-funded workers were not permitted at Dandenong Hospital Unit 4. Consumers were also not allowed leave. Leave for defined therapies or therapeutic purposes was approved on a case-by-case basis. Community Visitors reported that morale was very low, with many consumers spending most of their time in their rooms or sleeping in the common rooms. Several consumers told Community Visitors that they desperately needed a change of environment and wanted to be given leave. Extended restrictions put even more stress and demand on staff and had a significant impact on consumer connections with family and friends, and their ability to access necessary outside services.

Another issue that emerged with COVID-19 was restricted access to banking services for some consumers. Consumers without a bank card found it very difficult to be issued with a new one because they could not go to the bank during restrictions. This left consumers who didn't have cash with no access to items for purchase within the hospital, and no ability to shop online. Access to money is essential for consumers who are in a facility for extended admissions.

SERVICE STORY :
IMPACT OF VISIT BANS

The Alfred Hospital had hospital-wide COVID-19 restrictions and protocols. In October 2021, no visitors were permitted at the Baringa Aged Assessment Unit unless related to end of life and only then with authorisation from the hospital executive. Staff told Community Visitors that the long-term ban on visitors was having a serious negative affect on consumer mental health. In some cases, staff were struggling to manage interactions with families who were desperate to visit. Staff were very concerned about the extra load on nurses, with other professionals only using telehealth for contact with consumers. Community Visitors queried why The Alfred had not acted in sync with the Victorian Government's easing of restrictions. In June 2022, the hospital still had limits on visiting.

Staff

Community Visitors observed a reduction in the availability of mental health beds because there were not enough staff to operate the services people needed. Some units reduced their bed capacity while others closed entire units.

During the state-wide Pandemic Code Brown, Mercy Health's Werribee acute inpatient unit closed a 13-bed pod to accommodate 4 mental health Intensive Care Area (ICA) beds needed by consumers who were COVID-positive. At the same time, there was a high number of mental health staff furloughed. Due to increased demand for access to acute mental health beds, the women-only ward had not been operating since February 2021 - plans are in place to reopen it in 2023. Community Visitors are concerned that there are now limited options across Victoria for women who need gender-specific mental health services, particularly women who have experienced sexual assault and trauma.

SERVICE STORY : IMPACT OF COVID-19 OUTBREAKS

In October 2021, the Albury and Wodonga communities had a serious COVID-19 outbreak. This impacted staff availability at Albury Wodonga Health. A difficult decision was made to temporarily close a CCU and relocate the 8 residents, so that nursing staff could be redeployed to acute and emergency services. With few alternatives available, most CCU consumers were sent home, and some were moved to a nearby PARC. Community Visitors reported that one resident was moved 3 times during the 3-month closure and was unable to see their regular doctor throughout.

Bendigo and Mildura Hospitals reported a 20 per cent shortfall in professional psychiatric staff in 2021-2022 due to COVID-19 furloughs, sick leave, and problems recruiting new staff. Shortages were managed through roster changes, agency staff and extended shifts, putting additional strain on existing staff. Community Visitors were told that there was minimal, if any, impact on consumers.

Aged care mental health facilities were hit particularly hard. Community Visitors reported that in one small facility, a month-long COVID-19 outbreak resulted in 2 consumers and 7 staff becoming infected. The unit was fully occupied, and staff sometimes worked 12-hour shifts in full PPE. Other hospital staff were only occasionally available to assist due to high demand across the service.

In May 2022, 5 personnel from the Australian Defence Force and 2 Department nurses assisted at Grutzner House, a psychogeriatric nursing home in Shepparton, for a week because of a severe staffing shortage there.

In addition to managing the impact of COVID-19, Community Visitors also reported on the impact of chronic staff turnover. In a 3-month period, one PARC had 3 graduates and 7 clinicians come and go. A manager of one unit told Community Visitors that:

> *"COVID-19, and now influenza, are impacting staffing levels with illness coming in waves. Shifts are covered with casuals and staff overtime…They are 9.5 EFT short… There have been few applications from experienced staff. They are looking at perhaps recruiting enrolled nurses and providing intensive education while they work full time. However, it also is challenging finding enough nurse educators."*

Staff shortages during a COVID-19 outbreak led to 4 beds being closed for 3 weeks at Mercy Health's Ursula Frayne Centre. In February 2022, during the state-wide pandemic Code Brown, Community Visitors reported that on the date of their visit, due to staff illness, 80 per cent of staff on shift that day were bank or agency staff.

Community Visitors also reported widespread challenges with the availability and recruitment of specialist staff. At Shepparton PARC, a family service position was advertised several times and was still vacant at 30 June. Bendigo Health's mental health facilities continued to operate without a neuropsychiatrist. Psychiatrists from overseas had accepted jobs at Bendigo Health but were unable to enter the country due to COVID-19.

Safety

This year, 342 safety issues were reported by Community Visitors, only slightly lower than the 352 in 2020-2021. Community Visitors reported serious safety concerns including suicide attempts, deaths by suicide, and violence and assaults, particularly in acute facilities.

Community Visitors reported that it takes too long for serious safety concerns to be responded to. There are few options to transfer consumers to other facilities to protect their safety due to the limited number of mental health beds available across the state. In some facilities, the layout makes separating consumers difficult. Community Visitors want quicker action to move consumers when abuse is reported. More gender-specific units are urgently needed to allow fast responses when consumers feel unsafe or abuse has occurred.

Suicide

Consumers who attempt suicide have often had multiple admissions to mental health units and have a history of family violence and other trauma. This year, at one rural acute inpatient unit, a consumer ripped up the lace curtains to attempt suicide. The facility has since removed the curtains, applied temporary block-out to external windows, and is considering long-term solutions including external shutters as part of building redevelopments.

At one metropolitan PARC, a consumer attempted to set themselves on fire, but was spared serious burns when another consumer alerted staff. Community Visitors reported that an autistic consumer with anxiety and depression attempted suicide by self-strangulation at an inpatient unit. A plan was subsequently developed by a multidisciplinary team, with sensory supports including music and writing, and other harm minimisation strategies.

Tragically, Community Visitors reported several deaths by suicide of people in mental health units, as well as while consumers were on leave or within days of discharge. Mental health units should be safe places, however in some units, staff had to cut consumers down from ligature points. One consumer died by asphyxia suicide after staff were unsuccessful in their attempts to resuscitate them. Community Visitors were also concerned about the circumstances surrounding the death of a rural consumer who died in a single car accident the day after he was discharged.

Community Visitors welcome the introduction of the Hospital Outreach Post-Suicidal Engagement (HOPE) initiative for people leaving hospital after a suicide attempt, and the commitment made by the state government for the program's expansion to all Victorian area mental health services. Community Visitors were also pleased to learn of Wellways Way Back Support Service which provides support to consumers and families following a suicide attempt.

Violence & Abuse

Community Visitors continue to be extremely concerned about consumer-to-consumer violence in mental health units. Community Visitors reported 41 assaults, including sexual assaults, and 61 other incidents of aggression, intimidation or harassment this year.

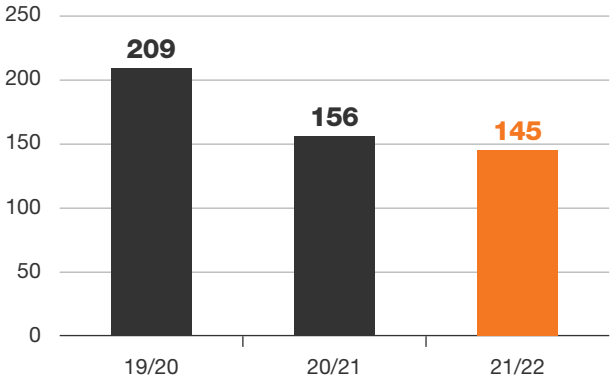
Most mental health consumers are not violent. In facilities with high rates of violence, incidents can often be attributed to only one or two consumers who are acutely unwell and have a history of trauma. For example, Community Visitors reported that at Bendigo Health Acute Inpatient Unit, 40 instances of aggression were recorded for one consumer in one month. At St Vincent's Adult Inpatient Unit, Community Visitors noted 47 incidents of aggression related to one consumer in one month who had a forensic history. Emergency services attended after he extensively damaged property and flooded a unit.

Community Visitors are concerned when police are called into mental health units. Police attended the Mildura Acute Inpatient Unit on two occasions in March 2022 as a result of armed confrontations. Chemical suppression spray was utilised as part of the police response for a consumer who was not able to be calmed down. One consumer had taken a metal sign down from the wall, shaped it into a weapon and was threatening to harm himself and others. Both incidents resulted in the seclusion of consumers.

Police were also called to the Banksia Unit at the Royal Children's Hospital after a Code Black incident involving property damage to the seclusion and intensive care areas. Policies and procedures have since been reviewed and staffing and on-call support increased. A metal detector was also purchased after a consumer threatened self-harm using a concealed blade.

At one rural dual diagnosis unit, a consumer told Community Visitors she had been repeatedly verbally abused and threatened by another consumer for 2 weeks, causing panic attacks.

Figure 3. Mental Health stream assaults & violence, 19/20–21/22



She said she was well-supported by staff, who developed a safety management plan. She also made a formal complaint.

Consumer-to-staff abuse was frequently reported this year, with nursing staff subject to physical assaults, threats, and verbal abuse. In one facility, options to support staff were discussed with the Victorian Equal Opportunity and Human Rights Commission following reports of racial abuse. Leave taken by staff following assaults added to staffing shortages across the state.

Community Visitors reported some allegations of staff-to-resident abuse. At one acute inpatient unit, a witness reported unacceptable behaviour by a nurse towards a resident. An investigation, which included police, found the allegations unsubstantiated but education sessions were provided to staff to improve practice.

Sexual safety & sexual assaults

Community Visitors reported numerous breaches of sexual safety this year. Mental health units are required to report all sexual incidents to the Office of the Chief Psychiatrist (OCP) within 24 hours.

Some consumers told Community Visitors that they would prefer to be in a separate unit or area by gender, and in some facilities women-only units or lounges have recently been established where women or others identified as being at risk can have swipe card access.

At one PARC, an alleged sexual assault resulted in a review of procedures by the service including better screening processes to ensure that new consumers did not require active overnight support.

JODIE'S STORY

Community Visitors advocated for 4 months on behalf of Jodie who was living in a specialist mental health unit. Jodie alleged she had been physically and sexually assaulted and repeatedly verbally abused by 2 male consumers. Jodie told Community Visitors she felt unsafe and extremely distressed, and Community Visitors were informed she was self-harming.

One of the male consumers was moved to another unit and security guards were employed 24/7. Community Visitors raised concerns with the multiple levels of management, and Jodie's legal guardian. The Public Advocate also wrote to the Office of the Chief Psychiatrist (OCP) requesting urgent intervention. The mental health unit reviewed all incidents and implemented strategies to keep Jodie safe including using NDIS-funded workers to support her to take leave from the unit. On 30 June 2022, Jodie remained at the mental health unit and still felt unsafe. Plans are underway for her to move into a new home with NDIS-funded support.

Dangerous Conditions

Community Visitors reported on dangerous contraband in facilities including plastic bags, knives, razors, and cigarette lighters, enabling one consumer to light a fire in a seclusion area.

Consumers were able to barricade doors at one of St Vincent's acute inpatient units. New doors with windows were approved, however there were challenges obtaining doors with ligature-free handles. Community Visitors reported the issue over several months, however it was still unresolved at the end of June.

Community Visitors reported that several consumers in Mildura had left the acute inpatient unit and PARC without staff knowledge, in one instance because door alarms did not wake sleep-over staff. A consumer subsequently self-harmed and had to be admitted to the acute unit.

Community Visitors often report that older people have falls in mental health units. Alfred Health told Community Visitors about one patient who, due to his condition, kept putting himself on the floor to sleep. As staff were concerned about the risk of pressure areas, the care team agreed that he could sleep on a mattress on the floor as he would not stay on a bed. Alfred Health also routinely uses bed sensor alarms and a low bed position for patients who are a high falls risk.

Drugs & Alcohol

Community Visitors continue to report problems with drugs and alcohol in mental health facilities. In December 2021, one rural inpatient unit manager told Community Visitors that most admissions to their unit involved drugs or alcohol, possibly due to the impact of COVID-19 restrictions on consumer mental health.

Community Visitors report that drugs are sometimes brought in by visitors or by consumers when they return from leave. At Broadmeadows Health Acute Inpatient Unit, staff conducted fortnightly drug searches. In one instance, a consumer's NDIS support worker was reported to the NDIA due to allegations of drug dealing.

Smoking

The enforcement of smoking bans in mental health units continues to be an issue that consumers raise with Community Visitors. Nicotine replacements are usually available to patients in acute units and some units provide these to consumers for up to 3 months after discharge.

Community Visitors reported that a consumer in one acute inpatient unit verbally abused and threatened staff because he wanted more cigarettes. He eventually responded well to a management plan which also reduced the risks associated with cigarette lighter use in the unit. At the Royal Melbourne Hospital's John Cade Unit, a consumer headbutted a glass panel when he was refused a cigarette.

Treatment & Care

This year, Community Visitors reported 381 issues relating to treatment and care which included admissions, bed availability, medication, restraint and seclusion, electroconvulsive therapy (ECT), COVID-19, discharge, and housing availability.

Admissions & Capacity

Community Visitors reported an increase in people going to hospital for mental health assessments this year. One large metropolitan hospital had a significant increase in presentations over November and December 2021 because police were bringing in people with mental health issues who posed a risk to themselves or others (under Section 351 of the Mental Health Act). At times, there were up to 12 ambulances waiting. They reported that the strain on emergency departments due to COVID-19 meant that people with acute mental health issues were waiting for many hours to be seen. Corridors were used for treatment. Only people who were the most acutely unwell were admitted. Other consumers who might typically have been admitted were referred back to a general practitioner or a community mental health service.

Regional and rural emergency departments also faced unprecedented pressure. A manager of one rural crisis assessment and treatment team (CATT) told Community Visitors that on just one day, there were more than 40 people, some with mental health issues, waiting for care in the emergency department with ambulances ramping.

Community Visitors also reported that people with a history of self-harm and suicidal ideation were inappropriately placed in non-acute settings during COVID-19 restrictions. One PARC was pressured and agreed to take a consumer who was suicidal direct from an emergency department.

Restraint & Seclusion

Safewards is a program introduced by the Department of Health that is now used in 24 mental health units and services across Victoria. The program supports staff to identify and address the causes of behaviour in themselves and in consumers that most often lead to the use of restraint, seclusion, and other restrictive interventions. Community Visitors have seen great results since the introduction of Safewards.

Community Visitors reported 21 issues about restraint and seclusion this year. At times, safety was the reason given for the use of restraints, for example, when a consumer presented at an emergency department and was in an erratic and threatening state. At other times, restraints and seclusion were used to give consumers treatment. For example, a compulsory patient with an eating disorder was restrained at one unit for medication and nutrition. The protocol for treating them was followed including reporting to the Office of the Chief Psychiatrist.

Community Visitors raised concerns in one mental health facility about an increase in the use of mechanical restraint. The Nurse Unit Manager explained that there had been no intensive care beds or seclusion rooms available in the inpatient unit for several months due to delays associated with a major refurbishment. Consumers requiring intensive monitoring and support were transferred to another hospital, however after all other available options had been employed, staff used mechanical restraints.

At one unit, Community Visitors reported that the seclusion area was used for the first time in a while due to consumer-to-staff aggression. Staff at one metropolitan acute unit explained that one patient, due to the low availability of ECU beds and other patients needing to be on their own, was nursed twice in 2 months in seclusion.

Some consumers in forensic units are in seclusion for long periods of time. Community Visitors report that one consumer at Thomas Embling Hospital has been in seclusion for many months after seriously assaulting other consumers when they were in a shared unit. Another consumer at Thomas Embling Hospital has been in seclusion for most of the last six years. A transition plan is in place for them to return to a shared unit. When Community Visitors visited in March 2022, they reported that the person was spending two hours per day in an interview room or courtyard.

Community Visitors were told Warrnambool Acute Inpatient Unit, which uses the Safewards model, had drastically reduced the use of seclusion over the last 12 months. The service was supporting staff to use other options and ensured consumers were debriefed following seclusion. Bendigo Health's Older Persons Unit also employs Safewards and has not used seclusion for 4 years.

Medication

Community Visitors reported consumer concerns about medication side effects, medication errors and inadequate supply. One consumer in an acute inpatient unit told Community Visitors they were worried about the sedating effect of their medication, and the impact of long-term use. Another consumer had severe itchiness from their medication and said he had not understood the potential side effects when it was prescribed. Staff told Community Visitors he had been given written information, however this may not have been adequate. Some consumers told Community Visitors they wanted to trial other medications. Others complained that medication was not given on time due to staff shortages.

Consumers also reported medication errors, with opened packages causing confusion about the timing of medication and incorrect medications being provided by pharmacies. One large chain pharmacy made errors using an automatic dispenser, affecting multiple hospital units, which was resolved by extensive liaison with the pharmacy management.

Electroconvulsive therapy (ECT)

ECT is usually a last resort therapy for people with chronic mental health issues and it requires approval by the Mental Health Tribunal if a person is unable to give informed consent. Community Visitors reported that one consumer felt pressured to have ECT and wanted staff to respect her decision to refuse. Another consumer who had been in hospital for a long period, and had been verbally and physically abusive towards staff, recovered well after receiving ECT and was discharged.

Bed Availability

Community Visitors reported 17 issues about the availability and suitability of mental health beds, many of which related to the impact of COVID-19. Entire mental health units were repurposed, prioritising the needs of COVID-19 patients over mental health consumers. As staff took sick leave to recover from COVID-19, some services were reduced so that acute and emergency services could continue to operate. Community Visitors reported that bed shortages were exacerbated by an increase in pandemic-related mental health issues, including eating disorders. More autistic people were also presenting for mental health treatment.

At one health service, bed shortages contributed to consumers moving between facilities. One consumer told Community Visitors that she was moved 3 times within a month and was also concerned that she was not able to see her own doctor. Community Visitors also reported that renovations and repairs undertaken to improve the functionality, safety and amenity of one unit were delayed, adding to bed pressures this year.

