Office of the Public Advocate

Community Visitors

Annual Report 2019–20

Residential Services
Disability Services
Mental Health

Safeguarding the rights and interests of people with disability

Dianne Chenery
To Take a Sweet Flight with You
Mixed media

About the cover image

To Take a Sweet Flight with You was exhibited at State Trustees' annual CONNECTED art exhibition, to engage vulnerable Victorians and promote their social inclusion and sharing of their unique experiences.

"My inspiration was to imagine how different life looks for a bird."

– Dianne Chenery

About the case studies

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

Safeguarding the rights and interests of people with disability

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Community Visitors Annual Report 2019–2020

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Letter of transmission

9 October 2020

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

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

Level 22, 50 Lonsdale Street
Melbourne VIC 3000

Dear Ministers

RE: Community Visitors Annual Report 2019–2020

In accordance with the *Disability Act 2006*, the *Mental Health Act 2014* and the *Supported Residential Services (Private Proprietors) Act 2010*, please find enclosed the *Community Visitors Annual Report 2019-2020*.

This year, the findings have been drawn from 4142 visits by 400 active volunteer Community Visitors across the state.

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

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

The report also reports on Community Visitor work during the COVID-19 pandemic including by engaging with remote 'visiting' and their findings during this time.

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

Yours sincerely

Colleen Pearce
Public Advocate and Chairperson of the Combined Board

Contents

Report from the Public Advocate

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

Even in these challenging times, during a global pandemic, the Community Visitors have sought to maintain their essential role of being the 'eyes and ears' of the community by whatever means possible.

Reporting of abuse-related incidents

Community Visitors continue to highlight the increased vulnerability of Victorians with a disability or mental health condition to abuse, neglect and exploitation. This is shown in the data on assaults and abuse reported below, for the three streams of the program.

This year, Community Visitors recorded 669 abuse-related issues, representing a 36 per cent increase over last year.

Subsequently, 63 abuse and neglect referrals were made to the Office of the Disability Services Commissioner (DSC) for former Department of Health and Human Services (DHHS) disability homes.

Fifty-two referrals were made to the NDIS Quality and Safeguards Commission, with 47 medium and low risk referrals to the service provider of the Community Service Organisation-managed disability homes.

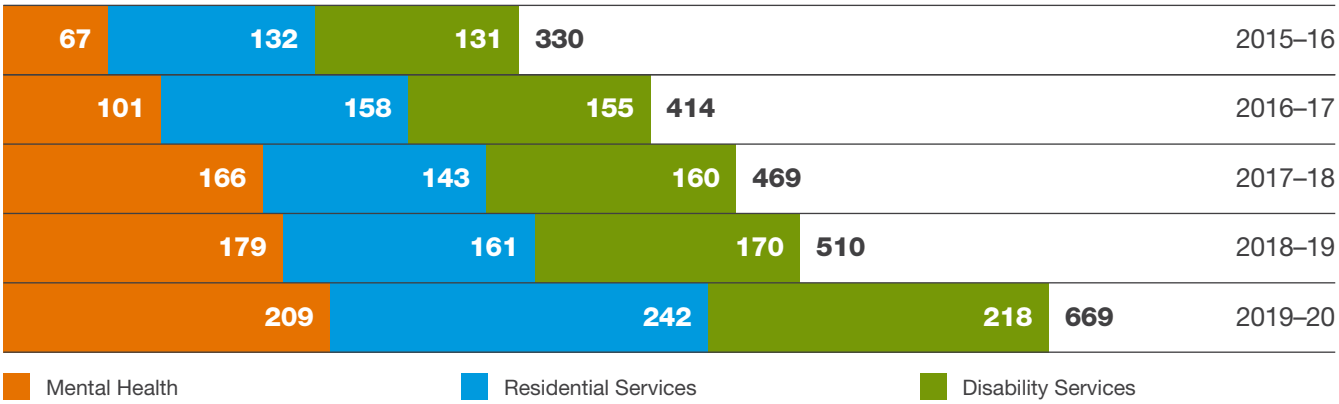
In addition, 65 abuse and neglect matters were made to the DHHS for various Supported Residential Services (SRS) across Victoria.

The continued rollout of abuse detection training has increased the capability of Community Visitors to identify and report cases of abuse and neglect. Work has continued to ensure that these matters are escalated promptly to the NDIS Quality and Safeguards Commission and the DSC for investigation.

COVID-19 pandemic

The vulnerabilities of people with a disability increased during the course of the COVID-19 pandemic. Many people who Community Visitors visit have an increased risk of acquiring COVID-19 due to underlying medical conditions, living in congregate care settings where social distancing is difficult, they are sharing bathrooms and, in some cases, bedrooms and the difficulty of many to comply with the stage 4 restrictions.

Figure 1. Community Visitor reports of abuse, neglect and assaults across all streams, 15/16–19/20



The COVID-19 pandemic and subsequent lockdown added a further layer of complexity to already existing issues within the sector, such as a highly casualised workforce and skill shortages. This situation was especially difficult for services in rural areas that, earlier in the year, had been impacted by the bushfires.

Remote safeguarding

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.

Thanks to the Victorian Government's grant of $78,000, Community Visitors trialled remote safeguarding during the pandemic.

Community Visitors quickly became familiar with accessing and using technology to enable phone and video visits. Phone visits commenced in SRS, which were prioritised as they are larger facilities with an average of 30 residents, many with limited supports independent of the SRS. Phone visits to mental health units and disability accommodation facilities were subsequently trialled and then commenced across Victoria.

These trials were positively received by residents, staff and Community Visitors alike, and I commend their ability to adapt to very different working conditions in what is becoming the 'new normal'. I wish to acknowledge that many accommodation and mental health unit providers have willingly adapted their processes to phone and video visits by Community Visitors. They have also been creative in establishing in-house activities and finding creative ways toward helping people not to feel isolated. I commend the dedication of disability, mental health and care staff at this very difficult time.

However, access to incident reports, which provide Community Visitors with an understanding of incidents that have occurred between visits, has become more difficult because of the inability to view these in person. Ongoing communication with disability, SRS and mental health providers as well as changes to some agency policies and procedures are required to ensure Community Visitors have access to information about the incidents occurring within services.

