



Office of the Public Advocate

Great Expectations: 35 years of Community Visitors



NOVEMBER 2023



About the cover:

Community Visitors Recruitment Poster from early 1990s. The graphic from this poster was digitally recreated and updated by designer, Nicholas Hopkins in 2023. The graphic was updated to reflect the Community Visitor collateral from the same period, with modern elements added.

Acknowledgement of Country:

This report was written on the land of the Wurundjeri and Boon Wurrung people of the Kulin Nation. We acknowledge and pay our respects to Aboriginal and Torres Strait Islander peoples and Traditional Custodians throughout Victoria, including Elders past and present. We also acknowledge the strength and resilience of all First Nations people. We acknowledge sovereignty was never ceded and First Nations people continue to experience the negative impacts of colonisation.

READER DISCRETION IS ADVISED

This report contains sensitive content related to abuse, neglect, and death, which may be distressing. Additionally, historical language used in the report may now be considered offensive. Please be mindful of the potential impact on your emotional well-being and seek support if required.

You can access a list of support services here: health.gov.au/topics/mental-health-and-suicide-prevention/mental-health-and-suicide-prevention-contacts

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Testimony: extracts from Community Visitors' annual reports

Happy 35th Birthday Community Visitors



Community Visitors celebrated the 35th anniversary of the launch of the program at the Office of the Public Advocate Volunteer Conference in October 2022. Board members (from left to right) pictured below – Anne Fahey, Mental Health Board; David Stafford, Residential Services Board; Linda Peterson, Disability Services Board; Colleen Pearce, Public Advocate and Chairperson.



Watershed moments: Community Visitors Program



1986 was a **VERY BIG YEAR**

1986

In the beginning – 1986 was a very big year.

In 1986, three Acts of Parliament, enable the Community Visitors Program to be established.

- *Guardianship and Administration Act 1986*
- *Intellectually Disabled Persons Services Act 1986*
- *Mental Health Act 1986*

September 1987

Opening the doors.

The Office of the Public Advocate, including the Community Visitors Program, opens in Drummond Street, Carlton. In December 1987, the first group of Community Visitors is appointed by the Governor-in-Council. By June 1988 there are 168 Community Visitors.

1988

Explosive report by Community Visitors.

The Community Visitors' report to the Minister on Caloola Training Centre, Sunbury *Violence at Caloola*, helps lead to its closure.

May 1991

Further exposure of institutions failing people with disability.

Following the reports of Community Visitors, OPA informs the Minister of its concerns for the well-being of residents of Aradale Hospital and Residential Services leading to an investigation and its later closure.

1991

Expansion of Community Visitors into private supported accommodation houses.

Visits to Supported Accommodation Houses (now SRSs) are added to the responsibilities of Community Visitors under the *Health Services Act*.

1986-2023

1986–2023



1993 1994 1996 1998 2002

November 1993
Community Visitors Program under threat with change of government.
 Through Department of Health and Community Services inaction, the re-appointment of over 100 Community Visitors does not occur, leading to a critical situation. The state government announces a review of the Community Visitors Program but in December 1993, the program co-ordinator receives correspondence advising that the appointments would proceed and the program would not be reviewed.

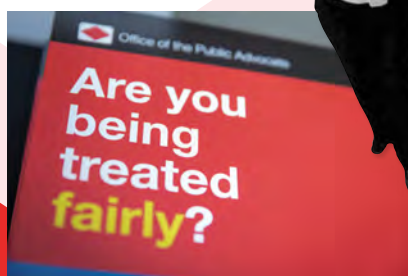
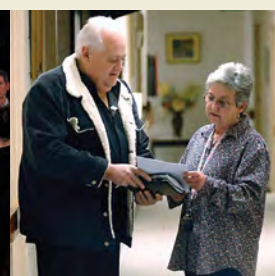
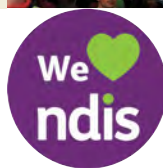
January 1994
First Community Visitor honoured with Order of Australia award.
 Marjorie Phillips receives the Medal of the Order of Australian for 'services to people with intellectual disabilities' as a Community Visitor. There are now 370 Community Visitors across Victoria.

April 1996
Tragic fire at Kew kills nine men with intellectual disability.
 A fire in a unit at Kew Cottages kills nine men living there and the first hearing of the Coroner's Kew Fire inquest held. In October 1997, the Coroner found that the men died in the fire because of neglect by successive state governments. OPA takes a prominent role in the inquest, drawing on the reports of Community Visitors.

May 1998
The Program is independently evaluated – 'ideal role' identified.
 An evaluation report of the Community Visitors Program to the Department of Human Services recommends that the ideal role of Community Visitors is the identification of individual consumer problems discerned through regular visitation. This established the advocacy role of Community Visitors. The role of independent volunteers was strongly endorsed.

May 2002
Community Visitors cited in decision to close Kew Residential Services.
 Premier Steve Bracks and Community Services Minister Sherryl Garbutt cite Community Visitors' reports in their announcement of the closure but it was not completed until 4 June 2008.

1986–2023



2007

2009

2011

2016

30 March 2007

Australia signs the Convention on the Rights of Persons with Disabilities.

Australia signs the United Nations *Convention on the Rights of Persons with Disabilities*, signifying its acceptance of the human rights of people with disabilities. The *Victorian Charter of Human Rights and Responsibilities Act 2006* comes into effect on 1 January 2008.

8 June 2007

A change in focus for the program.

At the 20th Anniversary Conference of the Community Visitors Program, the vision is reset to a focus on “the people and the services they need rather than the facilities that shelter them”.

June 2009

Two steps forward, one step back.

Publication of *Two steps forward, one step back: an analysis of five years of Community Visitor Annual Reports 2003-2007*.

October 2009

CV project reveals psychiatric patients kept in locked accommodation much longer than allowed.

The *Herald Sun* and *The Age* champion the results of the Community Visitors ‘Long-stay patient project’ which finds 99 mental health patients have been locked in secure extended care units (SECU) well beyond their treatment period, one for 21 years.

3 March 2011

Ombudsman’s investigation upholds CV reports of mistreatment.

Following persistent questioning by Community Visitors, the Ombudsman finds that Department of Human Services staff covered up a violent incident in which a man sustained second degree burns and was left untreated for 24 hours.

2016

NDIS rolls out massive changes.

The official national rollout of the NDIS begins along with the transfer of services at hundreds of state government disability accommodation sites to non-government providers, shifting escalation pathways for Community Visitors. There are also changes to tenancy rights for people in group homes.



December 2018

COAG commissions report on Community Visitor Schemes across Australia.

The Community Visitor Schemes Review commissioned by COAG investigates whether Community Visitor Schemes should have a role in preventing abuse, neglect and exploitation under NDIS. It found that Community Visitors Schemes do have a safeguarding role, and recommended nationally consistent reporting arrangements and practices.

2019

Last of the big institutions closes.

Closure of Colanda in Colac, the last large-scale institution in Victoria for people with intellectual disability. Community Visitors support residents through the long process and continue to report on their well-being in the community.

December 2019

CVs reveal extent of abuse in disability group homes.

OPA publishes the report *"I'm too scared to come out of my room": Preventing and responding to violence and abuse between co-residents in group homes*. This report includes case studies from Community Visitors annual reports. The report was tabled as part OPA's submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability at its Melbourne public hearings on 3 December 2019.

August 2020

Is anybody out there?

Hambleton House SRS is closed by state government after years of reports on appalling conditions by Community Visitors. More SRS closures follow with changes in the government's regulatory focus.

October 2022

Review of NDIS and role of Community Visitors.

An independent review of the NDIS is announced with the role of Community Visitor Schemes canvassed. Report to government due in October 2023.

28 September 2023

2023 Disability Royal Commission concludes.

The final report to be released after 4 years of hearings and evidence.

2023

A message from the Public Advocate

Dr Colleen Pearce



Dr Colleen Pearce has been Victoria's Public Advocate since September 2007. She is also Chairperson of the Community Visitors boards, as well as a board member of Connecting Home, an organisation established in response to the recommendations arising from the Stolen Generations Taskforce Report.

As Victoria's Public Advocate, I have a vision of a world in which people with disability live free from abuse, neglect and exploitation and have satisfying, enjoyable lives, respected and welcome in their community. Through such inclusion, it is not only people with disability who benefit. The community itself flourishes and becomes better; more open, welcoming and supportive of all its members.

This was a vision shared by human rights advocates and the family members of people with disability living in the closed environment of large institutions until the mid-20th century. It was the vision from which the Public Advocate's Office and the Community Visitors Program was born. Early Community Visitors were inspired by the idea of being a bridge between the institutions and the community and looked with optimism and expectation to a future in which the human rights and dignity of people with disability would be respected and their voices heard about how they wished to live.

An important aspect of achieving that vision in Victoria is the involvement of volunteer members of the community from a wide range of backgrounds and life experience. This has the effect of opening the circumstances of the lives of people living in closed or semi-closed places to everyday people who care enough to freely give their time and energy. They ask a basic question from which everything else follows: "Would I, or someone I care about, want to live here?" Through their experiences and observations as Visitors, their perspectives, insights and commitment to human rights and better more engaged lives for the people they visit spread naturally through the wider community.

This report is a celebration of thirty-five years of visiting by many thousands of Community Visitors. It looks at their achievements, frustrations, triumphs, disappointments and challenges in carrying forward their role on behalf of the wider community; of being given the authority of Governor-in-Council appointments and the responsibility to report to their fellow-Victorians through annual reports to Parliament. Many of the major disability policy reforms over these years have drawn on the reports of Community Visitors. And in countless small but important ways that never reach public attention, Community Visitors have made life a little better for the people they visit.

The disability landscape has changed dramatically in 35 years. The move into smaller group homes from the large, forbidding, closed edifices on the hill was already underway and was accompanied by greater recognition of each person's needs and individuality. Despite these positive changes, involvement and acceptance by the community did not just follow naturally and continues to be a work in progress. We have learnt that being located in the community does not automatically mean being part of, and involved in, community life.

The last of the large institutions for people with intellectual and psychiatric disability was only closed in 2019. While many of those living in institutions for people with intellectual disability moved into small group homes run by government, those who had lived in psychiatric facilities could frequently only find accommodation and support in Supported Residential Services that are private businesses with an average of thirty residents. These are sometimes described as trans-institutions where residents still have little independence or choice and where their needs and aspirations are rarely met.

At the same time the aspirations of younger people with disability have changed and opportunities to live independently rather than in group homes are now being enthusiastically taken up. The introduction of the National Disability Insurance Scheme (NDIS) was another fundamental shift in the disability landscape with the withdrawal of governments from direct services and the creation of a marketplace of disability accommodation and support providers, both not-for-profit and private, registered and unregistered. The disability landscape has become a rather crowded space, and we all need to find our way around it so that people with disability can reap the benefits in their everyday lives that these opportunities provide.

For the Community Visitors Program the overall aims remain the same. First, to uncover and stop the abuse, neglect and exploitation of people living in closed and semi-closed environments of significant power imbalance. Second, by visiting unannounced, to prevent standards slipping and abuse occurring. Third, by visiting, to foster their wellbeing, independence and inclusion in the community. The lives of many people with disability have undoubtedly become better. They have also become more complicated and the systems they need to deal with more difficult and remote. The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability has shown that violence, abuse, neglect and exploitation still occur. The Independent Review of the NDIS foreshadows changes in Community Visitor Schemes across Australia. The safeguarding and human rights role of Community Visitors is as important and necessary now as it was in 1988 although the context and approaches will change to respond to changed environments. Just as important is the ongoing role of Community Visitors in fostering wellbeing and opportunities for a better life.

" The safeguarding and human rights role of Community Visitors is as important and necessary now as it was in 1988."

— Dr Colleen Pearce

Community Visitor Schemes across Australia have developed and evolved within each State. They share similar philosophies and principles but there is presently little interaction between them. Following the Disability Royal Commission and the review of the NDIS, both of which have looked at Community Visitor Schemes from a national perspective, this is likely to change with greater interaction between States, consistent principles, co-design with people with disability and clearer definition where and who Community Visitors can visit. In keeping with a more overt human rights perspective, the focus of visits is likely to shift from the place to the person although it is less clear how this may work in practice. What is clear is that the Community Visitors Program is seriously underfunded, and significant resources will be needed to support the extended reach of the Program anticipated in the future.

I thank sincerely the successive Victorian governments that have supported the Program for 35 years. I am ever grateful to Community Visitors, past and present, and to the OPA staff who provide coordination, support and backing to their work. I am proud of Victoria's Community Visitors Program and will strive to retain its defining character into the future, including the Program's incorporation into the Office of the Public Advocate, its basis in volunteering and its direct reports to the people's house, Parliament. I do not suggest that other states should follow Victoria's lead as Victoria has both a long tradition of volunteering and a more manageable geographical spread than most other States. I do believe, however, that we can learn from each other, and I look forward to working together with people with disability and the other states and territories so that human rights are promoted, communities become welcoming and inclusive and great expectations are fostered and realised.

Dr Colleen Pearce
Public Advocate and Chairperson of the
Community Visitors boards

1.0



The Community Visitors Program thus far



This report tells the story of the Community Visitors Program. It speaks of people with disability who live in facilities and group homes that most of us will never see, of the Community Visitors who call on these people and shine a light on their situation, of the decision-makers who are responsible for policy and service delivery, and of all of us as we have responsibility for building a fairer, more welcoming community.



**Take nothing on its looks;
take everything on evidence.
There's no better rule.**

— Charles Dickens, *Great Expectations*

— 2023

1988



The first chapter draws on the work of Dr Mark Feigan, who wrote the history of the Office of the Public Advocate from 1986 to 2007.¹

The Community Visitors Program is an important disability advocacy program within the Office of the Public Advocate; it reaches more people with disability than any other OPA activity. Victoria's Disability Advocacy Resource Unit defines 'disability advocacy' as acting, speaking or writing to promote, protect and defend the human rights of people with disability. The Community Visitors Program does this as part of the work of OPA and together with other disability advocacy organisations throughout Victoria.

For 35 years Community Visitors have been part of Victoria's commitment to safeguarding the rights and interests of people with disability, protecting them from abuse, neglect and exploitation, and including them in the life of the community. The Community Visitors Program began in 1988, the realisation of a conviction on the part of social reformers and disability activists that people with disability deserve better than to live their lives separated and largely excluded from the rest of society. These were the great expectations that formed the basis of the Program.



¹

Mark Feigan, 'The Victorian Office of the Public Advocate: a first history 1986–2007' (PhD thesis, Latrobe University, Melbourne, 2011). University, Melbourne, 2011).

1.1 Background to the Program

The 1960s and 1970s were a period of gradual change in attitudes towards people with disability. Before this, in Victoria as in other parts of Australia and in many Western countries, most people with major cognitive, psychiatric and physical disabilities were either cared for by their families or placed in large state-run institutions where they were kept apart from the rest of the community. It was generally assumed that people with high support needs in these institutions were being properly looked after by the state or by charitable organisations.² Families were advised that their loved ones would be best cared for if they lived in safety and security with their peers. There was little support available to help families keep family members with disability at home if they wished to. At the same time, historical investigations of Australia's institutions 'consistently reported inadequacies and abuse of residents, lack of developmental opportunities, overcrowding, poor living conditions, understaffing and mismanagement'.³

So what changed, in attitudes, legislation and practice, that led to the establishment of the Community Visitors Program and a different view about people with disability?

At the international level the Universal Declaration of Human Rights, adopted by the UN General Assembly in 1948, reflected changing attitudes towards human disadvantage and disability. An international movement concerned with the rights of people with disability, the emergence of social justice theories and civil rights movements. In Australia, publicity about conditions in mental hospitals and other institutions gradually gave heart and voice to the struggle and advocacy of parents and others calling for reform. By 1986 it was acknowledged that within the closed environment of institutions there was greater opportunity for abuse and ill-treatment and little likelihood that such behaviours would be detected.⁴ The closure of large-scale institutions and the opportunities and right of people with disability to be integrated into the community, and be visible in the community, became the focus of the disability rights movement.⁵

That is not to say things happened quickly or without opposition: the last large-scale Victorian institution for people with intellectual disability—Colanda, in Colac—did not close until 2019. People who had lived in such institutions mostly moved into smaller supported residential accommodation,⁶ variously called community residential units or disability group homes, and continued to be visited by Community Visitors from the Disability Stream of the Community Visitors Program.

Nevertheless, many people with cognitive disability and mental illness who in earlier times might have lived in one of the large institutions continue to live in institutional or quasi-institutional accommodation with others they have not met before moving there and have only a limited say in relation to the basics of their everyday lives and the care provided. They also often have little real involvement in their local community.



The Universal Declaration of Human Rights, reflected changing attitudes towards human disadvantage and disability



Colanda, in Colac—did not close until 2019

- 2 Mark Feigan, 'The Victorian Office of the Public Advocate: a first history 1986–2007' (PhD thesis, Latrobe University, Melbourne, 2011) 3.
- 3 Errol Cocks, *An introduction to intellectual disability in Australia*, (3rd ed, Fyshwick: Australian Institute on Intellectual Disability, 1998) 19.
- 4 SC Hayes S, 'Out of the Frying Pan—making de-institutionalisation work' (1984) 10(4) *Australia and New Zealand Journal of Developmental Disabilities* 187, cited in Mark Feigan, 'The Victorian Office of the Public Advocate: a first history 1986–2007' (PhD thesis, Latrobe University, Melbourne 2011) 34.
- 5 These views reflected the influence of normalisation theory and the work of Wolf Wolfensberger, a German–American social theorist.
- 6 In this report the term 'supported accommodation' refers to group houses in the Disability Stream, Specialist Disability Accommodation (SDA) and Supported Independent Living (SIL) accommodation and Supported Residential Services (SRS).

1.2 Establishment of the Program

We cannot describe the establishment of the Community Visitors Program without talking about Victoria's first Public Advocate, Ben Bodna: he was central to the character and ethos of both OPA and the Program. Appointed on 8 July 1986 and sworn in on 30 July of that year, Ben promised to represent and protect people with disability when they were being 'abused, assaulted, neglected or exploited by those who care for them'.⁷



In July of 1986, Ben Bodna becomes Victoria's first Public Advocate

After a long career in the public service, culminating in his position as Director-General of Community Welfare Services, Ben was appointed to administer the Law Department under Attorney-General Jim Kennan in the Cain Labour Government of 1982 to 1990. In that role he led the implementation project for the *Guardianship and Administration Act 1986* and argued for OPA to be situated in the Justice Department rather than the Community Services Department. He proposed parliamentary protection for the Public Advocate and drafted new Community Visitor provisions for the Mental Health Bill and the Intellectually Disabled Persons' Services Bill.⁸

Important features of the Community Visitors Program that distinguished it from previous official visitor roles were its integration into the newly established OPA, the appointment of local volunteers rather than paid officials as visitors, the Program's independence from government departments providing relevant services, its annual reports to parliament, and the position of the Public Advocate as chair of the Community Visitors Boards. Throughout his term as Public Advocate, Ben worked with the first coordinator of the Community Visitors Program, Eric Mushins, to establish the Program as credible, considered and well-informed, and respected and trusted by government, community advocacy organisations, people with disability, the public and service providers. His commitment was such that he elected to be a Community Visitor after his retirement.

1.3 Navigating the early years

The Community Visitors Program began in 1987 within the structure of the Office of the Public Advocate. In the early years the Program was coordinated by Eric Mushins, who remained with the Program until 1999. By the end of its first year the Program had 168 Visitors, having aimed, perhaps ambitiously, for more than 240. They were recruited through advertisements and articles in local newspapers, as a result of talks to community advocacy, family and disability groups, and through the personal contacts and networks of the coordinator and the Public Advocate.⁹



Local volunteers were appointed as visitors, rather than paid officials

⁷ Mark Feigan, *A Short History of the Victorian Public Advocate 1986–2011: twenty-five years of fighting for the rights of people with a disability* (Office of the Public Advocate, 2011) 8.

⁸ Mark Feigan, 'The Victorian Office of the Public Advocate: a first history 1986–2007' (PhD thesis, Latrobe University, Melbourne 2011) 85.

⁹ Mark Feigan, 'The Victorian Office of the Public Advocate: a first history 1986–2007' (PhD thesis, Latrobe University, Melbourne 2011) 206.

The purpose of the Community Visitors was to minimise abuse and neglect in services and institutions and, by visiting residential care and treatment facilities, to open these services to the gaze of the community. The Visitors not only aimed to improve the lives of people living in congregate (group, or multiple-occupant) housing: through their presence and reports, they also aimed to make the wider community more inclusive and welcoming of people with disability. From the beginning the Visitors were seen as more than inspectors of services or a government watchdog: they were able to make inquiries and to ask questions, and they were viewed as building a bridge of understanding and experience that could encourage the social inclusion of people with disability.¹⁰



The first annual report of Community Visitors was published in 1988

Being ‘an ordinary person’ was integral to this function. From the beginning, Community Visitors were described as change agents, this being in part based on their authority to report to the relevant Minister and to parliament. The advocacy nature of their role was asserted very early through their reports. An example is a statement in the first annual report: ‘We will not shirk from ensuring the best possible conditions of care for people with disability, as this is a right, not a privilege’.¹¹

Ben Bodna emphasised that the Visitors should be ‘fair dinkum and not be in cahoots’ with service providers or government. Visitors saw their value as remaining connected to the external realities of community life while seeing and engaging with people being poorly treated in the institutions where they lived. They asked, ‘Would you or I want to live like this?’

The level of authority and independence afforded Community Visitors was greater than that afforded any comparable official visitor initiative in Australia or elsewhere. The Program was ground-breaking for its time, and Ben Bodna was aware that its credibility and success would depend on volunteers acting in a disciplined and respectful manner at all times. Achieving this while maintaining the ‘fire in their belly’ and their passion for the rights of people with disability continues to be the challenge for Community Visitors and the Community Visitors Program as a whole.¹²

In the first years of the Program there were two streams—the Disability Stream, set up under the *Intellectually Disabled Person’s Services Act 1986*, and the Mental Health Stream, set up under the *Mental Health Act 1986*. Participants in the Disability Stream visited institutions and community residential units operated by the Community Services Department for people with intellectual disability; participants in the Mental Health Stream visited psychiatric hospitals and residences operated by the Health Department for people with mental illness. In 1991 the Residential Stream was added: established under the *Health Services Act 1988*, to visit people with a range of disabilities who live in private supported accommodation.

As OPA’s early annual reports on the Community Visitors Program reflect, the quality and standard of what were then called ‘special accommodation houses’ varied. Many were providing good care and accommodation, usually the ones that charged higher fees. Places providing accommodation and care for people whose only financial resource was their pension varied greatly: some took a keen interest and provided good support for their residents; others were, in a word, terrible. This remains the case.

¹⁰ Mark Feigan, ‘The Victorian Office of the Public Advocate: a first history 1986–2007’ (PhD thesis, Latrobe University, Melbourne 2011) 7.

¹¹ Office of the Public Advocate, *Annual Report of Community Visitors 1988: Intellectually Disabled Persons’ Services Act 1986* (Report, 1988) 5.

¹² Mark Feigan, ‘The Victorian Office of the Public Advocate: a first history 1986–2007’ (PhD thesis, Latrobe University, Melbourne 2011) 127.

In the Program's Disability Stream, the focus was mainly on conditions for people still living in institutions, and comparisons were drawn with those already living in community residential units. OPA's first annual report, in 1988, cited a report from Chris Borthwick, one of the first Community Visitors, on Caloola, the Sunbury Training Centre:

As Community Visitors we know these people (the residents) well. We do not deny their disabilities or underestimate the problems of adjustment they will have. We do not see community living as a panacea. We believe, however that while life outside may go well or badly, depending how vigorous a commitment comes from the government and community, life inside has no possibilities at all. It cannot be right for a person to be fed, clothed, sheltered and left like a penned ox for sixty years. The waste of human lives ... is immoral. The Centre cannot be salvaged.¹³



Front cover of Community Visitor Commemorative Edition, 1987-1997

The early annual reports on the Mental Health stream described Visitors' work in comparing the care provided in Office of Psychiatric Services facilities with community standards and finding it did not meet community expectations.¹⁴ The Visitors reported on 'helping individual OPS clients in many ways—to get services they needed, to pursue complaints or to enforce their rights under the Mental Health Act'. The main problems identified in the 1989 report related to the difficulties registered clients of Intellectual Disability Services faced by remaining in psychiatric facilities after the resolution of their psychiatric illness. The Visitors also commented on the overall lack of resources for providing programs and services for people in psychiatric facilities and how this particularly disadvantaged people who were clients of the Office of Intellectual Disability Services. The shortage of trained professional staff able to meet the required standards as well as a pressing need to upgrade the physical conditions and state of the facilities were also noted, along with the lack of suitable residential options.

The early annual reports also noted the importance of educating the public about mental health and promoting an accurate image of clients of the Office of Intellectual Disability Services. Problems associated with communal living were also identified in the 1989 report:

The Visitors are not naïve to the extent that they believe that every patient can be provided with private facilities. Visitors do believe, however, that much more can be done to improve individuals' access to privacy and personal space.

Some people choose to live in communal living arrangements. Most do not. Those that do not make this choice can usually endure it for a short period but are glad when the experience is over. However, people admitted to psychiatric facilities have no choice.

People of different backgrounds, beliefs, language etc are placed together in wards with the only common denominator being their psychiatric disability ... Community Visitors have noticed that in facilities where patients are able to have greater individual freedom and privacy, both ... patients and staff are significantly more content.¹⁵

¹³ Office of the Public Advocate, *Annual Report of Community Visitors 1988: Intellectually Disabled Persons' Services Act 1986* (Report, 1988) 11.

¹⁴ Office of the Public Advocate, *Annual Report of Community Visitors 1989: Mental Health Act 1986* (Report, 1989).

¹⁵ Office of the Public Advocate, *Annual Report of Community Visitors 1989: Intellectually Disabled Persons' Services Act 1986* (Report, 1989) 9-10.

The importance of the connection between the OPA staff advocates and the Community Visitors was stressed.¹⁶

In addition to specific cases, they were involved with, the OPA advocates had a charter to deal with systemic problems. Close liaison between advocates and Community Visitors was seen as valuable in dealing with such circumstances. During these early years the Community Visitors Program was closely integrated with other OPA programs, but these close and valuable connections have not been able to keep up with the expansion in OPA staff numbers and functions.

In 1991, visiting 'special accommodation houses' (now called supported residential services) was added to the remit of Community Visitors with the aim of extending this to all 322 SRSs in four years. The Visitors' authority in this area arose through the *Health Services Act*, to ensure that these facilities, which are run as private for-profit businesses, met community standards.

In 1992, the report on the Residential Stream it was noted that there had been improvements in the basic areas of nutrition, clothing and adequate heating and that there were fewer serious problems than in the first year.¹⁷ Improvements in fire safety, the response of the State Trust and the provision of recreation opportunities were also mentioned. One major concern expressed in the early reports was that pension-only SRSs took all a resident's pension, leaving them with no disposable income and dependent on the proprietor for every aspect of their lives:

These people, the large majority of whom appear to be pension dependent, have no disposable income of their own and are therefore placed in the position of being beholden to proprietors and staff of SRSs for the bare necessities of life such as where their next face washer, towel or comb might come from. This places an already vulnerable group in a position of total dependence. Community Visitors consider the continuation of this system in its present form to be unacceptable.¹⁸

Community Visitors contrasted this situation with that in aged-care hostels funded by the Australian Government; in the latter case residents were required to have 12.5 per cent of their pension available for personal use. In the early 1990s the pension-only SRSs were the discharge destination for many people with psychiatric and intellectual disabilities who had previously lived in large-scale institutions.¹⁹ The 1992 report noted that de-institutionalisation had saved taxpayers an enormous amount of money and questioned precisely what responsibility the state had for its former patients and clients.