Adolescent beds

The lack of intensive care beds for adolescents continues to be reported by Community Visitors this year in metropolitan, regional and rural areas. At the Austin Hospital unit for children, there is no high dependency or intensive care area. Children with high support needs were transferred to a unit managed by Monash Health or the unit reduced admissions to ensure consumer safety, leaving other consumers without access to services.

ALICE'S STORY

Alice, a teenage consumer, spent 44 hours in a regional hospital's emergency department. She presented with suicidal ideation and was intermittently shackled and chemically restrained - at times this was at Alice's own request. She needed to access a statewide adolescent and child service which is only based in Melbourne, so she was eventually transported by ambulance to a hospital several hours from home. On discharge, arrangements were made for her to receive support from the local Child and Adolescent Mental Health service.

Community Visitors also reported that police were called by a rural emergency department to assist with a 13-year-old who was aggressive. Community Visitors asked about local treatment options given she could not be admitted to the adult mental health unit. She also did not meet the criteria for the local youth PARC. The closest adolescent unit was two hours' drive from her family. The remaining option was admission to the rural hospital general paediatrics unit.

At one adolescent unit, staff told Community Visitors that they had only one bed available for consumers requiring high dependency support, forcing some consumers to sleep on the floor. Staff were concerned that young consumers without proper beds felt they were in seclusion when they were not.

Communication

Consumers often tell Community Visitors that they want more communication from staff about their treatment. Some consumers report that they are uncertain about when they had last been seen by a psychiatrist. Community Visitors advocated on behalf of a consumer with an unsettled baby who was sleep deprived and felt that she needed more staff support more often.

One consumer who has had many admissions told Community Visitors that the face-to-face time he had with the treating psychiatrist was too brief and that they appeared not to have read his records before his first consultation, therefore wasting valuable time. Another consumer reported that a treating psychiatrist directed questions at him but then only discussed his possible diagnosis with another doctor present, as if he was not there. He told Community Visitors that nobody would talk with him after the consultation about what had been recorded or decided.

A consumer at another inpatient unit complained about seeing 3 different psychiatrists in a month, making it difficult to establish rapport, and requiring them to explain their situation repeatedly.

Community Visitors also reported that some consumers were transferred between facilities without proper communication. One consumer complained that they had not received an explanation for a transfer that happened with no notice and had not been given a choice or any options. They said the lack of communication and consultation had worsened their mental health. In one PARC, consumers said they were given very short notice about the possible closure of the facility and plans for their transfer to another unit.

RICK'S STORY

Rick is Deaf and a long-term resident of a mental health facility. An interpreter is provided during medical appointments and meetings with staff and therapists. Rick depends on handwritten notes and lipreading for communication at other times. Community Visitors queried why staff and other consumers have not been offered Auslan training and were advised that his preference is to use written communication and to lipread. He is learning how to use technology (smartphone) to support his communication.

Gender

Young mental health consumers need support that is gender sensitive, and Community Visitors report varied practice across the state. Community Visitors reported that the Banksia Unit at the Royal Children's Hospital has gender-specific areas for consumers and uses trauma-informed practices such as the allocation of staff by gender. The unit also allocates consumers to rooms according to gender and uses consumers' preferred pronouns.

Consumers at the Austin Health's adolescent unit complained about incorrect pronouns on bedroom doors and directives to use toilets not in line with their gender identity. Community Visitors were advised that all consumers are asked to identify their preferred pronouns on admission, and staff are encouraged to correct each other and apologise if they misgender a consumer. The unit has four bathrooms – two gender-neutral and two gender specific.

Prevention & Recovery Care (PARC)

PARC services are community-based residential services that provide short-term support for people with mental health issues who do not need, or no longer require, a hospital admission. Consumers often speak positively about PARCs. On one visit, Community Visitors received positive feedback from 4 consumers about Mercy Health's PARC in Deer Park. One consumer was happy to be preparing to cook with produce harvested from the on-site vegetable patch. Another consumer told Community Visitors about his positive experience at a Bendigo PARC. He had attempted suicide prior to admission and was being discharged into community mental health care. The unit had also organised his application for the NDIS.

Community Visitors raised concerns about long waiting lists and the lack of PARC beds in some areas. Staff at the Broadmeadows PARC said the facility was unable to meet referral demands and a consumer told Community Visitors they were concerned that in an emergency, they would have to go into the hospital acute unit even though a PARC stay would be more beneficial.

Discharge

This year, Community Visitors reported serious concerns about discharge from mental health units, particularly where people did not have housing to return to, and where they required ongoing specialist support. At Mercy Health's Werribee CCU, staff told Community Visitors that there was a "dire lack of options" preventing timely discharge. Some mental health units have a strict time limit and consumers must leave even if they are still unwell.

One consumer did not want to return to living with his mother and needed housing that would support his recovery, including not being exposed to drug or alcohol use. He was working with a case manager to find the right place, but there were few options and a lack of available public housing.

Finding housing is particularly challenging for consumers with a forensic history, or drug and alcohol issues, and for people with dual disability. One consumer was discharged to a motel after breaching CCU policy by returning from leave intoxicated. He was readmitted to the CCU after three weeks in the motel because no alternative housing could be found.

Some consumers told Community Visitors they were anxious about managing their condition after discharge, with one reporting that he feels suicidal at home even with outreach services and NDIS support workers. His discharge plan included a short-term stay in a staffed specialist unit with another consumer.

Following the Royal Commission into Aged Care Quality and Safety, admissions to residential aged care are restricted for people under 65 years of age, but alternatives for younger people with dementia are not yet widely available. This leaves consumers with unnecessary extended stays in assessment and specialist units. Community Visitors reported that Bendigo Health has for a long time been unable to find suitable options for 3 people under the age of 65 who have dementia.

CHRISTINE'S STORY

Christine is in her 50s and has early onset dementia. She was admitted to hospital more than 7 months ago and is living in an older persons' mental health unit which does not offer dementia-specific support. Due to her age, no residential aged care facility near her family has been willing to offer her a bed. Christine could be discharged if she could access NDIS support workers with expertise in dementia and with the right housing.

The mental health service has raised their concerns with the Department of Health, the Office of the Chief Psychiatrist, and senior NDIS staff about Christine's housing and support needs. Christine may have no option but to live a long distance away from her family. Christine's Support Coordinator is pursuing alternatives through the NDIS.

Mental health services told Community Visitors there were often delays discharging NDIS participants. One Nurse Unit Manager said that the NDIA sets roadblocks for consumer discharge but takes no responsibility for finding a solution. Community Visitors were told that the NDIA disallows an Aged Care Assessment Service (ACAS) assessment but does not suggest alternatives to aged care for participants who do not qualify for any other type of NDIS-funded housing. One hospital told Community Visitors they thought every facility should have a dedicated NDIS discharge planner.

MIN'S STORY

Community Visitors reported that Min, a consumer with dementia who is under the age of 65, had been living for many months at an aged acute assessment unit. Min had an NDIS plan. They could have been discharged months earlier if suitable housing and supports had been available. A social worker spent 4 months looking for options; a significant use of resources for one consumer. Min was eventually accepted into a residential aged care facility, but the offer was withdrawn when requested funding for extra care was denied.

Facility Management

Community Visitors reported 140 issues relating to the management and maintenance of mental health facilities ranging from cleanliness, graffiti, problems with technology, and poor upkeep. Community Visitors have escalated concerns about many of the problems more than once and too many remain outstanding.

Community Visitors reported ongoing issues at Albury Wodonga Health's Willows Unit with maintenance in bathrooms, toilets and stained carpets. At Albury Wodonga Health's Kerferd Inpatient Unit, a clothes drier did not work for months and there was a broken sink and finding tradespeople to attend to small jobs continues to be a challenge there. Community Visitors also reported problems with the telephone connection, answering machine and CCTV over several months in the Benambra Unit.

A consumer in the Latrobe Hospital complained to Community Visitors about the lack of privacy due to window tinting peeling off so that staff could see into their bedroom from the office window. Community Visitors raised concerns with management about the lack of cleanliness at Maroondah Hospital Unit 1 and they responded by increasing the cleaning of floors, courtyards and carpets.

Community Visitors report that some building maintenance issues take an extraordinary time to resolve. In their last 2 annual reports, Community Visitors reported on the need for soundproofing of a room at Shepparton used for Mental Health Tribunal hearings to ensure consumer privacy. While funding approval was received, works stalled due to COVID-19 restrictions.

SERVICE STORY :
A GOOD NIGHT'S SLEEP

In 2019, all beds in the Bendigo Health's Dual Diagnosis Unit were replaced. Almost immediately, Community Visitors began documenting complaints by residents about the new mattresses. They were initially too firm, and within a year, had sunk into a U-shape.

The mattresses were interfering with consumers' sleep and Community Visitors were concerned about the negative impact on their treatment and recovery. Community Visitors requested that mattresses be replaced as soon as possible but were told that the hospital's budget could not afford replacements without pursuing a warranty claim. Community Visitors continued raising the issue in consecutive liaison meetings with management.

Community Visitors escalated their concerns to the Director of Nursing 2 years after first reporting on it. New mattresses were finally installed in May 2022. While Bendigo Health cited COVID-related supply chain issues for the delay, Community Visitors believe the issue should have been pursued with greater urgency.

Problems with bedding and mattresses were also reported in other parts of the state. Some services, like St Vincent's Hospital and Barwon Health, have regular replacement programs in place but other hospitals do not.

Technology

During COVID-19 restrictions and lockdowns, access to reliable internet became paramount so that consumers could communicate with friends, family and outside services. Consumers also use the internet for listening to music for relaxation and mindfulness. Staff use the internet for running group activities.

Community Visitors have repeatedly reported problems with the internet at Alfred Hospital. Consumers report that the Wi-Fi speed is variable and at times unreliable, and that one of the computers used by consumers wasn't working - all computers were recently replaced. At Monash Health's Middle South CCU, the Wi-Fi was not working when Community Visitors were on site and consumers complained it had been patchy for months. At Bendigo Health's PARC and YPARC, Community Visitors also reported Wi-Fi issues, with consumers reporting that the internet frequently drops out.

At Narre Warren PARC, a consumer told Community Visitors the Wi-Fi access was too slow. Community Visitors were informed the Wi-Fi was fixed but in June 2022 it stopped working again. Community Visitors are keen for a long-term solution to be found.

New Works

The Mental Health Board was concerned about long delays with building works due to COVID-19 restrictions and supply issues, and that unspent funds might be reclaimed by government. The Department of Health confirmed that health networks could retain allocated funds for the purpose it was given.

Community Visitors were pleased to see that at Eastern Health's Maroondah Hospital Unit 1 there is now a 'Man Cave', which was built following consumer feedback. Community Visitors also reported that a renovation at Bendigo Health's Simpkin House has enlivened the unit with improved illumination in all areas, new paint throughout, the installation of activity rooms, new sensory areas, and outdoor landscaping.

At Bendigo Health's Dual Diagnosis Unit, improvements to outdoor spaces and the installation of security cameras are in progress and expected to be completed by the end of 2022. Planning is underway for a major service expansion at Forensicare's Thomas Embling Hospital, providing an additional 107 beds over several floors by 2026. This project is still in the initial stages.

Programs & Activities

Meaningful programs and activities in mental health facilities are imperative to support the recovery of mental health consumers. Community Visitors reported 119 issues about programs and activities including many examples of good practice. This year, Community Visitors observed exercise programs, music therapy, cooking classes, meditation, gardening, movie nights, and social outings. During Victoria's lockdowns, Community Visitors observed concerted efforts by staff at most facilities to keep programs and activities going and commend mental health staff for their extra commitment during a difficult time.

However, even after the lockdowns ended, Community Visitors reported that some programs and activities had not resumed due to staff shortages and ongoing COVID-19 restrictions. Community Visitors received many complaints from consumers and staff about the imposition of facility restrictions beyond what was expected of the broader community.

At Eastern Health's Maroondah Hospital, Community Visitors reported that psychiatrists, occupational therapists and nurses were running activities, including outside in the courtyard and art groups on the weekend. Staff from Melbourne Health's Norfolk Terrace CCU accompanied residents on a 3-night camp at Shoreham which consumers told Community Visitors they enjoyed. Activities included kayaking, a visit to hot springs, a pub meal, and the chair lift at Arthur's seat.

At Bendigo Health's Older Persons Unit, consumers were not permitted on unaccompanied leave for recreation during the COVID-19 lockdowns, but staff regularly took them outside for walks and to the gym. Consumers were also offered exercise classes with an exercise physiologist designed for people with dementia.

At Monash Health's Casey Hospital Ward E, an allied health worker created a mental health activity booklet that was distributed to consumers during lockdowns. The booklet has since been revised and may be shared with other facilities.

At Werribee Mercy's acute unit, Community Visitors reported a lack of organised activities for consumers including group therapy, and a lack of information available about the art and sensory rooms. Several consumers complained to Community Visitors that they were bored. Community Visitors formally raised concerns with staff in February and June 2022, however these concerns remain unresolved due to persistent staffing shortages.

At Goulburn Valley Health's Wanyarra Unit, Community Visitors twice reported on the lack of an activities officer or occupational therapist on staff. In February 2022, Community Visitors reported that Maroondah Hospital's activity charts had expired and showed the previous fortnight's activities. The day and date board also showed it was Friday with some consumers therefore unaware it was Monday. Community Visitors also reported that Alfred Health's patient noticeboard showed a 3-day-old day and date.

NDIS

Community Visitors reported 25 specific NDIS issues, with another 22 issues relating to the NDIS reported under other categories. Most were about delays in NDIS funding approvals and the slow implementation of plans. In one case, it took 9 months after NDIS plan approval for the participant to start receiving services.

NDIS delays prevent consumers from accessing essential supports, aids and equipment, and often affect discharge planning. Consumers typically needed assistance from a hospital social worker or other allied health practitioners for their NDIS applications, and to follow-up when there were delays or a review or appeal was needed. Professionals with relevant NDIS expertise were often unavailable.

VAN'S STORY

Van is an NDIS participant and strong self-advocate with many interests. He has lived in an aged care mental health unit for more than 5 years but is much younger than the other residents. The past year has been particularly difficult for Van as COVID-19 lockdowns meant that his NDIS-funded support workers could not take him out. He was very frustrated and his physical and mental health deteriorated dramatically.

Van's placement at the unit was initially presented to him as a stop-gap solution. Community Visitors have advocated in support of his preference to live independently in the community. Community Visitors advocated for the involvement of the state government's Intensive Support Team (IST) which assists people with complex support needs who have critical problems with the NDIS.

Van's support coordinator and the IST prepared an application for Specialist Disability Accommodation (SDA) funding, which was rejected by the NDIA, requiring an appeal to the Administrative Appeals Tribunal. Van withdrew his appeal because he ran out of NDIS funding for other supports while waiting for his case to be heard. Van remains stuck until another option is found.

Consumers regularly complained to Community Visitors this year about restrictions banning NDIS-funded workers from visiting due to COVID-19 protocols. They told Community Visitors they were bored and frustrated. Community Visitors were concerned that consumers' recovery would be hampered by the lack of access to necessary NDIS services including therapies.

Community Visitors also reported problems with the quality of some NDIS-funded support workers who lacked relevant training to effectively support consumers. In some cases, support workers were asked by mental health services not to return.

Community Visitors also observed NDIS success stories where funding enabled long-stay consumers to move out of mental health units. One young Aboriginal man, who had been in a mental health unit for more than a year and a half, used NDIS funding to access the support he needed to move into his own home.

Legal Rights & Information

Mental health consumers are entitled to information on their legal rights, and on other services including advocacy and complaints bodies. This year, Community Visitors observed some good practice examples, including where consumers were given quality written information. However, Community Visitors reported 128 issues where required information was not made available to consumers.

In one acute unit, Community Visitors reported that there was no information available about how consumers could make complaints or seek legal advice, and the service appeared to be relying on consumers seeking out the information before providing it. Community Visitors were also concerned that consumers were only receiving verbal information about their rights, treatment, and activities.

Mental Health Tribunal

The Mental Health Tribunal is an independent tribunal that determines whether people need compulsory mental health treatment. The tribunal conducts hearings to identify the least restrictive treatment options for consumers. Community Visitors continue to ensure that consumers have information about the Mental Health Tribunal and access to support during hearings. Community Visitors also proactively inform consumers of their right to a second psychiatric opinion.

Community Visitors reported that they were present when consumers in one inpatient unit received texts from the Mental Health Tribunal advising of their hearing date. One consumer was confused because he believed he was a voluntary patient. Hospital staff told Community Visitors they had asked the tribunal to let them know when texts were sent so that they could be prepared for consumer questions.

Community Visitors reported that one consumer was due for a tribunal hearing at which she planned to request to be discharged. Community Visitors suggested the Aboriginal Health Service may support her. The Acting Nurse Unit Manager offered to organise for the hospital's Aboriginal Liaison Officer to support the consumer at the hearing.

The tribunal moved to remote hearings in 2020 because of COVID-19. Hearings continued to be held by video link even after the end of COVID-19 lockdowns. While some consumers appreciate not having to travel to or appear before the tribunal in person, Community Visitors were also concerned that some consumers may not be able to fully participate in the process remotely.

Peer Support

Peer support workers play a valuable role in providing information about consumer rights and accessing support services. One facility manager told Community Visitors that, "Our peer workforce continues to work on getting the message around supports out there. We are currently having further support links printed and supplied by our peer consultant." Another service utilised the peer workforce in the review of planned improvements to a High Dependency Unit including reconsidering the location of a seclusion room. Community Visitors consistently hear from consumers about the positive impact of having access to peer support staff.

Awareness of Community Visitors

At some facilities, services offered by OPA and the Community Visitors Program are not well understood or publicised. Due to high staff rotation at one emergency department, the nurse in charge was reluctant to talk with Community Visitors about an admission. The service provided information to all emergency department personnel about Community Visitors following their request that they do so. At another service, Community Visitors raised concerns that information about the Community Visitors Program was not known to staff and pamphlets were not available in the emergency department as they should be.

Stakeholder Relationships

The Community Visitors Program did not receive the Victorian government's response to the Community Visitors Annual Report 2019-2020 until June 2022, almost two years after the report was submitted. Fortunately, all recommendations from the Mental Health Board were accepted including recommendation 10 that the government adequately resource the Community Visitors Program to:

- undertake monthly visits to all mental health beds designated under the *Mental Health Act 2014*, including those in private hospitals
- enable the use of technology to efficiently and effectively carry out its critical safeguarding role.