While there is no substitute for face-to-face visits, the remote safeguarding initiative ensures that people with disability living in high-risk situations continue to be supported. Their vulnerability is exacerbated due to their inability to attend outside activities and, like all Victorians, they are missing the social contacts outside their place of residence.

"The onset of the COVID-19 pandemic and subsequent lockdown added a further layer of complexity to already existing issues within the sector."

Continued NDIS rollout

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 to 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.

Concerns have been raised about the poor communication between different NDIS stakeholders and a lack of consultation in relation to planning. The quality of service provided to participants by some support coordinators and other NDIS workers has also been raised.

Community Visitors continue to encounter difficulties in accessing information relating to NDIS plans, restricting their ability to perform their safeguarding role. They patiently await the Disability Ministers' Forum to formally recognise the contribution of state-based community visitor schemes to the NDIS Quality and Safeguarding Framework. This will allow the Community Visitors Program to determine the parameters of the community visitor schemes operating within NDIS services, not only in Victoria but across the country, and to be further supported in its interface with the NDIS Quality and Safeguards Commission. In the interim, the commitment of the Victorian Government to the continuation of the program is very pleasing.

The implementation of the NDIS has substantially changed the disability landscape and has affected Community Visitors, particular those in the disability stream. The New Operating Model Steering Committee, consisting of representatives from DHHS, Department of Justice and Community Safety (DJCS), OPA staff and volunteers, began its work in 2019. Since then, several operational issues have been dealt with including identifying facilities to be visited, assessment of group homes to determine priority for visiting, and improving pathways for the escalation of issues.

Oversight of Supported Residential Services

DHHS' approach to the monitoring and regulation of SRS has undergone substantial change in recent years with the centralisation of regulatory functions under the DHHS Human Services Regulator (HSR).

The oversight of SRS within DHHS is split between the HSR, the Supported Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) and the policy area of the department. With this fragmented approach to the oversight of SRS, it is difficult to understand where the overarching leadership of SRS sits within DHHS. Community Visitors are very frustrated at what they see as a leadership vacuum and believe addressing this pressing issue would contribute to positive outcomes for the thousands of vulnerable Victorians living in SRS.

Consistent with the role played by other regulators, Community Visitors would like the HSR to:

- provide greater regulatory guidance explaining how and when it will exercise its legislative powers
- explain how it interprets the law, describing principles underlying its approach
- give practical guidance to how regulated entities may decide to meet their obligations.

This would greatly assist proprietors better understand their roles and responsibilities.

During the COVID-19 pandemic, there have been coordinated supports offered to proprietors and ongoing practical guidance about how regulated entities may decide to meet their obligations.

Community Visitors would like to see the coordinated support approach extended beyond the pandemic.

Mental Health

Victoria needs a robust and caring mental health system that is effective in supporting people in distress.

The Royal Commission into Victoria's Mental Health System offers an opportunity to improve a fragmented and under-resourced system, which is considerably stressed.

A recommendation from its interim report was the purchase of 35 mental health beds in private hospital settings for the care of public consumers who would otherwise be treated in a public mental health service. Community Visitors advocate for their critical safeguarding role to be extended into these settings to ensure the rights of people in private facilities are also protected.

This year's report highlights that, despite the best efforts of many mental health workers, there are still numerous examples of consumers being harmed in facilities that are meant to assist their recovery.

Too often, Community Visitors hear about people who circulate through the mental health system into SRS or other unsuitable housing options, regularly returning to the mental health system. Frequently, this is due to poor discharge planning, the lack of affordable housing and few community support options.

Community Visitors are concerned about a shortage of forensic mental health beds, particularly for women. This shortage places pressure on forensic settings and leaves patients inadequately supported while they wait for the specialist forensic care they need. Limited forensic beds can adversely impact the rehabilitation and return of forensic patients to the community.

Royal Commission contributions

Community Visitors' insights and knowledge of the disability and mental health service system are an invaluable contribution to the systemic advocacy work of the office. Their reports, findings and data have been integral to the submissions from my office to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability and the Royal Commission into Victoria's Mental Health System.

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. I congratulate them both on their statements, along with all Community Visitors, for the invaluable contributions they make to driving systemic change and improving the lives of people with disability.

Thank you

In concluding, my thanks go to the 400 active Community Visitors right across the State for their diligent work which makes this report possible.

It is based on direct reports following their visits and, so, reflects their immediate observations and learnings.

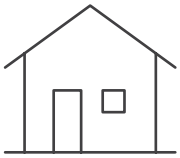
The volunteers donate their private time and energy to this work and, on behalf of the community, I thank and acknowledge them.

I trust their findings will, once more, help protect Victorians with a disability from abuse, neglect and exploitation by highlighting them here.

Colleen Pearce
Public Advocate and
Chairperson of the Combined Board

2019–20 Snapshot

400
active Community Visitors



4142
total visits

1466
facilities visited

443
appointed Community Visitors

91
referrals to DHHS in SRS

6940
issues identified

669
abuse-related issues
36% increase over last year

246
requested visits

52
referrals to NDIS Quality & Safeguards Commission

63
abuse referrals to Disability Services Commissioner

Introducing the Combined Board

Public Advocate and Board Chair

Dr Colleen Pearce

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

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

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

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

Colleen's outstanding contribution to community services in Victoria was recognised with a Commonwealth Centenary Medal. In 2016, she was added to the Victorian Honour Roll of Women. Colleen was awarded an honorary doctorate from RMIT in recognition of her work in the disability sector in 2018. In 2020, she was awarded an Order of Australia medal.

She is also a board member of Connecting Home, an organisation that works with the Victorian Stolen Generations.

Colleen is a proud Yuin woman from southern NSW.

Residential Services Board

Lynn Wallace-Clancy

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

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

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

Amanda Kunkler

Amanda Kunkler was appointed as a Community Visitor in 2015 and this is her first term on the Residential Services Board.

She relocated to Melbourne after a professional career in NSW, which included 20 years work as a journalist, two years working with foster carers and eight years in policy and advocacy for regional investment and development. Amanda has a Master's Degree in Journalism and postgraduate qualifications in community engagement from the University of Melbourne. Amanda works as a Community Engagement and Advocacy Officer in the policy team at Council on the Ageing (COTA) Victoria.