¹⁶ In the early years of the Office of the Public Advocate, advocates were allocated to regions and worked closely with services and with Community Visitors in their region.

¹⁷ Office of the Public Advocate, *Annual Report of Community Visitors 1992: Health Services Act 1988* (Report, 1992).

¹⁸ Office of the Public Advocate, *Annual Report of Community Visitors 1992: Health Services Act 1988* (Report, 1992).

¹⁹ Office of the Public Advocate, *Annual Report of Community Visitors 1992: Health Services Act 1988* (Report, 1992).

1.4 The 1990s and early 2000s

The 1990s included some difficult times for the Community Visitors Program—and for OPA generally. After Public Advocate Ben Bodna retired in 1993 the government did not appoint someone to replace him; instead, it appointed Glenn Carlton as acting Public Advocate, without the protections of the Public Advocate’s role, pending the results of a review of OPA and its functions. During this time recommendations for the appointment of Community Visitors were not acted on and the Program faced the possibility of having insufficient Governor-in-Council appointees to allow them to perform their functions.²⁰



Glenn Carleton commences as acting Public Advocate in July, 1993

Ultimately, the recommendations of the review were not accepted by Cabinet, and in September 1995 David Green was appointed the second Public Advocate; the structure and functions of OPA, including the role of Community Visitors, remained unchanged. By June 1995 there were approximately 370 Community Visitors (compared with 168 in June 1988). After his appointment David Green helped the Community Visitors adjust to the steep decline in large-scale congregate housing and treatment for people with an intellectual disability and mental illness relative to the growth in community services.

This was difficult because the Program’s historical basis lay in visiting many residents congregated in large-scale segregated facilities. The purpose of this visiting was unchanged, but new approaches were needed for the new, dispersed service environment. This situation can be likened to the challenges faced today as more people with disability move into homes shared with fewer people using Specialist Disability Accommodation funding²¹ and supported independent living funding under the National Disability Insurance Scheme.

De-institutionalisation particularly affected Community Visitors in the Mental Health stream: they previously had had a continuing relationship with residents, whom they would visit month after month. The ‘mainstreaming’ process in mental health had meant the closure of about 5000 residential beds in Victoria’s older institutional services and hospitals—such as those at Lakeside, Ararat and Larundel.

Under the *Mental Health Act 1986* the Community Visitors could visit only prescribed facilities and they could not follow patients into their new settings. The result was the Visitors mostly saw different people each time they visited. This effectively brought about a narrowing of Community Visitors’ role in mental health as people and systems grappled with the transformation from institutional to community-based services.

²⁰ Office of the Public Advocate, *Office of the Public Advocate Annual Report 1994* (Report, 1994) 58.

²¹ ‘Specialist disability accommodation (SDA) is a range of housing designed for people with extreme functional impairment or very high support needs.’—see ‘Specialist disability accommodation’, NDIS (web page) <<https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/specialist-disability-accommodation>>.

These processes of mainstreaming and de-institutionalisation also meant the role of the private supported residential services had to change. They moved away from primarily providing accommodation for frail ageing people. The pension-only SRSs quickly began accommodating a larger, more diverse group, including more people with mental illness—a trend that had been noted in preceding annual reports. These services became the focus of Community Visitors' concerns about systemic abuse and neglect among people with disability and mental illness.



David Green becomes the second Public Advocate in September, 1995

An evaluation of the Community Visitors Program was completed in 1998.²² The outcome was an independent, confidential report that was the property of the Department of Human Services, which had coordinated the evaluation and funded the project. The review process had begun at the end of 1997, and it proceeded through the first three months of 1998. The consultants travelled to all parts of Victoria and spoke with hundreds of people, among them Community Visitors, service providers, professionals, peak organisations, advocacy groups and DHS officials. After finalisation, the report was submitted to government in May 1998.

One of the report's main findings concerned the 'confusion and variability amongst service providers and Community Visitors' in relation to their 'ideal role'. The role the consultants recommended for the Community Visitors was the 'identification of individual consumer problems', as discerned through regular visits. They suggested the Visitors could provide 'a form of representation' as a 'means of protecting consumers'. The report also emphasised the assistance the Community Visitors could provide to the Department of Human Services in its 'challenge to demonstrate service quality'.²³ This supported the legitimacy of the Visitors' advocacy role through the identification of individual consumers' problems. There was strong support for the overall contribution of independently appointed volunteers in carrying out formal duties in residential settings on behalf of people with disability.

One result of the report was an increase in funding for the coordinating unit of professional staff in OPA who supported the Community Visitors. In addition, goals and objectives were set each year to enhance the program of visits and the reporting format. As an example, training in the Disability Stream gave Community Visitors the opportunity to learn more about what it means for people with disability to have help with living safer sexual lives, the right to a fair justice system, access to the best possible health treatment and the best possible communication systems.²⁴

During his term as Public Advocate (1995 to 1999) David Green was impressed by the advocacy skills, understanding and long-term view of the Community Visitors who attended Kew Cottages. At that time Kew Cottages was subject to considerable contention over de-institutionalisation. Although the Community Visitors had no immediate role in the aftermath of the 1996 fire at Kew that killed nine men, this tragic event led to an increased profile for the Visitors. Later, Visitors would be involved in the transition to community-based accommodation, following the government's decision to close Kew Cottages in May 2002. When she announced Kew's closure, the Minister for Community Services, Sherryl Garbutt, cited Community Visitor reports to justify the decision. Their role had already been acknowledged by Premier Steve Bracks in his own announcement.

²² Office of the Public Advocate, *Annual Report 1999* (Report, 1999) The evaluation report is referred to on page 38.

²³ Mark Feigan, 'The Victorian Office of the Public Advocate: a first history 1986–2007' (PhD thesis, Latrobe University, Melbourne 2011) 233.

²⁴ Office of the Public Advocate, *Annual Report of Community Visitors 2000: Intellectually Disabled Persons' Services Act 1986* (Report, 2000) 3.

1.5 The changing landscape of the early 2000s

Gaining sufficient resourcing for the care, treatment and accommodation of people with serious mental illness and severe disability continued to be a problem as Victoria entered the 21st century. This was after more than 15 years of operation of the three enabling Acts of 1986 and 1988, which were framed in the context of equality.

Julian Gardner, appointed Public Advocate in February 2000, brought a strong human rights emphasis to the position. He was prepared to speak out on important matters and played a prominent role in defending the state government's decision to close Kew Residential Services, rejecting accusations that the decision was ideologically based and contrary to the interests of the residents.²⁵ He was determined that the focus of any action taken should remain on the residents; using the evidence provided in Community Visitor reports, he rejected attempts to paint the decision as simply a land grab by the government and emphasised the project's potential benefits for residents.

It had been decided to redevelop the Kew site as high-end housing, and the government had promised that every cent of the money accruing from the development would go to disability services. Despite such good intentions, however, the public-private partnership the government entered into with the Walker Corporation did not ultimately result in the promised influx of money to the disability sector ... or to the government.

Shortly after completing his term as Public Advocate in 2007, Julian Gardner addressed the 20th anniversary conference of the Community Visitors:

Twenty years ago, people lived in large institutions where abuse occurred partly because they were obscure: they weren't open to scrutiny. But that's no longer the case. The fact that your visits take place at all has a salutary effect. The fact that people running these places know you will visit means they are conscious of what they need to do. The visits are in themselves a way of bringing about a consciousness of the need to respond to outside scrutiny and to seek improvement that benefits those with disability. There have been a number of incidents in the last year—or years—about problems in Commonwealth-funded aged care facilities. In contrast, we have not had in the facilities you visit the equivalent of the kerosene bath incident.

I don't want to say it's solely because of your work, *but maybe it is*. Maybe there's a difference in those facilities that know they're going to be looked at, know that you will do something about it, know that you have the power. I think that is really important.²⁶



Julian Gardner demonstrated a particular focus on human rights, as Public Advocate

²⁵ See, for example Julian Gardner. 'Opening doors for the disabled' *Herald Sun* 8 August 2003.

²⁶ Address by former Public Advocate, Julian Gardner, Community Visitors AGM 8 June 2007. Speakers Notes. OPA files.

In 2009, OPA published an analysis of five years of Community Visitor annual reports, from 2003 to 2007.²⁷ The analysis drew out common themes that were discussed using the rights-based framework of the UN Convention on the Rights of Persons with Disabilities.²⁸ During the period reviewed, more than 500 Community Visitors made more than 5000 visits each year. Although the Community Visitors operate in three streams under three different Acts, the consistent focus of reporting overall was as follows:

- the appropriateness of the services
- the adequacy of services in meeting people's needs
- the standard of facilities
- opportunities for participation in leisure, recreation and skill development
- whether a particular facility provides treatment and care as required by the legislation and the adequacy of complaints mechanisms.

The report concluded:

This five-year analysis finds that the most regularly and commonly reported issue by Community Visitors across mental health, health services and disability services is that the physical environments of the visited facilities are substandard. While more salient issues are also reported, it could be argued that all other issues are secondary if the physical environments of these funded and/or regulated services cannot meet community and service specific standards.²⁹

The analysis also found a cluster of shortcomings that were continually reported in connection with standards of care and treatment. These fell into two main categories—operational considerations such as staffing and funding and practice factors relating to the capacity of services and the staff who work in them to provide high-level support, treatment and care. The group that seemed most vulnerable within this system were people with high and complex needs. Their requirements could not be met by a system that had major operational and practice flaws.

Community Visitor annual reports during this period highlighted the inadequacy of the government-funded and/or -regulated residential and/or treatment system for Victorians with disability. The analysis found service-wide problems that were threatening the human rights of people with disability who rely on these services. It was recommended that placing these factors within a human rights framework could strengthen the advocacy message of the Community Visitor Program for these Victorians, whose vulnerability was exacerbated by their reliance on such services.

²⁷ Office of the Public Advocate, *Two steps forward, one step back: an analysis of five years of Community Visitor annual reports, 2003–2007* (Research paper, June 2009).

²⁸ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008).

²⁹ Office of the Public Advocate. *Two steps forward, one step back; an analysis of five years of Community visitors annual reports 2003-2007*. (Report 2009) 37.

1.5.1 Twenty years on

The 1986 legislation had provided a basis for moving away from a model of care dominated by large-scale, dominating institutions. Twenty years later that task was largely complete: only two institutions remained—Sandhurst in Bendigo and Colanda in Colac. Work was under way to help people in those places gradually move into the community. Through their visiting, Community Visitors continued to work to see that the new accommodation was comfortable and safe, that residents' needs were being met, and that they had opportunities to thrive and take part in the community.

De-institutionalisation has also been complete in the mental health psychiatric system: closure of the last large-scale institutions occurred in the late 1990s. In contrast with the approach taken by institutions that had housed people with intellectual disability, the mental health system focussed on incorporating psychiatric primary health in the public health system and moving people from institutions into the community with multi-disciplinary support from community mental health services. Community Care Units and Prevention and Recovery Units were established for people not ready to move into the community after a period of treatment in a psychiatric unit.

The system was based on a recovery model, so there was little emphasis on people with dual disabilities and psychosocial disability, who might have struggled to live independently in the community and had higher support needs. The consequence was that, although many people thrived independently, others needed considerable support from their families, became homeless, or found their way into boarding houses or supported residential services. The level of support and the staff training needed for caring for many people with psychosocial disability was not, and is not, adequate within the SRS model. As a retired social worker from a psychiatric institution noted:

It has worked for some and not for others. Often Jack will call out to me when I'm around town and say, 'Hey Josie, I'm free. I've got my flat and I've got my dog, and I can do what I want'. On the other hand, I can go into some SRS[s] and see people sitting around doing nothing day after day whereas in [the institution] they might have done woodwork or other things that interested them and were meaningful.³⁰

1.5.2 Human rights protection

Australia signed the UN Convention on the Rights of Persons with Disabilities on 30 March 2007, being one of the original state parties that were signatories to the convention. The convention states that people with a disability have the right to an adequate standard of living, which includes an adequate standard of housing.³¹ Although there is no clear definition of what is 'adequate', Community Visitors use their 'community gaze' and their knowledge of service-specific standards to determine the quality of the service and supports and to report on these.

³⁰ Personal discussion.

³¹ *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 28.

The Victorian *Charter of Human Rights and Responsibilities Act 2006* came into full effect on 1 January 2008, enshrining civil, political and cultural rights in Victorian law. People working for government and public authorities must act in a way that is compatible with human rights and, when making a decision, must give proper consideration to relevant human rights.³² The charter strengthens the protection of the rights of people with disability in Victoria.



Colleen Pearce is appointed
Public Advocate in 2007

1.6 Diversification and expansion: from 2007

Colleen Pearce became Victoria's Public Advocate on 14 August 2007. Under her leadership, OPA has particularly concentrated on violence, abuse and neglect affecting people with disability and on these people's rights to equality and opportunities to live their lives as accepted, and included, members of the community. Again, reports from the Community Visitors have provided much of the basis for this focus.

Speaking on the 20th anniversary of the Community Visitors Program in June 2007, the coordinator, Ron Tiffen, set out a new vision for the Community Visitors, one of active advocacy for the people they visit:

Our vision must be to promote the social conceptualization of disability. Our benchmark must continue to be the people and the services they need rather than the facilities that shelter them. We must advocate for the service providers to do more than provide a safe and secure facility for people. We will advocate to ensure the people we visit are respected as people with aspirations, needs, talents and rights, which can be met when programs assist them graduate to situations of their choice. *We have moved our benchmark from facility type to service improvement and we need to take even greater emphasis on outcomes for residents and patients.*³³

Although there is evidence that the idea of understanding people with disability as individuals with aspirations, talents, needs and rights is gradually bearing fruit, there is less evidence that supports are available to help people graduate to living situations of their choice. This is particularly the case in SRSs, which have emerged as a form of trans-institutionalisation.³⁴

³² *Charter of Human Rights and Responsibilities Act 2006 (Vic)* s 38.

³³ Ron Tiffen, 'Vision, Voice and Volunteers: Thoughts on the future for the Community Visitors Program' (Speech, Community Visitors Conference, 8 June 2007).

³⁴ A 2018 census report found the average number of residents in SRS facilities at the time was 26. SRS may have up to 80 residents. See: Insync Surveys Research Consulting, *Department of Health and Human Services 2018 Supported Residential Services Census* (Report, 2019) 11; Elroy Dearn, et al, 'Supported Residential Services as a Type of "total Institution": Implications for the National Disability Insurance Scheme (NDIS)' (2023) 58(2) *Australian Journal of Social Issues*, 3.

'Trans-institutionalisation' is defined as the movement of people with disability and mental illness from large-scale geographically isolated institutions to alternative institutions—for example, aged-care facilities, private congregate care, and homelessness and correctional facilities.³⁵ These institutions are usually smaller than the institutions of the past but are still medium-sized or even large and bear many of the features of large-scale institutions. Previously, as a result of the lack of suitable and affordable housing, they became the default discharge point for people leaving institutions and psychiatric hospitals.³⁶

Very few people living in SRSs actually choose to live there.³⁷ Some SRSs try to provide everyday choices in things such as meals and outings, but few allow for pervasive aspirational choices in areas such as health, housing, education, employment and financial control.³⁸ In the absence of considerable investment by governments, graduating to situations of their choice remains a dream that will not be realised for residents of SRSs.

An interim report by the Mental Health Legal Service in Victoria, commissioned by the Federal Government, showed 'alarming examples of exploitation of people with disability, including NDIS participants, across the Supported Residential Services system.'³⁹

As Public Advocate, Colleen Pearce has used the power of OPA's systemic advocacy function and the media to highlight the importance of identifying violence and abuse in order to improve people's dignity, safety, autonomy and basic human rights. OPA's research and policy work draws heavily on Community Visitors' experiences and the various reports on the Program.

Reflecting a deliberate realignment of OPA's original purpose, the organisation's mission has become 'To uphold the rights and interests of people with a disability and work to eliminate abuse, neglect and exploitation.' Colleen Pearce has promoted this mission through a wide range of activities, often in concert with other organisations, lending the weight and authority of the Public Advocate to discussions and debates.

In 2009 Colleen reported that vulnerable women were being sexually assaulted and raped in supported accommodation.⁴⁰ In October 2009 the *Herald Sun* and *The Age* newspapers reported the results of the *Community Visitors Long-stay Patient Project*, which found that 99 mental health patients had been locked in secure extended care units well beyond their treatment period—one for 21 years. In September 2010 OPA lent its weight to a campaign against the sexual assault of women in mental health units; this resulted in the state government providing funds to alleviate the problem.

³⁵ E Dearn, 'Choice and control? Understanding how residents with psychosocial disabilities remain in 'transinstitutional' settings despite the 'once in a lifetime' opportunity of the National Disability Insurance Scheme'. (PhD Thesis, RMIT University 2021) Melbourne. 32.

³⁶ A 2018 census found that 47% of residents of SRS had a psychosocial disability and 25% of residents had aged-related frailty. Residents at SRS also include people with intellectual disability and people with acquired brain injury. Insync Surveys Research Consulting, Department of Health and Human Services 2018 Supported Residential Services Census (Report, 2019) 75, 78. The proportion of residents with psychosocial disability at two SRS that were considered in a 2019 study was 85% and 79% respectively. See: Dearn, E et al, 'Supported Residential Services as a Type of "total Institution": Implications for the National Disability Insurance Scheme (NDIS)' 5.

³⁷ Elroy Dearn, et al, 'Supported Residential Services as a Type of "total Institution": Implications for the National Disability Insurance Scheme (NDIS)' (2023) 58(2) *Australian Journal of Social Issues*, 10.

³⁸ E Dearn, 'Choice and control? Understanding how residents with psychosocial disabilities remain in 'transinstitutional' settings despite the 'once in a lifetime' opportunity of the National Disability Insurance Scheme'. (PhD Thesis, RMIT University 2021) Melbourne.xvii.

³⁹ Hon Bill Shorten: *Damning report into boarding houses for NDIS participants*. Ministers for the Department of Social Services. Media release. 19 May 2023.

⁴⁰ Colleen Pearce, 'Failing our vulnerable', *The Age* (Melbourne, 25 September 2009).

In 2011 OPA led a campaign to stop violence against the vulnerable and people with disability; part of this involved releasing a report on 86 cases of violence detailed in the files of Community Visitors and OPA guardians.⁴¹ In 2014 Women with Disabilities Victoria published *Voices against Violence*, the result of a two-year research project with partners OPA and the Domestic Violence Resource Centre Victoria. The seven papers published as a consequence of the project examined the intersecting forms of gendered and disability-based violence experienced by women with disability.⁴²



The powerfully named *I'm Too Scared to Come out of My Room* was first published in 2019

During this period the work of the Community Visitors and the detailed annual reports on the Program have also provided strong stories to support OPA's publications and its submissions to a range of commissions and other inquiries. This includes the powerfully named *I'm Too Scared to Come out of My Room*.⁴³

Appearing before the Disability Royal Commission on 9 December 2021, the Public Advocate said:

Community Visitors play a vital role in safeguarding the rights and wellbeing of people with a disability. I would describe them as being the eyes and ears of the community. They go into settings where often the only other people to enter into those settings are paid workers. Community Visitors visit eligible Victorian accommodation facilities for people with a disability or mental illness in their local area. They monitor and report on the adequacy of the services provided and, where possible, communicate with residents or patients to ensure they are being treated with dignity and respect. They visit to ensure that people are free from violence, abuse, neglect and exploitation and have the opportunity to lead a meaningful and flourishing life.⁴⁴

The impact of the NDIS has been dominant during this period of the Program's history. Introduced by the Gillard Labor Government in 2013, the NDIS began to be rolled out across Australia in 2016. Its implementation has substantially changed the disability 'landscape', involving the continuing transfer of government-run disability accommodation to non-government and private providers and changes to the regulation of tenancy rights for people in disability group homes.

In the area of support services and support coordination, Community Visitors have reported repeated NDIS-related difficulties, including barriers to eligibility, inconsistent planning processes, long delays in planning and planning reviews, and extended waiting times for supports (including specialist services), with regional areas being more affected.⁴⁵ One major shortcoming reported has been poor communication between different NDIS stakeholders and a lack of consultation in planning. Whether these are teething problems or systemic structural problems is a matter of debate.

⁴¹ M Griffin, 'When the visitors call', *The Age* (Melbourne, 27 July 2011).

⁴² Farrah Tomazin, 'Violent deaths and soaring abuse in residential homes', *The Age* (Melbourne, 23 October 2012).

⁴³ These include: submission on the Mental Health and Wellbeing Act (2021), submission on the review of the Disability Act (October 2021), multiple submissions and reports on the NDIS, multiple submissions and appearances at the Royal Commission into Violence, Neglect, Abuse and Exploitation of People with Disabilities. See also the OPA report *I'm Too Scared to Come out of My Room*. The report is informed by a lived experience consultation facilitated by the VALID.

⁴⁴ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Transcript of Proceedings, Public Hearing 20* (Transcript, December 2021).

⁴⁵ Office of the Public Advocate, *Community Visitors Annual Report 2019–2020* (Report, 2020).

The NDIS has affected all areas of Community Visitors' work. In the Disability Stream most residents are now NDIS participants. About 40 per cent of SRS residents are NDIS participants. The monitoring and regulation of SRSs in Victoria has undergone substantial change as a result of the centralisation of regulatory functions under the Department of Families Fairness and Housing's Human Services Regulator.

In consultations, the most common description Community Visitors use when discussing the NDIS's impact on the people the Visitors have contact with is that the people's lives and the system have become fragmented and they do not have a great degree of meaningful choice in their lives. The Visitors know it is positive that people are being treated as individuals and that they often enjoy their activities and outings, but they are concerned about inconsistent staffing in accommodation and unreliability in the provision of support services, with support workers changing without notice or sometimes not attending at all. One regional convenor described people's lives as resembling a jigsaw that sometimes fits together and sometimes doesn't.⁴⁶

What of the future? Each period of the Community Visitors Program has had its challenges, successes and disappointments. At present the place of state-based community visitor programs within the NDIS and its Quality and Safeguarding Framework is under consideration.

But, despite any changes that might be introduced, the value of Community Visitors who show up, talk with and listen to people with disability living in various types of facilities in Australia is clear.

⁴⁶ Consultation with Regional Convenors in the Disability Stream (Barbara Carter, Office of the Public Advocate, April 14, 2023).

2.0



Guiding principles and values

Community Visitors play a vital role in safeguarding the rights of people with disability and disadvantage living in supported accommodation and mental health facilities, promoting positive change in their lives and encouraging their inclusion in society.⁴⁷

⁴⁷ Office of the Public Advocate, *Community Visitors Annual Report 2019–2020* (Report, 2020).



Being ‘an ordinary person’ was integral to this function. They asked, ‘Would you or I want to live like this?’

— PAGE 16



2.1 The framework of the Community Visitors Program



The statements that follow describe the context in which the Community Visitors Program operates and how it contributes to safeguarding the rights of people living in supported accommodation and mental health facilities. They reflect the operation of the Program over many years:

- All people have the right to be safe and live their lives free of abuse, neglect and exploitation.
- Governments are responsible for ensuring that people with disability have access to support services—including the personal assistance needed to support living and inclusion in the community.
- The Program is established under Victorian legislation that aims to protect the rights and interests of people living in disability homes, SRS and people receiving services in mental health units. People living in these facilities can (if they are eligible) also receive support through the NDIS, mental health services, aged-care services and mainstream community services.
- The Program contributes to the safeguarding role of governments in the broad meaning of the term ‘safety’.⁴⁸
- People living in institutional or quasi-institutional settings are inherently at greater risk of exploitation, abuse and neglect than other people as a consequence of the power imbalance associated with these settings.
- People living in these types of accommodation are likely to be at greater risk if they have disability, have little or no support from family and friends, are isolated from the community, have high support needs or have all services delivered by a single provider.
- Community Visitors provide an important link between people living in accommodation facilities and the community and contribute to building a more inclusive and accepting society. The interaction between Community Visitors and the people they visit is intended to be relational rather than transactional.
- In an increasingly dispersed, remotely operated and fragmented service system, Community Visitors can provide regular, familiar, person-to-person contact and assistance for people living in accommodation facilities.



Through the Program, the Community Visitors bring the ‘community gaze’ to the lives of the residents, listen and report on what they see and experience and press for systemic change and improvement. Their function is to report to relevant authorities and regulators on whether the accommodation meets community standards and expectations, how well people’s individual needs and goals are being met, and how the systems that support these people can be improved to increase their wellbeing and inclusion in society.

⁴⁸ Safety means different things to different people. It can mean being free from violence and abuse. It can also mean being respected, well supported, connected to family, culture or community, and in control of one’s own health and wellbeing. How people experience safety can differ depending on a range of factors, including their gender, cultural background and disability. See also Australian Government NDIS Review, *NDIS Participant Safeguarding Proposals Paper* (May 2023).



In carrying out their Program responsibilities, Community Visitors will do the following:

- treat all people they visit with dignity and respect, in the knowledge that it is a privilege to visit people where they live
- engage with each person in a friendly way that will help build trust and rapport, including celebrating good things in people's lives and empathising with their problems and feelings
- respect and promote the will and preferences of the people they visit in the actions that they take
- foster the inclusion of the people they visit in the life of the community
- liaise with service providers, staff and others in a person's life to resolve problems that arise at the facility level
- help people achieve their goals in connection with the direction they would like their life to take
- support people in speaking up for themselves, helping them do so if they want this, and speaking on their behalf when necessary
- refer matters that cannot be resolved at the facility level to facility management or the OPA coordinating unit
- through OPA, make referrals, reports and complaints to service providers, advocacy organisations, regulators or government agencies
- engage in regular training and education in order to meet the responsibilities of their role
- always adhere to the Code of Conduct of Community Visitors.



Community Visitors engage with people in a friendly way to build trust and rapport

2.2 Program principles

The principles of the Program are largely drawn from the Victorian legislation under which Community Visitors' roles and functions are established:

- the *Disability Act 2006*
- the *Mental Health Act 2014*—soon to be replaced by the *Mental Health and Wellbeing Act 2022*
- the *Supported Residential Services (Private Providers) Act 2010*
- the *Guardianship and Administration Act 2019*.

2.3 Program values

The values adopted by the Community Visitors in their roles are the values of the Office of the Public Advocate, as expressed in OPA's volunteer charter. They focus on and encompass many of the values that underpin disability generally.

- **Respect.** We treat everyone equally and with dignity and justice. We accept each person's individuality, acknowledge diversity and promote self-determination.
- **Compassion.** We accept people as they are and understand, acknowledge and empathise with their circumstances.
- **Ethical behaviour.** We will act at all times in a principled and informed manner, treat people fairly, accept accountability and uphold justice.
- **Independence.** We will be free-thinking and impartial and where necessary will challenge the status quo.

The Community Visitors Code of Conduct describes the manner in which the Visitors operate.

2.4 Theories underpinning disability policy

This section discusses some of the thinking that has guided the work of disability advocacy organisations and programs since the 1980s. Descriptions of the associated values and principles generally reflects what has been important and made sense in the social and political context of the time.