The Board expects that these recommendations, and the recommendations made by the Royal Commission into Victoria's Mental Health System, will be swiftly acted on. This year, Victoria's mental health reform agenda led to an expansion and restructure of the Mental Health and Well-being Division of the Department of Health. Staffing changes resulted in long delays in regular liaison meetings with the Community Visitors Mental Health Board. Meetings resumed in May 2022.

Access to incident reports

Community Visitors have continued to maintain good relationships with health networks at a regional level, however the provision of access to incident reports remains a contentious issue. Some health networks provide Community Visitors with secure electronic access to incident reports. Other health networks have been reluctant to provide incident reports electronically. Limiting access to incident reports for Community Visitors to in-person visits only was problematic when visitor restrictions allowed for remote visits only. Access to electronic incident reports allows Community Visitors to spend more time talking with consumers and staff during a visit and less time reviewing records on site.

Conclusion

A review of the Mental Health Act promises increased powers for Community Visitors in mental health services. OPA's submission to the Department of Health on the new Mental Health and Wellbeing Act in August 2021 argued for the role of the Community Visitors and OPA to be strengthened, including that:

- regulations and guidelines relating to advocacy services and other supports reference both Community Visitors and Independent Mental Health Advocacy (IMHA)
- the new Act recognise the Public Advocate and the Community Visitors' statutory safeguarding role and ensure the Act contain provisions that enable effective sharing of information with OPA and Community Visitors in support of their statutory duties
- the equivalent section 217(1)(c) of the Mental Health Act 2014 in the new Mental Health and Wellbeing Act be amended to recognise that Community Visitors have the power to inspect a range of records, including incident reports.

The Board is pleased to note that the powers of Community Visitors to conduct remote visits, to take photographs, and to view a range of records including incident reports, were endorsed in the draft bill before the Victorian Parliament.

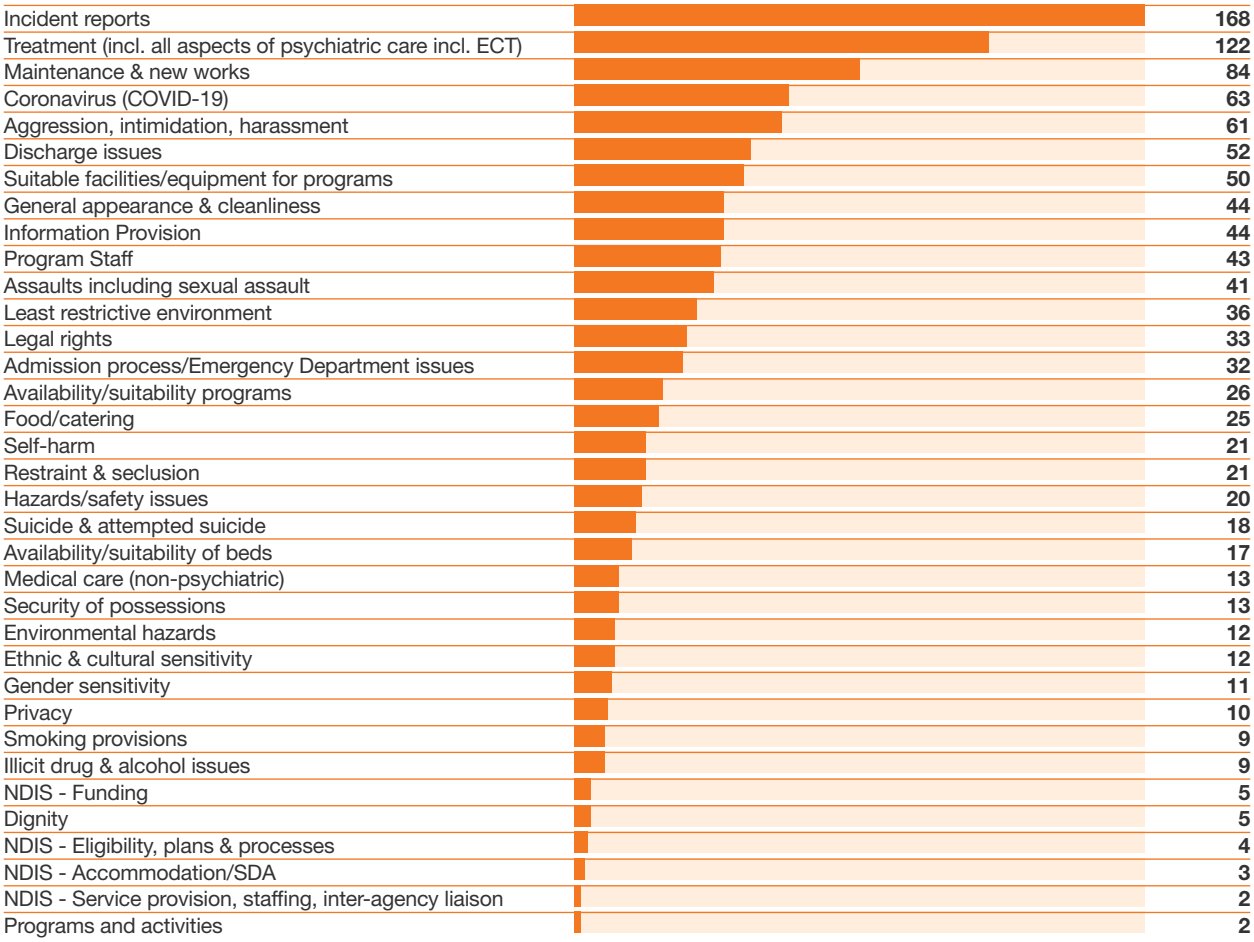
The Victorian Government's 2020-2021 budget commitment to spend $868.8 million on mental health reforms makes it a hopeful time for Community Visitors who want to see a significant improvement in mental health services across Victoria. Additional funding will provide much needed relief to services that are currently overstretched. Community Visitors would also like to see that the future expansion of community-based and outreach services will result in fewer people needing inpatient services in the future.

The Royal Commission into Victoria's Mental Health System also recommended the elimination of restrictive interventions within 10 years. Many services are reducing their use of restrictive interventions, but considerable change in practice will be required to reach the goal by the target date.

The Mental Health Board also commends the Victorian government's commitment to provide an additional 224 inpatient beds and an additional 127 forensic beds as part of their mental health reforms.

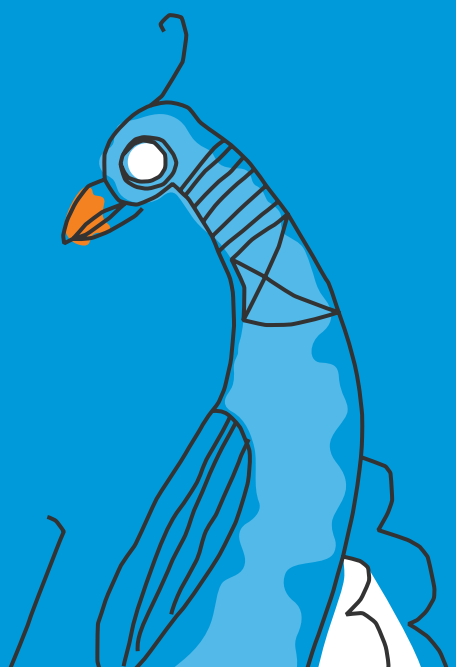
Community Visitors consider that workforce issues are the greatest challenge for mental health services now. Mental health services cannot expand without additional skilled staff including peer support workers, and qualified and experienced clinicians and specialists. The workforce issues must be tackled urgently to relieve current pressures on mental health services so that consumers can see more positive outcomes.

Figure 4. Disaggregation of issues reported by Community Visitors, 21/22



02

Residential Services



Recommendations

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

1. Ensure 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; and, minimum standards for meaningful activities that facilitate social connections

2. Devote resources to strengthening the working relationship between mental health services and SRS

3. 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

4. Ensure that appropriate training and education is provided to the SRS sector on the impending changes to mental health legislation

5. Fund staff training in Supported Residential Services to deescalate conflict and violence, and Mental Health First Aid courses

6. Work with the National Disability Insurance Agency to review all SRS that are also NDIS service providers to ensure transparency in financial reporting so that residents receive the supports they are entitled to

7. Require all workers entering Supported Residential Services to carry identification that includes their organisation's name

8. Ensure that Community Visitors have the legislated power to take photos to support the documentation of issues

9. Provides additional funding to ensure that the Community Visitors Program has the resources and technology required to effectively fulfil its important safeguarding role.

Statewide Report

Introduction

Supported Residential Services (SRS) provide accommodation and personal support to some of the most at-risk members of the Victorian community. All SRS residents need assistance daily with everyday tasks. Many live with multiple complex health conditions. Some residents are frail and elderly and many struggle with serious mental health issues. Conflict and violence between residents are not uncommon. Too many residents live in fear.

Community Visitors know more than most about the lives of people who live in SRS. Despite the disruption caused by the COVID-19 pandemic, this year 67 Community Visitors conducted 743 visits to SRS across Victoria. Visits were conducted either in person or remotely via phone or video when care facility visitor restrictions applied. During these visits, a total of 1422 issues were raised.

While welcoming the commitment shown by the State Government and the new Human Services Regulator to reform, Community Visitors remain frustrated at the slow rate of improvement to the quality of life of many at-risk Victorians in SRS and delays in receiving a response to the recommendations of previous reports. The Residential Services Board received the Victorian Government's response to the Community Visitors Annual Report 2019-20 on 27 June 2022.

Despite the long delay, the Board is pleased with many of the policy and funding directions in the response, particularly on mental health supports. However, the Board also notes that most of the initiatives described in the government's response are yet to be fully developed or implemented.

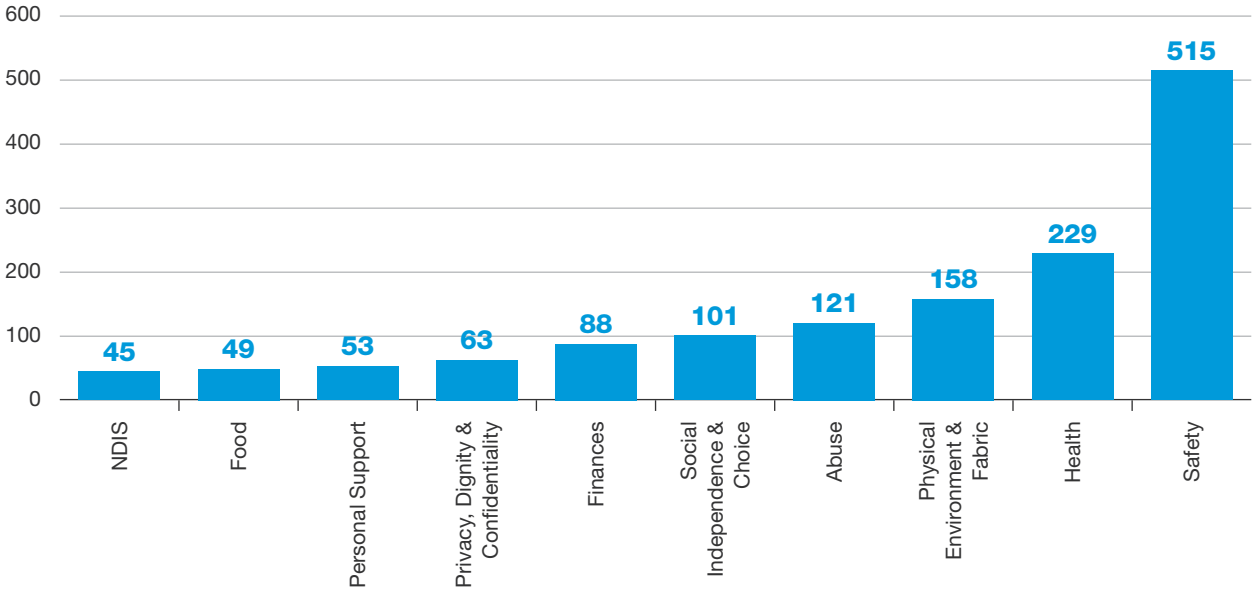
The Board is also disappointed that, at the time of writing, they had not received a response to the Community Visitors Annual Report 2020-21. Once again, the recommendations in this year's report have been prepared without a formal government response to the previous year's report. Community Visitors are hopeful that future responses will be received in a reasonable time frame.

The Board would like to express its gratitude and say thank you to Community Visitors for their continued commitment to safeguarding the rights and interests of people with disability despite the challenges posed by the COVID-19 Pandemic. Community Visitors again pivoted to remote engagement with SRS staff and residents by phone or video when restrictions prevented them from visiting in person, enabling them to continue providing valuable support while facilities were in lockdown.

Table 3. Total visits Residential Services stream, 21/22

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	39	13	14	177	**191**
North Division	22	11	11	176	**187**
South Division	38	22	13	204	**217**
West Division	19	21	5	143	**148**
Total	**118**	**67**	**43**	**700**	**743**

Figure 5. **Issues reported by Community Visitors, 21/22**



About Supported Residential Services

SRS are nearly always private, for-profit businesses, that provide accommodation and personal support services for people who need daily assistance with everyday tasks. Each SRS determines which support services it offers and the fees it charges. The majority of SRS operate on pension-only fees, charging between 85-95 per cent of the aged or disability pension for a bedroom, support, and meals. Pension-plus facilities charge fees at a rate they choose.

As of end June 2022, there were 114 SRS in Victoria providing accommodation and personal support to approximately 3100 Victorians. Many SRS residents have complex support needs, including people with cognitive disability and people with mental health issues. People who live in SRS have few, if any, alternatives, especially in regional areas. Most SRS have around 30 residents, but some have up to 80 people congregated together. Some residents share bedrooms with people they do not choose with only a curtain between.

During 2021–2022, Community Visitors reported on issues at 118 SRS, but by the end of the year, 4 SRS had closed. This represents a significant decline from 125 SRS that Community Visitors visited in 2020-2021. In the previous Community Visitor Annual Report, the Residential Services Board raised concerns about the longer-term viability of the SRS sector. This year, the decline of some pension-level SRS is more apparent. Community Visitors acknowledge the significant pressures SRS proprietors have identified over the past 12 months, which may lead to further closures including:

- increased cost of business due to the COVID-19 pandemic
- proprietors and staff experiencing COVID-19 pandemic burn-out
- high vacancy rates
- significant increases in expenses such as food and utilities which are likely to continue to rise
- widespread staffing shortages across the sector
- experienced staff leaving for other NDIS providers or to set up their own business.

These pressures apply equally to pension-level and pension-plus SRS. However, the pension-plus SRS have been additionally impacted by the increased availability of support packages for older Australians to stay in their own homes longer, moving directly to Residential Aged Care when they are closer to the end of their lives and have complex support needs; the apparent reluctance of older Victorians to move into congregate facilities, particularly after observing the experience of people living in Residential Aged Care during COVID-19 lockdowns; and the availability of options beyond SRS for people with NDIS funding.

Extraordinary times: visiting in a pandemic

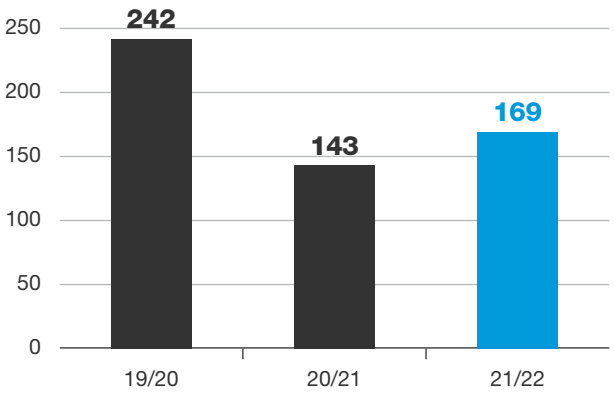
The COVID-19 pandemic continued to have a significant impact on Community Visitors and the people they visit, with most of the state in long periods of lockdown (totalling 89 days) to prevent the spread of the virus. Community Visitors continued face-to-face visits when allowed and undertook remote visits when they could not. Remote visits involve Community Visitors phoning or videoconferencing with SRS proprietors and staff, and where possible, with residents. This made it difficult for Community Visitors to report on the physical state of the facilities. Community Visitors were often unable to have direct and confidential contact with residents because they do not have access to a mobile or phone credit or can only use the landline in the proprietor's office where conversations may not be private.

Community Visitors therefore relied heavily on analysing incident reports to understand the experience of residents. Consequently, the data from SRS visits this year shows a high number and proportion of issues under the heading 'Safety', capturing the concerns raised by Community Visitors from incident reports. Some of the reports were about one-off incidents resolved locally between the SRS and Community Visitors. However, patterns observed by Community Visitors in incident reports show systemic problems in SRS across the state. This report reflects mainly on systemic issues.

Abuse, neglect and violence

Many SRS are not the "Safe Environment" envisaged by legislation and regulation. Community Visitors reported 121 issues related to abuse, violence, and neglect. The slightly lower number of issues reported this year reflects the challenges of remote safeguarding during periods of lockdown, as there were limitations on communication between residents and Community Visitors, and they were more likely to raise concerns about abuse and neglect when meeting with them in person. Community Visitors report that violence and abuse between residents, or directed towards staff, is disturbingly prevalent, occurring mainly in pension-level SRS.

Figure 6. Issues of abuse, neglect and violence identified in Residential Services stream, 19/20–21/22



Across the state, Community Visitors reported:

- frequent physical altercations between residents, including where residents needed to be hospitalised - in one incident, a resident was assaulted with a knife by another resident
- several physical assaults on staff
- threats to kill or harm residents and staff
- a resident who set bedding alight after an altercation
- many examples of damage to property
- verbal abuse between residents.

Community Visitors reported that alcohol or drug misuse often precipitated or exacerbated violence and aggression.

There were also multiple allegations of sexual abuse and assault, sexual harassment, and unwanted touching by residents towards other residents, and by residents to SRS staff and on staff from outside service providers.