Amanda is looking forward to deepening her knowledge and understanding of the Community Visitors Program through her work on the Board.

Disability Services Board

David Roche

This is David Roche's third term on the Disability Services Board having served one year in 2009-2010 and, subsequently, being re-elected twice. David is Chair of the Combined Board's Policy Review Steering Committee, a Panel Secretary and a former Regional Convenor and has served on the Training Steering Committee.

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

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

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

Rosemary Shaw

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

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

Her community activism is extensive as she volunteers with the Young People in Nursing Homes National Alliance supporting young people in Aged Care, and those likely to go into it, due to the shortage of suitable accommodation. She is also a committee member with the Uniting Church, supports the Royal Children's Hospital and founded Kids Under Kanvas, a camping program for children and young people with disabilities which is now under the auspice of Wesley Mission.

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

Mental Health Board

Jenny Martin

Jenny Martin was appointed as a Community Visitor in 2015 and has enjoyed the opportunity to extend her contribution to the program in her second year on the Board.

She is currently panel secretary for the Austin Emergency Department and the Psychiatric and Assessment Planning Unit as well a panel member for the Austin Secure Extended Care Unit, the Adult Acute Unit and the Mothers and Babies Unit. Jenny is past panel secretary for Austin - Community Recovery Program, Transition Support Unit, the Heidelberg PARC and the Northern Hospital Psychiatric Units 1-2 plus their Emergency Department. Her experience has provided her with a wide view of consumer, and at times, carer experiences of mental health services.

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

Sam Haoucher

Sam Haouchar was appointed as a Community Visitor in 2016, has been a Regional Convenor and this is her first term on the Mental Health Board.

Sam has an arts degree majoring in psychology and social research from Victoria University and a Master of Business Administration from Deakin University. She is currently employed as APAC Supply Chain COE Lead at PPG Australia.

As an Australian with Lebanese migrant parents, Sam has focused on expanding her understanding and awareness of the mental health supports required for our diverse communities. She has also used her operations, systems and governance experiences to contribute in areas of data and processes across the mental health system.

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

About Community Visitors

Community Visitors are independent volunteers who safeguard the human rights of people with a disability by engaging directly with them on an ongoing basis and monitoring their care.

They are supported by the Community Visitors Program which is part of OPA.

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

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

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

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

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

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

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

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

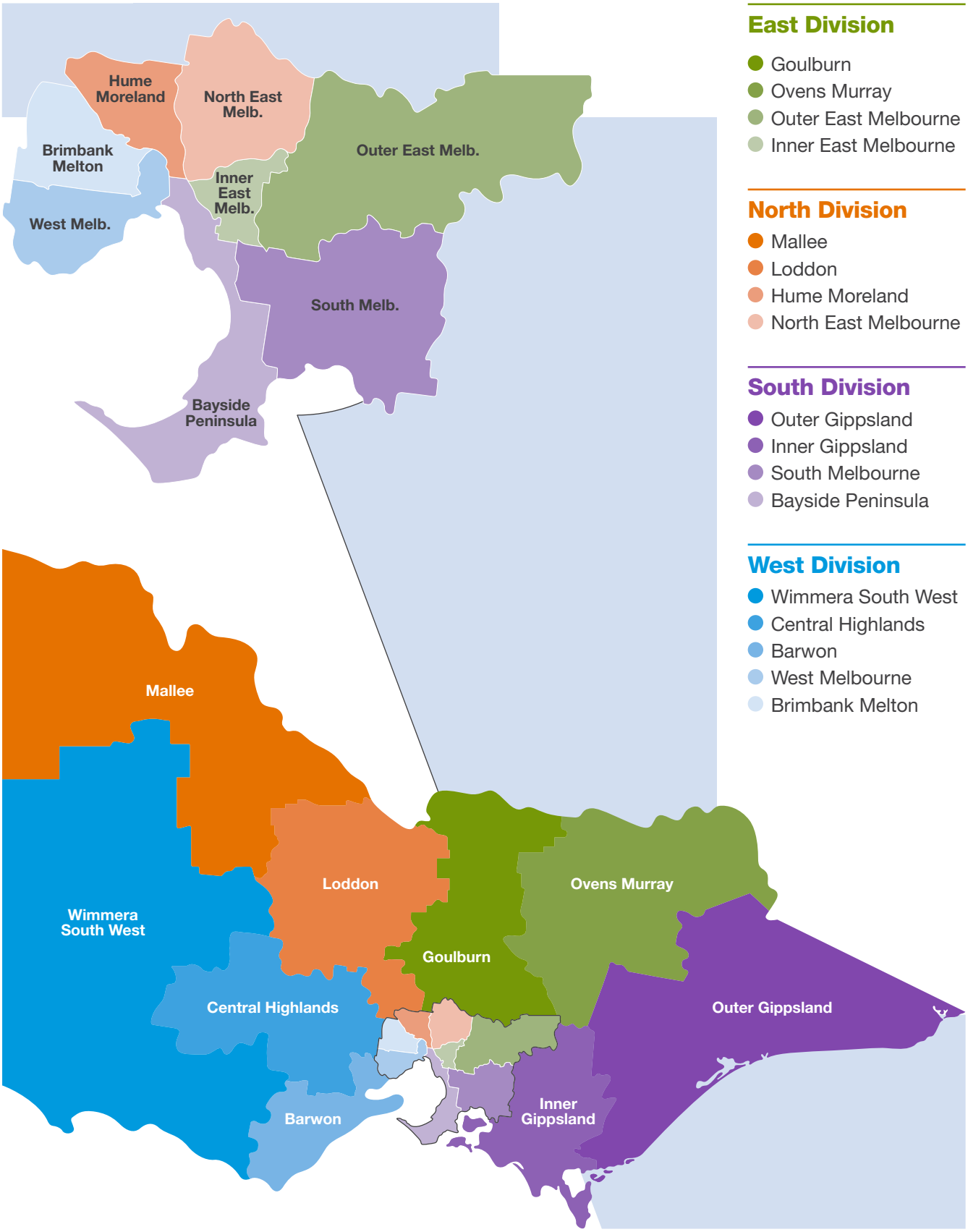
While the vast majority of visits are scheduled and unannounced, a significant number are in response to specific complaints. This includes referrals to the program via OPA's Advice Service. On occasions, repeated visits are necessary to certain facilities over a short period in response to serious issues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

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

Table 1. Number of active Community Visitors and number of visits, 19/20

Stream	Active Community Visitors	Visits
Residential Services	70	828
Disability Services	248	2079
Mental Health	82	1235
Total	**400**	**4142**

Reporting Divisions



Residential Services

> The right to a safe environment is a fundamental human right, including for SRS residents."