2.4.1 Normalisation and social role valorisation

In the lead-up to and the establishment of the Community Visitors Program disability advocates were strongly influenced by the thinking surrounding normalisation and ‘social role valorisation’.

The basic principle of normalisation involves affording people with disability patterns and conditions of everyday life that are as close as possible to the circumstances and ways of living of others in the community. The concept of social role valorisation was developed in the early 1980s by German–American academic Wolf Wolfensberger as an extension of normalisation theory. The basic tenet is that the good things society can offer to its citizens are more easily available to those who have valued social roles. Wolfensberger’s principles of normalisation were systematised into the values-based training program PASSING (Program Analysis of Service Systems’ Implementation of Normalization Goals). Ben Bodna, Eric Mushins and the first group of OPA Community Visitors participated in the program in 1987.

Although normalisation theory fell from prominence in the 1990s, it is present in much of the discourse about people with disability having a right to live their lives in the ways that those who do not have disability live. It is particularly evident in the basis of the NDIS. The term itself possibly fell from favour as a result of efforts to avoid the implication that people with disability were not ‘normal’ and because of perceptions that such thinking required that people with disability closely adhere to normative standards in order to be accepted in society.

2.4.2 Protection and safeguarding

Since the reform legislation of the 1980s that established, among other things, the Office of the Public Advocate and the Community Visitors Program, protection of people with disability from abuse, neglect and exploitation has been a central principle of the work of most advocacy organisations. When people with disability were ‘warehoused’ in large institutions, there was clear evidence that they were subjected to abuse and neglect and deprived of the usual opportunities of life. With time, however, as people moved into the community in smaller groups, it became apparent that in quasi-institutional accommodation abuse, neglect and exploitation continued and the need for a protective advocacy role such as that of Community Visitors remained. Under the privatised, market-based approach of the NDIS, abuse, neglect and exploitation continue to occur.

Abuse, neglect and exploitation thrive where there is a power imbalance, an opportunity, secrecy and the possibility of profit. Protection is now encompassed within safeguarding and expressed in human rights terms as ‘safeguarding the right of people with disability to be free from abuse, neglect and exploitation’. It remains a central element of the Community Visitor role.

The basic tenet of social role valorisation, is that the good things society can offer to its citizens are more easily available to those who have valued social roles.

But governments, agencies and systems are only part of the equation. Ordinary people are equally important. If we are to keep people with disability safe and connected with their community, Professor Sally Robinson has observed:

the priorities for younger people with disabilities are around 'feeling comfortable, feeling safe, feeling known and feeling their communities are accessible to them – places where they feel not only physically able to go, but where they feel welcome... As a community, we probably think that people are looked after by our systems, but it's not actually the place of systems to take care of people'.⁴⁹

2.4.3 Independence and interdependence

Promoting the independence of people with disability is a consistent and important principle of disability services. At its best, it expresses the principle that people with disability should be supported in making their own decisions and living their lives without being unduly dependent on others and with respect for their privacy and choices. At its worst, it can be used as an excuse for leaving people to live diminished, unsupported and isolated lives.

Promoting independence can, however, entail the risk of forgetting that human beings are social animals who live in communities, or tribes. We are all interdependent and we all have responsibilities towards one another. The notion of reciprocity as a guiding principle is present in the principles and philosophies of most civilisations. It is interdependence and interpersonal responsibility that hold societies together.

2.4.4 Dignity and respect

The concept of human dignity is fundamental to moral, ethical, social and political thinking. It signifies that all people are born fully and equally human and remain so no matter what they do or what is done to them during their lives. The concept is dialogue-based and is imparted to others and exercised in relationship to others; this is expressed by the Austrian–Israeli philosopher Martin Buber as the I–Thou (or I–You) relationship.⁵⁰

2.4.5 Inclusion

Perhaps the most important value in disability policy today is inclusion. For an initiative such as the Community Visitors Program, which was established to promote de-institutionalisation, inclusion is seen as a pathway to a good society. The first objective of Victoria's *Disability Act 2006* is 'to advance the inclusion and participation in the community of persons with a disability'. A great deal of public policy and effort is directed towards inclusion and participation.

Connections can facilitate inclusion, but inclusion is more than that. To be included in the wider society a person must be accepted and valued as equal by people who are already part of broader society. The CEO of the South Australian Council of Social Service, Ross Womersley, has put it this way:

⁴⁹ Helen Frost, 'Disability inclusion should involve more than community connections', *ABC News* (online, 16 July 2020) <<https://www.abc.net.au/news/2020-07-16/disability-community-at-risk-of-isolation-and-abuse/12442108>>.

⁵⁰ Barbara Carter, 'Seeking the essence of guardianship: beyond the UNCRPD' (Conference Paper, 2nd World Congress on Adult Guardianship, Melbourne October 2012).

We have to embrace people, we have to decide that people who live with disability, who might be vulnerable are in fact of value to us as a community ... If we were really thinking of them as valuable human beings we would have them present in all the aspects of our lives ... By being present, people would be much more likely to build relationships, not necessarily because they're paid to be with them ... The more that people are kept separate, the less they have the opportunity to make those relationships that we all rely on to stay safe and secure through most of our lives.⁵¹

2.4.6 Justice

American philosopher Martha Nussbaum has paid particular attention to the question of justice and disability. She starts from the idea that human beings cooperate with each other for various reasons, among them compassion and a love of justice and fairness. Together with Indian philosopher and economist Amartya Sen, she adopts a Capabilities approach to justice for people with disability and identifies 10 minimum capabilities or entitlements that should be available to all people if they are to experience a flourishing life. These include the following:

- being able to live with and towards others
- bodily health and integrity—being adequately nourished and having adequate shelter
- having control over one's environment
- having emotional attachments to people and things outside of yourself, being able to express feelings of love, grief and justifiable anger without fear.⁵²

2.4.7 The human rights approach

A human rights approach constitutes the overall structure that incorporates the values discussed. It begins by recognising people with disability as 'rights bearers', both moral and legal. Uppermost is respect for the dignity of people with disability. International human rights treaties offer the most widely accepted framework for protecting individual dignity and promoting the flourishing of communities.⁵³ The UN Convention on the Rights of Persons with Disabilities expresses what must be done to provide dignity for all people with disability.

The human rights approach affirms the essential worth of every individual and aims to protect universal rights. It promotes real equal opportunity, effective participation and full inclusion in society, and creating a culture, both broadly in society and within organisations, that fosters a human rights mindset. Culture is viewed as the product of our values and our actions, including the words we use.

Seen in this way, a human rights approach provides a platform for the achievement of social justice for all citizens and for redressing imbalances of power present in society.

The pursuit of human rights through law, UN conventions and policy is not a goal in itself: rather, it offers a path towards full acceptance of all people.

⁵¹ Helen Frost, 'Disability inclusion should involve more than community connections', ABC News (online, 16 July 2020) <<https://www.abc.net.au/news/2020-07-16/disability-community-at-risk-of-isolation-and-abuse/12442108>>.

⁵² Martha Nussbaum, *Frontiers of Justice: Disability, Nationality, Species Membership* (Harvard University Press, 2007); Amartya Sen *The Idea of Justice* (Harvard University Press, 2009).

⁵³ Australian Human Rights Commission, *What are human rights?* (Web Page) <<https://humanrights.gov.au>>.

3.0

I would [contact a Community Visitor]. If [the person] can't actually speak for themselves, I would.

— PAGE 46

The Community Visitors Program today

Community Visitors give freely of their time and energy and often remain in the program for many years. *Why do they do it?*



People become Community Visitors for many reasons. When asked about this during consultations for this report, some noted the following reasons:

- to make a contribution to the community
- to promote human rights
- to use their professional background and skills to improve life for people with disability when the Visitor was no longer working full time
- because of a personal connection with someone in their family or a friend who has a disability
- to be part of changing things for the better
- to gain experience and skills that would help the Visitor obtain work in the disability field or enrich their life.



3.1 The structure of the Program

The Community Visitors Program is governed by three Boards, one for each of the three streams of the Program:

- the Disability Services stream—supported disability accommodation as defined under the *Disability Act 2006*.⁵⁴
- the Mental Health stream—public mental health units under the *Mental Health and Wellbeing Act 2022*.⁵⁵
- the Residential Services stream—Supported Residential Services registered under the *Supported Residential Services (Private Proprietors) Act 2010* (to be replaced by the *Social Services Regulation Act 2021*, which comes into effect on 1 July 2024).⁵⁶



Dr Colleen Pearce, Public Advocate and Board Chair

The Public Advocate is the Chair of each Board.

Community Visitors are appointed by the Governor in Council for a three-year term. Under the Program’s legislation, the Visitors are required to report to the Victorian Parliament each year. They do this by preparing a comprehensive annual report.

The safeguarding functions and powers of the three streams are set out in legislation.⁵⁷ Community Visitors in the three streams have similar functions and powers. In general terms, these are to visit and inquire into the following:

- the appropriateness and standard of facilities
- the adequacy of opportunities for inclusion and participation by residents
- whether the services being delivered to residents are provided in accordance with the relevant principles, legislation, rules and regulations
- whether individual plans for residents exist and are being complied with and updated
- whether people are being physically or chemically restricted or isolated in any way and, if so, how this is justified and monitored
- whether information is being provided to residents as required
- residents’ wellbeing and safety
- whether residents have complaints and the nature of complaints procedures and the speed and extent of complaint resolution.

The three Community Visitors Program streams



⁵⁴ Disability group homes are commonly group homes with approximately five residents, although the number of residents can vary. Most residents of disability group homes are people with intellectual disability. Some residents may also have physical disability or psychosocial disability or they may be a person with autism.

⁵⁵ Community Visitors in the Mental Health stream visit a range of mental health facilities, including acute psychiatric units and emergency departments in public hospitals, child and adolescent units, eating disorder units, mother and baby units, psycho-geriatric units, community care units, prevention and recovery care services and forensic services.

⁵⁶ ‘SRSs are privately operated facilities that provide accommodation and support for people who require assistance with daily living—for example, people who are frail or have a disability. An SRS must be registered with the State Government.’ (Insync Surveys Research Consulting, Department of health and Human Services 2018 Supported Residential Services Census (Report, 2019) 8 < <https://services.dffh.vic.gov.au/2018-census-supported-residential-services-full-report> >).

⁵⁷ *Disability Act 2006* ss 30, 30A, 129–130; *Supported Residential Services (Private Proprietors) Act 2010* ss 184, 186–187; *Mental Health Act 2014* ss 216–217; *Mental Health and Wellbeing Act 2022* ss. 399–401.

3.1.1 Frequency and organisation of visits

Visits are organised through the volunteer regional convenors in each stream, who are responsible for between five and 45 facilities. In most cases visits are unannounced. For specific reasons, some visits can, however, be scheduled, often to follow up on matters identified in response to an earlier visit. At least two Visitors must be present at each visit. The frequency of visits is generally as follows:

- the Disability stream—at least twice a year, with the aim of visiting four times a year
- the Mental Health stream—monthly
- the Residential stream—monthly in pension-only facilities, quarterly in pension-plus facilities.

In all streams Visitors will make further visits if requested or to follow-up on matters raised in earlier visits. As noted, these visits can be scheduled. When COVID restrictions were in force Visitors made different arrangements in order to maintain their connection, using phone or video ‘visits’ wherever possible.

Community Visitors are supported by professional OPA staff, among them a program manager, a team leader and four divisional coordinators who work across the three streams, a volunteer coordinator, a training officer, and administration and technical support officers.

Much of a visit’s power lies in Community Visitors connecting with residents—observing, listening, asking questions—and reporting what they see and hear during their visit.

Community Visitors have a right to enter all registered houses and facilities.⁵⁸ Visitors also have access to reports about incidents that have occurred in a facility and documentation relating to each person (apart from their medical records).⁵⁹

At the end of each visit the Visitors write a report to house management. They discuss the contents of the report with staff on duty if possible and ask them to sign an acknowledgment that they have received the report. They also send a copy of the report to the OPA coordinating unit. House management is required to respond to any action items noted in the report within 21 days. As far as is possible, Visitors seek the consent of individuals before putting any information about them in a report. If serious shortcomings are raised, particularly in connection with staff, Community Visitors can prepare a supplementary report to the service provider; this is not left at the facility.

At any time, Visitors can discuss matters with their regional convenor. Such things might be a lack of responsiveness on the part of house management, situations of risk, an emerging pattern of problems or serious incidents. In some circumstances OPA program staff, or even the Public Advocate, must be alerted to serious concerns.



Visits are organised through regional convenors, and frequency of visits vary, relative to program stream and facility

⁵⁸ *Disability Act 2006 s.130; Supported Residential Services (Private Proprietors) Act 2010 s.187; Mental Health Act 2014 s. 217 (and from 1 September under Mental Health and Wellbeing Act 2022 s. 401).*

⁵⁹ *Disability Act 2006 s.130; Supported Residential Services (Private Proprietors) Act 2010 s.187; Mental Health Act 2014 s. 217 (and from 1 September under Mental Health and Wellbeing Act 2022 s. 401).*

Regional convenors can discuss matters with program coordination staff and can call liaison meetings with middle management and operations managers of service providers to resolve difficulties. These meetings are minuted and agreed actions are noted. They are part of overall program documentation. The liaison meetings can also be attended by OPA program coordinators; these officers attended 358 liaison meetings in 2022–23.

A parallel escalation process operates with regional convenors in each stream, who meet quarterly. Matters arising from these meetings can be referred to the relevant Boards, which also meet quarterly. The Board for each stream consists of two members elected by Community Visitors in that stream and the Public Advocate, who, as noted, is the chair of each board. The three Boards meet as a combined Board quarterly. Matters that remain unresolved can be reported on in the annual report to parliament. The Public Advocate also has authority to speak publicly about particular concerns at any time.

In response to the complex and diversified environment in which Community Visitors operate, protocols with a range of authorities, including accommodation providers and regulators, continue to be developed. These protocols, which can link the Community Visitor Program and accommodation providers at corresponding levels, have led to a more streamlined process of communication and resolution of problems.⁶⁰

The Program can also make referrals (including giving notice of complaints) to organisations and authorities such as the NDIS Commission, the Human Services Regulator, and the Mental Health and Wellbeing Commission. The escalation process goes from the Community Visitors to the regional convenor, to the Program coordinator and their team leader, to the Manager, Safeguarding, Inclusion and Volunteers Program, and finally to the Public Advocate.

This strong structure—and the support afforded Community Visitors at every point and level of the Program—is fundamental to the Program’s success. It provides a framework for upholding the human rights of each person living in places visited through the Program, for problems being resolved if possible at the local level, and for structural and systemic concerns within the sector to be brought to public attention and redressed.

3.1.2 Recruitment and training

The Community Visitors Program adheres to the National Standards for Volunteer Involvement and to the rights and responsibilities of Volunteering Victoria. It recruits Community Visitors in the three streams.⁶¹ Three priority areas have been established for Victorian resource centres under their current strategic plan—people with disability, people from culturally and linguistically diverse communities, and First Nations people. This places the associated organisations in friendly competition when it comes to attracting people. Funding cuts to these centres have exacerbated the problem.



2023 Community Visitor board members at the 35th anniversary of the program

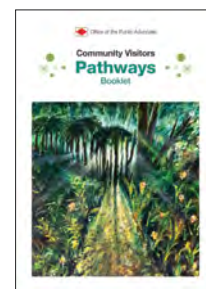
⁶⁰ Consultation with Claire Robbs, CEO Life without Barriers, May 2023.

⁶¹ The program recruits through a range of sources including: volunteer expos, newspaper advertising, word of mouth, volunteer resource centres, websites such as Go Volunteer/ Seek Volunteer, Pro Bono and the OPA website, U3A's, libraries, neighbourhood houses, community centres, service clubs, The largest referral source is through Go Volunteer/ Seek Volunteer.

There are no specific background or skill requirements for people seeking to become Community Visitors, beyond being able to fulfil the responsibilities of the role and the fact that it is important that as a group they are reasonably reflective of the wider community. If Visitors come from a broad cross-section of the community, it is easier for the Program to bring the ‘community gaze’ to the lives of people with disability living in the facilities they visit and to judge whether the facilities meet community expectations. Even so, there are many among the Visitors who have worked professionally in the health or disability areas, have now retired and want to volunteer in a way that uses their experience and wisdom. As one applicant remarked: ‘I may have retired but my grey matter hasn’t’. A Community Visitor brings their whole self to the role.

The Community Visitors Program requires people interested in becoming a volunteer to complete an application form demonstrating the qualities, attitudes and experience they can bring to the role, to provide references, and to undergo an interview and other checks (such as police checks).

Community Visitors participate in induction training, observation and reflection, as well as receiving stream-specific training.⁶² The basic induction training covers the relevant legislation, the functions of a Community Visitor, Program policies and operations, and knowledge and understanding of factors affecting people who live with a disability or mental illness. After this, they are required to complete a further day’s training specific to the stream in which they hope to participate. Once they have completed 10 hours of observation visits and the necessary training, they must be recommended by their regional convenor before they can be put forward for appointment.⁶³ Community Visitors are appointed through the Governor-in-Council process⁶⁴ for a three-year term and can be re-appointed following completion of a term. There is mandatory update training every three years for all Community Visitors, and targeted webinars and training sessions are provided throughout the year. In 2022–23 the Program conducted 70 training sessions (in person and via Zoom), with 399 participants attending, and three webinars covering specific topics.



A set of select introductory publications, specific to Community Visitor training

Number of Community Visitors and trainees and number of visits 2022–2023

| Stream | Appointed visitors | Trainee visitors | Total visits |
|----------------------|--------------------|------------------|--------------|
| Disability Services | 246 | 72 | 2178 |
| Mental Health | 68 | 29 | 828 |
| Residential Services | 70 | 16 | 745 |
| Total | 384 | 117 | 3751 |

⁶² Training includes induction training, observation visits, stream-specific training, good group homes, parts 1 and 2, report writing and advocacy and update training. Report writing and advocacy covers the reporting process for Community Visitors, the audience for reports, good practice in report writing, and the ways in which the report is used as an advocacy tool.

⁶³ A regional convenor needs to recommend to the Minister that the person be appointed a Community Visitor. Community Visitors are Governor in Council appointments made on the recommendation of a Minister.

⁶⁴ ‘Governor in Council’ comprises the State Governor as Chair and members of the Executive Council. ‘The Executive Council is made up of the Premier and his or her Ministers who have been sworn into that office by the Governor, usually immediately after they have been sworn in as Ministers’. See ‘Government in Australia’, *Governor of Victoria*, (Web Page) < <https://www.governor.vic.gov.au/government-house/government-australia#:~:text=The%20%27Governor%20in%20Council%27%20is,members%20of%20the%20Executive%20Council%20> >.

A Community Visitor is encouraged to bring their whole self to the role



Although efforts are consistently made to make the Program more inclusive and reflective of both the wider community and the cohort of people visited, the Community Visitors Program is already quite diverse in terms of the background of volunteers; it includes people from culturally and linguistically diverse communities, people with physical and sensory disabilities, people with mental health issues, and many others.

OPA pays an honorarium to Community Visitors in recognition of their contribution. It also pays for expenses incurred and in a range of ways seeks to show Visitors how much they are valued, including nominating them for awards and other forms of community recognition.

3.1.3 A typical visit

A typical visit by Community Visitors to residential premises might go like this.

Two Community Visitors⁶⁵ knock on the door of the house or supported residential service. They have not told anyone in the place they will be coming so they are not expected.⁶⁶ They wear their photo identification on a red Community Visitors lanyard. They introduce themselves to whoever answers the door, be it a resident or a staff member, and explain why they are there. They ask if they may come in. They do have a legal right of entry but it is not usually necessary to say that since most such places know about the role of Community Visitors. They can be there for two hours or so.



The role of Community Visitors is to observe, listen, question and monitor

They introduce themselves and, depending on whether staff are busy, either talk to residents for a time or talk with the staff member. In most cases they have met the residents on previous visits. They assess the home environment: is it well maintained, safe, comfortably furnished and at a comfortable temperature? is the food provided adequate? is there a support plan for each resident and, if so, is the resident receiving the support described in their plan? They check documentation relating to events occurring in the house since their last visit, including incident reports. They follow up on action items from previous visits if necessary. Throughout the visit, they observe how staff are interacting with residents.

Community Visitors never enter the bedroom of a resident, although they may stand at the door if the person wants to show them their room. The Visitors are always in sight of one another while on the property.

The Visitors look, listen, talk and otherwise communicate with people (using communication aids if necessary and possible): how are they going? what are they doing? what is happening for them? is there anything special coming up? is there anything they would like to talk about? A lot of listening happens. Visitors ensure that if a person says they would like to talk to them privately that can happen without other residents or staff being within hearing. If someone raises problems or concerns, the Visitor will ask if they are comfortable with that being put in the report detailing the visit.

Each Community Visitor has a journal in which to record their observations and reflections; this information must be kept confidential.

⁶⁵ Community Visitors visiting in pairs are known as a 'panel'.

⁶⁶ COVID-19 has meant that Community Visitors may need to contact a disability group home or SRS to check that there is no COVID outbreak in the house.

At the end of their visit, either before leaving the premises or soon after, the Community Visitors write a report on what they have seen and heard. The panel secretary/lead completes the report, which documents the panel's agreed findings. The report can be provided in hard copy in the report book or electronically.

The report will be sent to the facility, the Community Visitor regional convenor, and either emailed directly to the house or forwarded to the house by OPA. The Visitors do not go to more than two places a day. The panel can also complete a supplementary report that is not provided to a facility; for example, this might occur if a resident raises something they do not want shared directly with staff.

In a 2015 investigation the Victorian Ombudsman reviewed a random sample of visit records, finding as follows:

The Records of Visit reviewed by my officers were generally consistent with the Community Visitors' statutory functions, indicative of careful observations, and compliant with Community Visitor Scheme requirements.

They consistently mention:

- the condition and mood of the house: if it is tidy, homely, bare or cold
- the standard of meals and nutrition
- building and maintenance issues
- the demeanour of residents seen and spoken with
- activities residents were undertaking
- whether incident reports and documents were available to view, noting an absence of documents, restricted access, incorrectly completed forms or out of date documents.⁶⁷

The report provided two examples of notes from Community Visitor records of visit:

- Problems continue and are escalating at this house; police recently called when the resident attempted to strangle a female staff member; the resident had attempted to kick and strangle another resident and when a staff member intervened, the staff member was assaulted; there is a BSP [Behaviour Support Plan] to follow and PRN ['as needed'] medication for the resident; the atmosphere in the house is radically changed—it is no longer happy; pictures removed from walls; the CVs [Community Visitors] spoke to residents; the sectioned off part of the house is bare and unhomely there is an unfortunate mix of permanent residents; stability is needed.
- CVs made to feel welcome by staff and residents; house is old and non-purpose built but is tidy, clean and homely; residents' rooms are personalised and decorated; residents' placements and activities are noted. Not enough staff, faulty equipment—out of order or broken, house supervisor missing, lack of continuity of staff for clients who are very high needs.⁶⁸

⁶⁷ Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 – The effectiveness of statutory oversight* (Report, 2015) 75.

⁶⁸ Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 – The effectiveness of statutory oversight* (Report, 2015) 75.

Visits to mental health facilities are somewhat different. Community Visitors first introduce themselves to staff; this is because most patients do not stay for long periods in psychiatric facilities, so are less likely to recognise Visitors or be recognised by them. The Visitors also focus more on health and treatment, as well as complaints about food, personal rights and the environment. In the mental health system there is greater clarity about lines of responsibility, including who is responsible for acting on matters raised in reports.

3.1.4 Current tensions

The slow pace of individual and systemic change is often a cause of frustration for Community Visitors, who report repeatedly on factors affecting people and on systemic problems but feel that nothing is changing. One example is a person having to wait more than two years for a wheelchair after receiving approval and waiting many months between therapy appointments, with changes of therapist during that time. At the facility level, Community Visitors find it ridiculous that it can take months for something as simple as a broken outside light to be fixed. Visitors sometimes resign for these reasons.

Adequate program funding remains an issue. The Victorian Ombudsman noted in 2015:

[T]he Community Visitors program of volunteers who visit supported accommodation, provide an important protection at a minimal cost, and actively foster the social inclusion of people with disability in the community.

...

In 2013–14, the Community Visitors scheme cost \$1,614,115 to run, more than double the funds provided by the department.

Rising costs associated with running Community Visitors and fewer people volunteering makes it increasingly difficult to meet the demand to visit all the residential settings at a minimum frequency. This is consistent with the findings of the Productivity Commission's Report which pointed to the rising costs of using volunteers.

Computerised systems in facilities are often creating a barrier to the work of Community Visitors: information can be held on multiple databases in an organisation and access can be dependent on an individual staff member who is on duty and has access. The computer systems used also differ between organisations.

There are also challenges for some regional convenors in using OPA's computerised system. Department of Justice and Community Safety requires new users to meet robust standards of proficiency to access the sensitive information kept on the OPA database. They are the same standards as those required of new employees.

Regional convenors' workload is heavy. In some regions and streams the position has been vacant from time to time. In these cases the OPA division coordinator has taken on the additional role of regional convenor until a volunteer can be found. As one Regional Convenor said: 'At the end of the day, we are all just volunteers'.

Among other things, the Program's effectiveness depends on the level of support volunteers receive through OPA staff and the ability of the overall Program to deal with problems that are reported.

In the aftermath of COVID-19, all organisations in Victoria are having trouble attracting volunteers. Although the Community Visitors Program continues to attract new people interested in becoming Visitors, it is not yet known how severe this obstacle will prove to be. The increased cost of living has exacerbated the problem, as has the fact that many volunteers now want only short-term or episodic volunteering work or to do online volunteering. Despite these pressures, though, there were 117 trainee visitors in 2022–23.

There are also challenges associated with providing appropriate visiting for First Nations people, people from culturally and linguistically diverse communities and people with cognitive disability; these lie mainly in attracting volunteers who are representative of the community in question, especially in the case of people with cognitive disability. For example, in 2021 the Victorian Aboriginal Legal Service observed:

It is crucial that any work concerning the expansion of the existing Community Visitor model under the provisions of the *Disability Act 2006* be undertaken with the meaningful and effective participation of the Aboriginal community and ACCOs [Aboriginal Community Controlled Organisations] ... This will be critical to ensuring that the Community Visitors program will be culturally appropriate for Aboriginal people.

s28 of the *Disabilities Act 2006* should be amended to include a specific provision requiring the appointment of an Aboriginal Community Visitor to perform oversight and reporting functions relating to Aboriginal persons with disabilities placed in residential settings or accommodated at NDIS dwellings ... [T]he inclusion of such a provision would further enhance the recognition of the self-determination of Aboriginal peoples of Victoria, as well as the expertise and knowledge of members of the Aboriginal community concerning the needs and interest of Aboriginal persons with disability.⁶⁹

The number of sites Community Visitors in the Disability stream are able to visit has increased under NDIS, and the Program's capacity to provide regular visits is being threatened. Further, the Community Visitors Program is now dealing with a very wide range of residential service providers, regulators and funding bodies and escalation paths are not always clear. Protocols and MOUs are necessary and helpful in clarifying roles and responsibilities between Community Visitors and the many organisations with which they interact. Developing and maintaining relationships with hundreds of organisations is a continuing challenge.

These and other NDIS-related impacts will be discussed below in Chapter 5, *The NDIS: opportunities and challenges*.