It is very clear from Community Visitor reports that a lack of mental health supports contributes to the aggressive behaviour of some residents in pension-level SRS. For example:

> *Two residents with chronic mental health issues caused extensive damage to their own rooms and shared areas of the SRS, which was distressing for both residents and staff.*

COVID-19

The COVID-19 pandemic continued to have a big impact on life in SRS. Community Visitors became aware of more than 55 separate COVID-19 outbreaks this year, with some SRS experiencing multiple outbreaks. In some SRS, there were only isolated cases, while in others, most residents and staff were infected. Only residents with severe symptoms were admitted to hospital, with most being supported at the SRS. A few residents were placed in a designated COVID-19 isolation hotel or hostel if they did not require hospitalisation but could not be supported to isolate in their SRS. Many SRS reported they received good support from the High-Risk Accommodation Response team (HRAR) and the local Covid Support Team in regional areas.

At the start of the year, most SRS had arranged for residents to receive COVID-19 vaccinations and boosters (Community Visitors do not have access to data on whether vaccination rates in SRS are in line with the broader population). Some residents declined to be vaccinated, and one resident reported an adverse reaction to the vaccine they received. In January 2022, Community Visitors were informed that SRS had limited access to Rapid Antigen Tests (RATs) due to the community-wide shortage. Where RATs were in short supply, this impacted on residents' ability to go out in the community.

When lockdowns lifted and proof of vaccination was required to enter shops or go to events, residents without smartphones struggled. Community Visitors reported many SRS staff spending considerable time assisting SRS residents to access paper copies of their vaccination certificates that they could carry with them in the community and produce when required.

Many SRS went into additional shorter lockdowns due to close contact cases. In multiple instances the close contact was a support worker from an outside service provider, while several other cases were related to visits to a hospital clinic or planned outside activities.

Some SRS reported that back-up staff refused to come in when there was an outbreak. Some SRS managers worked additional hours themselves. One SRS experienced a severe outbreak of COVID-19 with 13 residents and 3 staff infected over Easter. The manager of this SRS worked 9 days straight during the outbreak.

While most SRS adapted their COVID-19 protocols for visitors, one was fined for breaches of public safety orders, including failing to provide proof of staff vaccination, and failing to display signs indicating maximum numbers of people allowed in communal areas. At one SRS where staff were not wearing masks while working, they donned them immediately when Community Visitors brought it to their attention.

Healthcare

Community Visitors reported on 229 issues relating to the health of SRS residents.

Many SRS residents live with multiple and complex health issues including chronic, debilitating illnesses such as diabetes, kidney disease (sometimes requiring dialysis), cardiovascular disease, amputations, epilepsy, vision impairment, stroke, dental problems, and cancer. These comorbidities often lead to complications and because residents do not always have adequate support to manage their health care, frequently result in acute medical emergencies. Some residents, due to their disability and lack of family or other advocacy support, require complex assistance with medical decision making which can delay treatment.

The disproportionate number of chronically ill people living in SRS compared with the general population can be partially explained by the relatively high proportion of older residents. People with disability and mental health issues living in SRS often have comorbidities requiring individualised support which they may or may not receive in SRS. Some residents admitted to hospital are unable to follow health care advice or routines without support due to their disability, which can both cause and extend hospital admissions.

The complex health support needs of residents are managed by SRS in conjunction with visiting doctors, nurses, and allied health professionals such as optometrists and podiatrists. However, some residents need higher levels of support beyond the capacity of the SRS staff. In one case, Community Visitors reported SRS staff were required to assist with palliative care for a resident, including administering medication for pain relief. The resident was subsequently moved to an aged care facility as his condition deteriorated and his care needs increased.

Medication

This year, medication errors included residents being given incorrect medication by SRS staff - and in one recorded incident by a visiting nurse - medications not stored securely, as well as residents refusing prescribed medication.

Community Visitors queried whether staff at some SRS should undertake additional medication training. In one incident, staff marked on the medication record that a resident had received medication before it was given. In another incident, the record showed medication had been provided to a resident despite that resident being away in hospital. In at least one instance, English language difficulties contributed to a medication error.

Community Visitors reported that a resident required hospitalisation for suicidal ideation after repeatedly refusing her medication and becoming increasingly delusional and distressed as a result. There were also instances where residents ran out of medications because repeat prescriptions were not organised. In one case reported by Community Visitors, a staff member had started accompanying a resident to GP appointments to provide assistance and ensure that new prescriptions were provided.

During one COVID-19 outbreak at an SRS, some residents were left in a dangerous situation without daily medication they needed because they had missed essential blood tests required for the administering of anti-psychotic medications, and subsequently were not given their usual medications.

Mental Health

A high proportion of people who currently live in SRS have mental health issues. A 2018 SRS census found that more than 47 per cent of SRS residents have mental health issues, and that serious mood and psychotic disorders are more common amongst residents of pension-level facilities than in pension-plus facilities.

Incidents involving suicidal ideation, attempted suicide and self-harm were reported frequently at SRS this year. Anti-social behaviour and aggression towards other residents and staff also occurred regularly, compounded by drug and alcohol misuse. One resident, whose mental health had deteriorated because of delays in medication administration during a COVID-19 lockdown, smeared faeces across the walls of another resident's room. SRS residents unable to be supported with their mental health issues often have poor personal hygiene, refuse to allow staff to clean their room, and are susceptible to hoarding.

Community Visitors frequently query the skill level and amount of training staff receive to effectively support residents with mental health issues. While mental health training has been mandated for pension-level SRS staff for a few years now, compliance with this requirement is variable, particularly due to ongoing staff shortages. Community Visitors are also concerned that clinical mental health services do not provide enough assistance to SRS to support residents with complex mental health support needs. There is often a lack of adequate handover information provided to SRS when a resident is discharged from hospital. There is also inconsistency around the involvement of SRS staff in discharge planning discussions and problems with access to appropriate follow-up from community-based mental health services.

ALEX'S STORY

SRS staff were finding it increasingly difficult to support Alex, a young resident with mental health issues. Alex had a history of suicidal ideation, and on several occasions was found lying in the road by passers-by, threatening to buy petrol and self-harm. She was often verbally abusive to other residents, who would retreat to their rooms.

Alex had several short admissions to the local mental health unit but was increasingly disengaged from the mental health care team and chose to cease contact with her case manager. A conduct agreement was devised as part of the Enhanced Risk Response Plan by the mental health team to which she agreed.

Community Visitors queried with DFFH whether the SRS had the capacity to support Alex given her acute mental health support needs. Community Visitors were also concerned about the impact on staff and other residents. DFFH promptly conducted an onsite visit and were satisfied that she understood the conduct agreement and potential repercussions. However, Alex continued to struggle with complying with the agreement and after a further admission to hospital, the SRS decided it was unable to readmit her.

Alex's story illustrates the breakdown in the continuity of care for people with mental health issues who are discharged from acute mental health facilities to SRS, which are not equipped to meet their needs, the importance of informed referrals, and the lack of other options for people who need more or different support than an SRS can offer.

GOOD PRACTICE : STAFF TRAINING

A young person lives in a regional SRS with residents who are much older and where alternative housing and support options are very limited. She has a physical disability and mental health issues. While the SRS had tried to provide the support she needs, unfortunately she self-harmed, requiring admission to hospital. During this time, the SRS manager engaged a behavioural psychologist to work with staff to better understand her mental health needs and to develop more effective support strategies.

Incident Reporting in SRS

Over the past 12 months, particularly in the context of the COVID-19 pandemic and limits on in-person visiting, incident reports have proven to be a crucial source of information for Community Visitors. Incident reports provide important context about serious events, patterns of persistent risk factors, and areas for service improvement. In cases where there is an unexpected death or serious assault requiring hospitalisation, SRS staff must notify DFFH promptly as prescribed reportable incidents.

Community Visitors encourage staff at SRS to document all incidents with as much detail as possible. While some SRS staff document incidents thoroughly, this is not consistent across the sector. Incidents are often under-reported and incorrectly categorised for risk and severity. Records can lack clarity and be written in multiple documents but incompletely. Community Visitors therefore query whether they are accessing a comprehensive account of the incidents that have taken place. On some visits, Community Visitors have been unable to view incident report books because rostered staff were unable to access the documents themselves.

Some Community Visitors have observed a downward trend in the number of incidents being recorded by the SRS. At one SRS, Community Visitors inquired whether the threshold for recording incidents had changed. In response, the SRS manager assured Community Visitors that newer SRS staff would be given further direction and training on incident reporting procedures.

ANDREW'S STORY

Community Visitors were informed on arrival at an SRS that resident Andrew had died unexpectedly earlier that day. The proprietor said it was likely that he had a seizure while sleeping and advised that the death had been reported to DFFH. Subsequently, Community Visitors were advised that there were inaccuracies in the incident documentation, that other incidents had not been reported, and that there was evidence that he had been ill the day before his death. Andrew's death is now the subject of a coronial investigation.

Notices to Vacate

Community Visitors recorded 39 notices to vacate in SRS during the year. Reasons for notices to vacate included stalking a staff member, stealing keys and food, throwing a Stanley knife at a staff member, and threatening to rape a support worker.

Some notices to vacate were the result of drug misuse that caused harm to resident health and wellbeing. After one resident was evicted, the SRS manager called in a specialist cleaner who found 8 used syringes in their room.

Other notices to vacate appeared to be fuelled by alcohol and drug misuse or because residents did not take prescribed medications, leading to yelling, damage to property, and one instance of a resident threatening to kill another resident.

Some residents broke house rules on smoking and drinking, despite repeated warnings.

SAM'S STORY

Sam was evicted for regularly smoking in their room. They moved to another SRS where the manager supported them to stop smoking in their room. However, Sam continued to do so and cut the connection to the smoke alarm in their room. They were issued with a notice to vacate, which they challenged at VCAT. The notice to vacate was overturned by VCAT, with their lawyer successfully arguing that the damage to the smoke alarm was due to their mental health issues.

Some residents' support needs increased while they were living in SRS. While they required a higher level of support, they declined to move out and were issued a notice to vacate. Residents required to vacate moved either into another SRS or temporary or crisis accommodation or were admitted to a mental health facility.

The Physical Environment

Community Visitors reported 158 issues on the physical environment of SRS impacting on the quality of life of residents. Community Visitors reported major problems with building maintenance.

SRS STORY : UNSTABLE ROOF

One SRS was in such a state of disrepair that DFFH directed that two rooms were not to be used following an inspection in response to a notification by Community Visitors. The ceilings in the attached bathrooms were completely mouldy and constituted a health hazard. Bowed ceilings throughout the SRS showed extensive water damage and, after the roof became unstable, WorkSafe threatened evacuation of the SRS unless the roof was made safe within two days. The ongoing roof repair work was still in progress at the time of writing.

Community Visitors reported:

- one SRS was in a state of major disrepair with cracks in walls, water damage and large holes in the plaster continuing over a seven-month period - these structural issues remain unresolved due to contention with the landlord
- black mould in bathrooms at several SRS - the proprietor of one SRS advised the solution to extensive black mould on a bathroom ceiling was that it was "*to be painted*"
- a collapsed floor at one SRS
- a large hole in a resident's window was not repaired over many months
- a resident sleeping on a damp mattress on the floor
- disputes with landlords causing delays to repairs.

Community Visitors also reported on grounds being poorly maintained, with rubbish, broken furniture and mattresses not being removed for long periods despite health and safety risks. SRS providers advised Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) funding was often critical to ensure maintenance was done in a timely manner.

Cleanliness

Despite the prevalence of public health messages on the importance of good hygiene during the COVID-19 pandemic, this year Community Visitors reported many instances of inadequate cleaning. This is of particular concern given the health issues of many SRS residents and the inherent risks of congregate living in a pandemic. Lack of cleaning in bathrooms was widely reported, and in one case, faecal matter was observed by Community Visitors on walls and ceilings. Bed bugs were found and treated in more than one SRS. In another case, an SRS managed a maggot infestation in a resident's bedroom.

Community Visitors also reported other hygiene issues including:

- a laundry so filthy that it was unusable by residents over several months
- overflowing and stinking garbage bins
- hand dryers not working, and no towel provided
- no toilet paper.

Community Visitors also reported on challenges for SRS staff in maintaining cleanliness while supporting residents who limit or refuse staff access to their rooms. Some SRS however manage this challenge by including information on cleaning of rooms in each resident's information pack upon entry. One SRS told Community Visitors that if an issue arises where a resident does not want their room cleaned, discussion takes place between the SRS Manager and the resident with either a family member, case manager or support worker present.

Disability access

A resident in a wheelchair at one SRS had difficulty accessing the bathroom. Prior to moving in it was understood that modifications would be funded by the TAC however this did not occur. This resident had to move to alternative accommodation.

Heating and Cooling

Community Visitors reported:

- cooling systems or air conditioning broken down for long periods in summer
- heating systems not working effectively in winter
- a practice of heating being turned off on 1 November, regardless of the temperature
- a dining room so cold that many residents were wearing coats - the manager responded quickly to Community Visitors' requests to address this.

Security of personal property

Community Visitors reported on several situations where the security of residents' personal possessions was compromised. In one instance, a resident's bank account was accessed using a card that had been stored at the SRS and a substantial amount of money withdrawn. Police are investigating the theft and DFFH is investigating money management practices at the SRS.

Safety

Community Visitors frequently raised concerns about safety issues that they observed during their visits. The combination of ageing residents, sub-standard physical environments, and inadequate service systems make for multiple risks. If Community Visitors believe their concerns have not been resolved by SRS staff and management, they escalate them to DFFH, that in turn liaises with other regulators including local councils around issues such as fire safety and food hygiene to address identified problems.

SRS STORY : FAMILY VIOLENCE REFUGE?

This year, a regional SRS began a trial partnership with a local family violence service to provide refuge accommodation alongside its regular SRS residents. Community Visitors were concerned at the security implications for SRS residents. The SRS has CCTV, but it is not monitored on a 24-hour basis, and staff on duty at night are paid to sleepover, not to provide active security. Community Visitors are continuing to liaise with SRS management on the security issues.

Fire safety and evacuation procedures

SRS are often older buildings with labyrinth-like layouts that pose significant fire risks. Community Visitors check that fire safety systems are kept up-to-date and evacuation procedures are routinely rehearsed. Some residents smoke cigarettes in their rooms, even though this may be prohibited in SRS house rules. Despite the known risks, Community Visitors reported extended delays in carrying out routine fire drills in some SRS this year.

SRS STORY : LOCKED EXITS

Community Visitors reported that exits at an SRS were locked. They advised management that this was unacceptable. Community Visitors were told by management that the doors had been kept locked to deter residents who "wander" and are at risk alone in the community.

At the next visit, locks had been removed from exits. However, many residents said that they felt safer with the locks activated. The SRS now has a system so that residents can exit the facility, but people cannot enter from outside. The SRS is considering the installation of CCTV in external areas to allay resident safety concerns.

Slippery flooring is another major safety hazard for residents, particularly older people and others with mobility issues. On occasions, Community Visitors observed pools of water on floors in shared areas, possibly the result of leaks. As noted earlier in this report, falls are a common issue in SRS.

MARY'S STORY

Mary is in her late 80s, uses a walking frame and has frequent falls. She had a stroke and a disability that impacts on her mobility. Mary's wrist was recently fractured after a fall. The SRS have provided her with a sensor net to detect when she gets up out of her chair, a pendant alarm for emergencies, and new shoes and trousers to reduce the risk of falls.

At one SRS, the steps leading from the rear exit were very steep and did not have a continuous railing. Following Community Visitors reports, DFFH investigated and found that minor adjustments would make the exit safer for residents. These upgrades were soon made by the SRS management.

Falls

This year, Community Visitors reported that residents had regular falls. Many were residents who are frail, older people. Other falls were a result of alcohol consumption or substance misuse. Some were severe enough to result in hospitalisation, including for fractures sustained in the fall.

At one SRS Community Visitors were concerned about a resident who had 11 falls in three months. At their next visit, they were informed that the resident had changed doctor and treatments, and various systems were implemented to help, such as a movement sensor and more regular staff assistance.

Food

SRS offer meals as part of residential service agreements. Menus must be balanced, nutritious, and offer reasonable choice to residents. In pension-level SRS, residents pay most of their pension to the facility for accommodation, food, and personal support services and therefore most residents cannot afford to buy food outside the facility. Many residents have chronic health conditions, so the quality of food provided by the SRS is critical to maintaining good physical health.

Many reports from Community Visitors this year have questioned the nutritional value of the meals offered, with residents frequently reporting that they would like more fruit and vegetables. Residents also often complained to Community Visitors about small portions, a lack of variety in menus or simply no menus on view, and no alternatives to the meal served if it didn't meet their dietary needs.

SRS STORY : MISSING MENU

The daily menu board in an SRS only showed lunch and the information displayed was not accurate. Community Visitors were told by a staff member it was "because I don't know what to cook until I come in and see what ingredients there are". The matter was escalated to DFFH who advised that the SRS were in the process of putting together a full and detailed menu with the assistance of a dietician. Community Visitors hope that this will enable the SRS to plan their meals more effectively and ensure that the information on display for residents is accurate.

Some residents of SRS have specific dietary requirements due to diabetes or other medical conditions. Community Visitors reported that in some SRS, they can find no advice to the cook about which residents have diabetes and what their specific needs are. Some residents with diabetes complained about menus which are not appropriate for their requirements. Similarly, one resident who was waiting for dentures was unable to eat much of the food provided. Community Visitors raised the issue with the facility and asked whether she should be provided with liquid nutritional supplements as well.

GOOD PRACTICE : TAILORED MEALS

Meals provided in one SRS were designed with the assistance of a health service to provide specific foods for residents with diabetes.

Given that many SRS residents have poor health, Community Visitors are very concerned about unsafe and dangerous food handling practices. At one SRS, Community Visitors observed chicken breasts thawing in water and were unable to find out how long they had been left there.

SRS STORY : ROTTEN FOOD

Community Visitors noted that there was a lot of food in the refrigerator past the use by dates including ready-made salads, cream, eggs, milk, meats, cakes, and doughnuts. Community Visitors reported on the issue repeatedly over multiple visits.