Recommendations

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

1. respond to all Community Visitor annual reports in a prompt and timely manner
2. in line with community expectations, lift minimum care and support standards in Supported Residential Services and strengthen the regulatory regime
3. consolidate the Supporting Accommodation for Vulnerable Victorians Initiative and Pension-Level Supported Residential Services Project funding and extend coverage to all pension-level Supported Residential Services
4. strengthen departmental oversight and accountability measures for Supported Residential Services receiving funding under the Supporting Accommodation for Vulnerable Victorians Initiative/Pension-Level Supported Residential Services Project programs
5. ask DHHS, in consultation with the National Disability Insurance Agency, to review all SRS that are also the agency's service providers to ensure transparency in financial reporting and that residents receive the funds and supports they are entitled to
6. set an annual target of 90 per cent of staff in each Supported Residential Service to complete free Mental Health Training sessions
7. establish a Supported Residential Services health project in collaboration with VicHealth to develop strategies to reduce tobacco use and improve health outcomes of residents in Supported Residential Services
8. increase education and guidance to connect Supported Residential Services proprietors with local community and health services to better meet the complex needs of all residents
9. ensure Supported Residential Services staff have adequate English language skills and competencies to manage documentation and provide a safe environment for residents in matters such as dispensing medications, safety and emergency procedures
10. offer training to proprietors on how to select and support a cohesive mix of residents and address challenging behaviours to promote resident safety and compatibility
11. provide additional funding to the Community Visitors Program to ensure the continued fulfilment of its safeguarding role during the pandemic.

Statewide Report

Introduction

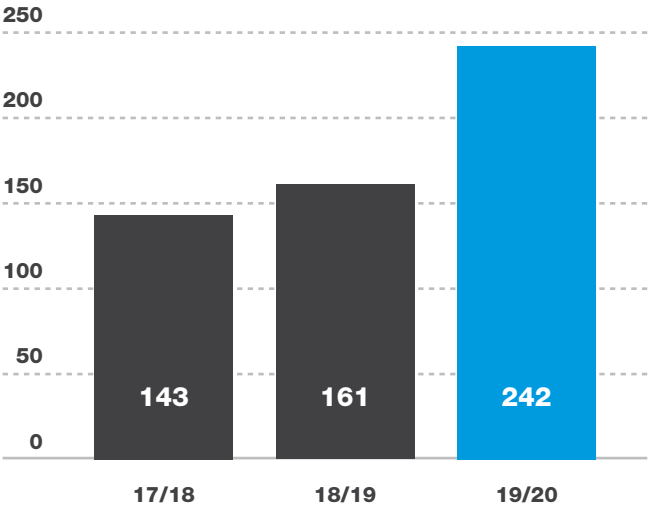
This report to State Government is different to past years in that it is a more expansive statewide analysis, in lieu of separate regional reports. The Board hopes it will bring greater attention to the increasing complex needs of approximately 4000 vulnerable Victorians who reside in SRS.

Supported Residential Services (SRS) are almost all privately operated facilities that provide accommodation and support for Victorians who need help with everyday activities. They are regulated by the Victorian Government under the *Supported Residential Services (Private Proprietors) Act 2010*. The purpose of the legislation is to create a regulatory framework for SRS that provide for minimum standards of accommodation and support to be upheld (s. 1) that 'protect the safety and wellbeing of residents' (s. 6).

The number of people in SRS can range from five to 80. Typically, each SRS has about 30 residents. SRS businesses can be broadly divided into two types: 'pension-plus' facilities where residents may pay more than $1000 a week for their room, meals, care and support, and 'pension-level' SRS where residents are charged 85-95 per cent of the disability or aged pension.

Pension-level SRS fill a gap in supported accommodation options for people with disability, particularly those who are not eligible for (or do not manage to secure a place in) Specialist Disability Accommodation or do not meet the criteria for mental health acute residential care. SRS are not always the most appropriate accommodation for these residents, just the best fit available and preferable to an unsupported environment, rooming house or homelessness.

Figure 2. Issues of abuse, neglect and violence identified in Residential Services stream, 17/18–19/20



Due to a shortage of accommodation options for people experiencing homelessness and serious mental health issues, the majority of SRS increasingly support a diverse mix of resident needs, from those who are ageing to a younger cohort referred from mental health or homelessness services.

Residents with complex needs eligible to receive the Newstart Allowance, or since 20 March 2020, the new Job Seeker payment, are generally unable to afford SRS fees. Their only alternative is unsupported rental accommodation in registered or unregistered rooming houses or homelessness.

Table 2. Total visits Residential Services stream, 19/20

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	38	15	28	184	**212**
North Division	23	12	14	131	**145**
South Division	42	22	24	255	**279**
West Division	24	21	18	174	**192**
Total	**127**	**70**	**84**	**744**	**828**

Community Visitors reported 1838 issues this year. Figure 3 shows the number of issues by category. Figure 4 (at the end of this report) provides a further disaggregation of these issues.

This year, 70 Community Visitors in the Residential Services stream conducted 828 visits to 127 SRS across eight regions of Victoria. From April 2020, following the outbreak of COVID-19, visits were conducted via phone calls with proprietors and staff.

The number of SRS in Victoria continues to decline. This year, two pension-plus SRS and one pension-level SRS in the West Division, closed, withdrawing 81 beds from the sector. There are now 124 SRS, 76 of which receive financial assistance from the Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) or the Pension-Level Supported Residential Services Project (PLP).

In addition to three closures, seven SRS registered a change of ownership to a new proprietor.

The annual report is the Community Visitors' opportunity to highlight the needs of SRS residents, showcase examples of best practice, suggest opportunities for quality improvements and provide recommendations for systemic reform. The SRS sector is subject to government regulation and many SRS receive substantial government funding to support the wellbeing of vulnerable residents.