The present tensions and challenges for the Program are largely reflective of the rapid expansion and change in the disability environment, and many are related to the introduction of the NDIS.

⁶⁹ Victorian Aboriginal Legal Service, Victorian Aboriginal Legal Service Submission to Department of Families, Fairness and Housing, Victoria. Review of the *Disability Act 2006* (Submission, October 2021) 10 <<https://vals73.wpengine.com/wp-content/uploads/2022/02/VALS-Submission-to-the-Disability-Act-Review-2021.pdf>>.

3.2 Reflections on the Program

In 2023 OPA asked people who have experience of being visited by Community Visitors, people with disability who are aware of the Program, and a former Community Visitor, for their reflections. Following are some of their comments and suggestions for the future. They are arranged by themes.

3.2.1 Being visited

In 2023, OPA asked people who have experience of being visited by Community Visitors and people with disability who are aware of the Program for their reflections. Below are the reflections and suggestions for the future that were shared. They are divided by themes.

The nature of contact

People had varying, although generally positive, views about the nature of contact with Community Visitors:

The staff tell me that they're coming.⁷⁰

[I know who they are because] they've got something on around their neck.

A Community Visitor is a person that's in ordinary clothes that goes into a place. They do let them know, but they don't know when they're going to be there. And they just pounce around the place just to check things to see how things are improving, or being cleaned, and that the people are being treated right, and that the outside's not dangerous for people with a disability or anyone.

You can feel it, you can feel it in the air.

I think it's a good idea to be on the sly side, to see what's been happening there or what's going on there.

[Community Visitors] will be more than happy to say, 'No, I want to talk to the person by myself'. So staff can't get away with things.

There's a difference between [advocacy organisations] coming in ... Community Visitors have more power.

At my house they come normally on one particular staff member's shifts. And this particular staff member often sees them. And yet I do see them from time to time myself. And I have a very good experience with them as they do with me.

I think I saw them like maybe six or seven times. Two or three of those times were the same two people, which was great.

I have had community visitors come and visit me and their job is to listen to people if they have any questions or if they're not happy, they try and fix that ... I guess their job is to try and fix the situation.

[They] talk to the staff or talk to clients. They ask me some questions if I'm happy or not and I say yes or no. Then [if] I say no and then I explain to them why I'm not happy, then they do the writing, then ... I'm not sure what else they do ...

⁷⁰ As a result of COVID-19, before they visit Community Visitors must check that there are no COVID cases in the premises.

I like how they don't question if you don't want to do it.

[They] check if there's leaks or things in the house which need to be fixed.

I knew what power they had ... but I still don't know what they can do.

I would assume they would just write what you say ... I've never asked where it goes.

Sometimes yes, [it's easy to talk to them] and sometimes no.

Knowing what to say ... I do still have problems talking to them ...

I find it easy to talk to the community visitors. I enjoy talking to them because I like to share things with them that I need to share.

I didn't know them at first and then I introduced myself and that makes me feel more comfortable.

Is there any type of pamphlet or plain English in language I can understand about why you're coming in? [And] what about if that information was in another format, like in a video format?

I find it easy to talk to the community visitors. I enjoy talking to them because I like to share things with them that I need to share.

Privacy 71

Some people had strong views about the importance of privacy:

They do go and talk to staff first. Which is okay because we do need support but it's also our home. I tell every staff member that it's my home but it's your workplace: 'I get it's your workplace, but it's my home'.

I agree that it's a good situation to be in if you need them ... [But their being able to obtain information about me] indirectly makes me lose my dignity.

From a normal person's perspective, you shouldn't be telling strangers your personal stuff. You can if you want. But, like, that's so backwards. And the idea of community visitors having the power to do whatever they wish is good, but it's just like, hang on a sec, can we talk about the Human Rights Charter? ... There's no way I can look at it and make sense.

No one took the time to tell me what the process was. Not that I had any fear, but [it would] just be nice to be treated normally ...

- 71 The *Disability Act 2006* sets out the functions and powers of Community Visitors in the Disability stream. The Disability Inclusion Bill Exposure Draft includes an amendment to the objectives of the Disability Act (See Engage Victoria, Disability Inclusion Bill Exposure Draft < <https://engage.vic.gov.au/disability-act> >.) The proposed change would add a new section 4(ab), so that section 4 would include: The objectives of this Act are to—
- (a) advance the inclusion and participation in the community of persons with disability
 - (ab) having regard to the Convention on the Rights of Persons with Disabilities, to promote and protect the human rights and the inherent dignity of people with disability

....

The operation of the Community Visitor Program plays an important role in giving effect to the Convention in relation to freedom from exploitation, violence and abuse (article 16) and other articles of the Convention.

Article 22 of the Convention is about respect for privacy. Powers to visit and to inspect documents are important for the promotion of freedom from exploitation, violence and abuse and other rights, but these powers can impinge on the privacy of residents. Limitations on a right can be justified because of the promotion of another right. Nevertheless, considerations about privacy will be an important focus for the program in the future.

I think it's a culture thing. I think community visitors, staff and disability field don't think we need to know the information or want to know the information. If I asked them I would feel comfortable that they would give more information, but it's not something that most people would think about. They're probably nervous about having two strangers in the house, having to talk about personal stuff.

I think you need that time and patience to get to know each other. And I think you also need to be able to say, 'yes I'd like you to come in' or 'no, I don't want you to come in' because it's my house or my home, or it's part of my home, I need to have some sort of say as well.

I wholeheartedly agree that the person with disability should have the right to say 'no thank you, I don't want to talk to you'. My concern is, why? I'd be concerned why didn't you want to talk.

There seems to be a fine line in making sure there is adequate service delivery and the other thing, the human right of people with disability — we all have a right to privacy.

What Community Visitors can look at ⁷²

Not all respondents had a clear idea about what information Community Visitors were actually permitted to see:

I have ideas. They have all the documentation, all the forms, all these things.

If I'm correct, the documents may be confidential but it's also information about you, so you can also ask to look at your files if you wish ...

It is confidential. But if you want to see what they're saying about you, you can do that.

They can look at everything, can't they?

I think they look at the fire information. If the house is up to date with the fire drills and stuff like that.

Self-advocacy

If there's negative things, we just speak up on our own behalf you know—like, have a say.

There's a charity model, there's a charity mindset in disability—and I'm not saying community visitors do that — but I think [Community Visitors] need to proactively interact and conduct themselves in a way that forces the staff to ... not act like that towards us ... I think they need to ask more questions or ask different questions because the questions are good, but it's just about human rights and safety and compliance. It's not questions that might matter to people with disability ... It's just, what would a normal person want to ask an external person [who] lives in a house that looks like a hospital, that's very sterile? It's about what matters to us.

'The best experts are those who live with disabilities.' End of quote.

⁷² Community Visitors can inspect reports about incidents that have occurred in a facility and documentation relating to each person (apart from their medical records).

It goes back to the old-school style of people with disability and advocates being, you know, fighting against everyone else. It's just like, we're all in it together ... Why are you trying to take my conversation to something that you think is going on?

I think people with disability should be there somehow or in some capacity because they may be the person who's got the skill or knowledge to maybe try and understand how the other person with a disability is feeling and thinking. I can maybe pick up on what they're trying to do or say, or trying to avoid a particular question or issue because they don't want to get in trouble... So that's what the person with a disability, I think, should be there for. Not only just to have a look and to see.

Contacting Community Visitors

Some responses about contacting Community Visitors—on one's own behalf or on behalf of someone else—were lukewarm:

[If we have a problem] they've actually got something up on one of the ... the medicine cabinets I think, that if we need the number, we can ring [the Community Visitors] up and they can come and talk to us.

I would [contact a Community Visitor]. If [the person] can't actually speak for themselves, I would.

That's happened to me too, but I've spoken up, on behalf [of the other person] to the house supervisor ... And [the staff member] didn't come back. He was a bit unpleasant.

My friend use to be in a home and I saw someone being abused. I acted dumb. I acted really dumb and I dobbed her in and she got fired.

Would I go to the community visitors? I would, but it wouldn't be my first option, only because I didn't even know that there was a number there to call. I thought they just come when they can find a spot, or choose the house at random or whatever it might be.

But I would probably go to [an advocacy organisation] first. Only because I know what they do. And that goes back to education, but it [also] goes back to the atmosphere of the situation I was in. So, I wouldn't call them, because I didn't know you could.

One of the things that scares me is that if I open my mouth and complain to you, then someone might dob me into the staff and then the staff will know that I am the one that made the complaint about you so you're going to make my life hell. So, we also need to be able to protect—I don't like the word 'protect' but that's the only word I can think of at the moment—to make sure that no harm or damage can come to that person. We also need to be aware, it happened in institutions—I'm not saying it's happening in community residential units because I don't know that area very well—I just want to put it out to say we need to think about this issue.

Community Visitors seeking the help of OPA staff ⁷³

Sometimes Community Visitors might feel they need the help of OPA staff to deal with a situation:

If these things are happening, does the office have a way to keep the person with disability involved in the conversation?

If [OPA] talk[s] to the ops manager or the house supervisor, is there a way to keep the person involved in that conversation?

I only say that because the culture and the attitude might change towards the person and the person might not want them to raise it because they're already having issues.

What happens if there is a report that goes to OPA, that goes to government, that goes here there and everywhere? How do we make sure that that report is being acted on?

[If] I see something that's going on, then I would need to go somewhere — whether that be through OPA or somewhere.

Choice in living arrangements

Some people would prefer different living arrangements, often because they are having problems with their current housemates:

In my group home, there was a six-bedroom, I would call it 'dorm' because it was just a straight hallway with large bedrooms. I think that the vacancy that I left is still open like six months later.

If we do go to [smaller] apartment style things, they have to get the group housemates correct because if they're not getting that right ...

You can't visit all the houses, right? But then [if] service providers aren't being completely transparent about what's going on ... How do you guys know who to visit?

I've had another resident [assault] me once.

I had an incident at my house with a housemate ... It was tough for me, let me tell you. He does [still live at the house]. I've been advised by the staff to be careful where I tread with that person.

A resident got angry at me because I by accident smiled at them.

⁷³ For example, OPA might make a complaint to the NDIS Quality and Safeguards Commission.

Changed living arrangements and a continuing role for Community Visitors

The question of changed living arrangements and a continuing role for Community Visitors elicited a variety of responses, generally in favour of the Visitors:

I think there's still a role about staff-client relationships. I don't think that's going to go away.

I think they should [keep visiting].

There might be times when there are those who are voiceless [who] need [Visitors] to speak up for them.

Are community visitors still going to be relevant if there's less group homes [and] people are living more by themselves with people they want to live with? ... It would fundamentally make the workload less ... I think they should continue what they're doing, because at the end of the day ... how many people volunteer? 500? And let's just say on average they've all got, like, five years of experience. That's over a thousand years of expertise that you can't replace ... But I think it does fundamentally change the idea of what community visitors are. I don't know what will be next, but there is a place for them to stay, yes.

There are other people with disability that may live with their family, that may be stuck in hospitals because of issues or their challenges, or even people with disability who don't have NDIS packages, that still are entitled to the same opportunities and fairness Community Visitors provide.

Victoria should follow the other states and make it possible for community visitors to visit [day placement centres] and this would be the best thing to happen to community visitors, I feel. I can give you a perfect example. I'm LGBTIQ and ... I had a really big issue at work. Because of that issue, and even though I reported it and got some help, I just think that if Community Visitors were able to visit services, then speak to people, then they can actually fix things that companies say they actually do. Sometimes a company might actually have a policy [and] say they have one and use it, but they actually don't. So that's a good reason why Community Visitors should be able to visit day services.



John Chesterman is the current Queensland Public Advocate. He was appointed Deputy Public Advocate of Victoria in 2018, and remained a Community Visitor for all of his time at OPA

3.2.2 Being a Visitor

The current Queensland Public Advocate, John Chesterman, became a Victorian volunteer Community Visitor in the Disability stream in late 2005. He joined OPA in 2009 as Manager of Policy and Education and was appointed Deputy Public Advocate in 2018. In 2021 he moved to Queensland to take up the position of Public Advocate. John remained a Community Visitor for all of his time at OPA. His experience has given him a unique perspective on the Victorian Community Visitors Program. He was interviewed for this project and his reflections are as follows:⁷⁴

⁷⁴ Consultation with Dr John Chesterman, Queensland Public Advocate (Barbara Carter, Office of the Public Advocate, April 2023).

The main concerns

[The main concerns during my 16 years with the Victorian Community Visitors Program] were violence and neglect, and I'd put in there the use of restrictive practices. Social inclusion, as well. Which people were going out? Those were kind of 'my things'—what I looked for. Some things are always there: the fabric maintenance of houses and so on. Almost every time, there was something on that score. One of the challenges with the program is that different people have different views as to what's important.

The scope has always been about being the eyes and ears of the community and asking, 'Does this situation meet community expectations?'

— John Chesterman

Social inclusion

The keywords for Community Visitors really were around social inclusion. They weren't established simply to be an abuse monitor. And, indeed, if you were setting up an abuse monitor, you wouldn't necessarily go with that model.

[One of the challenges] is that Community Visitors in the Disability stream were often very reliant on house staff members for information about what was happening. And when it came to looking for evidence of what's happening, they were reliant on staff members and where they could find other evidence like diary entries and so on. Also, CVs were limited in their own knowledge of what social inclusion possibilities would involve. So it's one thing to go and ask is such and such engaging with the community generally and then get a response. But CVs won't necessarily have the skills to be suggestive about other ideas for social activities. And so that's a bit of a challenge.

For meaningful social inclusion, it's two-way. Meaningful social inclusion ... is relational. It's not simply a matter of the individual's right.

And the other thing to say—and this is a more generic challenge—is about the kind of consumer choice environment that we're increasingly in. Sometimes, you ask about social inclusion and people would say, 'Oh well, this resident chooses not to engage much with the community and prefers to stay in his bedroom', to which you can respond, 'Is this because of past experiences or is that a genuine choice?'

[It's the] idea of leading a flourishing life versus a strict adherence to one's human right to just be able to do whatever you say you want to do.

Scope of the role

The scope [of the Community Visitor role] has always been about being the eyes and ears of the community and asking, 'Does this situation meet community expectations?' Now that's a general phrase in that generalist question 'What are our community expectations?' and we know there are differences of opinion as to what the community does expect in terms of social inclusion and special rights, and so on. But I actually found that a very helpful lens for Community Visitors to use in their reports, for instance, [was] saying, 'Well, this doesn't meet community expectations'.

... It's actually analogous to that much used legal term 'reasonable'. And that was never defined because once you start defining things like that you just have to lose some of the essence. But it's a term, 'community expectations', that can have variations in meaning, but it's actually quite helpful having that with possible applications.

The value of Community Visitors being volunteers

It's interesting because [it's] not a universally popular view that being volunteers is a good thing. I certainly share that view because it is very difficult to argue against the insight provided by a team of volunteers who are doing this because they believe passionately in the area, not because they are paid to do it. I think it's very important.

Expanding a Program to other facilities

Potentially, but I wouldn't be rushing at this point in time [to expand the community visitor schemes across Australia] because the schemes are struggling to operate as they are. I think with the wider range of accommodation settings emerging there needs to be some clarity.

We just need to be clear, it exists at the moment as primarily a disability-oriented scheme, so you may find that if community visitors were to branch out too much beyond the disability world, there may be difficulties in having meaningful escalation pathways, and so on. But I think it is a good time for government to consider whether the articulation of the places Community Visitors visit is the best articulation of those areas that would benefit from Community Visitors.

Community attitudes

I think people are increasingly appalled when the rights of people with disability are transgressed, when we are talking about obvious situations of abuse or even neglect.

At the same time, I don't see any commensurate improvement in deciding to be inclusive of people with disability in the general sense. I think it (society) probably is more inclusive for people with mental ill health. But with intellectual disability, I'm not sure that society is much more inclusive now than it was 20 to 30 years ago. It would be interesting to ask people with intellectual disability about their experiences of that and indeed how you would measure it. I'm not sure, but I don't see the same impulse to reach out as I do, say, the umbrage at obvious human rights abuse.

Measuring the success of the Community Visitors program

[The question of how to measure the success of the Program] goes to the question of what [Community Visitors] are trying to achieve because we have to answer that in order to work out whether they've achieved it.

We can point to deinstitutionalisation and basically the big advocacy wins. That is an important measure of success, but actually in all the time I visited, probably the most important role was speaking meaningfully with residents and also with staff members and just providing that sense that the community is watching what's happening which can stop bad things happening. Now, how you measure that is really difficult. Because, in essence, you are talking about a preventive mechanism.

But certainly talk about the advocacy successes—and although there's a difference between outcomes and outputs—you can talk about all the visits that have been conducted and the issues raised.

I think you can talk about the number of matters that are resolved and the resolutions that occur. But in some ways the biggest impact of this scheme has been those matters that haven't been resolved over a period of time that are escalated and can lead to major outcomes. I think also identifying the role Community Visitors have played in significant inquiries is quite important. I'm thinking particularly of various Ombudsman's inquiries that have relied heavily on Community Visitors' reports, which have even led to the instigation of inquiries in some instances.

4.0

The Program's achievements

Fostering social inclusion is central to the Community Visitors Program.

— PAGE 71



4.1 Closure of institutions

Facility visit reports document thousands of issues, large and small, that affect residents each year. The majority of these are dealt with at facility level and are the bedrock of the Community Visitors' work. Annual reports document system wide developments and ongoing situations. Extracts from the annual reports of 1990, 2000, 2010 and 2020 in the Appendix of this report are testament to how Community Visitors have brought these issues to public attention over the years. The story of Community Visitor involvement in the closure of institutions is told in this chapter, the reasons for the Program's success are examined, the place of the Community Visitors Program in the broader safeguarding framework, together with the value of volunteer Visitors is explored.



Aradale Hospital and Residential Services closed in 1991

4.1.1 Caloola

— They said, You are only here for a holiday.

On the Office of the Public Advocate's very first day of operation, in April 1987, *The Age* newspaper reported on violence at Sunbury Training Centre (known as Caloola), a matter that would subsequently be investigated by Community Services Victoria and OPA, forming the basis for the way OPA and the Community Visitors Program would operate.⁷⁵ At the first annual general meeting of Community Visitors in 1988, Chris Borthwick and Elaine Nyberg were elected to the Community Visitors Board.

In his candidacy statement for the Board position, Chris Borthwick wrote:

After six months at Caloola I am convinced that the centre is an outrage on the human dignity of the five hundred and fifty people that it holds. I also believe that there is no prospect of significantly improving it through casework with individual residents. The problem is simply not on that scale. The only way to make a major improvement is to close down the centre and that can only be done through decisions at government level ...

I am concerned that we [Community Visitors] use our collective power to bring about change. We are the only people concerned with these institutions who can say what we think without fear. We are not public servants, wary of future promotions: we are not parents, fearful that our children may suffer. We cannot be fired and we cannot be silenced.



Explosive report by Community Visitors, helps lead to closure of Caloola in 1998



State government closes Hambleton House in 2020, after years of reports by Community Visitors

⁷⁵ Mark Feigan, 'The Victorian Office of the Public Advocate: a first history 1986–2007' (PhD thesis, Latrobe University, Melbourne, 2011), 103.

Chris Borthwick, Kate Kennedy, Penny Mallia and Winifred Marshall wrote OPA's first investigative report to the Minister. In it they stated:

Most Caloola residents when asked said that they wanted to get out of Caloola. This matter is urgent. The residents of Caloola cannot simply be placed on hold until the Government gets around to it. In many cases their condition is actively deteriorating ... These things need not happen, they can be changed, they must be changed. We have been horrified at the conditions we found at Caloola. As Community Visitors we are [expected] to weigh up the institution against community standards. Caloola does not meet community standards in any particular and the community should not tolerate Australian citizens being held in these conditions any longer.

The report demonstrated how Community Visitors could use their knowledge and commitment to identify problems, document them and make responsible recommendations that could act as the basis for change.⁷⁶

Initially there was doubt about whether the report would be released to the public because of its explosive nature. But it was leaked to a television station and the serious neglect and abuse at Caloola became front-page news.

In December 2013, 21 years after Caloola's closure, Radio 3CR broadcast the Caloola 21 celebration, in which former residents, Community Visitors and the then Minister for Community Services, the Hon. Kay Setches, spoke of the way in which the entire community ultimately pulled together to bring about the closure of Caloola.

Graham Williams, a former resident, said:

My mother put me into Caloola when I was a boy, when I ... went from place to place. Still, they took me to Caloola. They said, 'You are only here for a holiday'. Which was not true. I was in a locked ward. I was in an institution for about 30 years. I got no training. I learned to read and write after I left.

Kate Kennedy, a Community Visitor at the time, said:

So often we saw evidence that those involved had lost their ability to clearly perceive and judge what was really happening. Any notion that the institution provided asylum for vulnerable people was a cruel fallacy. Every group involved in Caloola had a vested interest ... Residents lost out. Looking back on our reports, they are shocking, but they are the sanitised version.

One incident will stay with me for the rest of my life. It was a hot day and the residents were out in the yard. One tree, concrete and a few benches. Some were lying on the concrete in the hot sun and the staff were hosing out the toilet area. It leads straight into the yard and faeces were floating from the toilet down into the yard and washing up on those lying there.

Chris Borthwick, also a Community Visitor at the time, added:

Looking back, we'd done what the government has set us up to do. We told the government to do what it wanted to do but [it] didn't want to own up to it. They needed a cover story, and we were it. Augustine prayed. 'Give me chastity, Lord, but not just yet.' And that's roughly how governments tend to look on de-institutionalisation. We were licensed naggers.

And, of course, you have to say that we community visitors had much the easiest part of the task. We were specifically instructed to disregard limited resources and difficult choices and historical baggage. And, of course, those are the difficult bits. That's what we have politicians for. Luckily at that time we had politicians who were able to juggle all the different interests and budgets and electorates and rights and wrongs. Politicians like Kay Setches and Margaret Ray, who could make things happen in a way that we certainly couldn't.

Sunbury Citizen Advocacy, a non-profit organisation that supports people with intellectual disability, played an important part in Caloola's closure. There had already been good connections between Sunbury locals and the residents of Caloola, and many volunteers who had cared for residents there during a strike in 1985 were locals who had never before been inside the institution. Shocked by what they saw, they held a public meeting that resulted in the creation of The Sunbury Project to advocate for residents and for greater connection between Caloola and the community.

The following year, the project became the Sunbury and District Citizen Advocacy Program, which was active in helping former residents of Caloola when they moved into the community. The program was special in two ways: it was established by people who had had no professional involvement in the care of people with disability, and it was the only citizen advocacy project focussing on an institution in the local community and attempting to make members of that community more aware of something they had ignored in the past.⁷⁷

Kay Setches described the difficult political landscape that had to be negotiated in order to have Caloola closed:

First of all, Race Mathews [at that time a Victorian MP] got the [Community Visitors'] report and said we were going to close Caloola forthwith without going to the cabinet. He just said it was going to be done. Then all hell broke loose, and we were in an election campaign with Caloola having to have staff members and volunteers going in because the union was out on the grass and were not going to provide services until we reached some sort of agreement with them.

We built 48 houses. We built two new sections in two other institutions, and we doubled the funding. The funding to Caloola was \$25 million and we doubled the funding for the 14 months. And we had an additional \$18 million for capital. But just getting to that point required an unbelievable step of confidence in ourselves as a government, in me, as a Minister. And the Premier, Joan Kirner had that confidence, and so did Margaret Ray, a very influential woman who ... was an MP for Box Hill, and also Tony Sheehan, who was the Treasurer at the time. We had no money. We had two terrible recessions in Victoria and things were bad.

In retrospect Kay Setches commented:

Really, when I look back on it, there were thousands of people that wanted this to happen and wanted us to succeed, and especially wanted to assist the people that were living in Caloola to go and live somewhere else, somewhere where they would be happier. Somewhere that they would have control over their lives. And the unions now, the unions were frightened in 1991 and 1990, but they had the guts, the absolute guts to go with us, to take non-direct care positions and to change them over to direct care positions, because out at Caloola there were 700 and something staff and half of those were non-direct care positions.

A Latrobe University assessment following up on residents three years later found that nobody had a worse life after leaving Caloola and that almost all of them had a measurably better life.

4.1.2 Kew Residential Services

Thirty-four years is too long

The closure of Kew Residential Services was the most widely debated and publicised closure of an institution in Victoria. There had been debate about de-institutionalisation, what the nature of group housing in the community should be, and whether it should include cluster housing. Additionally, there were political considerations and there was conflict about the decision to redevelop the site for high-end housing in a public-private partnership, the government commitment that the benefits from the development would go to supporting people with disability across the state, the heritage value of the site, and the environmental impact of turning a large area of open land in Kew into high-density suburban housing.

Among the many agendas and the clamour of voices, Community Visitors continued to provide an independent voice to government and the community, reporting what they saw happening in the lives of Kew residents. In 1992 the Community Visitors reported a commitment by government to close all remaining institutions by 2000. Before the September 1999 election both major parties gave commitments to either close or redevelop Kew.

Between 1978 and 1999 the number of residents living in large-scale congregate care facilities in Victoria fell from 4439 to 873. Community Visitors called for the closure of Kew in 1999. When Premier Steve Bracks announced Kew's closure in 2001, there were still 462 residents living there.⁷⁸ The first group of residents were relocated into the community in October 2002, and 360 residents were subsequently relocated by August 2006. The final group of residents moved into houses on the former Kew site in April 2008. On 4 June 2008 the Premier announced that the Kew Cottages redevelopment was complete.⁷⁹

⁷⁸ Office of the Premier, 'Kew residential services to be redeveloped' (Media Release, 4 May 2001).

⁷⁹ Office of the Premier, 'Kew Cottages redevelopment complete' (Media Release, 4 June 2008).

The main opposition to the closure of Kew came from parents who were fearful about the way their adult children would be accepted in the community and thought that there should be a choice for their family member to remain on the Kew site in a cluster-housing arrangement. They were ultimately successful in having 20 houses built in a cluster on the Kew site, rather than those houses being spread throughout the area. It had originally been intended that 100 residents would move to houses spread throughout the site.

When the government announced the closure, the Minister for Community Services, the Hon. Sherryl Garbutt, noted that Community Visitors had for years reported that conditions at Kew were completely unacceptable. As with the closure of Caloola, the government drew on the Community Visitors' reports to provide evidence of the need for change. In an article in *The Age* on 17 June 2003 the Minister observed:

Kew Cottages is an outdated institution that cannot meet the basic standards of accommodation. Kew Cottages belongs to a bygone era where people with an intellectual disability were hidden from the community like a shameful secret. That is why we are closing them. This decision has been supported and reinforced by many community visitor reports.

The 2003 Community Visitors annual report of the Disability stream included a section entitled 'Institutions in review', highlighting statements presented in reports between 1992 and 2003 about Victoria's institutions. The situation at Kew had been documented in increasing detail and the report contained personal responses from individual Community Visitors over the years.