Community Visitors took photos and made a notification to DFFH. The department contacted the local council, who sent Regulatory Officers to do a spot check. The claims were substantiated. The manager was issued with a warning, and the council visited a second time to follow up. The local council kept Community Visitors informed regarding their enquiries. The Community Visitors will continue to monitor to ensure it doesn't happen again.

Community Visitors also reported unusual and inappropriate mealtimes at SRS, for example, evening meals served at 4.30pm. DFFH intervention improved the practice at one SRS where Community Visitors had reported the issue.

Activities

The COVID-19 pandemic appears to have had a detrimental effect on the quantity and quality of activities offered to residents by many SRS. Limited activities resumed in some SRS following COVID-19 lockdowns. Residents told Community Visitors that they wanted more activities. One SRS manager said that staffing shortages were preventing SRS from providing more activities.

Activities organised by SRS are particularly important for many residents who have few, if any, other social connections. Many residents do not have the resources to access, or are not eligible for, services under the NDIS to enable them to access activities in the community. Some NDIS participants living in SRS do not have funding they can use to go out.

One SRS used SAVVI funding to create a greenhouse and to grow their own vegetables, with residents maintaining the garden beds. Another SRS found that residents were motivated to participate in food-related activities.

GOOD PRACTICE : VALUING LIFE EXPERIENCE

In an SRS with many older residents from diverse backgrounds the SRS Wellbeing Coordinator and a local service provider obtained a grant to make a film. The film, *A Taste of Culture*, highlighted the significance of food across cultures. Using the SRS kitchen, residents prepared and spoke about dishes of cultural significance to them.

The residents had fun planning and preparing the dishes as well as filming. They were also pleased to share the outcome with their families. The activity publicly valued the experiences of older Victorians from a variety of backgrounds. This was particularly encouraging given many older Victorians, including SRS residents, saw their social engagement limited by the COVID-19 pandemic. The film, titled "A Taste of Culture", is available on YouTube. The SRS plans to continue the program.

GOOD PRACTICE : GOING OUT

A staff member organised a trip for four residents to a regional town to attend a comedy show and have a meal at a local restaurant. The same staff member has planned another trip for two residents to Melbourne, including an overnight stay, a visit to the MCG for a game and a tour of the MCG museum, and a visit to a fire station where the father of one resident worked all his life.

Staffing and Support

SRS management across the state have told Community Visitors they have struggled to fill staffing vacancies, and to replace staff isolating due to COVID-19. This year, Community Visitors reported that there has been more demand on fewer staff, increasing the risk of staff burnout. SRS - along with aged care, health, and disability services - need to think creatively about how they can attract more staff to the sector.

Staffing shortages impact on the quality of support provided to residents and create skills gaps that can put residents at risk. Sometimes casual staff working in SRS are unable to answer Community Visitors' queries or provide access to key documents such as incident reports and support plans. At one SRS, the manager stated that staff and management have access to online training modules but it was unclear whether all staff were accessing the online modules and which staff had completed them.

Support Plans

Community Visitors frequently find that Personal Support Plans (PSP) are either non-existent, out-of-date or are not readily accessible. Sometimes the information recorded is scant or poorly organised or does not give an accurate picture of an individual and their support needs.

PSPs are central to guiding the support provided by staff to residents in SRS. The timeliness and quality of the initial planning process, as well regular plan updates, is crucial to maximising the quality of life for residents – they are considered a living document. PSPs are also valuable to Community Visitors, giving insight into the individual circumstances of residents and their support needs. Community Visitors rely on PSPs to guide their inquiries about each resident.

Hygiene and Personal Care

Many residents at SRS have complex support needs and require assistance with personal care. Community Visitors regularly see residents who appear dishevelled and need more support with their personal care. Some residents have been observed to be reluctant to access personal care support. Community Visitors inquire about the steps that SRS are taking to both respect the dignity and choice of the residents while also upholding the SRS' duty of care.

CHRIS'S STORY

Chris is an elderly resident of an SRS who was usually able to shower himself however during the onset of the COVID-19 pandemic, and because of worsening depression, he found it increasingly difficult to manage incontinence without support. Other residents began to complain about the odour.

Community Visitors were advised that Chris underwent an Aged Care Assessment Service (ACAS) assessment and was approved for an Aged Care Home Package. He received continence pads and personal care support as part of the package. However, Chris sometimes declined the support, verbally abusing staff and residents. Despite an increase to the funding package, the incontinence issues continued to be problematic, and he was again reassessed by ACAS. Chris has now moved into Residential Aged Care.

NDIS

Community Visitors welcome the positive impact of the NDIS in the lives of many SRS residents and can see the difference that it is making when they visit. However, the rollout of the National Disability Insurance Scheme (NDIS) has meant that two of the Community Visitors' streams - Disability Services and Residential Services - now operate in a more ambiguous legal context. Victorian legislation sets out the functions and powers of Community Visitors and the NDIS is established under Commonwealth legislation. Community Visitors are not recognised in the NDIS Act, and there is a lack of clarity about the authority of the Community Visitors within some NDIS-funded settings. This is despite recommendations in the Productivity Commission's Inquiry into Disability Care and Support (2011) that the NDIS recognise the importance of Community Visitors as a critical safeguard across the country.

Coercion, forgery and overcharging

Recent media attention has exposed the downsides of the NDIS for people in situations where poor practices are more likely to go undetected and has generated greater public awareness of the problems faced by many SRS residents.

On 13 January 2022, The Age newspaper reported on an investigation by the Victorian Government into SRS which revealed "coercion and abuse of residents, uninhabitable living conditions, forgery of signatures and access to NDIS services being hindered" (*State seizes control of supported care homes over abuse, 'uninhabitable conditions'*), echoing a 2020 investigation where The Age described similar problems in SRS including allegations of abuse and residents being moved out in the middle of the night.

Community Visitors are aware that increasing numbers of SRS proprietors are setting up NDIS businesses in Victoria. Some lack transparency and accountability about the use of SRS residents' NDIS funds. This year, Community Visitors reported on situations where residents appear to be charged twice for services such as personal care – once from their disability pension which they pay to the proprietor and again from their NDIS funding.

A complex regulatory matrix operates at the intersection of SRS and NDIS. Regulation can depend on the source of the funding, status of the provider, and legislation, which may not align. Where SRS residents are receiving NDIS-funded services from the SRS proprietor (by the same business or an affiliated business), the safeguarding and regulatory oversight is unclear.

Poor Quality

Community Visitors documented examples of poor professionalism and a low standard of service by some NDIS providers and support workers, specifically:

- failure to follow COVID-19 protocols
- failure to communicate their arrival or presence in an SRS
- failure to communicate where residents were going or when they would return when leaving the property
- 1:1 support workers appeared to be "killing time", not delivering on resident goals, including one worker who was observed "just sitting with a resident with no meaningful interaction"
- failure to find out about or support resident dietary requirements.

Eligibility, plans and processes

Community Visitors also reported on the concerns relating to NDIS planning and review processes that impacted significantly on many SRS residents, specifically:

- multiple reviews of NDIS plans accompanied by long delays in approvals
- slow responses from support coordinators to questions about NDIS funding amounts and delays in arranging assessments to access to NDIS funding
- failure to provide assistance to NDIS participants who were not receiving the services detailed in their plans
- failure to recognise and provide proactive assistance to people with decision making support so they can remain in control of the services they receive or should be receiving
- lack of communication and co-ordination across services to the participant's detriment.

ASHLEY'S STORY

Ashley told Community Visitors that he was enjoying attending an art class using his NDIS funding. He had also requested that the NDIS provide specialised food that he needs due to his disability. He explained that he has difficulty swallowing and that food often goes into his lungs causing infection, requiring regular antibiotics. He is hopeful that NDIS funding will provide the diet he needs for safe swallowing but does not know when a decision will be made.

Time for Reform

In Victoria, reforms are underway through the introduction of new Social Services Standards and the development of a new independent regulatory body to oversee them. Passage of the Social Services Regulation Bill 2021 will provide regulation of services including SRS, services for children, youth and families, family violence services, and homelessness and disability services that are not funded by the NDIS. Community Visitors are concerned about the effectiveness of a single regulator overseeing diverse sectors and eagerly await consultations on the new Social Service Standards which will be critical to the SRS sector.

Since the introduction of the NDIS in 2013, Community Visitors have been identifying ongoing and emerging issues where funding and service provision is becoming increasingly complex. NDIS participants who live in SRS may have become a lucrative source of revenue because of their large NDIS packages.

Community Visitors welcome the opportunities that NDIS funding can afford SRS residents including exploring other living arrangements beyond SRS and can expect transparent and honest support in making decisions about how to best use their funding. Concerningly, Community Visitors learned that NDIS providers had been entering at least one SRS without invitation or permission to persuade residents to move to their own NDIS-funded property. Similarly, Community Visitors reported that support workers were allegedly exerting undue influence on people who need support with decision-making to change services. Community Visitors are also aware of situations where residents have been moved out of SRS by other NDIS providers without involving support coordinators or case managers whose role it is to assist the person with funding decisions. In one case, it appeared a provider may have exploited a resident's desire to live independently without delivering the support the person would need to succeed.

Government and Regulators

Victorian government funding for Supported Residential Services

Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) and Pension-Level Program (PLP) funding provides critical financial support to pension-level SRS. This year, Community Visitors reported delays to facility improvements and maintenance due to the lack of SAVVI funding. One SRS was unable to complete essential renovations to two bathrooms because SAVVI funding could not be accessed until the next financial year.

At another SRS, SAVVI funding that had been used in previous years for maintenance, including replacing furniture and curtains, and to purchase Christmas gifts for residents, was not accessible this year, and there had been no communication from the Supporting Connections provider to the SRS about the rationale for the change.

SAVVI funding is also essential for SRS to provide activities for residents, particularly for residents who do not have NDIS or My Aged Care (MAC) funding.

SRS STORY : NO ACTIVITIES

Community Visitors inquired about activities offered to the residents because there was no evidence of an activities program. Following a notification to DFFH, Community Visitors were informed that a Community Health Service had since been contracted to provide art, physical activity, and social programs with SAVVI funding.

Several pension-level SRS are not currently eligible for SAVVI funding. Despite the change in SRS resident demographics since the inception of SAVVI funding, including an observed increase in the number of people with higher support needs, SRS who did not join the scheme from the start cannot currently apply. This has led to an inequitable funding system among pension-level SRS who have residents with comparable support needs but do not receive similar funding.

Community Visitors welcome the announcement of a review by Homes Victoria of SRS as detailed in the Victorian Government Response to the Community Visitors Annual Report 2019-20. The review is expected to be completed by the end of 2022. Community Visitors are keen to see that the review results in changes in SRS that benefit Victorians with a disability, and lead to real action that is prompt and effective.

Human Services Regulator

Community Visitors continue to be the eyes and ears on behalf of the broader community, reporting on the quality of life of SRS residents to regulators. SRS are regulated by the Human Services Regulator (HSR) under the *SRS (Private Proprietors) Act* 2010, and the *Supported Residential Services (Private Proprietors) Regulations* 2012. The constructive relationship between Community Visitors and the HSR in 2021-22 has resulted in strong regulatory action in response to Community Visitor notifications. Community Visitors welcome this improved relationship.

In December 2021, a new operational protocol was signed by the Community Visitors Program, the Office of the Public Advocate, and the Human Services Regulator, replacing the previous 2014-2017 Protocol. This important document was created through a collaborative process including Community Visitors Residential Services Board members, OPA staff and DFFH during 2020-21. The protocol details agreements allowing Regulatory Officers to share information more easily with Community Visitors via a new DFFH IT system. The protocol is part of the HSR Regulatory Strategy which focusses on harm minimisation and incorporates a risk matrix that balances risk likelihood with risk consequences.

Some features of the new protocol are:

- a new electronic format for Notice For Investigation (NFI) procedures between Community Visitors and DFFH/HSR
- a three-tiered response timeframe with capacity for urgent response where required
- a Compliance Register and regular advice from DFFH to CVP on compliance issues
- undertakings to regularly share information about closures, changes of ownership and registrations, and new SRS registrations.

The new protocol has been operational since January 2022 and the HSR has provided comprehensive and well-received training to Community Visitors on the changes. Community Visitors report that they are now receiving more streamlined responses to issues of concern that they raise with DFFH.

Community Visitors have been pleased to note that the HSR used its legislative powers more proactively to protect SRS residents this year including sanctions against non-compliant SRS that prevent new admissions, the revocation of the registration of SRS, and placing two SRS into administration.

SRS STORY : INVESTIGATIONS & DEREGISTRATIONS

For several years, Community Visitors had reported serious concerns about two pension-level SRS operated by the same proprietor located in the west of Melbourne: Gracemanor and Sydenham Grace.

They included poor quality of care, bullying, intimidation, coercion and abuse of residents, squalid living conditions, insufficient quality and quantity of food, obstructing access to NDIS and health services, falsifying records, operating with insufficient staffing, and obstructing communications between residents, their family members and appointed guardians.

In January 2022, DFFH appointed Ernst & Young as the administrator of Gracemanor and Sydenham Grace and brought in specialist aged care provider Wintringham as the service provider.

Community Visitors reported extensive practice improvements with the new service provider implementing changes quickly including facilitating long-overdue access to dental care, employing enrolled nurses to oversee the administration of medication and providing residents with quality, nutritionally balanced meals. Hairdressing and an onsite coffee van were also welcomed by residents.

DFFH advised that extensive investigations uncovered 27 serious contraventions of the Supported Residential Services (Private Proprietors) Act 2010 at Gracemanor and 23 serious contraventions by Sydenham Grace. By the end of June 2022, DFFH announced it had revoked the registration of both Gracemanor and Sydenham Grace to protect the health and wellbeing of the residents.

Evidence collected by Regulatory Officers included affidavits signed by current and former employees, allied health workers, residents and their families; compliance breaches; and a forensic examination of records that supported concerns the Community Visitor Program had reported for several years. The evidence also indicated that the service was not financially viable.

Community Visitors commend DFFH for its investigations and decisive action against the proprietors who altogether failed the residents. Community Visitors urge DFFH to continue to use the resources available to them to ensure the residents have the support they need and deserve.

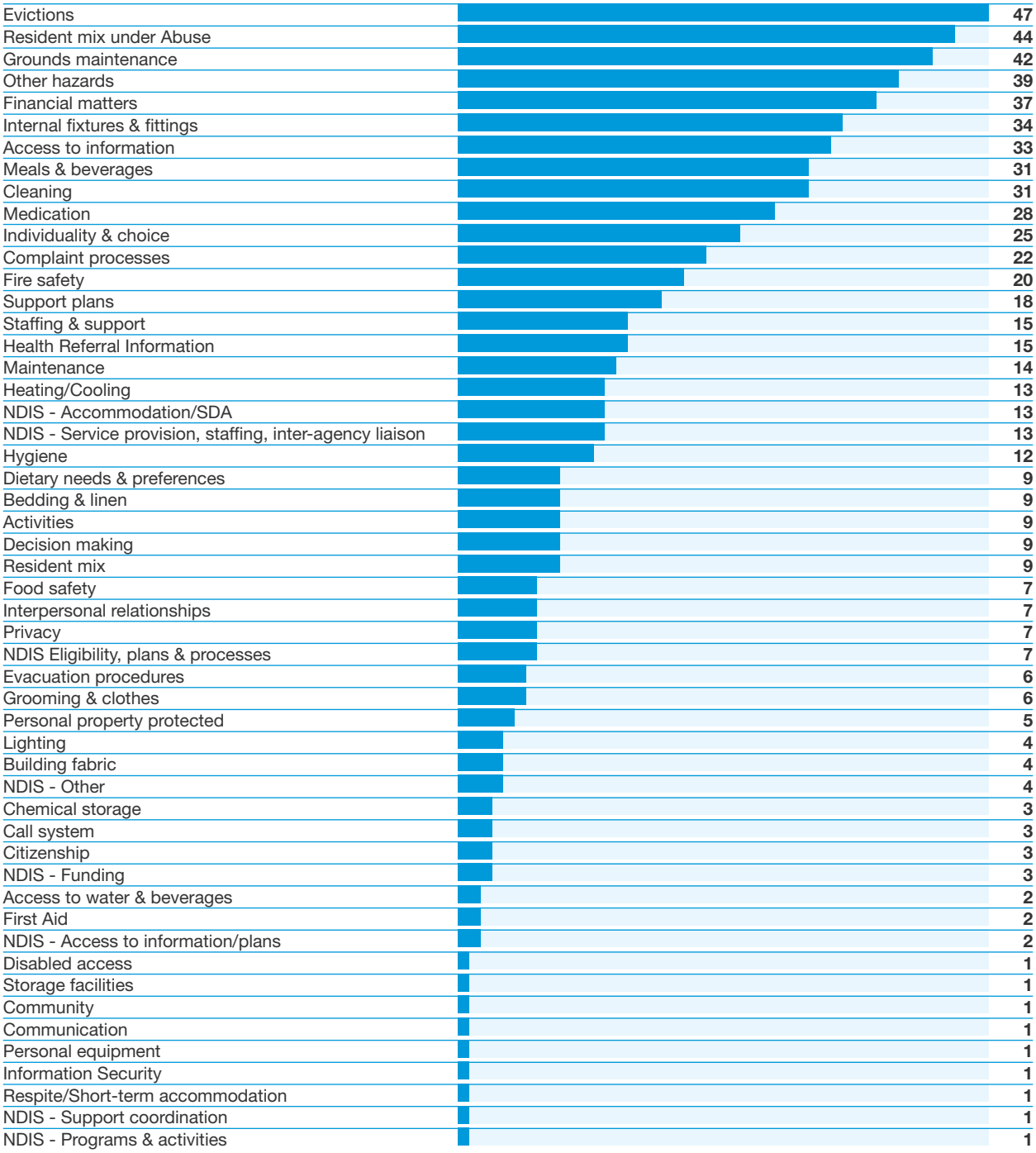
Conclusion

Everyone has the right to feel safe in their own home and to receive the support they need to live a meaningful life. SRS residents continue to face many challenges in having lives similar to other Victorians. Many residents do not have access to the means to complain when they are subjected to abuse or neglect, and fear retribution if they do.

Community Visitors know that when people are provided with quality homes, have genuine relationships, can access enjoyable and nutritious meals, have good support, and when their complaints are taken seriously and acted on, good lives become a realistic goal.