The Board notes with disappointment that it did not receive a response from the State Government to the recommendations in the *Community Visitors Annual Report 2018-2019*. Therefore, this years' recommendations have been prepared without the benefit of this feedback.

Given the immense challenges facing SRS residents, the Board encourages the State Government to prioritise the preparation of future responses with accountable actions and within time frames reflective of the Community Visitors' annual reporting cycle.

Committed and passionate community members volunteer their time to protect the wellbeing and advocate for the human rights of residents of SRS. The Board believes the continued delays in responding to their reports is disrespectful and disheartening for the volunteers in this critical safeguarding role.

Abuse, neglect and violence

Community Visitors reported 242 new instances of abuse, neglect and violence. There were a further 28 instances that remain unresolved from the previous year.

The cohort of residents living in SRS, especially pension-level SRS, includes a significant number of people with serious mental health issues which impacts on their ability to live harmoniously in a congregate care environment.

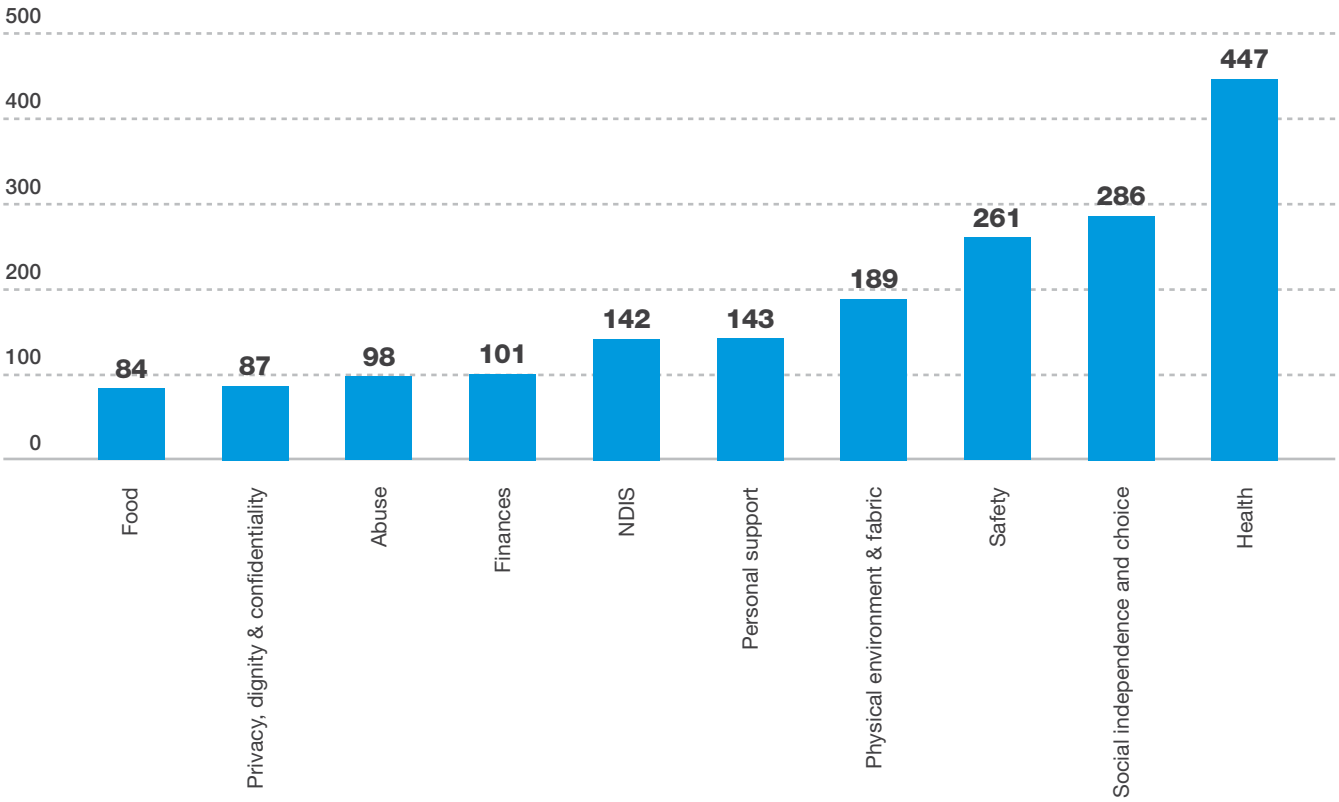
Community Visitors reported three allegations of rape, as well as multiple allegations of sexual assault, sexual abuse, inappropriate sexualised touching and sexual harassment. In some instances, these allegations resulted in police interviews and/or criminal charges and intervention orders against alleged perpetrators. Community Visitors noted some SRS more frequently made use of support agencies such as Centres Against Sexual Assault (CASA).

Some SRS can be threatening environments for some vulnerable Victorians. This year, in almost all regions, Community Visitors documented a large number of incidents of resident-on-resident assault, resident-on-staff assault, verbal aggression and intimidation of residents by other residents and verbal aggression and intimidation of staff by residents, as well as property damage often preceded by mental health episodes.

These included:

- residents taken to hospital as a result of assaults by other residents, including one case where the victim's leg was fractured
- many incidents of resident-on-resident assault, in which police and ambulance services were called
- an intervention order was taken out by one resident against another as a result of alleged assaults
- multiple incidents of residents fighting at one SRS
- a male resident who bit a female resident
- an allegation of one resident stabbing another with a syringe
- female staff members in more than one SRS were assaulted by other residents
- a staff member allegedly assaulting a manager
- an allegation of a resident driving while intoxicated, having an accident and injuring other residents in the car at the time
- incidents of self-harm
- verbal abuse, bullying, threats and intimidation, including with a knife, of other residents, staff and even a volunteer.
- multiple reports of property damage including fires being lit by a resident.

Figure 3. Issues reported by Community Visitors, 19/20



This year, OPA sent two consolidated referrals to the Department of Health and Human Services (DHHS) containing 145 abuse referrals recorded by Community Visitors. Sixty-five of these relate to this year. DHHS acknowledged receiving the reports, however, the Board is disappointed that there has been no feedback about the abuse referrals prior to the end of the reporting period to address Community Visitors concerns.