I have been a community visitor now for approximately six months. I had been visiting residential houses for this period and wanted to visit Kew Residential Services to see for myself whether the rumours and stories that I have heard over the years are actually true. Much to my horror not only are the stories true but much worse than I ever could have imagined. It was a beautiful day in the late afternoon. We only saw two residents in the grounds. I could not believe there were more than five hundred residents actually living on the premises. Empty playing fields, empty ovals, empty outside seats—overall an empty feel. I walked away with tears in my eyes (and anger in my heart).⁸⁰

Jo Cohen, who was originally an OPA research officer, joined the Community Visitors Program as a program coordinator in the late 1990s and became a Community Visitor some time later. In relation to Kew Residential Services she commented, 'I obviously had a lot of experience and thoughts [from my time at OPA] but going to Kew was just like a punch in the face. It was unbelievable'.⁸¹

⁸⁰ Office of the Public Advocate, 'Institutions in Review', *Community Visitors Annual Report 2002–03: Intellectually Disabled Persons' Services Act 1986, Disability Services Act 1981* (Report, 2003) 24. (Comment from the Office of the Public Advocate, *Community Visitors Annual Report 1997: Intellectually Disabled Persons' Services Act 1986* (Report, 1997).

⁸¹ Consultation with Jo Cohen and Fay Richards (Barbara Carter, Office of the Public Advocate, 20 April 2023).

Fay Richards, a respected regional convenor and Community Visitors board member throughout the Kew redevelopment period noted:

Visiting regularly, you got to know some of the identities. There was a man who used to always come up to us and tell us how long he'd lived in Kew, I think he started off at 30 years and he added a year every year. He'd say, 'Thirty-four years is too long to live in Kew. When can I have a house?' He was always in the back of my mind and I wonder how he's gone in the houses since he moved.⁸²

When it comes to the influence Community Visitors had on the closure of Kew, Fay and Jo both said they had great influence, both through their consistent visiting and through their interaction with management and staff—and in annual reports 'when we started writing about what we actually saw'.⁸³ In about the late 1990s the Community Visitor Boards made the decision to tell the stories of what they were seeing in stronger terms, using less sanitised language. In the 1998 Disability Stream annual report the principles of the Disability Act were listed alongside the observations of the Community Visitors in a powerful statement about the need for change.

Another important contribution by the Community Visitors as Kew residents were relocated over four years was to ensure that residents' wishes and preferences were being respected in decisions about where they would move. The Visitors continued to visit people in their new homes to ensure that they were settling in and that any problems were being sorted out.

The work of Community Visitors at Kew Residential Services stands out as an example of how a respected, credible program can consistently and tenaciously work for the continuing benefit of people with disability, with every level of an organisation and through to the highest levels of government.

4.1.3 The Long-stay Patient Project

There is nowhere else for them to go

By 2004 Community Visitors had become concerned about the inappropriate long-term placement of patients in mental health units.⁸⁴ This led, in 2007 and 2008, to the Long-stay Patient Project, which involved Community Visitors gathering information for a 12-month snapshot of the situation in mental health units.⁸⁵ Community Visitors identified 99 patients in Victoria who had been inpatients in adult mental health units beyond what was seen as a 'reasonable' length of stay. For example, for community care units 'reasonable' was defined as more than two years and for secure extended care units it was more than six months.

⁸² Consultation with Jo Cohen and Fay Richards (Barbara Carter, Office of the Public Advocate, 20 April 2023).

⁸³ Consultation with Jo Cohen and Fay Richards (Barbara Carter, Office of the Public Advocate, 20 April 2023).

⁸⁴ Community Visitors noted these concerns in the 2004 annual report and in subsequent reports: Office of the Public Advocate, *Community Visitors Annual Report 2003–2004* (Report, 2004).

⁸⁵ Office of the Public Advocate, *Community Visitors Annual Report 2007–2008* (Report, 2008) 24.

At the conclusion of the project Community Visitors collaborated with OPA to prepare a report⁸⁶ and OPA advocate guardians engaged in individual advocacy on behalf of several long-stay patients.⁸⁷ The report stressed that most long-stay patients were considered ready for discharge but were unable to move to the next level of care because of shortages of suitable accommodation and support. It recommended, among other things, investment in an intensive case-management program.⁸⁸

Of the 99 long-stay patients, Community Visitors identified 40 patients who had been in a mental health unit for between five and 20 years and 16 patients who had been in a community care unit or secure extended care unit for between 10 and 20 years.⁸⁹ The report challenged the prevailing assumptions about long-stay patients:

Long-stay patients are often assumed to be consumers who present a risk to public safety due to intractable behavioural issues relating to their mental illness. This is an incorrect assumption which is not born out by the findings of Community Visitors whose reports show that only ten patients were classified as 'unable to be discharged' due to a history of violence or aggression.⁹⁰

Public Advocate Colleen Pearce expressed her concern that 'Mental health units are not intended to provide life-long accommodation and support yet many involuntary patients appear to be living out the course of their lives in these settings, many of which are locked, because there is nowhere else for them to go'.⁹¹

This important project had highlighted the concerning reality that shortages of suitable accommodation and support had meant that in 2008:

Despite the adoption of the policy of de-institutionalisation in the 1990s and the closure of the remaining stand-alone institutions during that time, some people with a long-term mental illness do not have the opportunity to live and participate in the life of the community.⁹²

During the six years from 2006–07 to 2011–12 Community Visitors continued to collect information on long-stay people in mental health facilities.

The project has seen many successes. In the 2009–10 budget, the Victorian State Government funded 50 intensive psychosocial rehabilitation support packages, some [of] which enabled the discharge of long-stay SECU [secure extended care unit] patients into the community.⁹³

⁸⁶ Office of the Public Advocate, *Long-stay Patient Project Full Report* (Report, April 2009).

⁸⁷ Office of the Public Advocate, *Office of the Public Advocate Annual Report 2012–2013* (Report, 2013) 22.

⁸⁸ Office of the Public Advocate, *Long-Stay Patient Project Full Report* (Report, April 2009) 26–28.

⁸⁹ Office of the Public Advocate, *Long-Stay Patient Project Full Report* (Report, April 2009) 10–11.

⁹⁰ Office of the Public Advocate, *Long-Stay Patient Project Full Report* (Report, April 2009) 22.

⁹¹ Office of the Public Advocate, *Long-Stay Patient Project Full Report* (Report, April 2009) 3.

⁹² Office of the Public Advocate, *Long-Stay Patient Project Full Report* (Report, April 2009) 4.

⁹³ Office of the Public Advocate, *Community Visitors Annual Report 2011–2012* (Report, 2012) 19–20.

After follow-up meetings between the Public Advocate, the Chief Psychiatrist, the Senior Practitioner, the Director of Disability Services and experts at the Austin Hospital, six patients with dual disabilities were offered intensive funding support and permanent homes in purpose-built accommodation:

[By 2012] the original six patients with dual disabilities at the Austin identified by Community Visitors in 2007–08 [had] been discharged into suitable and supported accommodation in the community. These people [had] a primary diagnosis of intellectual disability and had lived in a SECU-type setting for between eight and 21 years ... Community Visitors encourage[d] further collaboration between the department and DHS, the provision of more supervised 24-hour care models and additional individualised funding packages to secure the transition of more long-stay patients into the community.⁹⁴

4.1.4 Hambleton House

Is there anybody out there?

Sometimes Community Visitors feel that no matter what they say or how often they say it, nobody is listening. This was the case with Hambleton House, a supported residential service in Melbourne's Albert Park housing more than 30 residents. Community Visitors had been expressing serious concern about the welfare of residents for some time.

Between 2017 and 2020 Community Visitors had identified 88 critical concerns—more than three times the average number of concerns reported for other pension-level SRSs in the area. In 2019 Community Visitors nominated 45 critical concerns about the Hambleton House living environment and support provided to residents and referred six formal notifications to the Department of Health and Human Services (now the Department of Families, Fairness and Housing).

The main problems identified were continuing infestations of bed bugs and cockroaches and bites on a resident; residents complaining about being cold, especially at night; toilets without toilet paper, soap or hand towels; residents reporting assaults and being afraid of other residents; and intimidation of residents, family and visiting professionals, including threats of eviction and inappropriate and abusive behaviour towards Community Visitors and OPA staff.

At the request of the department, Community Visitors collected photographic evidence of the squalid conditions in bedrooms, bathrooms and communal areas—including overflowing rubbish bins, dirty and torn curtains, mould, missing tiles in bathrooms, and unhygienic fridges containing old and rotting vegetables.

In November 2019 the Public Advocate wrote to the department about the inadequacy of responses to notifications made during the year and, in her view, the apparent ineffectiveness of any action that had been taken. In January 2020 Community Visitors raised further concerns, this time about the inadequacy of personal support plans. In one case Community Visitors provided to the department photographic evidence of a diabetic's plan, which simply said, '... is a diabetic. Enjoy all her meals. Loves drinking cola'.

⁹⁴ Office of the Public Advocate, *Community Visitors Annual Report 2011–2012* (Report, 2012) 19–20.

In late March 2020, when unannounced visits were suspended because of COVID-19, Community Visitors introduced 'remote safeguarding' in an effort to keep in touch with residents and proprietors in SRSs and made numerous attempts to arrange phone visits. When a phone visit was arranged with Hambleton House in late April, the proprietor refused to answer questions or provide reasonable assistance, as required under the Act. In June 2020 the Public Advocate again wrote to the department, advising that interventions with the facility had not adequately addressed the issues that included verbal abuse and intimidation of Community Visitors and OPA staff.

The situation came to a head when there was an outbreak of COVID-19 in the facility. Giving evidence to the Disability Royal Commission, the Public Advocate, Colleen Pearce, stated:

To cut a long story short, we did a report to Government about Hambleton House but it wasn't until Covid struck and they were wandering about leafy Albert Park and the Covid task force went in that (Hambleton House) was suddenly found to be non-compliant. And I don't care what anyone says about it being compliant we have photographs of people with bedbug bites on their arms ... We had a woman who told us she slept in her coat at night ... because she was so cold.⁹⁵

The Public Advocate further stated that although there was now a different level of responsiveness and cooperation, the regulatory system for SRS overall is not equipped to keep pace with the challenges presented by NDIS.

My issue is not that they [the Human Services Regulator] are not acting now ... It's the length of time that it takes to take regulatory action even if they are determined to take it ... It's a long process and it takes up a lot of time and resources. So the regulatory system, in my view, is not agile, it's not nimble, it's very difficult to move quickly. And as the service system is evolving quickly since the advent of NDIS, the regulatory system, or the safeguarding or the oversight system isn't nimble. It can't move quickly.⁹⁶

The action the department took in relation to Hambleton House was to relocate the residents after the facility was closed in August 2020 and to commission a respected aged-care service for the homeless to find them suitable accommodation. The residents temporarily moved to a former backpacker hostel in St Kilda, and the service set about finding them suitable accommodation. It was successful in this for many residents, although some were approached by proprietors and moved to other SRSs or private unregistered housing without regulation. Some left and services were unable to find out where they went.

⁹⁵ Disability Royal Commission. Public Hearing 26. 1 September 2022. Evidence of Colleen Pearce.

⁹⁶ Disability Royal Commission Public Hearing 26. 1 September 2022. Evidence of Colleen Pearce.

Despite all this, we can say that Community Visitors played an important role in the regulatory oversight of Hambleton house, exposing the appalling living conditions that ultimately resulted in its closure. It demonstrated that Community Visitors can and do provide information and evidence to authorities, governments, regulators and the community of human rights abuses that might not otherwise be uncovered. This information and evidence can be used by regulators to assist in establishing the threshold they need to take action to safeguard vulnerable people. This has been evident in other examples where information provided by Community Visitors to regulatory bodies has been able to be used in regulatory interventions.

If Community visitors stopped visiting, things would slip back and people who are vulnerable would be subject to abuse.

In addition, there is now a protocol between the HSR and Community Visitors that recognises their respective roles in the safeguarding environment and there is much improved communication and understanding between them.⁹⁷ In retrospect much of the disagreement between the Community Visitors and regulators appears to lie in the difference in the perception of the Visitors about community expectations compared to what the regulations might say. Regulators went in and saw the same things that Community Visitors saw but did not necessarily see these things as being a breach of the regulations or assessed that they did not reach the threshold for the level of intervention that Community Visitors were seeking.

The Hambleton House saga was a bruising experience for Community Visitors and staff that affected the whole program. Some Community Visitors resigned during this period from frustration and anger about the situation. Notwithstanding this, Community Visitors can be satisfied that they steadfastly held the course and were a voice for abused and vulnerable people that was ultimately heard. It was a significant step in the right direction in a system that is increasingly difficult for all involved to navigate.

4.2 Reasons for the Program's success

The strengths of the Community Visitor Program lie in the fact that Community Visitors are independent, they are volunteers, and they report directly to parliament.

In consultations, Community Visitors agreed that they would always be needed. Asked what they thought would happen if they stopped their visits, they said: 'If Community visitors stopped visiting, things would slip back and people who are vulnerable would be subject to abuse.' It was also noted that different people bring important personal qualities and insights to the role of Community Visitor:

There is one situation that sticks in my mind. There was a trainee CV who had a nose for things and picked up things that perhaps I wouldn't have picked up. A house supervisor had been abusing one of the young women residents for a long time. It would have gone unnoticed but for the fact that she [the CV] was very suspicious, and the young women spoke to her, a woman, rather than the male Community Visitor she went with. And a good Community Visitor can scratch beneath the surface. You have more power than anybody else. Still, a lot goes on that you don't know about.⁹⁸

⁹⁷ Consultation with Anthony Kolmus, 27 April 2023.
⁹⁸ Consultation with Fay Richards 20 April 2023.

It is the following essential features of the role and powers of Community Visitors in Victoria that underpin the achievements of the Program.

Community Visitors:

- are Governor-in-Council appointments and are therefore independent of government⁹⁹
- provide an annual report to parliament, with recommendations for sector change and improvement¹⁰⁰
- are volunteers¹⁰¹
- advocate for people with disability who might have no one else to support them or no other person to advocate on their behalf
- have a human rights focus
- are an early warning system for the community
- describe what is happening in practice and whether or not policy and practice manuals are being used¹⁰²
- highlight where the system is failing and advocate for systemic change
- have the authority to gain access to incident reports¹⁰³ and report back to the Community Visitors Program on any matters of concern, all of which are recorded
- escalate more serious matters through the Community Visitors Board and the Public Advocate
- report publicly on serious incidents of violence, abuse and neglect concerning people with disability in disability services, residential services and mental health facilities
- are people who want to learn about disability, commit to undergo training, and provide a link to the community for people with disability.¹⁰⁴



Community Visitors highlight where the system is failing and advocate for systemic change

⁹⁹ The Community Visitor appointments are Governor-in Council appointments has been the case since the commencement of the Program in 1988. In 1988 these appointments were made under the *Intellectually Disabled Persons' Services Act 1986* s. 53, and *Mental Health Act 1986* s.108. From 1990 Community Visitor appointments were also made under the *Health Services Act 1988* s. 116. In 2023 these appointments are made under the *Disability Act 2006* s. 28; *Supported Residential Services (Private Proprietors) Act 2010* s. 182; *Mental Health Act 2014* s. 214 (and from 1 September 2023 under the *Mental Health and Wellbeing Act 2022* s. 395).

¹⁰⁰ There are requirements for the Community Visitor Boards (each comprising the Public Advocate and two community visitors elected by community visitors) to submit to the relevant Minister an annual report of the activities of community visitors, which the Minister must provide to both houses of Parliament. The Community Visitor Boards are required to do this under the *Disability Act 2006* s. 35; *Supported Residential Services (Private Proprietors) Act 2010* s. 195; *Mental Health Act 2014* s. 224 (and from 1 September under *Mental Health and Wellbeing Act 2022* s. 409).

¹⁰¹ Of the importance of Community Visitors being volunteers, the Public Advocate Colleen Pearce has stated: 'I believe there is a higher level of credibility in the Victorian Community Visitors Program on the basis that they work as volunteers. They are not paid to do this work; they are doing it because of their generous spirit.' See: Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 — The effectiveness of statutory oversight* (Report, 2015) 77.

¹⁰² Of the importance of independent Community Visitors, the Public Advocate Colleen Pearce has stated: 'You can put all the policies and procedures in place... but if you don't have an independent person going in and looking at it, how will you know. It's about bringing the world into that environment.' See: Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 — The effectiveness of statutory oversight* (Report, 2015) 77.

¹⁰³ *Disability Act 2006* s.130; *Supported Residential Services (Private Proprietors) Act 2010* s.187; *Mental Health Act 2014* s. 217 (and from 1 September under *Mental Health and Wellbeing Act 2022* s. 401).

¹⁰⁴ Community Visitors undertake training and observation visits before their appointment. They undertake an application process, must attend all-day induction training, 10 hours of observation visits incorporating a guided reflections process followed by stream-specific training. After this a Regional Convenor needs to recommend their appointment and paperwork must be sent to the Ministers office.

In 2022 Colleen Pearce said of the Community Visitors Program:

[It is] a model of empowerment and inclusion ... Community Visitors evolved from the visiting of institutions to group homes. They often live in the area of houses that they visit. They know people over the longer term. They are able to go at different times of the day or on the weekend. And they form friendships and relationships in a way that [isn't] possible with paid employees. They form part of the social capital of Victoria.

Victoria has a very strong and proud tradition of volunteers. And they have formed part of the community of people who live with disability in various housing options.

I say that a person who comes and works as a volunteer for us has had substantial training in disability-related, mental health-related issues, and when they leave they take that knowledge into the community.¹⁰⁵

4.2.1 Safeguarding human rights as part of a broader framework

The Community Visitors Program is part of a broader safeguarding framework, and it is vital that its role is adequately recognised: ¹⁰⁶

Community Visitors are there for the individual. And they shouldn't be caught up in changing their role [and] undertake any regulatory work. Their work is to be there primarily for the person and to listen to them and hear their stories and then to help tell their stories to anyone who would listen.

[R]egulation has to go hand in hand with a system that allows a focus on the individual. The problem is, of course, if you're not part of the same framework then you don't have to be listened to.

And just as the residents say, 'I wasn't listened to, I wasn't heard', Community Visitors who have been telling stories about appalling conditions ... feel that they have not been heard.

Everybody has a right to have a voice and everybody has the right to be heard, and that is what we are not hearing and seeing in the ... system currently.¹⁰⁷

¹⁰⁵ Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, *Transcript Day 4—Public Hearing 26, Parramatta* (Transcript, 1 September 2022) 333 <<https://disability.royalcommission.gov.au/publications/transcript-day-4-public-hearing-26-parramatta>>.

¹⁰⁶ This broader framework includes, for example, the NDIS Quality and Safeguards Commission (See: NDIS Quality and Safeguards Commission, Home <<https://www.ndiscommission.gov.au>>.) and the Victorian Human Services Regulator (See: Department of Families, Fairness and Housing, *Human Services Regulator* <<https://www.dffh.vic.gov.au/human-services-regulator>>.)

¹⁰⁷ Transcript Disability Royal Commission Public Hearing 26 transcript page 332.

The Victorian Ombudsman has observed that there are vital roles for both Community Visitors and advocacy within a framework that provides effective statutory oversight:

A person's vulnerability should dictate the protections afforded them and the nature of the allegation should determine the response to it—not which service provider they happened to access.

The role of Community Visitors is to observe, listen, question and monitor. They are empowered by law to visit accommodation facilities at any time unannounced ... They can speak with residents, identify concerns about the care being provided and liaise with staff and management to resolve these matters.¹⁰⁸

While Community Visitors have a role in advocating on behalf of people with disability and following up ... they are volunteers and their role does not extend to individual advocacy.¹⁰⁹

A safer system for people with disability also requires that every voice can be heard. While many people with disability can speak out for themselves when their care is unsatisfactory, and should be encouraged to do so, those who cannot are especially vulnerable. Victoria therefore requires a robust system of advocacy to ensure that those who need support to speak up when something is not right are able to access that support.¹¹⁰

It is also important that the Community Visitors Boards are able to refer matters. Victorian legislation recognises this, the Board being able to refer matters to the NDIS Quality and Safeguards Commission, the National Disability Insurance Agency and the Victorian Ombudsman, among others.¹¹¹

In response to concerns Community Visitors raised about a mental health facility, the Victorian Ombudsman undertook an investigation and in 2014 reported:

My view, shared by the Department of Health, is that the Mental Health Act 2014, which came into force on 1 July 2014, allows Community Visitors access to incident reports. Given the clear intention of the legislation to support the role of Community Visitors, ensure their access to relevant documentation to allow them to perform their statutory functions, and the secrecy obligations by which they are bound, I find the agency's interpretation of the law to be overly narrow.¹¹²

This extensive access to information granted to Community Visitors underscores the important role intended for them by Parliament. They have a significant part to play in scrutinising services provided to a particularly vulnerable group in our community—people receiving inpatient treatment for mental illness.¹¹³

¹⁰⁸ Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1—The effectiveness of statutory oversight* (Report, 2015) 9.

¹⁰⁹ Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1—The effectiveness of statutory oversight* (Report, 2015) 86.

¹¹⁰ Victorian Ombudsman, *Reporting and investigation of allegations of abuse in the disability sector: Phase 1—The effectiveness of statutory oversight* (Report, 2015) 9.

¹¹¹ *Disability Act 2006* s 33.

¹¹² Victorian Ombudsman, *Investigations following concerns raised by Community Visitors about a mental health facility* (Report, October 2014) 3.

¹¹³ Victorian Ombudsman, *Investigations following concerns raised by Community Visitors about a mental health facility* (Report, October 2014) 6.

... Community Visitors were concerned about allegations from five patients at the facility that excessive force had been used to restrain them, including:

- being dragged by the hair
- sustaining injuries to their shoulders from having their arms and hands held behind their back, and
- bruising and grazing to their forehead and legs.¹¹⁴

The Ombudsman reported that poor record-keeping at the facility meant that she could not reach firm conclusions about the patients' allegations but that the investigation had revealed that Community Visitors were being refused access to incident reports. In this regard, the Public Advocate stated: 'Access to incident reports is crucial for Community Visitors to be able to perform their role effectively; without this access, violence and abuse in mental health facilities could go unchecked'.¹¹⁵

Earlier on, in 2011, the Ombudsman had investigated a complaint from the Public Advocate on behalf of a community residential unit client with intellectual disability who is non-verbal:

As he is non-verbal the resident uses gestures and body language to indicate when he is happy, sad, hot or cold. He is unable to advocate for himself, his parents are deceased and at the time of the incident he did not have regular contact with his family.¹¹⁶

The Ombudsman further reported:

On 13 March 2008 a Community Visitor attended the residential unit. She noted that the unit's communication book contained an entry about the resident receiving medical treatment [for an injury] and asked a casual staff member how the injury occurred. At interview, the Community Visitor told my officers that the casual unit staff member advised her the injury was self-inflicted by the resident rubbing his back on the carpet in his bedroom.¹¹⁷

¹¹⁴ Victorian Ombudsman, *Investigations following concerns raised by Community Visitors about a mental health facility* (Report, October 2014) 6.

¹¹⁵ Office of the Public Advocate, *Ombudsman's report backs Victoria's volunteer Community Visitors* (Media release, 15 October 2014).

¹¹⁶ Victorian Ombudsman, *Ombudsman investigation: Assault of a disability services client by department of human services staff* (Report, March 2011) 6.

¹¹⁷ Victorian Ombudsman, *Ombudsman investigation: Assault of a disability services client by department of human services staff* (Report, March 2011) 27.

In an email to a senior staff member of the department's Disability Accommodation Services, the Community Visitor advised that, although she had initially accepted the casual staff member's explanation, she remained 'troubled' because of the 'practical difficulty for self-injury on that part of the body'. The Community Visitor went on to communicate multiple times with the department, sought meetings and escalated concerns. She remained dissatisfied with the department's response. The Ombudsman noted:

My investigation established that on 6 March 2008 the resident was dragged by two departmental staff members ... along a carpeted hallway in the unit, causing him to sustain a second degree burn to his back.

... He did not receive medical treatment until over 24 hours after the incident, despite a number of departmental staff and contractors being aware of his injury.¹¹⁸

... [P]hysically forcing the resident to attend day placement constituted a clear failure to treat him with dignity and respect. The treatment of the resident was also humiliating and caused him to suffer serious physical injury ... breach[ing] his human right to protection against cruel, inhumane or degrading treatment.¹¹⁹

My investigation established that at the time of the incident and subsequently the department failed to:

- investigate the incident
- correctly categorise the incident
- notify relevant parties
- take appropriate action against the staff members responsible for the resident's injury.¹²⁰

The Ombudsman concluded, 'The department failed to provide timely and frank responses to legitimate concerns raised by the Community Visitor in relation to the resident's injury'.¹²¹

Additionally, the Ombudsman made a number of recommendations, among them that the department consider disciplinary action for staff involved in the incident; that the department ensure that staff are aware of incident reporting and investigation guidelines; and that the 'department reinforce with staff the importance of the role Community Visitors play in the disability system and the requirement of staff to assist them'.¹²²

The Department of Human Services supported these recommendations. It also made a commitment to revise the protocol¹²³ with the Community Visitors Program, providing additional funding 'to support activities such as training for Community Visitors' and continuing its quarterly meeting with representatives from the Program.¹²⁴

¹¹⁸ Victorian Ombudsman, *Ombudsman investigation: Assault of a disability services client by department of human services staff* (Report, March 2011) 17.

¹¹⁹ Victorian Ombudsman, *Ombudsman investigation: Assault of a disability services client by department of human services staff* (Report, March 2011) 19.

¹²⁰ Victorian Ombudsman, *Ombudsman investigation: Assault of a disability services client by department of human services staff* (Report, March 2011) 20.

¹²¹ Victorian Ombudsman, *Ombudsman investigation: Assault of a disability services client by department of human services staff* (Report, March 2011) 31.

¹²² Victorian Ombudsman, *Ombudsman investigation: Assault of a disability services client by department of human services staff* (Report, March 2011) 39.

¹²³ OPA, the National Disability Services (NDS) and the department signed a revised tripartite protocol for the Community Visitors Program in June 2013 outlining the roles and responsibilities, with any person with a role in providing or monitoring residential services for people with a disability expected to familiarise themselves with the protocol.

¹²⁴ Victorian Ombudsman, *Ombudsman investigation: Assault of a disability services client by department of human services staff* (Report, March 2011) 40.

In addition to powers and functions set out in the *Guardianship and Administration Act 2019*, the Public Advocate has functions and powers that mirror those of Community Visitors.¹²⁵ Concerns reported by Community Visitors can be taken up by the Public Advocate. In 2010 a process was introduced to ensure that notifications are made to the Public Advocate in relation to serious matters:

Following a substantial increase in abuse and violence reported by Community Visitors in the 2009–2010 financial year, the Public Advocate required all program areas within OPA to notify her of matters concerning sexual assault, serious abuse, or unexplained injury. Previously, the Public Advocate was only informed when a concern could not be managed at the program level and needed to be escalated to a higher authority by the Public Advocate.¹²⁶

One resident was so traumatised she would toilet in her room rather than risk an encounter with other residents.

In 2019 OPA published its report entitled *'I'm Too Scared to Come Out of My Room': preventing and responding to violence and abuse between co-residents in group homes*. This report contains case studies drawn from Community Visitors' annual reports. The report was tabled as OPA's submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability at the commission's Melbourne public hearings on 3 December 2019.

The Public Advocate has said of the report:

[T]he thing that I found so astounding in that report was the level of disempowerment. People are really disempowered in that environment around the ability to—they think 'well, management decides where I live. I'm too scared to come out of my room', so this is incredible disempowerment.¹²⁷

The following case study, which appears in the report, lends weight to this:

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

When Community Visitors visited a few months later, DHHS had still not provided counselling for residents. One resident was so traumatised she would toilet in her room rather than risk an encounter with other residents.