Community Visitors urge the government to accept the carefully considered recommendations of this report and act quickly to implement them.

Figure 7. **Disaggregation of issues reported by Community Visitors, 21/22**



03

Disability Services

Recommendations

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

1. Advocates for legislative reform including to the NDIS Act to ensure that:
    a. Community Visitors continue to have a role in safeguarding the wellbeing of NDIS participants; and
    b. Community Visitor programs are recognised as a key component of NDIS safeguarding arrangements; and
    c. Disability services facilitate easy access for Community Visitors to documents as required under the Victorian *Disability Act 2006* that are held electronically including incident reports;
    d. Community Visitors and other comparable entities which are appointed under state and territory legislation are entitled to share and receive information to the extent necessary to advocate for participants and raise concerns with relevant bodies.
2. Proactively educates disability services on their legislated obligations to Community Visitors including right of entry, facilitating access to documents, and responding to Records of Visit within prescribed timeframes and enforces the requirements where necessary.
3. Establishes a process with the NDIA to ensure Community Visitors are promptly advised of new or changed facilities they are entitled to visit under legislation and provide additional funding to ensure Community Visitors are resourced to visit all facilities as required.
4. Establishes processes to provide urgent or last resort assistance to ensure all Victorians with disability, including people with complex and high support needs, are provided with suitable, safe and dignified supported accommodation while alternative arrangements are made.
5. Creates a legislative, policy or operational framework to ensure that disability supported accommodation is maintained to a standard consistent with landlord obligations under SDA residency agreements and/or residential rental agreements.
6. Provides additional funding to ensure that the Community Visitors Program has the resources and technology required to effectively fulfil its important safeguarding role.

Statewide Report

Introduction

This year, 241 appointed Disability Services Community Visitors and 74 trainee Community Visitors made 1952 visits. 1880 visits were undertaken as part of a regular visiting schedule and an additional 72 visits were made in response to requests to the OPA Advice Service for Community Visitors to attend particular homes.

The COVID-19 pandemic continued to impact on the work of Community Visitors, with Melbournians experiencing a total of 89 days of lockdown from July to October 2021. Community Visitors reported that many of the people they visited throughout the state were anxious and confused by the sudden change to routines without time to adjust.

When health directives permitted, most Community Visitors resumed in-person visits. Some service providers requested rapid antigen testing on-site prior to entry, while others did not. When in-person visits were not permitted, or not advised, Community Visitors continued to conduct visits via telephone or video, relying on staff for information about the wellbeing of the residents and issues in the home.

While technology has made remote visiting possible, some Community Visitors reported concerns that they were not able to independently verify the information provided to them, and couldn't communicate with or observe the residents and their homes in a meaningful way.

Unsurprisingly, the total number of visits made by Community Visitors has been lower over the past three years due to the complications of visiting during the pandemic. Despite the challenges, Community Visitors have continued to be active in their safeguarding work.

As restrictions eased, some of the earlier challenges remained, but in-person visits did become easier and the number of in-person visits increased in the second half of the year.

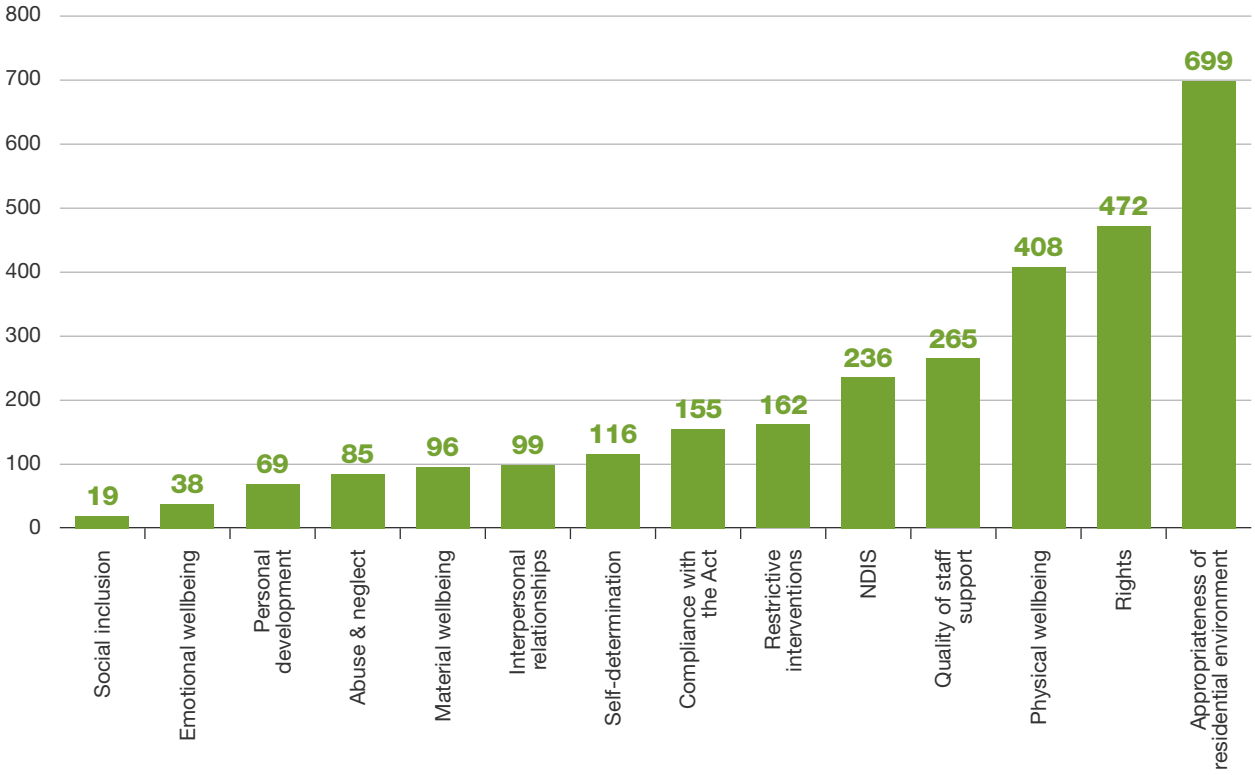
The charts below show the difference in the changes of the type of visiting undertaken between the first half of the 2021-2022 year to the second half. The difference in number of visits in the two halves of the year was less than 100 visits, but the way the visits were carried out was remarkably different (see Figures 10 & 11).

Visiting in-person remains the preference of Community Visitors but the connections made on remote visits have also strengthened relationships over the past few years. Community Visitors have made use of the information provided by services, for example, incident reports, allowing them to prepare questions for their next visit.

Table 4. Total visits Disability Services stream, 21/22

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	249	65	18	516	**534**
North Division	255	37	20	368	**388**
South Division	222	56	22	420	**442**
West Division	254	52	12	576	**588**
Total	**980**	**210**	**72**	**1880**	**1952**

Figure 8. **Issues reported by Community Visitors, 21/22**



GOOD PRACTICE : CHANGES DURING COVID-19

Community Visitors have been visiting one home for over 10 years. During this time, one resident was always seen sitting in his bedroom, and Community Visitors were instructed by support workers not to enter the room or engage with him. Another resident was always seated on the wooden floor alone in a lounge room and a third resident also spent most of her time in her bedroom. On resuming in-person visits following an extensive period of lockdown, Community Visitors noted that all residents were together with support workers in the main lounge room. Community Visitors reported that a new staff group had been employed at the home and were impressed with the positive changes they had made.

Issues Community Visitors most frequently reported on were related to the appropriateness of the home environment including the upkeep of the building itself as well as ongoing maintenance concerns. Community Visitors also frequently reported problems with accessing information they are entitled to see, particularly incident reports, as service providers move to online platforms for recordkeeping that Community Visitors don't yet have access to. Resident rights, physical well-being, quality of staff support, and problems with the NDIS were also top issues reported by Community Visitors this year.

Who we visit

Disability Services Community Visitors have a legislated right to visit:

- Specialist Disability Accommodation (SDA) enrolled dwellings where SDA residency agreements under the Residential Tenancies Act 1997 are in place (or by invitation if there are standard residential rental agreements);
- places where Short Term Accommodation and Assistance is offered by an NDIS provider;
- homes where residential services are provided under the Disability Act.

SDA is housing designed to be accessible for people with complex physical or other support needs. People who are eligible to live in SDA typically require significant personalised support every day and are usually required by the NDIA to share supports with others. Most have few, if any, alternatives if they are unhappy with who they share their home with and it is a complicated process to change the service provider that staffs the house.

As in previous years, Community Visitors were extremely concerned by instances where at-risk people with disability were forced to remain in unsuitable and unsafe homes for months or even years due to a lack of options or because of NDIS review delays. Community Visitors report that even when a resident is subjected to repeated violence, they are often forced to remain there. Too often, the situation is reduced to 'resident incompatibility' and solutions are slow to be found. In many cases, the violence is the result of a co-resident not receiving the supports they need. Such living arrangements are neither inevitable or acceptable.

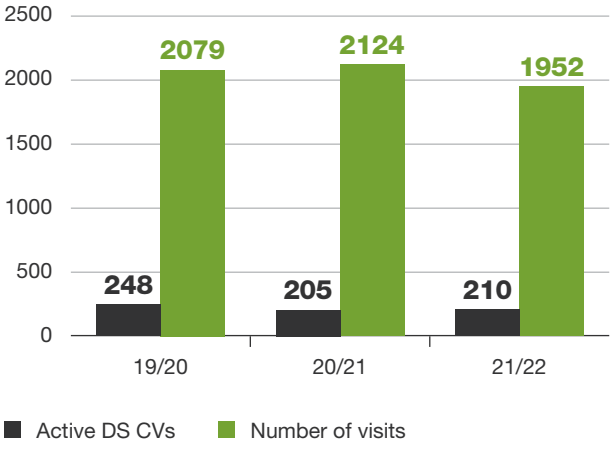
GOOD PRACTICE : DIGNITY IN DEINSTITUTIONALISATION

Since 2005, Community Visitors have visited five men who moved into a purpose-built home when a large Melbourne institution closed. Since leaving the institution, the men have enjoyed many social opportunities in their neighbourhood, have developed new skills and are accessing quality health and dental care. They have continuity of care into old age. One 89-year-old resident is thought to be the oldest surviving resident of the institution. He still participates in community activities, showing that with good support, everyone can enjoy a full and dignified life.

Disability Royal Commission

In December 2021, Community Visitors appeared before the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability *Public Hearing 20: Preventing and responding to violence, abuse, neglect and exploitation in disability services (two case studies)*. The hearing examined the experiences of people with disability who received supported accommodation services from Life Without Barriers.

Figure 9. Number of visits undertaken by active Community Visitors, 19/20–21/22



Community Visitors Christine Barbuto and Sue Rewell, along with the Public Advocate and Chair of the Community Visitor Board, Dr Colleen Pearce, and North Division Community Visitors Program Coordinator, Leonie Swift, gave evidence about significant problems at a home they regularly visit:

> *"There was a resident who had a chair broken over her head by another resident. She actually sustained a fractured finger when she was shielding her head…she wasn't checked for concussion…there was no immediate X-ray…The incident, I believe, happened on a Saturday. A locum [doctor] was not sought until the following day. Then it wasn't until the following Thursday that an X-ray was taken of her hand to determine that the finger had been fractured."*

They identified factors that had contributed to repeated violence in the home over a long period including a lack of training and support for staff by management, a high turnover of workers, and out-of-date or unused support plans and behaviour support plans. Community Visitors also described the persistent problems they had in accessing incident reports which meant they were unable to check if the provider had acted properly when the violence occurred.

Dr Pearce raised broader systemic concerns about NDIS funding delays that keep people in violent situations for months and years; new housing and support models that sit outside current regulatory and safeguarding frameworks; and information sharing barriers for Community Visitors and the NDIS Quality and Safeguards Commission. Dr Pearce concluded with a statement about the importance of the role of Community Visitors:

Figure 10. Type of visit July to December 2021

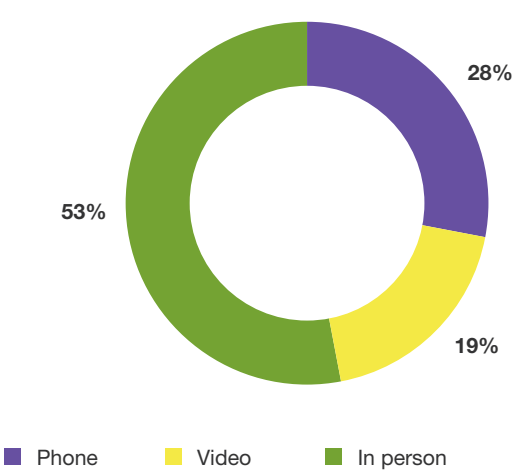
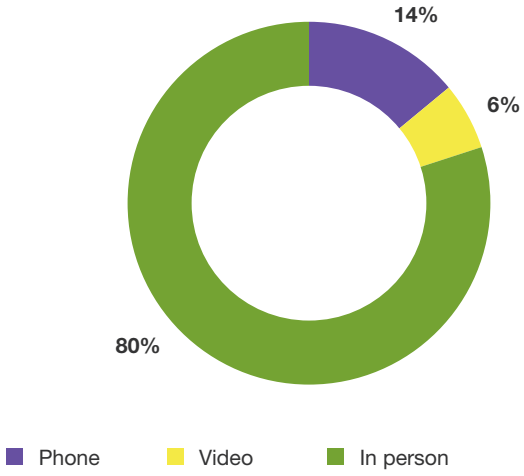


Figure 11. Type of visit January to June 2022



> *Aren't they impressive?…you can see how vital and critical they are for the promotion and protection of the human rights of people with disability, particularly in…closed environments…It is important, in my view, that Community Visitors retain their independence from…government and service providers, because you can see they are fearless human rights champions, and that independence gives them that ability to raise a raft of issues."*

Abuse, Neglect & Violence

Community Visitors remain vigilant in identifying and reporting on abuse or neglect in the homes they visit. They are trained to identify signs of abuse and neglect and on how to escalate their concerns. Last year they identified 89 instances of abuse and neglect – almost two every week. Community Visitors were particularly concerned about persistent and unacceptable violence between residents.

Complaints & Referrals

Over the past year, the Community Visitors Disability Board made 8 complaints about serious abuse and neglect to the NDIS Quality and Safeguards Commission. A further 7 matters assessed as medium-risk were sent to senior management at service providers to be addressed by the service directly. Where Community Visitors are unsatisfied with a service provider's response to a medium-risk referral, they escalate it as high-risk complaint to the NDIS Quality and Safeguards Commission.

DAN'S STORY

Dan moved from his family home into a group home with 3 existing residents. Dan struggled to settle in and get comfortable with new people and support workers. He assaulted residents and workers, and damaged property throughout the home. The other residents were losing sleep and started attacking workers too. Dan would frequently enter the bathroom when others were using it. After attempting many strategies with varying levels of success, behaviour support practitioners were engaged for each resident.

Community Visitors went to the home regularly as they were extremely concerned about the safety of everyone there. They documented their observations in detail and submitted many reports which led to a complaint to the NDIS Quality and Safeguards Commission. At the time of writing, Community Visitors were still awaiting a response from the Commission but report that the service provider is working with Dan and his family to identify housing that better meets his needs.

Abuse & Violence

Violence in homes can be the result of unmet needs, inadequate funding and few, if any, options for people to move to a home that they would choose. Solutions require cooperation and action by support coordinators, allied health professionals and the National Disability Insurance Agency (NDIA) and can be outside the immediate control of the in-home service provider who receives the Community Visitors' visit reports. Regardless, Community Visitors use every avenue available to raise their concerns.

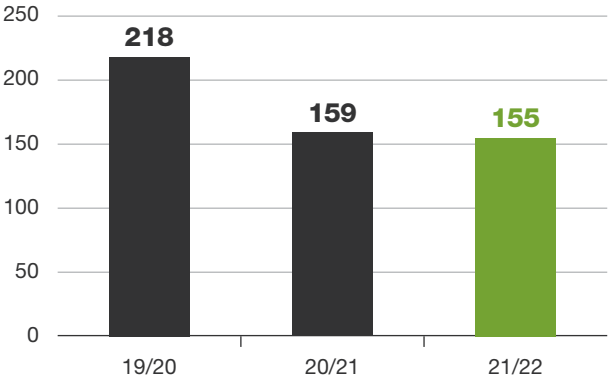
When a person is unhappy in or unsuited to the home they are living in, they can acquire a reputation for violence they would not have if they had the right home and supports sooner. Bad reputations can follow people for years or even decades. It is wrong and unfair that people with disability are judged on how they behave under unbearable conditions.

In one home, Community Visitors reported that a resident had 21 instances of recorded violence in one month including pinching, slapping, throwing drinks, hitting and inappropriately touching support workers. In another home, there was a violent attack by a resident on a co-resident who was subsequently hospitalised. Community Visitors are also aware of a home where a resident's violence towards support workers resulted in them taking leave and not returning to work.

Community Visitors review incident reports to identify serious harm and patterns of unresolved or persistent problems. In just one home, Community Visitors noted a high number of serious incidents including an alleged sexual assault by a male resident of a female resident when support workers were occupied; a female resident found unresponsive after she had broken into the medication cabinet and ingested over 180 tablets; and a pattern of physical assaults by one resident on others.

Community Visitors report on the unacceptable impact of NDIS delays on people living in situations which are stressful and unsafe. No one should feel unsafe or be subjected to violence in their own home.

Figure 12. Issues of abuse, neglect and violence identified in Disability Services stream, 19/20–21/22



ARUN'S STORY

Following a review of incident reports, Community Visitors identified a pattern of persistent violence in one home in regional Victoria. Arun, who had been violent towards other residents, had recently relocated to another home. Soon after, Arun's behaviour support practitioner contacted his previous home to advise he had made threats to damage and burn it down. The service provider engaged security to monitor the home but intermittently.

Two weeks later, Arun kicked his way through a door and forcibly entered the property late at night. The sole support worker on shift had to break a window to escape onto the road and contact emergency services while the other residents remained in their bedrooms. One week later Arun returned, assaulting a resident with a piece of wood, requiring them to be taken to hospital. He was subsequently picked up by police but returned again, verbally abusing residents and causing further property damage.