This year, Community Visitors reported that substance abuse, including heroin, ice and synthetic marijuana, were associated factors in incidents of violence, aggressive behaviours and even assaults in SRS. In many cases, delays or an inability to access a place in an alcohol or drug rehabilitation program exacerbated these problems.

CASE STUDY

Any assault is serious, and all victims deserve a voice. The right to a safe home environment is a fundamental human right, including for SRS residents.

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 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 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 remained 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. She 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.

Prescribed Reportable Incidents (PRI)

Under the Supported Residential Services (Private Proprietors) Act, residents of SRS have the right to freedom from abuse, neglect and exploitation, and proprietors should provide safe and comfortable surroundings and ensure that support services take account of the needs of individual residents as far as possible.

Section 77(3) of the Act requires a proprietor to notify the Secretary of any PRI that occurs on the premises of, or in relation to, the SRS within the prescribed reporting time.

There are four types of PRI:

- an unexpected death of a resident
- a serious injury of a resident
- a fire or other emergency event and
- an alleged serious assault (sexual or physical).

On several occasions this year, Community Visitors expressed concern that some SRS continue to record few PRIs, despite some deaths and serious injuries being recorded.

Impact of the COVID-19 pandemic

The COVID-19 pandemic restrictions impacted on residents in SRS and staff.

SRS residents are particularly vulnerable to COVID-19 because many live in facilities with shared bedrooms and bathrooms, social distancing can be difficult in communal areas, managers have low levels of understanding of infection control and many residents have difficulty understanding and complying with lockdown restrictions.

Managers reported increased costs and poor access to food, cleaning materials, personal protection equipment, and medication. Despite support letters from DHHS that additional food supplies were needed, some proprietors still experienced difficulties purchasing the quantity of food required.

Some SRS provided extra staff hours for additional cleaning, changed dining rooms and staggered mealtimes to allow for social distancing. Concerns were raised about contingency plans should staff or residents contracted the virus.

Various SRS reported some residents' health needs were met through telehealth appointments. However, Community Visitors also report that NDIS workers were prevented from visiting some SRS as staff were not differentiating between visitors and workers. Some SRS with their own NDIS businesses excluded other service providers from their premises. In some cases, this had the effect of forcing residents to use the NDIS services provided by the SRS.

Early in the pandemic, Community Visitors reported that residents missed out on their usual activities in the community, despite this not being a government requirement at the time. There were also reports of staff unlawfully restricting residents from partaking in essential shopping and exercise despite this being contrary to the Chief Health Officer guidance.

In some cases, residents were encouraged to remain home with alternative activities provided such as games, and in one case, a local health service provided activities via Zoom. At one SRS, residents were enthusiastic about exercise sessions using Zoom. The manager told Community Visitors the facility hoped to improve their physical fitness equipment area and also install a big screen TV that could be used for exercise as well as entertainment.

In another SRS, the manager said no resident activities had been arranged during lockdown, as they did not organise activities for residents without an NDIS plan.

Community Visitors noted at another SRS that some activities such as bingo may not have appealed to younger residents, and no alternative activity was offered.

GOOD PRACTICES

An SRS closed off its day room area with the large communal TV and the sitting room so they could extend the dining room space.

The SRS spread tables 1.5 metres apart and required the two residents sharing a room to occupy the same table. All residents have TVs in their rooms and are provided with fresh water twice a day.

Community Visitors were impressed that some SRS could provide more activities, one purchasing a pinball machine, streaming TV/movies, and providing other special activities for all residents. One resident taught knitting while another shared their guitar playing skills and led sing-alongs.

Several SRS reported the benefits of iPads purchased with SAVVI funding, which enabled residents to keep in touch with family, attend medical appointments, continue Arts Access activities and generally have fun discovering a world of games. NDIS workers and SRS staff have been integral to the process of assisting residents learn and use this technology.

Another SRS established a pop-up Men's Shed for the residents to do carpentry and mechanical work. The 'shed' is in a large basement area and operates three days a week with a supervisor, enabling three to six residents to attend regularly. It also has sporting equipment for those residents seeking exercise.

In response to the COVID-19 lockdown, a pension-plus SRS, catering to residents over 65 years of age, built a 'visiting pod' out of a converted shipping container. It is attached to the SRS and has two discrete entrances, one for residents and the other one for family members or visitors. There is a glass barrier between the two parties. The pod is heated and has audio facilities so residents can see and hear family. This has been a great comfort to and appreciated by elderly residents and their families.

Health

This year, Community Visitors found 447 issues related to healthcare, representing the largest issue category documented.

Complex and diverse health needs

Many residents have complex health needs, particularly in pension-level SRS where more residents have been adversely affected by poverty and lack of access to health and preventative services.

The SRS sector has become increasingly complex with residents with diverse health needs related to ageing, disability, complex mental health conditions and addiction issues. There are examples of serious issues occurring in SRS with little or no support from police and emergency health staff.

CASE STUDY

A woman seeking a supported independent living environment, accepted two weeks respite at an SRS following a suicide attempt. She lives with a serious mental health disorder, incontinence, and has hoarding issues.

Despite the commendable attempts of the manager to assist her, the care needs of the resident exceeded the capability of the SRS. Her behaviours were incompatible with existing residents, disrupting their day-to-day life and sense of security in their home.

The Community Visitors observed that the involvement of an NDIS support coordinator, mental health case worker, and another support worker, together with the resident's efforts to make a complaint to DHHS, were ineffective in preventing a Notice to Vacate.

With assistance, she found temporary accommodation, however, Community Visitors observed that more suitable accommodation options and case management were needed to coordinate her supports to ensure a better quality of life.

High care needed in a low care sector

Community Visitors report that 'low-care' SRS are increasingly accommodating residents with complex health needs, often with insufficient support, knowledge or skilled staff. This can contribute to a deterioration in a resident's health.

In one case, the manager noted that a resident who had waited for six months for a Home Care Package now required urgent additional care and palliative support. In another case, Community Visitors reported a resident was moved to a residential aged care facility after 23 incidents in two months.

Community Visitors remain concerned that there are no defined triggers for an SRS resident to move to alternative accommodation that better supports their high-care needs. In a sector with low margins and high costs, some proprietors may be under pressure to retain ageing residents in order to maintain viable occupancy levels.