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

¹²⁵ *Guardianship and Administration Act 2019*, s17.

¹²⁶ Office of the Public Advocate, *"I'm too scared to come out of my room": Preventing and responding to violence and abuse between co-residents in group homes* (Report, November 2019) 17 <<https://www.publicadvocate.vic.gov.au/opa-s-work/research/142-i-m-too-scared-to-come-out-of-my-room>>.

¹²⁷ The Royal Commission Into Violence, Abuse, Neglect And Exploitation Of People With Disability, *Transcript of Proceedings: Public Hearing 26 Thursday, 3 December 2019* (Transcript, December 2019) 136.

The report makes recommendations for changes to protect people with disability. It is an example of how Community Visitors' annual report case studies can shine a light on what is happening and highlight the need for change.

As noted, each year Community Visitors also provide an annual report to parliament, making recommendations for change:

Through their annual report findings, they have and continue to play a key role in seeking to resolve the harm that is occurring to residents in group homes, as well as in raising public awareness of the abuse and neglect that occurs in disability residential services.¹²⁸

The systemic problems raised in Community Visitors' reports are captured in these annual reports to parliament. Community Visitors are required by legislation to submit their annual report by 30 September.¹²⁹ The Minister must then provide the annual report to parliament.¹³⁰ The Public Advocate informed the Disability Royal Commission 'The [Community Visitors'] reports are tabled in Parliament and there is an understanding that government will respond to the reports within 12 months, as one would expect, given the seriousness of the issues that are raised ... So, you've got this incredible wealth of information.'¹³¹

4.2.2 The place of volunteers in today's Program

The Victorian model for volunteer community visitors represents a deliberate distancing of the Community Visitors Program from the official visitors to the institutions of earlier years. Volunteering has a long tradition in Victoria, growing out of the charity model of the late-19th century and first half of the 20th century of doing good for others less fortunate. It was not until the middle years of the 20th century, however, that the power of volunteerism to help build healthy societies began to be recognised and volunteering became associated with community development rather than simply welfare.

The value of volunteering is recognised in societies around the world:

A healthy society is one in which importance is given to formal and informal relationships that facilitate interaction and engagement and thus engender a sense of belonging. It is also one in which there is broad participation by all sections of the population. Communities with these characteristics do better in moving forward to meet common aspirations.¹³²



Community Visitors annual report, 2022–2023

¹²⁸ Office of the Public Advocate, *"I'm to scared to come out of my room": Preventing and responding to violence and abuse between co-residents in group homes* (Report, November 2019) 21.

¹²⁹ *Disability Act 2006* s. 35(1).

¹³⁰ *Disability Act 2006* s. 35(2).

¹³¹ The Royal Commission Into Violence, Abuse, Neglect And Exploitation Of People With Disability, *Transcript of Proceedings: Public Hearing 26 Thursday, 1 September 2022* (Transcript, September 2022) 329.

¹³² The Power of Volunteerism (UN Volunteers <https://www.unv.org/power-volunteerism>).

The diversity of disability services and the emphasis on self-determination and autonomy for people with disability have unintentionally created a disability system that many people, with and without disability, are finding very difficult to negotiate. The irony of this is that a system that was intended to promote independence and give power to the individual could leave an individual more isolated and more in need of support than they already were because many of the previous community supporting structures have been removed. Part of the response to this situation has been the emphasis on supported decision-making, capacity building and peer support.¹³³

Concomitant with these developments has been a questioning of whether volunteer community visitors can be expected to, or be able to, keep up with this rapidly changing, complex landscape in performing their safeguarding role.¹³⁴ Is it time to pass the role on to professionals?¹³⁵ Can the benefits of volunteer Community Visitors be retained at the same time as keeping faith with those being visited and the legislative requirements?

The value of the 'community gaze'

Much of the value of Victoria's Community Visitors Program lies in allowing the community to learn about the situations of people in supported accommodation and mental health facilities and reporting on whether these facilities meet community expectations. That is the fundamental responsibility of the Program, and many argue the task is better carried out by volunteers than by paid staff. Volunteers are 'of the community' by definition, bringing a breadth of perspective to their role and avoiding a one-size-fits-all approach to the generalised concept of community expectations. They also bring a high degree of local knowledge to the role. Additionally, and importantly, they are independent and so can be difficult to co-opt by those who might have a mind to do so. Volunteer Community Visitors have consistently shown that they are accomplished at expressing their concerns and seeking resolution of the problems they raise; in doing this they also gain considerable knowledge and expertise.

Today, however, Community Visitors are no longer the only players on the field. Understanding where to refer matters, where resolution might be found and where systemic change can be achieved is more complex. In this regard, the continuing success of the Program depends more on strong professional support by Program staff in OPA for Visitors, regional convenors and the Community Visitor Boards as well as the authority of the Public Advocate. Such a structure offers the best of both worlds: a wealth of evidence gathered by volunteers and professional support people to escalate individual and systemic concerns that cannot be resolved locally. The proviso, of course, is that sufficient resources must be provided to the Program—and that is the case whether or not volunteers are involved.

¹³³ Some critics have suggested that these measures, while undoubtedly having benefits, may be partly driven by a need to make the person fit the system rather than the system responding to the person.

¹³⁴ This question has been raised by many, including in a consultation with Anthony Kolmus, Victoria's Human Services Regulator.

¹³⁵ This is a live question in the context of the NDIS and whether there should be a national Community Visitors Scheme that is consistent across the States and territories.

Promoting wellbeing and opportunities for people to lead rewarding lives

When community visitors are volunteers the interaction is relational, offering benefits for all concerned. In support of the value of volunteers, UN Volunteers states:

Volunteerism is a basic expression of human relationships. It is about people's need to participate in their societies and to feel that they matter to others. We strongly believe that the social relationships intrinsic to volunteer work are critical to individual and community well-being.¹³⁶

The comments of the people visited reflect their awareness that Victoria's Community Visitors are there to support them and that they can get to know them and talk with them. The comments of Community Visitors reflect their appreciation of being able to be involved in the lives of people with disability and their awareness of the reciprocal dimensions of the relationship. Being local, the Visitors are also more likely to be aware of opportunities for purposeful involvement in the local community.¹³⁷

In consultations, Community Visitors commented that they were often able to support staff by alerting management to particular concerns, leading to a happier household environment for everyone.

Fostering social inclusion

Fostering social inclusion is central to the Community Visitors Program. Many Program volunteers have a professional background and expertise relevant to their role, but in their visiting they are there as everyday people, not as professionals. They encourage social inclusion by their very presence. In the earlier years of the Program, the volunteers were described as building a bridge between residents and the community, breaking down the barriers of separation and isolation; they are now described as 'agents of change' and 'human rights warriors'. No matter how they are described, they are powerful promoters of social inclusion.

The Victorian experience is that community visiting by volunteers brings benefit both to those visited and to the community. The difficulties of negotiating the complex and dispersed disability service system should not be underestimated, but they can be overcome if the volunteer role is accompanied by strong professional support within the structure of the Office of the Public Advocate.

... the social relationships intrinsic to volunteer work are critical to individual and community well-being.

¹³⁶ The Power of Volunteerism (UN Volunteers <https://www.unv.org/power-volunteerism>).
¹³⁷ In consultations, a regional convenor in the Disability Stream commented that a house in which people volunteered at the local op shop or worked at Bunnings or helped at the local footy club at the weekend had resulted in a much happier and more relaxed environment.

5.0

The NDIS: opportunities and challenges

Ultimately, Community Visitors give voice to concerns on behalf of residents.

— PAGE 81



5.1 Premises and promises of the NDIS

The National Disability Insurance Scheme was the result of a successful grassroots campaign led by people with disability and their families, which aimed to improve their access to life-enhancing disability supports and services. Trial sites were established in 2013 and the scheme achieved full rollout in July 2020. The scheme has resulted in an influx of resources and private providers, and, alongside the withdrawal of many state-funded and delivered services, this has created a very different service landscape.



The objects of the NDIS Act include:

- giving effect to Australia's human rights obligations as enshrined in the UN Convention on the Rights of Persons with Disabilities
- enabling the independence and social and economic participation of people with disability through the provision of reasonable and necessary supports
- 'enabl[ing] people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports'¹³⁸

The move away from a welfare model of disability services delivery to a social insurance model¹³⁹ and the creation of a privatised market for disability services for eligible participants has greatly increased support to many but has inadvertently created inequity and resulted in less support for others in need. For example, Community Visitors have observed apparently unequal planning outcomes for people with similar goals and needs.



Sometimes these inequities stem from 'thin markets' for the required services, and in other cases they stem from insufficient decision-making supports. OPA continues to advocate for better decision supports for people with decision making disability. This change would likely halt the nationwide growth in the use of adult guardianship that has accompanied the scheme, as well as better achieving its objectives.¹⁴⁰

The impacts of the NDIS on individual people and particular service sectors are multiple and varied and many of them are not germane to this report,¹⁴¹ which is concerned with the safeguarding benefits provided by the Community Visitors Program. In keeping with this, the NDIS-related changes that are discussed here are limited to those that have affected the operation of the Community Visitors Program and its safeguarding goals.

¹³⁸ *National Disability Insurance Scheme Act 2013* ss. 1(a)-(e).

¹³⁹ The social insurance model of investing in early intervention to reap the benefits of greater independence later does not always reflect the realities of the life of a person with cognitive disability and high support needs.

¹⁴⁰ Office of the Public Advocate, *Reflections on Guardianship: The law and practice in Victoria* (Report, 2023) 7.

¹⁴¹ For further context, OPA's *Decision Time* report (2021) discussed the consequences of the introduction of the NDIS on people with cognitive disability more broadly.



5.1.1 The Community Visitors Program goals and methods

In order to grasp the impact of the NDIS on the Community Visitors Program, one must understand how the NDIS has impinged on both the goals and the day-to-day operations of the Program. A basic overview follows.

The broad goal of the Community Visitors Program is to promote positive change for residents. To do this, Community Visitors (with support from Program staff where appropriate) first report potential problems and shortcomings they identify to the staff and management of the facility in question. If this fails to bring a satisfactory resolution, they can raise their concerns higher up the 'chain of command'. Regional convenors do much of this work (again with the support of Program staff). If resolution still cannot be achieved, Program staff can make notifications or complain to the relevant regulator, Minister or complaints body. The Public Advocate can also intervene with senior management of service providers or by making representations to government.

Simply put, Community Visitors seek beneficial change for residents by identifying concerns and bringing them to the attention of the responsible party, which then acts to redress the problem.

The efficacy of the Program (in relation to the goal of beneficial change for residents) has been affected in competing ways by the introduction of the NDIS. This has led to varying opinions about the outcomes of the NDIS for people with disability, both in the wider community and within the Program. Such opinions most probably spring from similar origins.

In connection with the Community Visitors Program, Community Visitor reports are found to be most effective when it is clear who is responsible for responding to the problems raised. Further, all parties need to agree on who is accountable for resolving each of the concerns Community Visitors identify. The Program's efficiency is enhanced by a shared understanding of accountability. Whenever there is disagreement about responsibilities, concerns are more likely to be conveyed to superior parties and be discussed in multiple forums. This delays resolution and requires additional Program resources.

Alongside clear and agreed accountabilities, available resources are (usually) equally important to the goal of achieving positive change for residents. In disability services, the availability of resources is predominantly determined by government budget decisions and the flexibility and responsiveness of the relevant systems. This is a simplification, but it is sufficient for the purposes of this chapter.

From the perspective of Community Visitors, there are two primary factors influencing the achievement of beneficial change for residents:

- Does the person responsible for fixing the problem know about the problem (and agree that they are responsible)?
- Does the person responsible have access to the necessary resources to fix the problem?

In addition, for the Program to have the greatest possible effect, Community Visitors must have sufficient access and information to enable them to accurately identify matters of concern and to target their visits to where they are likely to achieve the most beneficial change for residents. If parties are in agreement on their respective roles and responsibilities optimal information sharing is more likely to occur.

5.1.2 Agreed accountabilities

To promote beneficial change for residents, Community Visitors who have identified a problem need to report it to the facility concerned—that is, the supported residential service, the disability residential service or the mental health facility—and be confident that the party responsible for redressing the problem will hear about it and, ideally, respond appropriately.

Introduction of the NDIS has almost completely reconfigured lines of accountability in relation to funding and delivery of disability services. Beforehand, all disability services were funded and regulated (and often delivered) by the states and territories. Thus, for example, in Victoria the Community Visitors Program and the government both understood that the state was responsible for safe, high-quality disability and mental health services. Further, since the state was also responsible for funding, delivering and regulating the justice, education and health services sectors, although there were some arguments about which department or service sector was responsible for supporting a person, ultimately the Premier of Victoria could be held to account.

In the ‘old’ system, responsibilities were clear and agreed by all parties (most of the time). This allowed for confidence in the Community Visitor reporting process: reporting to the facility (which was funded, regulated or run by the state) occurred, and there was clarity about who was responsible and how to contact them when a problem was not dealt with ‘in house’. Reporting lines and accountabilities were comparatively straightforward, and the role of the Community Visitor in safeguarding facilities was largely understood and (usually) respected.

To be clear, the Victorian mental health system is still managed and funded by the state, so lines of accountability have not changed for Community Visitors in the Mental Health stream. Similarly, the state continues its regulatory role in relation to supported residential services. Accountability in relation to the services that should be being delivered to residents of SRSs or people in mental health facilities has not changed. What has changed in these settings is that Community Visitors are now aware of the untapped potential of the NDIS to improve residents’ wellbeing—and they want that for the residents. Additionally, many people living in SRSs or receiving mental health services are also NDIS participants.

The NDIS-associated move to nationalise the funding and regulation of disability services radically changed established lines of accountability along with the safeguarding landscape. This had impacts on the effectiveness of the Community Visitors Program for at least two important reasons. First, no longer is one person ultimately responsible for dealing with the failures that Community Visitors are reporting, and with this dispersal of responsibilities comes the potential for disagreement and blame-shifting. At the very least, some matters are taking much longer to resolve than previously as a result of disagreements about who is responsible or who should fund the ‘fix’.

Introduction of the NDIS has almost completely reconfigured lines of accountability in relation to funding and delivery of disability services.

Second, the tailoring of service delivery to individual needs and preferences means that some of the problems being reported to facilities are not things over which the facility has any direct control. In these situations, the Program is expecting the facility to advocate for the resident, usually in relation to the resident's engagement with other NDIS-funded services.

Ultimately, this need for individual advocacy and decision-making supports for residents unable to successfully find their way through the NDIS remains a difficulty for many scheme participants almost 10 years after the first NDIS trial sites were established. Community Visitors have frontline seats when it comes to seeing the impact on residents of this lack of advocacy and decision-making supports.

As volunteers, Community Visitors should not be expected to know who is responsible for dealing with every type of problem they see to be affecting residents' quality of life. It is more than enough that they are bringing these matters to the attention of paid staff and the Victorian Government (in their annual reports), which is at least partly responsible for ensuring that the NDIS serves the community well.

OPA's 2021 *Decision Time* report discussed the difficulties with the design of the NDIS—specifically its inadequate support for 'choice and control' goals for participants with significant cognitive impairment and without informal supporters and its heavy reliance on 'complaints-based' safeguards. If anything, Community Visitors have played an even more vital role in the lives of people with significant cognitive impairment since the introduction of the NDIS because these people's lives are likely to be fully 'managed' by paid staff in the privatised disability services sector, as opposed to people accountable to the Victorian Premier. In the past, people with significant cognitive impairment had access to state-funded case management if necessary, and it was understood that the case manager had ultimate responsibility for ensuring the person's welfare and access to services. The NDIA has not given support coordinators the same level of responsibility, and there is no support coordination service of last resort if private organisations do not want to offer it.

Indeed, after such a significant change to the disability services sector, it is perhaps not surprising that the fields of accountability and safeguarding relationships are still being worked out 10 years on.

The Community Visitors Program has long been aware of the shortcomings described in this section and has responded to the difficulties associated with unclear lines of accountability by building relationships with new players—for example, the NDIS Quality and Safeguards Commission. As discussed, having all parties agree on who is responsible for what facilitates the resolution of problems. Regional convenors also have regular meetings with residential service providers (at various levels of responsibility) and state regulatory bodies.

The Program has aimed to make optimal use of relations with the residential service providers, expecting them to advocate on behalf of their residents in relation to NDIS access and plans, as opposed to delving into those details themselves. As OPA is well aware, there is a lack of clarity within the NDIA itself as to the responsibilities of various NDIA-funded parties. For example, if a support coordinator is not seeking out the best services and supports, or not monitoring how a person's funding is being used to achieve their goals, who should step in? Or, if a person appears to be coerced into spending some of their NDIS package on services provided by their current supported residential service to avoid being evicted but the provider denies it, who should investigate?



OPA's 2021 report, *Decision Time: Activating the rights of adults with cognitive disability*

These questions need to be answered, and some might already have been but this has not been properly communicated to all the parties involved. The problems the Program continues to identify in relation to wanting residents to get the greatest benefit from their NDIS plans will be more effectively resolved once the NDIA and all the other state- and territory-level safeguarding bodies get together to decide and agree on their responsibilities. In the meantime, the Program continues to point out areas of concern and seek resolutions: it would simply be better if everyone knew how best to work together to benefit NDIS participants.

Further, if all parties agreed on their safeguarding responsibilities in relation to people with disability (including facility residents) and their role in ensuring that the promise of the NDIS is fulfilled, this would enable the development of useful memorandums of understanding and referral protocols. In turn, this would promote better information sharing and a more effective safeguarding system for all people with disability.

The Program has already been able to develop some of these protocols—for example, with the Victorian Disability Services Commissioner and the Mental Health Complaints Commission—but a comprehensive map of safeguarding relationships and responsibilities would further enhance Program effectiveness.

Much is asked or expected of Community Visitors, particularly in view of the demands posed by the COVID-19 pandemic on volunteering rates and the growth in the number of visitable properties, with residents being more dispersed and moving into homes containing fewer residents. Identifying all the properties involved has not been possible because it requires that information held by the NDIA be shared with the Program. This means some residents are not being visited.

Information-sharing agreements with the NDIA and the NDIS Commission would help the Program to decide which visitable properties are most in need of Community Visitors, ensuring that the Program promotes the greatest benefit for residents. The Program is particularly interested in having access to information about visitable properties in instances where the NDIS has determined that a person is deemed a 'vulnerable participant'.

5.1.3 More money in the system

The increased funding for disability services and supports that has come with the introduction of the NDIS has had an enormous impact on the Community Visitor Program's goal of positive change for residents. Before the NDIS, the organisations responsible for providing safe, good-quality disability services and supports did not always have sufficient resources to tailor individualised solutions to the matters Community Visitors reported. One common example of the impact of insufficient resources is situations where Community Visitors reported resident-to-resident violence in group homes, this usually being a result of residents' difficulty living with other people (or perhaps just a particular person). Instead of relocating members of these group homes, some residents were subjected to very restrictive practices such as chemical restraint or the construction of fences and walls within a house.

With more funds available, and a greater commitment to individually tailored disability services, supports and living arrangements, beneficial change for residents can be more easily achieved under the NDIS than was the case when funding was more limited. Change for the better is in closer reach if there is shared knowledge about who is responsible for dealing with a particular issue and the resources are available for implementing a personalised solution.

There are two main ways in which increased resourcing to the sector through NDIS has affected the effectiveness and efficiency of the Community Visitors Program:

- through the increased number and wider array of types of supported accommodation
- through dispersal of disability support responsibilities for residents across multiple disability service providers.

The impacts of these factors on the program, both positive and negative, will be explored below.

The NDIS has also led to something of a change in expectations of Community Visitors. This is understandable: Community Visitors see other residents they visit having access to tailored NDIS packages that are improving their quality of life and they want that for all residents. Although Visitors cannot involve themselves in the details of the NDIS, their expectations, inquiries and reports have the potential to encourage those responsible to act in this regard.

As discussed, Community Visitors bring community expectations to the table, and these have changed since the introduction of the NDIS. This has not impinged on the efficiency or effectiveness of the Community Visitors Program itself, but it does demonstrate the power of Community Visitors' adaptability.

More disability housing options

For eligible residents living in supported residential services or in larger disability group homes, the most positive aspect of the NDIS is the expansion of supported accommodation options. This expansion has the potential to solve problems stemming from incompatibility among residents. Such changes have had positive impacts on Program outcomes, with residents benefiting from new living arrangements. Sometimes, however, Visitors have been frustrated by the lengths they have had to go to resolve a matter and how long it can take to arrange things satisfactorily.

Further, OPA is aware that larger disability group homes (five- to six-bed properties) are now sometimes finding it difficult to fill their vacancies. This is because eligible residents (usually with a specific type of disability housing funding) are now able to act on their preference for living in homes with fewer co-residents or living on their own. This is a demonstration of the NDIS goals of 'choice and control', allowing residents to act on their support preferences.

The Community Visitors Program has had a front-row seat in witnessing the changes the NDIS has brought to the supported accommodation sector in Victoria. Alongside the positive impacts already discussed, the Program has also raised public awareness about the burgeoning opportunities for financial exploitation of people with disability that have attended the changes. Among other things, there have been feature articles in *The Age* newspaper, and there was a dedicated public hearing of the Disability Royal Commission looking at new, poorly regulated supported accommodation models that have emerged around the supported residential services sector.¹⁴² In order to fully understand how this has occurred, it is necessary to have some knowledge of NDIS funding categories and the various safeguarding regimes that apply to them.

¹⁴² Royce Millar & Jewel Topsfield, 'Care home closed amid allegations of bullying, abuse and poor food', *The Age* (July 2, 2022); Disability Royal Commission, *Public Hearing 26: Homelessness, including experience in boarding houses, hostels and other arrangements* (29 August to 2 September 2022).

For the purposes of this chapter, however, the primary facts relevant to the operation and coverage of the Community Visitors Program are as follows.

The NDIS was designed to include a ‘Specialist Disability Accommodation’ funding arm. The vast majority of pre-existing disability group homes visited by the Disability stream of the Program have now been enrolled in this new category. In addition, the funding for NDIS participants who meet SDA eligibility criteria made building new SDA an attractive investment proposition for private individuals and businesses. Newly built SDA premises must meet very strict building standards and be registered with the National Disability Insurance Agency. SDAs are legally visitable premises: depending on the type of tenancy agreement in place, Community Visitors are able to visit unannounced or at the request of a resident.¹⁴³

Theoretically, residents of newly built SDA premises have the same protections as residents living in pre-existing group homes. In practice, however, the Community Visitors Program has not received additional resources to provide this extended coverage and the NDIA has not provided to Community Visitors a list of enrolled SDA properties despite multiple requests.

Alongside the growth in newly built SDA properties, further supported accommodation options have also arisen from ‘pop-up’ disability accommodation, or ‘SIL-only’ properties. ‘SIL’, or ‘Supported Independent Living’, refers to an NDIS funding category that provides money in a person’s plan for supports associated with daily living (for example, cooking, showering and other things that take place in the home).

Before the NDIS, people who needed intensive support usually lived in disability group homes or SRS because at-home funding packages were insufficient to cover the cost of support. The NDIS has separated funding for supports (SIL and other funding) from funding for accommodation (SDA funding). A perhaps unexpected consequence of this has been the growth of SIL-only housing. This occurs when a disability support provider obtains a property and offers accommodation to people who have SIL funding on the condition that they use that provider for their at-home supports. These are usually head leased rental properties and, in OPA’s experience, the residents’ tenure arrangements are often uncertain and not always legally enforceable. Further, these are not yet visitable properties under Victorian law, although this will change from July 2024.

The lack of clear tenure safeguards and independent oversight by Community Visitors are reasons OPA and the Program have been concerned about these settings for some years. Nevertheless, in many cases the living conditions offered by these more intimate, personalised living arrangements do improve residents’ quality of life. In other cases — such as those referred to in *The Age*¹⁴⁴ and at the Disability Royal Commission — SIL-only disability service providers have ‘captured’ residents, limiting their choice and control and potentially providing substandard services.

The fact that Community Visitor oversight is currently not legally available to residents in SIL-only properties has adversely affected the coverage, and therefore the effectiveness, of the Community Visitors Program when it comes to safeguarding the Program’s usual client group — people with cognitive impairment and/or mental health issues who require support with activities of daily living.

¹⁴³ *Disability Act 2006 (Vic)* s. 30A.

¹⁴⁴ Royce Millar & Jewel Topsfield, “Ugly turf war as service providers tussle over NDIS clients with disabilities” *The Age* (September 20, 2021).

As noted, SIL-only properties in Victoria will be visitable from July 2024 at the latest or individually as identified by the relevant Minister.¹⁴⁵ Major administrative hurdles will, however, stand in the way of the identification of these types of properties because the relevant data required is held by the NDIA and not the state.

In addition to the legal and administrative hurdles to Community Visitors' access to new supported accommodation types, the Program has received no additional resources from the Victorian or Commonwealth Governments to enable these properties to be added to the visiting schedule. Indeed, community visitors programs throughout Australia are not yet recognised in the NDIS's legislative framework. This probably adds to the current administrative challenges. The COVID-19 pandemic also reduced the availability of volunteers in Australia, contributing to the negative effects on Program coverage.

With better financial support and improved information sharing, Community Visitors would be well placed to observe and report on concerns about exploitation, neglect and coercion in these new properties. As the Public Advocate told the Disability Royal Commission, residents in SIL-only properties can face a high risk of financial exploitation. In OPA's experience, people who have limited informal supports and who require support with decision-making are unlikely to avail themselves of NDIS complaints processes. This cohort might thus be targeted by unscrupulous providers.

More individualised services

The increased use of individualised services for residents who are NDIS participants has resulted in positive changes for many people. The intention of the NDIS is to support individual goals and promote community inclusion and involvement. When funds are used to support well-crafted NDIS plan goals, they can substantially improve residents' wellbeing and community engagement.

Community Visitors have seen both very successful and very uninspired uses of individualised community access funding. This makes them well placed to ask questions when they see or suspect poor practice. Further, being local community members means they might see residents they know out and about in the community with NDIS-funded support workers. Although this information cannot specifically be reported on, it can provide useful context for the inquiries Visitors make during subsequent visits.

This is another example of Community Visitors having adapted to the changed circumstances associated with the NDIS to encourage beneficial change for residents. The Visitors' goal has not changed, but their options for enhancing residents' wellbeing have. This is an example of how greater resources can promote opportunities for beneficial change and how Community Visitors can support this, increasing program efficacy—as long as all parties agree on whose responsibility it is to act on the matters Community Visitors raise.

A significant downside of the increased use of individualised services is that many of the people using them are unable or unlikely to use a complaints process if they are dissatisfied, unhappy or worse.

Community visitors programs throughout Australia are not yet recognised in the NDIS's legislative framework.

¹⁴⁵ *Disability and Social Services Regulation Amendment Act 2023* (Vic) s. 2(3).

5.2 Stronger together

Since the introduction of the NDIS disability services and supports have become more tailored and individualised. With the service system moving another step away from a one-size-fits-all model of disability support, related safeguarding systems also need to adapt. The Community Visitors Program has already adapted, building relationships with new and existing players, and is well placed to identify the concerns that are arising for NDIS participants who are in need of support so that they can gain maximum benefit from the new opportunities.