Community Visitors conducted a routine visit the next day, and escalated their concerns to the service provider's management. Residents told Community Visitors they were fearful Arun would return. As of June 2022, Community Visitors were continuing to advocate for better support for Arun and additional security to be put in place for residents.

OLIVER'S STORY

Community Visitors reported serious concerns for the safety of residents and support workers in a home they have visited for the past 7 years. Oliver has lived in the home for 12 years and has said that he wants to move out and live on his own or with one other person. He spits and throws objects at his co-residents, repeatedly slams doors, breaks items, yells, and screams. Support workers have been assaulted and Community Visitors noted one incident where Oliver took a wooden picture frame from another resident's bedroom door and threw it at him, hitting him above the eye causing bleeding.

Residents told Community Visitors they are distressed living with the violence. Some have retaliated. Others said that they stay in their bedrooms to avoid interacting with Oliver.

A behaviour support practitioner was engaged to provide training and strategies for staff. A multi-disciplinary team was also set up. However, an unstable staffing team has led to inconsistent application of strategies to support residents.

In late 2021, the Community Visitors Disability Services Board made a complaint to the NDIS Quality and Safeguards Commission. The Community Visitors Program also enlisted support from the OPA Advocacy Project Officer, who contacted Oliver's support coordinator and behaviour support practitioner about exploring other housing options.

Oliver's support coordinator applied for additional funding for him however this was denied by the NDIA. The NDIA also refused to fund Short Term Accommodation for Oliver due to the cost (4 weeks respite would reportedly cost $100,000) and on the basis that he already spent weekends with his parents.

Oliver's support coordinator lodged an appeal and the NDIA agreed to increase support coordination hours. However, the situation remains unresolved with violence still occurring at the home. Oliver still wants to move out.

Neglect

Community Visitors are uniquely able to identify, document and report on long-lasting problems in homes over repeated visits. In some homes, violence has become normalised and accepted as unavoidable. The apathy might be considered neglect. People with disability living in group homes have the same right to safety in their homes as everyone else in the community. Community Visitors expect that residents should live in homes that are not only safe, but which enhance their well-being and enable them to live their best life with freedom and dignity.

However, people living in group homes typically do not choose how many people they live with or who they live with, impacting on their privacy, health, relationships and independence. The NDIA continues to fund most people with intellectual disability and high support needs at group rates whether they want to live in groups or not.

Community Visitors report that violence occurs most often where residents aren't suited to living with each other, and particularly when residents clearly have opposite needs, for example, a person who needs a quiet environment living with someone who is usually loud. The solution put forward is to find ways to keep people separated inside their own home rather than being given options to live apart. The problems caused by the incompatibility of residents puts pressure on support workers and impacts on worker retention. Short staffing puts residents at risk of neglect.

CHARLIE'S STORY

Two new residents moved into a home where other residents had been living for a long time. One of the new residents, Charlie, had not lived away from their family before. Initially, they settled in well, but could be loud and overbearing, and soon began assaulting other residents. Support workers encouraged the residents to stay in different parts of their home as a strategy to manage the conflict. One resident broke down crying at the mention of Charlie's name, and their family became increasingly concerned about their welfare.

The service provider organised meetings with families and support coordinators to find solutions. Charlie said they wanted to move to another home and be more independent, but eventually returned to live with family until the right home and support could be found.

KAT'S STORY

Community Visitors have repeatedly reported concerns about the safety and well-being of residents with complex support needs living in one regional Victorian home.

COVID-19 had a severe impact on the already high levels of stress and anxiety of each resident. Residents were unable to attend their usual programs and endured long periods of separation from family and specialist services.

One resident, Kat, who is non-speaking, socially isolated, highly anxious, and physically vulnerable lives with co-residents who are loud and unpredictable. Some of the residents self-harm and can be aggressive towards each other and the support workers.

Lack of adequate NDIS funding for most residents has resulted in the use of crisis management strategies and continual violence. Support workers say that Kat would be better off in another home, but she doesn't have adequate NDIS funding to move.

The Community Visitor Program has met with the service provider's management on several occasions to discuss the problems, and a complaint was lodged with the NDIS Quality and Safeguards Commission in November 2021. However, there has been no reduction in the number of incidents or positive changes for the residents yet.

Restrictive Practice

Community Visitors continue to report on situations in the homes they visit where residents with complex behaviour support needs are grouped together. Community Visitors check that residents who need them have current behaviour support plans in place, that the strategies developed are necessary and are the least restrictive option. Community Visitors also ask support workers about how incidents are recorded and responded to, what support they receive to implement the plans and strategies, and the opportunities they have to give regular feedback to behaviour support practitioners and other allied health staff.

Because Community Visitors visit the same homes regularly, they get to know people well and see how people change over time. This year they reported that:

- some residents have high quality behaviour support plans that are skilfully implemented by support workers and their lives have significantly improved
- they found detailed behaviour support plans but no evidence that the recommended strategies were implemented
- residents had out-of-date behaviour support plans and were waiting long periods for a new one
- long delays on a new behaviour support plan meant that a resident was unable to attend their day program for 3 months
- support workers told them they do not know what is in the person's behaviour support plan
- support workers believed the behaviour support plan did not meet the person's needs, so they chose not to use it.

Healthcare

This year, Community Visitors identified significant problems with access to local dental services. Some residents need wheelchair accessible facilities such as hoist transfer or adaptive examination chairs or general anaesthetic for all treatments. Some people need practitioners who have specific expertise in working with people with disability. This, coupled with long wait lists for services at community clinics and public health services, means that many people Community Visitors visit do not have the same access to dental care as other citizens. The problems are particularly acute in regional areas.

Access to Electronic Records

Community Visitors have legislated powers to access certain records relating to the people they visit. For example, Community Visitors look at resident support plans which include information about what people do for work, recreation, and in their community. Reviewing records is a critical part of the safeguarding role of Community Visitors, ensuring that people are receiving the support and services they need. This is particularly important for residents who do not have family or other ongoing advocacy support in their lives. Community Visitors also expect access to incident reports so that they can look for patterns of good and poor practice, can see how providers have responded to incidents, and can consider potential future risks for residents.

As they have in the past few years, Community Visitors worked closely with service providers to develop or improve processes for accessing resident records and appreciated the extra work they did to provide information electronically when in-person visits were not possible during COVID-19 restrictions.

Most service providers meet their legislated obligations by providing easy access to records for Community Visitors. Community Visitors commend the efforts of service providers who have designed and successfully implemented electronic systems that both maximise the confidentially of resident information while also enabling Community Visitors to access the information they are entitled to see.

Community Visitors continue to be frustrated with a small number of service providers who do not comply. Service providers who use software with privacy settings that do not allow access for Community Visitors to fulfil their legislated role are not meeting their obligations. Some support workers say they do not have time to assist Community Visitors, and others refuse Community Visitors access to records because they do not understand Community Visitors' powers. Sometimes Community Visitors encounter support workers who do not know how to use the electronic records system themselves, which raises serious questions about whether they have access to critical information about how to support the person while on shift.

National Disability Insurance Scheme (NDIS)

Disability Services Community Visitors received training on the NDIS this year as part of the Disability Change Project which was funded by the Victorian state government to increase their knowledge on how to identify, enquire into, and resolve NDIS-related matters for the people they visit.

Community Visitors identified 236 NDIS-related issues including some persistent problems that remain unresolved from previous years. Community Visitors liaise with service providers who are delivering direct support in the home on the issues they identify, but increasingly find the root of the problem can be traced back to a lack of NDIS funding, NDIA decision-making delays, or the poor practices of other NDIS-funded service providers outside the person's home.

This year, Community Visitors continued to report on inadequate NDIS plan funding, unwarranted cuts to plans, and where funding was not being used to achieve stated plan goals. Community Visitors reported numerous instances where, due to underfunding or funding cuts, residents were trapped in unsuitable or even dangerous living arrangements, and sometimes were housebound for lack of 1:1 support to go out. Inadequate funding also impacted on residents being able to pursue their interests, or to exercise, or to go on holiday.

Community Visitors reported that professionals were making decisions about NDIS participants without an adequate understanding of their needs and without consulting them. The result is wasted opportunities, wasted funding and serious breaches of participants' rights. In OPA's September 2021 *Submission on the development of an NDIS Supported Decision Making Policy* to the NDIA, Community Visitors noted: "NDIS funding must enable the day-to-day lifestyle, personal and financial decisions of a person who requires the skilled support of a decision-supporter. This requires the provision of decision-making support, over a period, to build the decision-making capacity of participants." There has been little, if any, improvement in practice that puts NDIS participants who live in group homes at the centre of NDIS planning and implementation.

Community Visitors have repeatedly reported on inordinate delays in reviews of NDIS plans, resulting in essential services being suspended or withdrawn completely. Decisions regarding which services will be funded and which services can be included often appear random or illogical. For example, Community Visitors were advised that a resident was funded for psychology following the death of housemate. Only one session was utilised as the resident would not engage in talk therapy with the psychologist. At the same time, the resident's NDIS funding for art and music therapy, which worked well for them, was cut back.

DOM'S STORY

Community Visitors continue to monitor a situation where Dom, a resident with complex support needs, has had a significant NDIS funding cut, leaving them without critical supports. With two workers on shift, Dom had been able to build trust and confidence, and there was a marked decrease in behaviours of concern. The funding cut left Dom with just one worker on each shift. There is a high risk that reducing support will put Dom and support workers in danger, will increase their social isolation because they cannot safely go out, and lead to the reintroduction of behaviour modifying medication (chemical restraints). The support coordinator and service provider are seeking a review of the funding cuts, and will use the observations of Community Visitors have made about Dom over time as evidence in their submission.

Physical Environment

The physical environment of the homes people live in really matters, and Community Visitors look closely at the inside and outside of the homes they visit. The quality of the physical environment has a major impact on resident wellbeing and happiness, and on their reputation and relationships with their neighbours. Some residents like to give Community Visitors a tour of their home, pointing out spaces, furniture, and decor that they are particularly proud or fond of. They also tell Community Visitors about problems with the property that they wanted fixed.

Now that Community Visitors have returned to in-person visiting, it has been easier to identify and follow up on issues relating to the physical environments people live in. This year, Community Visitors have identified 386 issues relating to the upkeep of buildings and fittings. Frustratingly, many of these issues, both major and minor, have carried over from previous years of reporting. It often takes far too long for repairs to be made or broken appliances fixed or even black mould to be treated. Residents should be able to expect high quality homes that are repaired quickly when needed.

GOOD PRACTICE : POOLSIDE ON HOT DAYS

A service provider in sunny regional Victoria developed homes with outdoor pools and spa areas. For residents who may not wish to completely immerse themselves, there are a variety of unique features which spray out water. The spaces are accessible to residents with mobility issues. Pools and spas have the required safety features. The homes have well-designed outdoor entertainment areas that residents use for socialising with friends and family.

Maintenance

Community Visitors frequently report ongoing maintenance issues in the homes they visit, sometimes over months or even years. Community Visitors advocate for better homes for the people they visit, as they always have and will continue to do.

During the COVID-19 pandemic, non-urgent maintenance was put on hold. This year, Community Visitors hoped that the problems would be promptly addressed, however due to a shortage of tradespeople and materials, delays are ongoing.

In one home in regional Victoria, Community Visitors have reported for several years now about an extremely unsafe bathroom that is a hazard for an elderly resident with mobility issues. The tiles in the shower are lifting, creating a falls risk which could lead to serious harm to residents and support workers.

GOOD PRACTICE : HOME IMPROVEMENT

Residents were living in a badly deteriorated weatherboard home. The gardens were overgrown and in poor condition. A new service provider took over and immediately made vast improvements to the indoor and outdoor areas. Large cracks in the ceilings and walls were repaired and made safe. The walls were painted and new flooring was installed. New furniture was purchased, including a dining table, chairs and a sofa. The outside areas were completely cleaned up with fresh tanbark, the shrubs were trimmed, new plants were put in and swings were installed in the backyard, much to the residents' delight. The residents are now looking forward to moving into a brand new purpose-built home nearby.

Staff

Community Visitors have continued to see the impact of the COVID-19 pandemic on disability services. They report that many support workers have worked tirelessly to assist residents through lockdowns and restrictions. They have also observed state-wide labour shortages, with many casual and agency workers engaged to address the shortfalls. This is particularly challenging in regional and rural areas where service providers have to compete for well-trained, experienced staff. Community Visitors have observed long-serving support workers working extra hours so that residents are not faced with unfamiliar staff. Many are experiencing exhaustion and low morale. Community Visitors commend the dedication of support workers but hold concerns about their health and well-being and the potential for further shortages if they can't keep going.

In one home in metropolitan Melbourne, Community Visitors reported that due to worker shortages - and despite the best efforts of the service provider - more than half of rostered positions were being filled by temporary staff. This has had a significant impact on the wellbeing and safety of residents who rely on their support workers having an in-depth knowledge of their needs.

Community Visitors often build relationships with the people they visit and who look to them for support and advocacy. The impact of the Community Visitor is obvious when residents understand their role and are comfortable to ask for assistance. Where residents have complex communication support needs, or do not understand the role of Community Visitors, Community Visitors rely on support workers for information about what residents want and need. Residents who directly raise issues with Community Visitors also get outcomes for others who are unable to ask for help themselves.

GOOD PRACTICE : SPEAKING UP

In response to a call to the OPA Advice Service, Community Visitors met with two residents who had a complaint about how they had been treated by a support worker. They complained of being shouted and sworn at, and being belittled. They wanted the support worker to be removed from their home. The service provider investigated and the support worker no longer works there. The manager had regular meetings with the residents, and they received ongoing support for their mental health and welfare. Community Visitors reported that residents were much happier in subsequent visits because they had been listened to and positive changes had been made as a result of speaking up.

Many people who live in group homes now have NDIS funding to engage support workers to go out in the evening and on weekends. Community Visitors ask the people they visit what they do when they go out, but they are often unable to recall or communicate the details. In-home support workers report frustration and fear that they are not given more information about the staff who are taking people out and the lack of handover on their return. Community Visitors are concerned that support workers don't know the residents' goals, that they may not have the skills needed to support the person properly, and that support provided may not be value for money. Community Visitors are also concerned that no one will raise the alarm if something goes wrong.

MAL & JEAN'S STORY

Mal and Jean use wheelchairs and had plans to go out which required the assistance of 2 support workers. The support workers were to drive them in their van and accompany them for support. Instead, the support workers drove to one of their own homes, leaving Mal and Jean in the van with no explanation of what was happening.

This only came to the attention of Mal and Jean's in-home support workers the following week, when Jean mentioned that she did not want to go out with the support workers again. When asked why, she explained that they had been left in the bus for 2 hours the previous week, and that Mal had a seizure during this time. The service provider was able to verify her story.

At a visit 2 months later, Community Visitors were surprised to be informed that the 2 support workers involved had returned to work and were rostered on for the following weekend. They were told an internal investigation did not find there had been grounds for the support workers' removal.

PETER'S STORY

Community Visitors visited a home and spoke to a support worker who informed them that one of the residents, Peter, stayed overnight at his NDIS-funded worker's home. Peter told a family member that when he had accidentally dropped food on the floor the support worker said he could not have any more. In their report, Community Visitors asked if this was appropriate practice for a support worker to take a resident to their home for the night. There has been no response from the service provider.

Conclusion

The introduction of the NDIS has created new opportunities for people with disability to have more choice about where and with whom they live. People who currently live in group homes may want to live alone, or with a partner or friends and should be able to get NDIS funding to it. Ideally, there is strict separation between the disability service providing support in the home and the service who acts as the landlord, so that residents can choose a new in-home support provider without being forced to move house.

Only a small percentage of NDIS participants live in purpose-built SDA. In 2019, the Victorian government strengthened protections for people living in SDA by amending the Residential Tenancies Act 1997 (RTA) and giving SDA residents equal or greater rights compared with other Victorian renters.

People with disability who are not eligible for SDA have few other affordable housing options. They are increasingly being offered a room to rent in group homes that are owned or leased by an NDIS provider on the condition that they use the provider's own services. There is often no difference between the support needs of people with disability who live in SDA or one of these alternate arrangements, however current legislation does not allow Community Visitors to visit these new housing models.