DHHS informed Community Visitors that a Targeted Compliance Review was completed last year in pension-plus SRS to monitor the health of older residents. This led to DHHS providing funds to train SRS support workers through Leading Aged Services Australia and La Trobe University. To date, 48 SRS staff have attended the two-day Recognising and reporting changes in residents' health course.

DHHS wrote to all pension-plus SRS that had not sent staff to the training. The training was suspended due to COVID-19.

The board encourages DHHS to ensure courses are accessible to support workers in regional areas. Funding is required to enable regional SRS staff to access this much-needed training.

CASE STUDY

Allied health professionals were concerned that a resident was not receiving appropriate care for an infected ankle wound. The resident had been largely bed-bound following a fall two months previously, and Community Visitors queried whether the SRS had the capacity to provide the level of care he required.

There were delays in the resident receiving specialist wound care because the SRS was reluctant to allow a specialist podiatrist entry to the SRS citing COVID-19 visitor policy guidelines.

Although the specialist was subsequently able to attend the resident, his ankle wound had deteriorated substantially due to the delay. In addition, Community Visitors queried whether bruising on the wrists of the resident might have been indicative of undue restraint applied during hoist transfers.

Despite a notification to DHHS, made in May 2020, the matter is yet to be resolved. Community Visitors remain concerned that the health needs of the resident are addressed in a timely manner.

Medication administration issues

Issues identified during the year in relation to resident medication included incorrect or no medication administered, and an alternative medicine given to the resident with no explanation, resulting in the person, understandably, refusing to take the unknown medication. In some instances, this has resulted in the resident requiring hospitalisation and, in one case, the resident required admission to the Intensive Care Unit until they recovered.

In another example, Community Visitors received advice from a family member that a young woman with an intellectual disability went to a hospital emergency department following a medication error at the SRS. Residents and staff appeared upset by what had happened, however, Community Visitors noted that the incident report was brief and did not clearly identify what occurred. Although investigated promptly, Community Visitors questioned the thoroughness of the DHHS investigation.

CASE STUDY

Community Visitors initiated a notification to DHHS seeking clarification of the proprietor's obligations around medication management.

At an SRS, Community Visitors had observed multiple prescribed medications on a resident's bedside table. The resident explained that he did not always need what was prescribed to him.

His support plan contained contradictory information stating that staff should ensure the resident took medication and that the resident was able to manage his own medication administration.

The proprietor was unsure whether the resident had capacity to manage his own medication and sought advice from the treating doctor.

DHHS obtained written confirmation from the doctor who clarified that the resident had the capacity to manage his medication but needed help with timing from staff.

The resident's support plan was subsequently changed to reflect this.

Prevention – nutrition, smoking and physical activity

Disease prevention and proactive support for good health outcomes remain ongoing issues for many residents living in SRS.

Facilities often provide basic meals that are made in bulk. While they meet most resident needs, they are often high carbohydrate, fat, and salt with limited protein and vitamins. Community Visitors would like to see nutritious, interesting and diverse menus that support good health outcomes.

Residents often complained about limited meals, including a lack of vegetables or options that met specific dietary needs, such as diabetes or gluten intolerance. In some facilities, powdered milk is still being used despite residents stating they preferred fresh milk.

Smoking is an ongoing and critical issue for SRS residents' health, with 54 per cent of residents smoking compared to 12.8 per cent of the general population. Smoking is responsible for or exacerbates many health conditions experienced by residents and impacts on their financial wellbeing. However, some quit-smoking campaigns appeared to have limited results, with one SRS reporting only one resident quitting from a reduce smoking campaign. Community Visitors have seen little evidence of organised 'Quit' activities so more widespread action and support is needed for this cohort of residents.

Most SRS had no proactive exercise or activity programs to support residents' good health, apart from walks to nearby parks or around the block.

Mental health issues

Community Visitors continued to report concerns about the lack of documented referrals between mental health services and SRS, despite the Office of the Chief Psychiatrist introducing 'Mental health services and Supported Residential Services: A guideline to promote the collaborative support of residents' in 2018. Proprietors indicated that many discharge referrals from mental health services did not follow the procedure outlined in the guide.

In one case, after a resident died from a drug overdose, Community Visitors were informed that the referring mental health service had not communicated or followed up with the SRS since the resident's arrival two weeks earlier.

SRS managers frequently reported that patients are discharged from an acute mental health setting to an SRS with no notice and with limited or no referral paperwork and without community case management support in place, resulting in a lack of advice and accountability for the resident's wellbeing.

Community Visitors note that the SRS environment is becoming increasingly challenging for under-trained staff, some of who have limited English language skills, or the language proficiency required to communicate with a diverse mix of residents about their complex needs.

Despite DHHS actions to promote and monitor attendance at the SRS mental health training program provided free to the sector, there has been a limited response from SRS staff. During the year, only 88 staff booked into and completed training. Due to COVID-19, training was on hold from March 2020. This is a concern as many SRS are often left in the care of one staff member who may have no training other than a First Aid certificate.

It is noted that this mental health training would provide proprietors and staff the skills to effectively engage and manage residents with complex mental health presentations.

CASE STUDY

A resident locked himself in his room which was full of papers and soft drink cans. He would not allow anyone to tidy or clean, stating he felt under threat from others.

Community Visitors reviewed the resident's records which referred to "poor behaviours" but mental illness was not noted. The police and mental health assessment team had been called but were unable to help. The resident had been recently discharged from an acute mental health setting to the SRS following a referral from a housing officer.

The referral contained sparse information on the man's health condition or needs. Due to the poor quality of the referral, SRS staff were unable to accurately assess the suitability of this resident or their needs.

Following an incident where the resident climbed to the SRS' roof, removing tiles he thought were spying on him, he was readmitted to the mental health unit. The same housing officer later referred him to another SRS, where he again removed roofing tiles, causing considerable damage to the facility's plumbing. The cost of these repairs was later charged to his administrator.

In another incident in the same region, an acute mental health unit discharged a patient to an SRS and organised delivery of his medications, however, the resident never arrived. After investigation by the proprietor, it was discovered the man had gone to his mother's house. Community Visitors acknowledged the considerable efforts of the proprietor to ensure the resident's safety, however, were concerned that the discharge process was not properly communicated.