In recent years much of the work of the Community Visitors Program has in various ways been associated with the NDIS. While the NDIS is of both benefit and concern to participants, it is important that the NDIS work fits into the Program rather than the Program being too focussed on the NDIS at the expense of its other areas of responsibility. As a consequence, the Program might need to refine its advocacy goals in relation to the NDIS.

There are now more players in the disability services sector, and Community Visitors are but one of many safeguarding options that should be deployed according to the risk and need facing different people with disability. As was discussed by the NDIS review, not all people with disability who are living in SDA premises or receiving supports at home want or need the oversight provided by the Community Visitors Program.

The Program is, however, 'fit for purpose'. And that purpose is to promote beneficial change for residents of supported accommodation settings, the focus being on residents who have few informal supports and need help to uphold their rights because of their disability and the power imbalance inherent in their situation. The introduction of the NDIS has not changed this. Such residents remain at greater risk of harm as a result of their dependence on disability services and their lower rates of social capital. Indeed, some people in this group are now potentially more vulnerable to financial exploitation and coercion under the NDIS because of the additional funding they attract.

Along with the need for a comprehensive and agreed safeguarding framework, in which all parties are fully aware of their responsibilities, the other element that would enhance the effectiveness and efficiency of the work done by the Community Visitor Program is better access for residents to supported decision-making and disability advocacy services. This would contribute greatly to NDIS outcomes for participants with decision-making challenges; it would also contribute to the effectiveness of the Community Visitors Program. Indeed, the close alignment of the goals of the NDIS and the goals of the Program suggest the two organisations would make great allies.

Ultimately, Community Visitors give voice to concerns on behalf of residents. But in many NDIS-related cases, without the individualised advocacy and supported decision-making services to step in and explore options, the Community Visitors Program's goal of positive change and flourishing lives for residents will not be fully realised.

6.0

Taking stock

Community Visitors started visiting Victorians with disability in 1987. They were given authority by the Victorian Parliament to enter institutions and facilities and report on what they found to the public through annual reports to Parliament. Before that, these places were closed to outside scrutiny. Community Visitors volunteered their time, energy and abilities from the conviction that life for people with disability should and could be better. They had great optimism and an expectation that they could make a better life possible for people living in congregate care and closed environments.



**Community Visitors
raise the expectations
of what life can be.**

— PAGE 87

The early reports of Community Visitors into disability and mental health facilities gave some shocking stories of neglect, abuse and lack of meaningful activity or personal development; practices that were acceptable in times past but far from acceptable in the 1980s. De-institutionalisation was underway in Victoria with some residents with intellectual disability moving into group homes of five or six in towns and suburbs across the state. There was general agreement in the community that institutions should be improved and reformed, but debate remained about whether they should be closed completely.

In 1991, Community Visitors began to visit private supported accommodation, now known as SRS. These places, housing an average of 30 people but in some places up to 80, had previously provided largely for older people but increasingly became the place of last resort for younger people with psychosocial disability and mental health issues. Community Visitors reported that the level and quality of support in these places was generally much lower than in community-based group homes.

Throughout the 1990s the number of places visited expanded significantly through movement of people out of institutions into group homes and SRS. Community expectations for their quality of life and inclusion in the community also increased with greater attention being paid to the particular needs of each person. An increase in funding in the late 1990s was welcome but not sufficient for the Program to meet the visiting need.

By the end of the century, OPA had concluded from its visiting experience that congregate care for people with disability was inherently unsafe and called for the closure of all institutions. Shortly after this, the government announced that Kew Residential Services would be closed. The last large institution, Colanda, was closed in 2019. The number of sites eligible to be visited again increased.

Expectations for people to live more independently and inclusively in the community increased in the early part of this century in the lead-up to the United Nations Convention on the Rights of Persons with Disabilities. The Community Visitors Program developed greater focus on the people visited and their individual situations. At the same time, the differences in the opportunities and quality of life between people living in SRS and those living in the smaller group homes became starker. Community Visitors brought these inequities to the attention of government and the public through their reports.

With the introduction of the NDIS in 2013, expectations soared with the promise that people with disability would finally have real opportunities to choose how to live their lives. Many NDIS participants would be able to live independently with support rather than in group accommodation. Within SRSs in particular, Community Visitors noted increased inequality between those with NDIS support packages and those without. With an increase in people living either alone or in smaller numbers, and with NDIS regulation covering these properties, the number of facilities eligible to be visited has doubled.

In addition, the number of agencies and service providers that people deal with has created a complex environment for the Program to work with. Escalation points have become less clear. OPA has articulated its position that there is an inherent risk of institutional violence, abuse and neglect for people living in congregate and segregated environments. This is why Community Visitors visited people in the large institutions that have now closed and why they have continued to have powers to visit people in disability accommodation, in SRS, and in mental health units. They visit, not only to identify and prevent abuse and exploitation, important though that is. They also visit to encourage and inspire residents, staff and support workers to use the money now available more creatively for each person to have more meaningful, purposeful lives, develop their interests, perhaps have a job and generally contribute to the community and the lives of their families and friends. Where this is happening Community Visitors have observed that everybody is happier and more satisfied.



6.1 Moving forward

This is an important time in the history of the Community Visitors Program and changes made now will determine its future in the years ahead. Key decisions affecting the Program will be made at both national and state level.

6.1.1 The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Community Visitors, OPA staff and the Public Advocate put an enormous amount of effort into preparing information and evidence for the Disability Royal Commission, strongly supported by case studies drawn from Community Visitor reports. Four Community Visitors appeared at two public hearings. The Public Advocate gave evidence on four occasions and is extensively quoted in the final report.

The Disability Royal Commission made two key recommendations about Community Visitors; on national consistency across programs and on how Community Visitor schemes interact with the NDIS. Current schemes across the country operate differently, have different governance structures and visit different people—Western Australia and Tasmania do not have Community Visitor schemes. The Victorian program stands out from the others in its complex governance structure and the involvement of volunteers at all levels of the program.

On the issue of national consistency, the Disability Royal Commission recommended that Western Australia and Tasmania should urgently establish a Community Visitor scheme. In keeping with previous reports about Community Visitor schemes, the Disability Royal Commission also recommended visiting that takes into account individual risk factors. While Victorian Community Visitors already consider known risks to people to determine how often they visit, it would be quite different for some eligible properties not to be visited at all.

To achieve national consistency, the Disability Royal Commission has suggested that agreement is reached around:

- Which people community visitors visit
- The services or places they visit
- How risk is determined
- Community Visitor powers including viewing documents
- What Community Visitors are looking for when they visit
- The data they might record during visits.

The Disability Royal Commission has recommended that state and federal legislation is amended to allow for relevant information sharing between Community Visitor schemes, the NDIA and NDIS Commission; important as currently the NDIA will not provide any Community Visitor scheme with a list of visitable properties citing privacy concerns. The Disability Royal Commission also recommended the development of national information sharing agreements and recognition of Community Visitors in the NDIS Rules.

6.1.2 The Independent Review of the National Disability Insurance Scheme

Similar recommendations are expected from the NDIS independent review. In the 2023 *Participant Safeguarding Proposals* paper of the Review, the safeguarding value of Community Visitor schemes throughout Australia was acknowledged:

We consider that the role of any future outreach and visitation program should be focused on checking on and promoting the wellbeing of participants, particularly those with more limited personal and social capital and natural safeguards, and those in higher risk environments and circumstances such as people living in supported accommodation or living alone without good natural supports.

This would be complemented by ongoing monitoring of provider compliance by the NDIS Commission. We have formed the preliminary view that these outcomes are better delivered through improvements to CVS [community visitor schemes] delivered by states and territories

...

We acknowledge, however, that reform of the state and territory CVS is vital to enhance the role that CVS can perform as a safeguard for NDIS participants (as well as people with disability more broadly) and to better integrate CVS into the NDIS. Any reforms must be co-designed with people with disability who would be likely to be engaged with visitation and outreach services.¹⁴⁶

In response to this paper, OPA proposed that, given the range of safeguarding goals of Community Visitors, developing agreed national principles and mapping the safeguarding ground currently covered by each jurisdiction would be an appropriate starting place acknowledging that different jurisdictions have different legislative frameworks and local circumstances to respond to.¹⁴⁷

OPA has also acknowledged that, while the volunteer model works well in Victoria, it might not work in other jurisdictions. In OPA's view, states and territories should operate models which suit the needs of local people, with schemes operating with an agreed set of national principles.¹⁴⁸

In relation to the place of existing Community Visitor schemes and the NDIS, OPA has recommended that the Australian Government act to give schemes a clear role in Australia's Disability Strategy and Safety Targeted Action Plan and therefore provide operational certainty for at least the next five years.¹⁴⁹

¹⁴⁶ Independent Review of the National Disability Insurance Scheme, *NDIS Participant Safeguarding Proposals Paper on Participant Safeguarding*, May 2023, 41.

¹⁴⁷ Office of the Public Advocate, *Submission to the NDIS Participant Safeguarding Proposals Paper*, June 2023, <Submission to the NDIS Participant Safeguarding Proposals Paper - Office of the Public Advocate> pp 15-16.

¹⁴⁸ Office of the Public Advocate, *Submission to the NDIS Participant Safeguarding Proposals Paper*, June 2023, <Submission to the NDIS Participant Safeguarding Proposals Paper - Office of the Public Advocate> pp 15-16.

¹⁴⁹ Office of the Public Advocate, *Submission to the NDIS Participant Safeguarding Proposals Paper*, June 2023, <Submission to the NDIS Participant Safeguarding Proposals Paper - Office of the Public Advocate> pp 15-16.



Rosa Barton
Dare, 2015

Rosa says of her work that: "My dream one day is to walk again, freely, as if on air."

6.2 The future of the Victorian Community Visitors Program

The Victorian Community Visitors Program, through OPA is strongly committed to sustaining the three essential functions of the Program:

- Bringing the community gaze into the places visited to expose abuse, neglect and exploitation and assess whether the living situation and support provided meets community expectations
- Maintaining unannounced visits to prevent the occurrence of abuse and neglect
- Fostering the wellbeing of residents and their inclusion in the community.

Community visitors will always be important because they are fellow-citizens who come in person and communicate face-to-face in a society where that is increasingly rare. They are not at the end of a telephone tree or an email message. Their only agenda is the well-being of the people they visit. It is very important that this aspect of community visiting is not lost or diminished.

Given the recommendations of the Disability Royal Commission and the likely direction of the NDIS following its review, the expansion of sites eligible to be visited and the possible addition of places negotiated in agreement with other states will make it unfeasible for the Victorian program to operate without a quantum leap in funding. While the Disability Royal Commission has recommended that Community Visitor schemes be adequately funded to do all the visits that are needed, there is no indication yet of where the funding might come from.

The Disability Royal Commission has also recommended that the schemes adopt risk-based visiting where visits are made to places and people assessed to be at highest risk. Given what we know about abuse, neglect and violence in existing disability accommodation and

SRS, and the fact that the Community Visitors Program is already making decisions about how often to visit properties based on known risk, the Program could be reduced to an auditing, policing, or regulating role if this recommendation is adopted. This approach would remove some of the fundamental tenets of the Community Visitors Program, particularly its preventative role in safeguarding for people who speak up only when a Community Visitor they trust is standing in front of them. If living in segregated, congregated and closed environments is not considered a key risk factor in abuse and neglect by government and other safeguarding bodies, people will be at even higher risk than they are now. The essence of community visiting could be lost.

By design, Community Visitors are members of the Victorian community. That is why Victoria replaced official visitors with Community Visitors in 1987. In Victoria, the involvement of volunteers is a defining feature of the Program that is greatly valued. Volunteers bring broader community benefit far beyond the bounds of the Program itself. The Disability Royal Commission does not recommend for or against schemes operating with volunteers or all paid staff. Whether they are or are not volunteers, community members cannot be going into risky or potentially dangerous situations without adequate training and staff support. The Program will inevitably lose volunteers and staff if all visits are for only the most complex situations.

Community Visitors are not first responders to allegations of fraud, abuse or illegal activity. That is and must be the role of regulators, police or safeguarding agencies with appropriate protections for officials. The NDIA should also have processes that allow for in-person visiting by their staff where they consider a participant is at risk, and agreements that provide Community Visitor schemes with information about safety for visitors.

Ultimately, the value of Community Visitor schemes, and the Community Visitors Program in Victoria, should not be undermined by limiting them to safeguarding NDIS participants alone. Instead, the schemes should be considered as one crucial aspect of the national safeguarding system for all people with disability.

Keeping people with disability safe from abuse, neglect and exploitation is, and always will be essential. It is, however, not nearly enough. People with disability should be able to live with the usual comforts and personal space we all aspire to, with appetising and healthy meals they get to choose and help prepare, to look after themselves and their surroundings as far as they can, to receive support and training to work in areas that interest them, to move house if they wish, and to play an active part in the community and the lives of those close to them.

If Community Visitors focus only, or mainly on risk, the other equally important aspects of community visiting—fostering good and meaningful lives for people with disability—will not occur. Community Visitors raise the expectations of what life can be. They can help people (and their support workers and families) imagine how their lives could be better and help make those dreams reality. This is just as important as the safeguarding role that is receiving so much attention at present. People need to be safe but there needs to be a purpose in that safety. For Community Visitors, part of that purpose is to open the opportunity for a better life. People with disability deserve better than being the passive recipients of services, however well-meaning service providers are.

Looking to the future, the Community Visitors Program will most likely continue to be State-based but have closer ties and contact with Community Visitor Schemes in other states. Each state scheme will be conscious of its place in the national safeguarding framework and of other agencies in the framework. There will be a more overt focus on human rights and supported decision-making with changes and developments in the Program co-designed with people with disability who, where possible, have had contact or experience of life in supported accommodation. The Program will continue to strive to ensure that Community Visitors are reflective of the community including people of culturally and linguistically diverse backgrounds, First Nations people and people with disability.

There will be a greater focus on individuals in the visits and the impact of the location on each person. Whether an individual resident should be

given the option to opt-out of visits is a question that needs careful consideration. People currently can choose whether to engage with Community Visitors but there are deeper questions of individual privacy in access to personal information that need more consideration. The Program would want to ensure that any decision to opt-out of visits was an informed choice made without pressure. At this stage, OPA would not support an entire facility opting out of visits.

The Program has been underfunded for most of its history. The doubling of visitable places alone means that resources are more thinly spread, and the increased complexity of people's lives results in the role of the Community Visitor becoming more difficult and time-consuming in identifying the issues and concerns that affect them. The current and future success of the Victorian program depends on well-supported and resourced volunteers committed to showing how life can be more fulfilling for the people they visit. The development and maintenance of networks and relationships with other agencies is also essential and escalation pathways need to be clear and accessible. All this requires proper resourcing as the Program cannot continue to do more and more with less in the future as it has done in the past.

6.3 Final words

In Charles Dickens' *Great Expectations*, the protagonist, Pip, believes in the possibility of advancement in life, of making things better. He has great expectations and optimism for the future. Similarly, Victoria's Community Visitors Program is about giving a voice to people with disability, ensuring that they are heard by the community and by those with the ability and authority to bring about change and improvement in their lives.

Community Visitors are there so that people living in 'shadowed' environments will not be forgotten or silenced. They do this by the simple act of visiting their fellow citizens where they are living or when they are in hospital (in the case of the Mental Health stream). The power of these person-to-person visits and this human interaction is elemental.

In the consultations leading to the preparation of this report, the people with experience of being visited acknowledged the need for some people to have the help of a Community Visitor to speak up for them and noted the frustration that can arise if someone's voice is not heard.

During the Kew Residential Services closure, accompanied as it was by a clamour of competing voices and agendas, the Community Visitors provided a clear, independent voice to government and the community, their only agenda being the rights and interests of the people living at Kew Cottages.

The Victorian Ombudsman has spoken of the requirement for a robust system of advocacy to ensure that people who need support to speak up when something is not right are able to obtain that support. At the Disability Royal Commission, the Public Advocate called for a way for the voices of people with disability to be heard, noting that everyone has the right to a voice, and everyone has the right to have their voice heard.

During 2022–23, 501 community visitors (including trainees) made 3751 visits to people living in disability housing, supported residential services and mental health facilities. That is more than 10 visits every day. These visits are acts of solidarity, saying to the people visited and to the wider community 'We are all important and precious and should be treated fairly and with dignity and respect. We all have rights, and our rights must be recognised and cherished'.¹⁵⁰

For 35 years Community Visitors have been human rights advocates on small stages and in hidden places. This is where human rights matter most. Eleanor Roosevelt might well have been thinking of Victoria's Community Visitors when she said in 1958:

Where, after all, do universal human rights begin? In small places, close to home—so close and so small that they cannot be seen on any maps of the world. Yet they are the world of the individual person; the neighbourhood he lives in; the school or college he attends; the factory, farm, or office where he works. Such are the places where every man, woman, and child seek equal justice, equal opportunity, equal dignity without discrimination. Unless these rights have meaning there, they have little meaning anywhere.¹⁵¹

There will always be a need for Community Visitors where there are people living in situations where their voice is not being heard, where there is a power imbalance, where their human rights and dignity are not being respected, where they are at risk of abuse, neglect or unequal treatment and where their lives are lacking in purpose or enjoyment.

This is not to say that the great expectations of the early years of the Community Visitors Program failed to bear fruit: real progress has been made, and the work of Community Visitors continues to contribute to people with disability being able to lead safe, flourishing and engaged lives.



"Where, after all, do universal human rights begin? In small places, close to home."

— Eleanor Roosevelt

¹⁵⁰ Remarks from Dr Colleen Pearce at the experts forum on the Charter Of Rights For Parents And Carers With Disabilities Involved With Child Protection In Victoria, Melbourne, 12 July 2023.

¹⁵¹ Excerpt from Eleanor Roosevelt's famous speech at the presentation of "IN YOUR HANDS: A Guide for Community Action for the Tenth Anniversary of the Universal Declaration of Human Rights." March 27, 1958. United Nations, New York.

APPENDIX A

Testimony: extracts from Community Visitors' annual reports

The following extracts from the 1990, 2000, 2010 and 2020 Community Visitors' annual reports (published by the Office of the Public Advocate in the year in question) provide insight into the Program's operation over the decades. The extracts cannot fully do justice to the achievements of Community Visitors in the 35 years of the Program.

1990s 2000s
2010s 2020s
1990s 2000s
2010s 2020s
1990s 2000s
2010s 2020s

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1990s

Visitors report on the system as they find it, not the system as it is promised, and are therefore obliged to report that little has yet changed.

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Very little money has yet been spent under the Plan [the state plan to wind down institutions and provide adequate and appropriate services] ... Whatever the pressures on the State budget, it must be appreciated that those people who enjoyed none of the benefits of the boom years are being asked to bear the brunt of bad times ... The cuts will reduce the number of available alternative community placements and will worsen an already desperate situation ... Cuts to the existing budgets of facilities will make a bad situation even worse.

9

A common theme in Community Visitors panel reports is the extreme difficulty units experience in having minor repairs carried out.

Visitors in several Regions are concerned about the lack of compensation procedures for loss of residents' possessions.

The fundamental problem with community placements is, of course, that there are not enough of them, and that the number of Community Residential Units ... being acquired is insufficient to meet the need of people seeking accommodation even without considering the need for places for people moving out of institutions.

1990s

Institutions

Behavioural intervention teams have been set up in a number of facilities ... However, it must also be recognised that these behaviours are often simply responses to the peculiarly stressed environments in which institutional residents live, and cannot be adequately addressed without moving residents out. Visitors consistently report on the great behavioural improvements that come when residents leave their institutions for community life.

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Community Visitors to Sandhurst regularly monitor the use of restraint, seclusion and aversive therapy. In the course of this monitoring it has been established that approximately 50% of residents are on chemical restraint, in contrast to a figure of about 9% of the permanent residents in CRUs.

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Inappropriate placement

Colanda was an institution with more than 100 residents.

An eleven year old girl was inappropriately placed at Colanda after the death of her mother. She was placed in a unit far below her capabilities and age.

Visitors consider that the girl should never have been admitted to Colanda but rather should have been placed in a CS [child support] generic such as Glastonbury or a temporary foster home.

1990s



Visitors are adamant that the girl's admission to Colanda was totally inappropriate. By bowing to the pressure to take the girl, Colanda really did not do her any favour. They would have been better advised to refuse to admit the girl, thereby forcing the generic agencies to find her a placement.

Aradale Training Centre

Aradale was an institution with more than 200 residents.

1990s

Community Visitors have previously reported that there is a severe shortage of meaningful activity available to residents. This situation has not changed ... The main activities available to residents at Aradale during the day are watching television or walking down to the local betting shop.

Although there appears to be a real need for professional input to provide meaningful activities, when a therapist retired he was not replaced. If the present therapist goes on leave there is no activity for the residents other than the use of items some nurses may loan or bring from their own homes.



Some years ago Aradale accepted residents referred from Melbourne and these people had no friends or relatives in the Ararat area. There was, and still is, little to stimulate their minds. For example, in one ward a couple of residents have half an hour of therapy a week when the whole ward could well do with therapy every day if it were available.

The main activities seem to be limited to a bus trip once a month, use of the heated pool once a week, or bingo once a fortnight.



However, only a couple of residents can go at a time, so it may be two to three months before their turn comes up again. The women just sit in their chairs, or walk around aimlessly. The TV is on but seldom watched or noticed. The men seem to walk more. A couple sometimes have a quiet drink at the pub, others go down to the TAB just to hang around. Those that stay at Aradale sit on the seats outside or on the floor of the verandah. Some smoke, others sit inside, or stand around.

Janefield

Janefield was an institution with more than 400 residents.

1990s

Prior to his admission, Paul had lived for 24 years with his parents and was admitted as a result of their deteriorating health and subsequent inability to care for him. He had been used to living in a quiet, calm and secure environment where he understood the routine and behaviours of the people around him, but at Janefield he was placed into a unit with 37 other people with intellectual disability, sharing a dormitory and bathroom with 22 other young men and being subjected to a high degree of noise and confusion.



According to Paul's relatives, he lost two stone in weight after his admission. Over a period of two years, he was attacked by other residents on 17 occasions, mainly being bitten by a resident from another unit on his way to or at Janefield Special School Annex.

... Not only has Paul lost skills but he has developed several unacceptable social behaviours since residing at Janefield ... At the times Community Visitors have visited the unit, Paul has been observed to be unoccupied



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in any activity, sitting in a chair within the unit or on the ground outside, invariably sucking his hands.

... Community Visitors have encouraged and supported Paul's family to proceed with an application to the Intellectual Disability Review Panel to have his situation reviewed and are currently awaiting the Panel's recommendations.

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Perhaps the final comment in this case could be made by Paul's father who states that, if Paul was living at home in the condition he is now in, CSV [Community Services Victoria] would surely have taken action to remove him from their care.

Psychiatric facilities

A person with an intellectual disability who is an inpatient in a psychiatric hospital runs the risk that, once admitted, subsequent discharge causes problems to 'the system'. Community Visitors have found numerous examples of this. The problem has been prevalent for many years.

9

If psychiatric facilities are unable to attract professional staff they need, what are the reasons? Could it be that staff are not attracted to large and old facilities?

Many of the psychiatric facilities in Victoria were built at times when there was quite a different philosophy concerning mental illness. Their construction, and the type of accommodation they provide, belong in a different era and therein lies the core of the problem.

1990s

The environment ... is, in the view of Community Visitors, frankly depressing. Large, dark, cavernous day-rooms that appear uninviting and non-conducive to any form of social intercourse. There is an absence of provision for privacy for patients and/or their visitors which does not facilitate contact by friends, relatives and family. The toilet areas lack privacy and are dehumanising. This is achieved by low toilet doors which allow others to see over the top, lack of any form of privacy lock on the doors and an all too common absence of basic requirements such as hand soap and hand-drying aids near basins. In [one area] the toilet directly off the female dormitory boasts one toilet and a urinal. The majority of adult patients sleep in single sex dormitories. Each person has a bed and a wardrobe. There is no provision for privacy when dressing, undressing or sleeping. There is currently no provision for patients to store, and take responsibility for, personal possessions. The ward bathrooms lack adequate ventilation and consequently smell of mould. Privacy while showering is minimal or non-existent.

9

Of major concern has been the discovery of the answer to the riddle: When is a psychiatric service not a psychiatric service? The answer, as the Regional reports reveal, is that a service is not a psychiatric service when there is a major lack of appropriately trained professionals ... or when there is a lack of appropriate active treatment programs ... All too often, no real service seems to be provided programmatically nor, it seems physically, as a number of Regional reports cite significant instances of a poor standard of physical accommodation ... despite the fact that the cost to the patients concerned is up to 87.5 % of their pension and this contribution is heavily subsidised by the State ... [There is] little by way of training programs in place for individuals to meet their needs to improve skills for living in the community; [there is] the use of plastic crockery for all patients; [the] use of the term 'hospital

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1990s



parole' does nothing to increase patients' self esteem; patients complain to Community Visitors that they have nothing to do ... These concerns have been raised repeatedly on every visit. There has been a marked improvement at Parklands where there is an occupational therapist on duty all day. This improvement should continue throughout the hospital as there are now five occupational therapists employed there. The rehabilitation program is also undergoing an overhaul. Nonetheless, each of the wards visited is still characterised by patients sitting about and doing little but smoking cigarettes.

1990s

In last year's Annual Report, Community Visitors expressed their concern that fifteen men who had intellectual disability rather than psychiatric disability, were resident in Ward 3. It was acknowledged that the men received care and attention for their physical needs, however, their needs in relation to their intellectual disability could not be adequately provided by staff of a psychiatric hospital and furthermore, it seemed also could not be provided by local staff of the Office of Intellectual Disability Services (IDS).



The *Mental Health Act 1986* states plainly that people should be provided with services in the least restrictive environment having due regard to the circumstances. [While one facility] does have a long term program to open up several of their 'locked wards' ... in some instances Community Visitors question the measures being taken to achieve this objective. Fencing off an area so that patients can have more freedom of movement hardly meets the spirit of the Act. These concerns have been raised with senior management and the response has been good insofar as there has been an undertaking from the Director of Nursing (DON) to put the matter to rights.



There are concerns that a number of clients continue to remain in the Extended Care Unit ... when it would be more appropriate for them to live in the general community. The issue has been raised with senior management ... Community Visitors believe that it is the responsibility of OPS not to retain people in a psychiatric institution longer than is required. Visitors intend to continue to bring this situation to the attention of the Chief Executive Officer of the Region with a view to action being taken to secure suitable accommodation in the general community.

1990s

In the course of their visiting, Community Visitors have been approached by numerous patients and staff who have complained that they have experienced difficulties in communicating with a number of senior psychiatrists ... There has been absolutely no suggestion that the psychiatrists are not competent or are in any way unprofessional, simply that they cannot be easily understood. Clearly, an issue of this nature cannot be considered to be in the best interests of patients, many of whom are already traumatised as a result of their psychiatric illness, as it increases their alienation from the world around them. During the year there was an alleged sexual assault on a female patient in the ward. Enquiries made by Community Visitors showed that the hospital had a lack of clear procedures to deal with such matters. A number of female patients are concerned about lack of segregation of male and female sleeping arrangements in the ward. This leads to a fear for their personal safety.