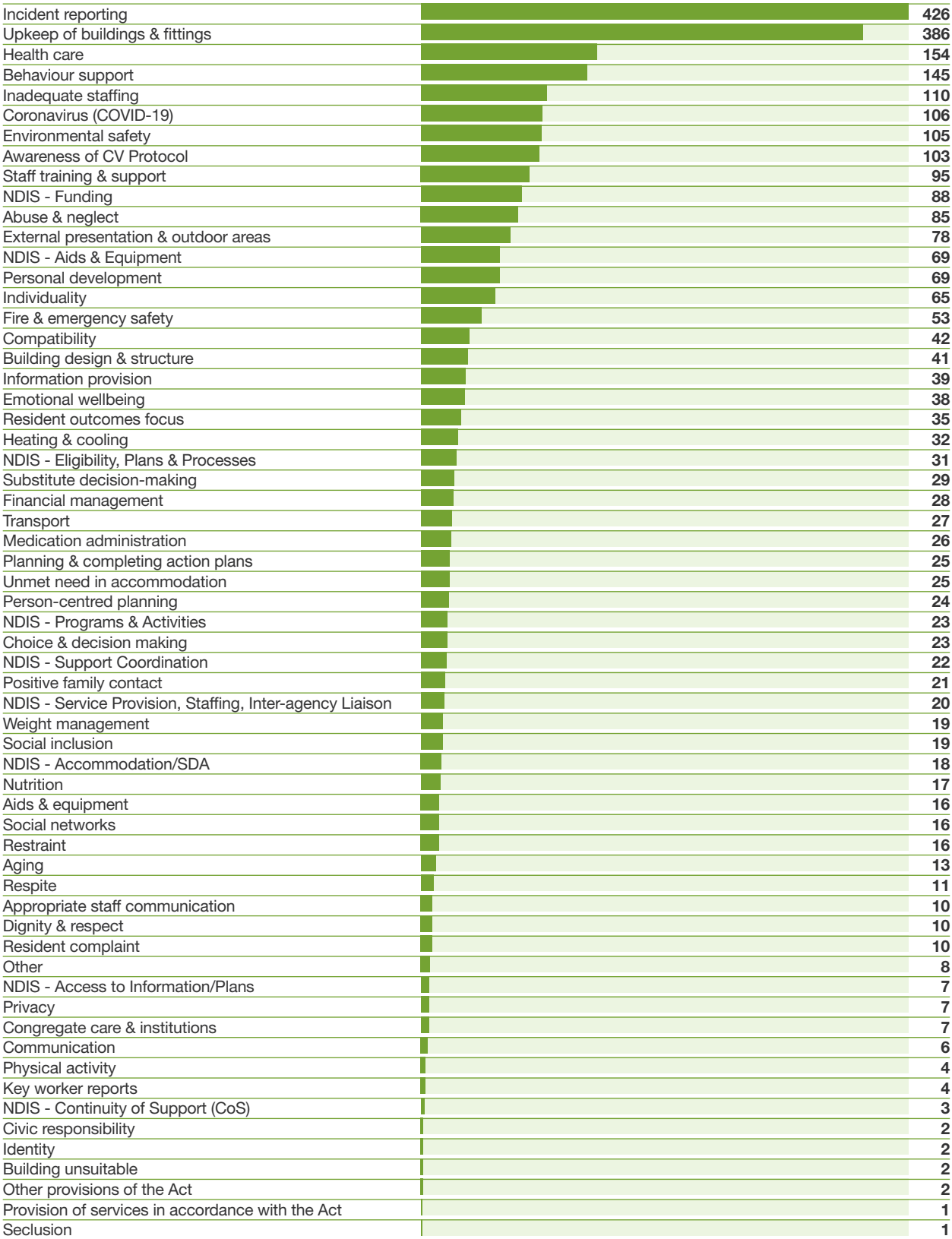
Community Visitors find out about new disability accommodation in their neighbourhood by word of mouth or from service providers who have an existing relationship with the Community Visitors Program. The growth in SDA-enrolled properties has been so rapid over the past few years, the Community Visitors Disability Services Board and OPA are unsure of the actual number now eligible to be visited. The Community Visitors have not been able to obtain a list of SDA-enrolled properties from the NDIA despite formally requesting it.

The growth in the number of eligible properties to be visited cannot be met by the Community Visitors without a considerable increase in funding. For now, Community Visitors remain committed to visiting the homes already on their database and will continue to lobby for funding to visit properties known to the program that are not yet being visited.

Community Visitors have also raised concerns this year about residents they have known for many years who have moved into properties they cannot visit, particularly where they believe the person is at risk of abuse, neglect and exploitation. There are alarming safeguarding gaps for people with disability living in private rental arrangements with service providers, and new service providers are often unaware of their obligations to people with disability under Victorian legislation.

It is unclear what the future role of the Community Visitors will be with so many changes occurring in the way that housing and disability support is provided. Community Visitors advocated for better housing and support options for people with disability who were living in large institutions in the past, and they will continue to advocate for people to have more and more choices in the future alongside guaranteed access to strong safeguards.

Figure 13. **Disaggregation of issues reported by Community Visitors, 21/22**



Appendix 1: Community Visitors 2021–2022

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.

Abeysinghe, Nanduvi
Ades, Deanne
Alexander, Ian
Allen, David
Allen, Jenny
Allen, Jo Deceased
Anderson, David
Argyropoulos, Gudrun
Baker, Sandra
Baker, Kim
Ball, Joyce
Baneth, Wendyn RC
Barbuto, Christine RC
Bartolo, Ricky
Beatson, Cheryl
Bellchambers, Efi
Beniwal, Manisha
Berry, Judith
Bink, Judith
Blanc, Franciska
Blustein, Rose RC
Blythman, Marion RC
Boland, Dominic
Bourke, Jo
Bowen, John
Braxton, Rebekah
Breedon, Fiona
Brewin, Robyn
Broughton, Sheena RC
Brown Deidre
Bryant, Lorraine
Buckles, Ian RC
Butler, Ronald RC
Cahill, Andrea
Campbell, Dorothy (Dot)
Campbell, Heather
Carrasco, Gerard
Cary, Debra
Castanelli, Ken
Castledine, Joan
Cerra, Pat RC
Chapman, Chris
Chater, Cecily
Chenco, Carol
Chesterman, John
Chitale, Shri
Clark, Belinda
Clarke, Toni
Coffey, Frances
Cohen, Jo
Collins, Liza
Collison, Terry
Connelly, Janneane
Cortecci, Stefania
Coughlin, Robyn
Coulter, Jeanette RC
Coutts, Adele RC
Coverdale, Georgia
Coverdale, Joanne
Cowley, Erin
Crebbin, Bryan RC
Cromarty, Fiona RC
Cross, Patricia RC
Crutchfield, Graeme
Cunningham, Robyn RC
Da Silva Bernardo, Miguel
Dalliston, Philip
Davies, Ian
Davies, Wendy
Davison, Pat
Dawson, Meryl
Devidas, Bev RC
Dib, L'shae
Dickinson, Graham RC
Dimer, Christine
Dixon, Di
Dobes, Alex
Dobrzynski, Kerrie
Donaldson, Jenny
Donohue, Diana RC
Doran, Wendy
Douglas, Sheila
Droney, Wendy
Dudfield, Francine
Dunbar, Jan
Dunn, Ian
Dunn, Jennifer
Dussuyer, Inez
Eddie, Anne
Edwards, Megan
Ellery, Daisy
Elms, Elizabeth
Evans, Pam
Fahey, Anne
Fallshaw, Eveline RC
Farbrother, Mary
Farrugia, Isabella
Faulkner, Beth
Fawcett, Gillian
Fenwick, Jennifer
Ferguson, David RC
Findlay, Jeanette
Findlay, Roger RC
Firth, Trudy
Fitzgerald, Judy
Flanagan, Christy
Fontana, Maureen RC
Forbes, Marilyn
Ford, Gen
Forde, Christopher
Forsyth, Jan
Fourie, Natalie
Fowler, Debbie
Frame, David
Fraser, Paulette
Freeman, Ian
Freidin, Judith
Freudenberger Kay, Anne
Frisch, Emma
Gallo, Jayne
George, Sandra
Gibbs, Ken
Giles, Pam RC
Gorrie, Yan
Goy, Mark
Grace, Audrey
Graham, Eddie
Graham, Ruth
Graham, Shane
Granrott, Brian
Gray, Mandy
Gregory, Kay
Grigson, Alan
Grint, Bill
Grogan, Gerard
Gruner, Alan RC
Guy, Wendy
Haidar, Ghassan
Haouchar, Sam
Hargrave, Sally
Harraway, Susan RC
Harris OAM, Lynette
Harrison, Ian
Hart, Tanya
Hartelt, Vera
Hayes, Barbara
Hayes, Lynette
Heath, John
Heazlewood, Coral
Henderson, Neil
Henry, Jennifer
Herbst, Sue
Heron, Judy
Hewavitharana, Pradeep
Hickey, Bill RC
Hickey, Robyn
Hinckson, Colin
Holland, Wendy
Horan, Pat
Howarth, Stephane
Howlett, Mary
Ienco, Giordana
Ingram, Chris RC
Isaacs, Dallas
Jack, Felicity
Jacob, Beverley
Jacobsen, Maureen
Jambrich, Thomas
Jamel, Hibba
James, Mary RC
Johnson, Lyn
Johnson, Raymond
Johnson, Valerie
Jolley, Prue
Jones, Barry
Jones, Robyn
Jonker, Debbie
Judkins, Lynda
Juniper, Don
Katamish, Boudie
Kaur, Karamjeet RC
Kelly, Julie
Kent, Paul
Kerr, Jenny RC
Kershaw-Ryan, Liam
Khan, Saima
Kiley, Brian
King, Debbie
King, Mary
Klok, Julie
Kohn, Alan
Krakowiak, John
Kunkler, Amanda
Lagerwey, Francina (Tineke)
Lau Gooey, Suzanne
Lawler, Sandra RC
Lawrence, David
Lawrence, Jayne
Lawrence, Susan
Lee, Debra
Leeman OAM, Lawrie RC
Leeman, Robyn
Lewis, Lynette
Lewis, Mark
Lewis, Rob RC
Libbis, Beverley
Licata, Nuala
Lloyd, Vashti
Long, Louise
Lush, Jennifer
Mack, Virginia
Madan, Umberine

Maher, Carole RC
Maiolo, Jenny
Manners, Kaye
Mapa, Dinuka
Marie, Jessica RC
Markowiec, Linda
Marlow, Rohan
Masterson, Cindy RC
Matthews, Brian
Maugey, Julian
Mayne, Wendy
McBeath, Ian
McCarthy OAM, James
McCarthy, Patrice
McClure-Leckie, Kaye
McElvaney, Carole
McElwee, Stephen
McGennisken, Paddy
McGowan, Catherine
McGrath, Irene
McGregor, Pamela
McLachlan, Deborah RC
McLeish, Heather
McMinn, Brenda RC
McPhee, Louise RC
McRobert, Catherine
Messenger, Laurie
Miragliotta, Frank
Mobach, Nina
Moore, Joanne
Mulder, Rachel
Munro, Marj RC
Murphy, Alan RC
Mutubuki, Gerald
Myers, Phillip
Neale, Danielle
Ng, Craig
O'Brien, Sue RC
O'Donoghue, Kim
O'Neill, Janine
Ottaway, Jack
Patchett, Wendy
Paxton, Cheryl
Peterson, Linda RC
Peterson, Stephen
Petrasek, Daniel
Pietruschka, Max
Plunkett, Lesley
Pollack, Sally
Prakash, Regina
Price, Nancy
Proudlock, Robert
Purves, Margaret
Randall, Rose
Rawicki, Helen
Ray, Ann RC
Ray, Neil
Rea, June
Rewell, Sue RC
Rhodes, Maureen RC
Richards, Kathy
Richardson, Dawn
Ritchie, Julie
Roberts, Dany
Robinson, Hugh
Roche, David
Roche, Vivienne
Rochlin, Greg
Rogers, Mark
Roth, Pam
Rothwell, Suzanne
Rubinstein, Linda
Schepisi, Frances
Scholz, Axel
Seren, Diane
Sevistianov, Debra RC
Shaw OAM, Rosemary
Shawyer, Tracey
Sheehan, Robert
Shiek, Daphne
Singh, Awtar
Singh, Manmohan
Singh, Mohini
Singleton, Kim
Sivakumar, Puvana
Smith, Phillip
Smith, Royce
Smyth, Nicole
Soutar, June
Sparrow, Helen
Stafford, David
Staunton, Glenn
Steadman, Ray RC
Stein, Gideon
Straney (Beaton), Suzanne
Strofeldt, Susan
Summons, Sheryl
Swaiti, Gossain
Swiger, Robert
Tait, Anne RC
Talacko, Anna
Talukdar, Alan
Thompson, Sue-Anne
Thornton, Graeme
Thorsen, Kerren
Thurrowgood, Rosslyn RC
Tivendale, Julia
Trevillyan, John
Tribe, Helen
Trompf, Julie
Tsaroumis, Demi
Tunstall, Merrill
Turcan, Kathy
Turner, Gary
van Draanen, Linda
Vandersman, Carmel
Veitch, Adam
Veneracion, Antonia
Walker, Kate
Wallace-Clancy, Lynn RC
Walsh, Daniel
Walton AO, Sylvia
Waluk, Sebastian
Waters, Betty
Watt, Melinda
Weber, Jennifer
Weetch, Christine
Weisshardt, Brenda
Wellard, Sally
Wereta, Wendy
White, Calvin RC
White, Michael
Whittle, Peter
Whyte, Liz
Wilde, Dianne
Williams, Carole
Williams, John
Williamson, Joanna
Williamson, Ros
Wilson, Elaine
Wilson, Linda RC
Winter, Sheila RC
Wood, Lyn RC
Wood, Megan
Woodcock, Tricia
Woodrow, Rhonda
Yew, Ying
Yu, Ping
Zahra, Annie
Zammit, Susan
Zanetidis, Ignatius

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

ACSO (Formerly Australian Community Support Organisation)

AGAPI Care Inc.

Alkira Centre - Box Hill Inc.

Amicus

Annecto Inc.

Araluen

Aruma (Formerly House with No Steps & Tipping Foundation)

Asteria Inc

Bayley House

BJ Care Solutions

Care Choice

Carinya Society

Claro (Formerly ACARES)

Colac Otway Disability Accommodation Inc.

Community Living and Respite Services Inc.

ConnectGV

Cooinda

Department of Families, Fairness and Housing

DPV Health (Formerly Plenty Valley)

Encompass

Ermha

Expression Australia

Focus ISS (Formerly Kindilian)

Gateways Support Services

Gellibrand Support Services

genU Karingal St Laurence

Give A Care

Golden City Support Services

Healthscope Independence Services

Home @ Scope

IDV Inc (Formerly Ivanhoe Diamond Valley)

Independence Australia

InLife Independent Living

Jesuit Social Services Limited

Jewish Care (Victoria) Inc.

Jigsaw Blue

Journey Health Solutions

Just Better Care

Kirinari Community Services Inc.

Kyeema Support Services Inc.

Life Without Barriers

Mansfield Autism Statewide Services (Formerly Mansfield Autistic Statewide)

McCallum Disability Services Inc.

Melba Support Services

Melbourne City Mission Inc.

MH&R Holdings

Mind Australia

Mirridong Services Inc.

Monkami Centre Inc.

Multiple Sclerosis Ltd

Nadrasca

NEXTT (Formerly AAA Nextt)

Noraccom

Noweyung Limited

OC Connections

ONCALL Group Australia

One Doorway

PALS (Providing All Living Supports)

Pinnacle Inc.

Possability

SASI (Formerly Statewide Autistic Services)

Scope Australia

South Stay Disability Services (Formerly Southern Way)

SRS (Formerly Sunraysia Residential Services)

St John of God Marillac (formerly St John of God)

Sunrise2Sunrise

TRIO Support Services

Uniting Victoria & Tasmania Ltd

VMCH (Formerly Villa Maria Society)

Wallara Australia Ltd

We Are Vivid (Formerly Vivid)

Woodbine Inc.

Yooralla

Mental Health Providers

Aged Persons Mental Health Program

Albury Wodonga Health

Alfred Health

Austin Health

Ballarat Health

Ballarat Mental Health Services

Barwon Health

Bendigo Health

Eastern Health

Forensicare – Thomas Embling Hospital

Goulburn Valley Health

Latrobe Regional Hospital

Lyndoch Living

Melbourne Health

Mercy Health

Mildura Base Public Hospital

Monash Health

North Eastern Health

Northern Health

Orygen Youth Services

Peninsula Health

Royal Children's Hospital

Royal Melbourne Hospital

South West Health Care

Sunshine Hospital

St Albans Hospital

St Vincent's Hospital Melbourne

Stawell Regional Health

West Wimmera Health

Western District Health

Supported Residential Services

Absalom (Closed 30 August 2021)

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

Blue Bells Crofton House

Blue Willows Residential Aged Care

Brooklea Lodge

Brooklyn House

Browen Lee Home - Ballarat

Browen Lee Lodge SRS - Brown Hill

Brunswick Lodge

Burwood Lodge

Caulfield House

Caulfield Manor

Chatsworth Terrace

Chippendale Lodge

Coorondo Home

Corandirk House

Covenant House

Cranhaven Lodge

Crystal Manor

Darebin Lodge

Doncaster Manor

Dorset Lodge

Dunelm

Edwards Lodge

Elgar Home

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

Gracemanor SRS (Formerly Meadowbrook - Closed 10 June 2022)

Gracevale Grange

Gracevale Lodge

Grand Villa Mentone

Grandel (Closed 4 October 2021)

Greenhaven

Greenslopes SRS

Hamble Court

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 Supported Residential Service

Kilara House

Kooralbyn Retirement Lodge

Kyneton Lodge

L'abri

Lilydale Lodge

Manalin House

Maroondah House Supported Residential Service

Mayfair Lodge

Melton Willows

Merriwa Grove

Mont Albert Manor

Mornington House

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

Sunset Waters (Formerly Eagle Manor)

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 SRS

Westley Garden

Westpeak Residential Services Belmont

Westpeak Residential Services Mount Waverley (Closed 24 June 2022)

Westpeak Residential Services Surfcoast

Westpeak Residential Services Vermont

Whitehaven

Appendix 3: Glossary

This is an alphabetical index that explains the acronyms used in this report.

ACAS	Aged Care Assessment Service assessment
CCU	Community Care Units
CATT	Crisis assessment and treatment team
DFFH	Department of Families, Fairness and Housing
ECT	Electroconvulsive therapy
ECU	Extended Care Units
HRAR	High-Risk Accommodation Response team
HOPE	Hospital Outreach Post-Suicidal Engagement
HSR	Human Services Regulator
IMHA	Independent Mental Health Advocacy
ICA	Intensive Care Area
IST	Intensive Support Team
MAC	My Aged Care funding
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NFI	Notice to Investigate
NUM	Nurse Unit Manager
OCP	Office of the Chief Psychiatrist
OPA	Office of the Public Advocate
PLP	Pension-Level Program funding
PSP	Personal Support Plans
PARC	Prevention and Recovery Care
PAPU	Psychiatric assessment and planning unit/s
RAT	Rapid Antigen Test
RTA	Residential Tenancies Act 1997
STA/STAA	Short Term Accommodation and Assistance
SIL	Supported Independent Living
SDA	Specialist Disability Accommodation
SRS	Supported Residential Services
SAVVI	Supporting Accommodation for Vulnerable Victorians funding
YPARC	Youth Prevention and Recovery Care

Office of the Public Advocate

Now Recruiting

THE OFFICE OF THE PUBLIC ADVOCATE IS LOOKING FOR PEOPLE TO VOLUNTEER AS COMMUNITY VISITORS

Community Visitors are the eyes and ears of the community who safeguard the human rights of people with disability and/or mental health issues by visiting accommodation facilities and monitoring and reporting on the services provided. These are unique volunteer positions which are official Victorian Governor in Council appointments. Training and reimbursement of expenses are provided.

To learn more about this volunteering opportunity, contact the OPA Volunteer Coordinator: 1300 309 337
communityvisitors@justice.vic.gov.au
www.publicadvocate.vic.gov.au

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