Bruce is a young man with mild intellectual disability. His family upbringing by a mildly psychotic parent further complicated his disability. Bruce came to Mont Park as a result of a breakdown of his parent and the inability of his introverted sibling to cope with his impulsive and occasionally physically aggressive behaviour. Bruce has poorly developed interpersonal skills but he



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does have lots of energy, an outgoing personality and a clear understanding of what he wants and does not want in life. Bruce found Mont Park interesting for its people but after some 12 months it was not meeting his needs for a home, stability and some direction in his life and his behaviour was disruptive to other patients. He told everyone, including Community Visitors, he didn't want to stay. Working with Bruce's doctor, the nursing staff and Bruce, the Community Visitors have encouraged Bruce's referral to IDS. He was eventually accepted into temporary accommodation until a new program, more suited to his needs, was opened some four months later.

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Community Visitors recommended that consideration be given to the development of a transcultural psychiatric centre managed and integrated with the existing services of Dandenong Psychiatric Centre. Visitors have learnt that 30% of admissions to Dandenong Psychiatric Centre are of non-English speaking people. The needs of non-English speaking people need to be addressed e.g. in Springvale alone, there are 45 different nationalities speaking some 80 different languages ... Visitors believe there are great difficulties for many non-English speaking clients, particularly those without supportive family and community ties; clients who are severely depressed or withdrawn; or older dementia sufferers. Community Visitors have observed several such people who they consider presented as isolated and socially disadvantaged.

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Supported Residential Services

The Residential Services stream of the Community Visitors Program came into operation on 1 February 1991. The first annual report for the stream was published in 1991, so the extracts here are from the 1991 annual report.

1990s

Community Visitors are entrusted with the task of being arbiters of acceptable standards of care and accommodation for supported residential service residents in Victoria, and carry out this task on behalf of the wider community ... In the first few months of visiting, Community Visitors have found that many services are run well, and some very well. A minority of services, however, do not provide good care and in some cases the quality of accommodation and care can only be described as shocking. Where this is the case, a number of failures of public policy and practice seem to converge on this extremely vulnerable group of Victorians and combine to make their lives a misery.

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Almost all SRS residents suffer one or more disabilities usually combined with advancing age. The most common disabilities are varying degrees of dementia, intellectual disability, psychiatric illness and alcohol-related brain damage ... For many of these people, that is, those whose only income is the pension, the choice between a hostel and [an] SRS is not a real one. Intending residents, even supposing they understood the differences between hostels and SRSs, do not make this choice themselves. Usually, it is made for them by well-meaning placement staff in health and welfare agencies; staff who are increasingly hemmed in by a lack of options. This is a great pity, since placement in [an] SRS—particularly in a 'pension-only facility—can mean that a resident's life is riddled with ambiguity, uncertainty and, in some cases, straight out physical deprivation.

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1990s



Although, SRS residents are one of the most vulnerable groups in the Victorian community they do not enjoy any of the protections afforded by either the Residential Tenancies Act or the Rooming Houses Act. Community Visitors consider this situation should be remedied as soon as possible either by amendment to existing legislation or by additions to the Health Service Regulations.[O]ne of the first things [a Community Visitor] inquires about when visiting an SRS is what contact the residents have with their local community. Almost without exception the responses of residents have been disappointing. Visitors have heard things like ‘There used to be a bus that called a couple of years ago to take them for an occasional drive but it does not come any more’. A more usual reply has been ‘They do not want to go out. They would not go, even if we suggested it’. This latter response was proved wrong in one recent case where a Visitor noticed that after a change of ownership at a particular SRS several residents began to attend a local day centre and really enjoyed it!

1990s

Unlike a hostel, there is no requirement to rebate the SRS resident 12.5% of their pension, or any money for that matter. Most proprietors of pension-only facilities claim to rebate something to their residents, if not in cash then in kind. Often this is done by providing cigarettes or sweets. The Community Visitors believed the continuance of this practice is an affront to people’s human dignity ... The absence of any disposable income at all in pension-only SRS attacks residents’ self-respect since they lack even the basic wherewithal to make personal phone calls or even buy their own small necessities. As a consequence, proprietors and staff may acquire clothes from opportunity shops and other such places. Sometimes residents in these pension-only facilities do not have personal clothing but share underwear and other clothes from a common pool. Residents may have no personal toiletries. At [one SRS] a panel of Visitors found all 12 residents using a single toothbrush! ... Shared combs are also common in pension-only SRSs. These kinds of living conditions are an affront to the Victorian community and must be changed. It is not acceptable for a section of the community to be discriminated against through no fault of its own; particularly when the group of people in question is so vulnerable and unable to advocate for its own rights.



The quantity and quality of food varies greatly from place to place. An absence of fresh fruit has been noticed by Visitors in many SRSs ... Of course eating is an important part of everyone’s life but it seems to be more so for those who live in an institutionalised or semi-institutionalised setting. Community Visitors have received frequent complaints about food and drink. For example ... Community Visitors witnessed an evening meal that consisted of thin soup with a few cut-up sausages leftover from lunch, floating on the top. This has not been an isolated case. In some pension-only SRSs the residents would be better off in a Victorian prison in terms of the quantity and quality of food they receive ... Usually the main meal is served at midday. This can have unfortunate results for those few residents who may attend day programs outside these facilities. The management may or may not keep a meal for these residents so they can have it at night. If the meal is not kept, this can be the price for attending activities outside the facility ... In pension-only SRSs it is not uncommon for evening meals—often soup and/or sandwiches—to be served well before 6 pm and frequently between 4 pm and 5 pm. One anonymous resident caller from an SRS ... claimed that residents had so little food that many went to bed hungry, but she was ‘lucky’ because she was able to walk to the village to buy extra food for herself. However, she said she felt ‘sad for the others’ ... Where adequate food and drink is provided, it sometimes does not take account of the likes or tastes

1990s



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of residents ... [One woman] refused to eat any meat at all because she feared eating pork by mistake since she was a Muslim and it was never clear to her what was being served. Community Visitors have raised a number of concerns about [a] doctor's behaviour [after the following incident] ... Community Visitors witnessed all 26 residents lined up in the corridor, to be seen one by one, with the door left open. Each resident was asked to sign a Medicare form but was not given their own patient copy. Each consultation lasted about one minute, after which each resident was given 10 cigarettes or some sweets, according to their tastes ... It is hard for Community Visitors to know where to start with an incident like this since it takes in so many issues from lack of privacy and dignity afforded to residents right through to possible fraud of the Medicare system.

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Another health problem that Community Visitors have come across and which appears to be widespread is over-medication, particularly with sedatives. One resident recently removed from [an SRS to a hospital] had been thought to have little communication ability. Once away from the SRS and off the enormous doses of sedatives that she had been receiving, this resident showed signs of being able to communicate much better than before.

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In many pension-only SRSs heating is very inadequate; often only one room, where most residents sit, will be heated to an acceptable level. Visitors in [one region] have found elderly frail residents in bed, fully clothed, to keep warm.

1990s

Community Visitors presume that the Government's policy of de-institutionalisation is based on a premise that the lives of ex-residents of the intellectual disability and psychiatric systems will be improved by placement away from the large, old institutions ... It seems that for years large numbers of these ex-institutional residents have been placed in SRSs. Often this has been done by well-meaning welfare workers and placement officers, who promise continuing support to the proprietor because of the new resident's sometimes challenging behaviour ... In the experience of the Community Visitors almost all proprietors who have such ex-residents are seriously critical of the intellectual disability and psychiatric service systems for their failure to follow through with promised support. In fact, next to no services are available for these residents.

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The plight of some of these ex-institutional residents in SRSs has to be seen to be believed. Lacking any outside support, proprietors are thrown back on their own resources. They may, or may not, understand the needs of these residents ... All too often the proprietor and staff response is to manage the situation by controlling people's lives in any number of small ways and by recourse to medication ... The idea that all de-institutionalised ex-residents of the intellectual disability and psychiatric systems have had their quality of life improved by transfer into SRSs is largely illusory. In the worst instances seen by Visitors, the social and emotional impoverishment of these people coupled, in some instances, with real physical deprivation is shocking, leading some Visitors to speculate whether or not these residents have not, in effect, been re-institutionalised in small groups within the community.

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Quite apart from proprietors, there are a number of problems with the selection and approval of SRS staff ... Choice of staff is now the sole prerogative of proprietors ... Earlier this year the advertisement [following] ... appeared in [a local newspaper]: 'Couple required for live-in position, house provided, small wage ... for enquiries'. Community Visitors believe that

1990s

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readers could be forgiven for thinking this was an invitation for a couple to look after someone's pets while they went overseas. In reality the job entailed looking after 34 residents of an SRS, some of whom were intellectually disabled and some non-verbal. The successful couple were required to serve the evening meal, give out all medications and then put the residents to bed. After that, the couple had to be available through the night in case of emergencies ... After a few weeks at the SRS, the male partner in the newly recruited couple was taken into custody ... and subsequently charged with armed robbery. At this point it was ascertained that this staff member had a long drug-related criminal history with violence.

1990s

Many Community Visitors have been alarmed by the lack of fire safety in SRSs that they have visited ... From the beginning of the visiting program it quickly became apparent that many SRSs, particularly those housed in older buildings (the vast majority) were fire traps. According to Health Department Managers, there have been four fires in SRSs in the last 12 months. Two of these were not serious and two were, including the fire at Liege Court at Noble Park, which took four lives ... [W]hen it comes to fire safety there are problems of policy and regulatory fragmentation ... [F]ire safety is left to the fire authorities, [but] the fire authorities, after pointing out the deficiencies, say they are powerless to intervene directly unless invited to do so by the Health Department ... This situation is untenable and must be changed.

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The Disability Services stream

Community Visitors noticed few positive outcomes for the majority of residents at Kew Residential Services (KRS). With an election imminent in September 1999, both major political parties produced policies promising major change at this facility ... The possibility of the eventual closure of KRS, as it is today, seemed achievable. Community Visitors were hopeful that the Principles of the *Intellectually Disabled Persons' Services Act 1986* would finally come to fruition for the remaining 466 people living in this institutionalised environment. However, at the end of June 2000, [there is only funding] for a 50 bed on-site facility to commence development after July 2001. The 163 people who expressed an interest in a move to the community in 1997, continue to be denied that opportunity.



'Jock' is a recognised artist whose work, produced at an independently run day service he attends, is shown in exhibitions around Australia and is purchased by overseas visitors. Community Visitors were concerned about the acknowledgment of ownership of Jock's artistic worth within his own home, as well as the legal entitlement to the proceeds of his art. After protracted negotiations, Community Visitors were pleased when finally one framed product of Jock's artwork was hung in his own home. In September 1999, it was clarified that Jock owns his entire art product and that it is marketed according to standard procedures in the art industry (where he receives a percentage of the selling price).

2000s

Community Visitors reported how distressed they were when visiting 18 men who live in one particular unit. Community Visitors would usually find the residents lying on the floor, sitting around, wandering aimlessly, and often in conflict with co-residents. Community Visitors reported that they 'considered conditions in this unit, both environmental and attitudinal, were creating a deprived and unacceptable living situation for these men'. Following a visit from the Minister for Community Services in February 2000, many improvements were directed to occur in the unit and as at June 2000 these continue to be implemented.



Community Visitors in this region are strongly of the view that the practice of adults sharing bedrooms for physical and economic expedience is totally unacceptable and can lead to unintended and serious consequences, which in turn impacts badly on duty of care responsibilities ... Community Visitors [in the region identified six houses with shared bedrooms including an] older, small four-bedroom house where two men share a small bedroom. These men do not share the same interests which causes them problems ... [and a house where] two adult men with high support needs share a bedroom.



2000s



New facilities that have been purpose-built as CRUs, have now been well-established in the region. Community Visitors have observed in the past year ... that the residents in [several] facilities have settled well and are enjoying their new homes ... [I]ndividuals [can] move on to a more independent mode of living. Such is the case for 'Max' [who a]fter many years of supervised accommodation, has tried living by himself with outreach services support and found he really enjoyed it.

2000s

The need for each individual to have a quiet space to retreat to in a busy shared house has long been recognised by Community Visitors.

Last year Community Visitors recorded the positive move of 'Jim' to a unit built at the rear of [the CRU]. Jim has now been in the unit for 18 months and is thriving. He had a history of behavioural problems in previous environments, but these issues have dissipated now that he has choice and his own space.



The Mental Health stream

Community Visitors received several complaints around the use of police rather than the Crisis Assessment Team particularly from Aboriginal patients, with two specific complaints of rough handling and being handcuffed when brought into the adult acute unit. One Aboriginal woman had six police bring her into the unit.



Community Visitors [in one region] have expressed particular concerns about the differing treatments for many Aboriginal patients and the importance of developing improved cultural awareness and acceptance. The role of the Koori Liaison Officer is pivotal. [In this region] there is the capacity for two liaison officers, however the second position has been vacant for a significant period of time.

As one would hope, the statewide building program has meant that the majority of regions report that many more patients are now being housed in bright, modern custom-built facilities. These improved living conditions for the patients and [the] working environment for staff have had a positive effect for all concerned. However, not all facilities have been re-housed and some patients continue to be treated in very poor conditions. [At one facility a patient] was sent across to the general hospital for an x-ray soon after her admission and, after waiting a period of time, became distressed and began to rock and vocalise. The radiologist allegedly slapped the patient across the face. The context of this alleged physical attack and what was reportedly said at the time are currently being investigated by the Medical Practitioners' Board. The Community Visitor on behalf of the patient brought the matter to the attention of this Board and it is expected that this will be finalised early in the next reporting period.

2000s





The Residential Services stream

Community Visitors observe that, while some low-fee SRSs provide good care for their residents (within the limits of available resources), there are some facilities where the care falls well below current community expectations. The majority of people who live in SRSs have complex care needs. Many residents are older people in need of special care because of either a physical or a psychiatric disability—or even both. During the past year, Community Visitors have become increasingly concerned about the rising numbers of younger men and women, many of whom have experienced a debilitating psychotic episode, who now make the low-fee SRS their home. After leaving hospital such individuals often have very few accommodation options. The current practice of early discharge from hospital means that people suffering from a mental illness are commonly placed in SRSs which charge the pension or less. Sometimes this occurs well before their condition has stabilised. While most staff make every effort to meet the needs of these younger residents, the scarcity of trained staff, as well as the low staff/resident ratio in SRSs, means that the necessary support and care generally cannot be provided.



Jenni was placed in an SRS in the metropolitan area about six months ago. She suffers from schizophrenia and has hallucinations. She frequently talks to plants and objects in the yard. She is paranoid and very suspicious when spoken to. On one visit, Community Visitors observed her cutting her hair—making it look a complete mess. They noted that she seemed very ill and in need of much more support than could possibly be provided by untrained staff in an SRS with many residents, and all with differing and complex needs.

2000s

At one SRS, Community Visitors noticed John—a resident who appeared to have significant care needs. The Visitors were advised by staff that John was waiting for an aged care facility (nursing home) placement. On a visit a month later Visitors were concerned that John was still at the SRS. His needs were great. For example, he needed to be turned in his bed regularly and could not be transferred from his bed to a chair without assistance. The Visitors were particularly concerned that John’s communication bell had been dismantled. The DHS was contacted and John was eventually admitted to hospital until a suitable placement was found for him.



Community Visitors have long been concerned about the lack of privacy experienced by some residents, particularly in the low-fee SRSs ... At a facility in the outer metropolitan area, five residents share dormitory-like accommodation. Beds in this section of the SRS are divided from each other, to some extent, through the arrangement of furniture and with curtains.



The guidelines for bed placement] highlight the basic difficulty in relation to the regulation of the SRS industry by the DHS—that is, the shortage of low-cost housing for people with disabilities prevents the full insistence on, and maintenance of, reasonable standards of care ... The threat of homelessness facing individuals who live in low-fee SRSs underpins the monitoring process and means that many compromises are made in relation to their care.

2000s

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[At one SRS] Community Visitors noted that medications were left on the table instead of being distributed directly to residents. They found that few residents had toothbrushes, bathrooms did not have soap and toilets did not have toilet paper. Many residents had inadequate underwear and sleep wear ... Meals were often at inappropriate times ...Community Visitors have been writing reports over the past 18 months highlighting the poor standard of cleanliness and related care issues at one particular metropolitan SRS. DHS Program Advisors have acknowledged problems at this home and visit regularly to advise the proprietor, and to attempt to ensure that standards are raised. Yet the improvements made at this home have only been marginal over a long period ... [T]he enforcement of reasonable standards of care seems to be very slow and prolonged, perhaps even unachievable, under the present system.

2000s

An SRS in the metropolitan area has 66 residents. Some are frail and elderly, while the majority have psychiatric illness ... The home is a three-storey building. In this home, there is only one staff member on duty at night.

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Community Visitors called at an SRS at afternoon tea time ... The tea was served in cups without saucers, the biscuit was placed directly on the plastic tablecloth which was torn and dirty. The floor was dirty from spills at previous meals. There was no cheer, or encouragement to socialise, in this dismal setting.

A young female resident has been permitted to keep her dog at an SRS where the proprietors have fitted some shelving in her room for storage of its tinned and dried food. It is noted that they have been extremely considerate in this matter. After a troubled period initially, this resident has now settled in very well.

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OPA does not receive sufficient funds from the Department of Human Services (DHS) and the Department of Health (DH) to enable the Community Visitors Program to meet its legislative mandate.

Within each stream, Community Visitors report that the dignity and rights of people are constantly under threat. Lack of consideration for residents' privacy, dignity and freedom of choice pervades the health services [SRS stream]. In mental health, the lack of response by some hospitals to requests by consumers to see a Community Visitor or for information and consultation demonstrates a lack of respect for the person's dignity and rights. While in disability there is inadequate attention to supporting people to speak for themselves ... Poor resident mix leads to incompatibility and some residents' peace and safety is adversely impacted by the unsupported and challenging behaviours of others ... Sexuality, sexual safety and the right to sexual expression is another area where the challenges are not being met.

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The Residential Services stream

This year Community Visitors became aware of a pension-plus SRS where an elderly resident with dementia was being restrained in a chair when out of bed, which amounted to approximately 11 hours per day. This was of great concern to Community Visitors as staff had no training in the use of restraint and were not aware that there could be significant adverse effects for the resident because of the use of restraint ... Documentation on the use of restraint for the resident was only commenced after Community Visitors queried its use. As a result of Community Visitor involvement, the Public Advocate immediately wrote to the DH, highlighting the importance of restraints 'not being a substitute for inadequate staffing or unsuitable environment' and that 'Restraint of any sort should not be part of a care regime in an SRS' ...

In response to Community Visitor inquiries, the resident was assessed by an Aged Care Assessment Service as well as an occupational therapist. As a result, the SRS began to minimise the use of physical restraint with a view to ceasing it once there were alternative strategies in place ... There is a significant need for SRS regulations to be developed with clearly defined standards for the use of restraint if required, and consequences if standards are not met. This must happen if the community is to be confident that there will be an appropriate standard of care in SRS.

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The Mental Health stream

The lack of access to appropriate housing or other accommodation options continues to affect the discharge process for consumers across the care continuum. This includes consumers in acute, CCU [community care unit] and SECU [secure extended care unit] facilities and public housing. The lack of accommodation affects bed availability, which creates 'blockages' in the system. There are further concerns that insufficient accommodation options contribute to a 'revolving door' situation for consumers.

2010s

Community Visitors [attending a facility discovered a frail and older consumer with complex healthcare needs] had been assaulted by a younger consumer during his stay at the adult acute unit. Community Visitors had concerns about the safety of this consumer while he continued to remain as an inpatient. This matter was discussed and confirmed with the unit manager, who agreed that this consumer would be more appropriately placed in an aged-care unit.



The Disability Services stream

A chronic lack of adequate resources severely affects the ability of Community Visitors to execute their statutory function [affecting] the program's ability to recruit, train and properly support Community Visitors in their roles. A shortage of supporting staff, antiquated technology and obsolete systems have made visiting targets almost impossible in some regions, and, in other regions, Community Visitors struggle to cover large areas and many facilities ... Despite all these obstacles, Community Visitors continue to regularly visit residential services in their regions. They report issues of concern regarding the rights, dignity and quality of life for people with a disability, and follow up these issues with service providers towards resolution and better life outcomes for residents.



[One facility] is a house with five residents, each with extreme disabilities or health issues. All residents use medication [with varying success] for their epilepsy, and all have been known to have nocturnal seizures at one time or another, some quite recently. Two women require turning at night to relieve pressure sores. Another resident has been found by sleepover staff to have aspirated during the night. Despite the severity of their disabilities, and the fact that they all have epilepsy, there is no active night support in this house. Community Visitors have been advocating for this since August 2009, when one resident was found to be soaked in urine most mornings, because he had suffered seizures during the night. Community Visitors remain concerned that each and every resident is at risk of having a life threatening seizure at night and it is the responsibility of DHS to minimise the risk of this happening unnoticed. Despite the publication of several issues reports following repeated visits and meetings with DHS, the standard of care at night at this house continues to fall well below acceptable day-care standards. The case has been referred to OPA, resulting in the allocation of an advocate for one of the residents.

2010s



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2020s

The pandemic significantly impacted the Community Visitors' safeguarding work. The resulting restrictions led to the Community Visitors adapting to remote safeguarding practices, as on-site, face-to-face visits were suspended in late March ... Community Visitors quickly became familiar with accessing and using technology to enable phone and video visits.

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The role of Community Visitors continues to be impacted by many significant changes in the sector, including the rollout of the NDIS; the ongoing transfer of government-run disability accommodation to non-government providers; and changes to the regulation of tenancy in Specialist Disability Accommodation (SDA), in particular. While the NDIS has enabled people with disability to access supports better tailored to their individual needs. Some residents have experienced a reduction of support or new challenges in obtaining suitable accommodation: the accommodation market can at times be scarce, restricting the choice and control afforded participants. Community Visitors reported repeated NDIS-related issues, including barriers to eligibility, inconsistent planning processes, long delays in planning and plan reviews, and extended waiting times for supports including specialist services and equipment. These issues are often more pronounced in regional areas.

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2020s

Two Community Visitors were invited by the Disability Royal Commission to appear as a witness. They spoke about violence between co-residents in group homes and related observations they have acquired over many years of on-the-ground experience.

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The Residential Services stream

A female resident who suffered from seizures and some memory loss as a result of treatment for a brain tumour was physically assaulted by another [female] resident. She suffered a laceration to her head, requiring medical assessment, and the incident caused ongoing emotional distress. Following an altercation with attending police, the perpetrator [of the assault] was admitted to an acute mental health unit; she later returned to the SRS and, despite police and the SRS manager's intervention, continued to harass the victim. A statement of complaint was made by the victim to police, in the presence of the proprietor rather than with an independent third person, as required in the Victoria Police Manual. The victim was very fearful of the perpetrator and remain in her room in order to avoid further assaults. Community Visitors identified that despite the assault being a prescribed reportable incident (PRI), the proprietor failed to notify DHHS as required. They therefore notified DHHS of a potential breach of the Act. DHHS determined the incident caused minor abrasions and no further action was required. The Public Advocate considered the DHHS actions were inadequate and requested it undertake a review. [The Public Advocate] was aware the victim was not spoken to by DHHS and that a further review of the CCTV footage would clearly show a serious assault requiring a PRI.

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2020s



An SRS housing more than 30 residents in a two-storey terrace house ... has been the subject of Community Visitor concerns over an extended period of time. During 2017–20, 88 critical issues were identified by Community Visitors ... Photographic evidence collected at the request of DHHS and supporting four formal notifications illustrated, among other things, the squalid and filthy condition of bedrooms, bathrooms and communal areas, overflowing rubbish bins in bathrooms, dirty and torn curtains, mould on bedroom walls, broken and missing tiles in bathrooms and toilets, and unhygienic fridges containing old and rotting vegetables ... Community Visitors describe the DHHS regulatory response so far as ineffective and consider that vulnerable residents have been left in substandard living arrangements without adequate supports ...

2020s

The Disability Services stream

The Public Advocate wrote to disability service provider CEOs and staff in group homes to inform them of the remote safeguarding model that had been developed and to request their assistance in facilitating it. The mailout also included an Easy Read feedback form and reply-paid envelope for each disability resident (at some 1400 locations) to inform them that Community Visitors were still interested in their wellbeing and were contactable even though they were unable to make face-to-face visits.



This year, 218 issues were recorded by Community Visitors. The most serious incidents led to notifications to the Public Advocate, the Office of the Disability Services Commissioner and/or the NDIS Quality and Safeguards Commission ... This year, Community Visitors contributed to OPA's report *'I'm Too Scared to Come Out of My Room': preventing and responding to violence and abuse between co-residents in group homes*, which was submitted to the Royal Commission in response to its Group Homes Issues Paper. The report draws directly on the lived experience of people with cognitive impairment, as well as on the findings of Community Visitors to illustrate the impact of system failures on the lives of group home residents. The input of Community Visitors was central, building on the past 30 years of Community Visitors reporting incidents of violence and abuse within services to the Victorian Parliament in its annual report.



2020s

Community Visitors were advised that a resident, 'John', had been moved from his home on the basis that his behaviour endangered the safety of other residents and staff. The service provider did not issue a Notice of Temporary Relocation until one month after the resident had been relocated. The service provider alleged that John perpetrated serious incidents involving weapons and assault, however, incident reports were incomplete and lacked detail. John has experienced constant changes that have been detrimental to his overall wellbeing and have facilitated an escalation of serious behaviours. His NDIS plan has been grossly inadequate to meet his complex needs and he lacks informal supports to advocate for him and uphold his will and preference. Community Visitors referred this matter to OPA's Disability Act Officer, who has been actively involved in the matter and supports a recommendation by a behaviour support practitioner to apply to VCAT for guardianship ... A response from the service provider about what strategies and supports have been implemented to support John's co-residents who had been traumatised by the events is pending. John continues to live in alternative accommodation.



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Community Visitors expressed ongoing concerns about some disability group homes neglecting residents. Some issues of neglect indicate a lack of proper staff training or procedures to ensure proper quality of care. In one situation, a resident was found distressed in the morning and very uncomfortable because he was wearing badly soiled continence pads. He had returned to the home from hospital the previous evening, but the pads had not been changed since, despite a staff member being present all night. In this case, the provider agreed to investigate the matter, however, there have been no meaningful changes to night duty staff procedures to ensure this could not happen again.

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The Mental Health stream

Incidents noted this year include serious physical and sexual assaults which shocked the Community Visitors, and several incidents where consumers injured themselves or were placed at risk because of insufficient supervision or medication errors ... An anonymous call to OPA advised of a sexual assault on Kala, a female consumer in an acute inpatient unit ... Kala alerted staff and was moved to another unit. The male remained at the unit but was transferred to a high-dependency area. The incident was escalated by Community Visitors. It was also reported to the Office of the Chief Psychiatrist (OCP), which investigated ...

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Rob had only just been admitted into [the] Emergency Department and was speaking with staff when Community Visitors visited. Five security guards and police were present. Rob's arms and legs were restrained. A nurse said he had been brought in shackled.

2020s

John has autism, a mental illness and limited verbal communication. Staff reported that he was not able to engage in long-term rehabilitation due to his complex needs. The Community Care Unit is not able to fully meet John's care and support needs. However, staff are actively working with John and his family to move him to longer-term accommodation with an appropriate support. His application for SDA [specialist disability accommodation] was declined. Unit staff are assisting John to appeal this decision.

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This report also includes encouraging examples of innovative caring practice and environmental changes that seem to be making a positive difference to consumer recovery. These changes are the result of increased government resourcing, staff commitment, and the input of people with lived experience and their family and carers.

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2020s

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