The recording of deaths

Community Visitors also observed different practices in the recording of deaths. Some were recorded in incident reports, others not. Sometimes Community Visitors were advised by DHHS of an unexpected death in an SRS and at other times no information was provided.

Social independence and choice

Individuality and choice

A positive feature of the legislation that governs the operation of SRS is its emphasis on the residents' right to social independence and choice. Community Visitors are concerned when residents' choices are not prioritised or considered.

Community Visitors only became aware of two SRS closing through the local newspaper. Neither Community Visitors nor the OPA guardians with represented persons residing at the facility were informed of meetings with residents about the closures. No independent advocacy was available to support residents at a very stressful time. The Board continues to strongly advocate that vulnerable residents should be provided with independent advocacy when any facility closes.

In another case, Community Visitors were concerned at the social isolation felt by a younger SRS resident where all other residents were elderly. As it was a regional area, the younger resident had limited choice where she lived. Community Visitors commended the SRS for the large range of activities appropriate to older residents and sought options for the resident who was decades younger. In response, the SRS reviewed the resident's personal support plan and advocated to have her NDIS plan reviewed to accommodate more social inclusion.

At one SRS, a resident complained that dinner was served at 4.30pm. The manager explained the resident was offered the option to eat later, however, Community Visitors perceived this could be challenging to arrange on a regular basis.

At another SRS, a resident was not receiving financial statements from their financial management provider. Following advocacy from the SRS and the Community Visitors this issue was addressed. Community Visitors also note that the most frequently appointed financial management provider, State Trustees, is yet to visit some of their clients in a regional SRS.

Activities

Being active is critical to the mental and physical health of all Victorians. This is especially true for pension-level SRS residents, many who do not have family contacts or strong social networks.

Community Visitors reports show that some SRS provide a range of activities funded by the facility while others with a similar resident profile provide almost none. This is particularly the case in pension-level SRS.

The new proprietor of a regional SRS, which had previously offered activities valued by residents, told Community Visitors that the failure to provide activities was due to a delay in receiving SAVVI funding. For those residents not eligible for or awaiting NDIS funding applications for activities, the lack of facility-run activities was detrimental to their wellbeing.

By contrast, in many SRS, there is a strong sense of community and belonging, nurtured by proprietors and staff who recognise the value of activities to resident wellbeing. In one SRS with 25 residents, everyone has a role, from unpacking shopping to bringing in the bins, tending the garden or setting the tables for lunch. Community Visitors comment on the courtesy and respect for others which enhances life in this SRS and makes everyone feel at home.

Activities during the COVID-19 pandemic

The COVID-19 pandemic has impacted greatly on the activities available to residents with most external activities restricted or stopped entirely, including employment and NDIS-funded activities.

Community Visitors have been maintaining contact via phone visits and are very pleased to note that many SRS have responded with more inhouse activities and some very innovative solutions to occupying residents. They included:

- an in-house canteen for residents to buy snacks
- a pop-up Men's Shed in the basement of the SRS-operated and supervised three days a week
- exercise facilities such as boxing within the SRS
- virtual trips with residents encouraged to pack and dress for the occasion e.g. a plane flight, a desert island
- a pinball machine purchased by an SRS with PLP funding
- exercise activities continued via Zoom
- YouTube activities – eg mindfulness sessions and Bollywood dancing sessions
- pamper sessions
- cooking lessons
- a ceramics workshop in partnership with NDIS but funded by the SRS
- knitting groups run by residents
- assistance by outside agencies in the provision of activity packs including puzzles, colouring books, DVDs and games for residents.

Safety

Moving on – closures, Notices to Vacate and evictions

A 68-bed facility relocated from Ballarat to Bendigo due to a lease issue. Vulnerable residents received 28-days' notice of the closure. Residents were given the option of relocating to another SRS in a different regional centre or finding local accommodation. Some residents with minimal or no supports had limited alternative and available accommodation options that could meet their needs.

In other SRS, Community Visitors reported a number of instances of residents being given Notices to Vacate, and the eviction of residents including those receiving respite accommodation. They note, with concern, the frequency of the following chain of events: substance abuse leading to allegations of assault leading to eviction.

Community Visitors, especially in Barwon and Western Metropolitan Melbourne area, were also concerned by a lack of timely access to drug and alcohol support services, noting this gap would likely result in many continuing a dangerous spiral of abuse and violence.

There are also concerns about the process used by many SRS to select their residents. If a resident is referred from a mental health facility with no case notes, the proprietor is unable to adequately assess needs and prepare an appropriate support plan. Resident 'fit' and staff capacity to manage the needs of residents is also an issue. Targeted training and support for proprietors, especially newer proprietors, may assist this process – and impact on the viability of the SRS business.

CASE STUDY

A resident requested Community Visitors contact their SRS to address their tenancy concerns.

The proprietor advised the client's four-week tenancy would be reviewed the following day. Although non-committal about the likely outcome of the review, the proprietor denied any imminent risk to the resident's tenancy.

A few hours later, the resident's support worker advised that the client had been issued a Notice to Vacate by the following day.

Community Visitors requested DHHS investigate the matter. DHHS advised that the resident was asked to vacate due to a range of complaints about behaviour that had been appropriately documented. The decision not to extend the residential and services agreement and the reasons for the decision were communicated to the resident both verbally and in a letter.

However, DHHS acknowledged the letter was not a Notice to Vacate as defined in the Act. The proprietor was required to review their systems and documentation to ensure that the terms of a residential and services agreement were clearly articulated so that residents understood the content.

Community Visitors were concerned that the proprietor's actions to issue a letter to vacate was a direct result of the phone call by the resident requesting a Community Visitor to raise issues on their behalf.

Physical environment and fabric

Community Visitors continued to report issues relating to the physical environment in which SRS residents live.

Building

For more than a year, Community Visitors advocated for the repair of broken floorboards on a verandah of an SRS, they considered was a significant risk to the safety for elderly residents. DHHS advised there was a dispute between the landlord and the SRS and took action against the SRS. The SRS closed in February 2020 before the repairs occurred.

Demountables at an SRS

Reservoir Lodge SRS has the capacity to provide accommodation for up to 100 residents. The facility includes 28 demountable units on the site closely situated to the main building.

Since the demountable units at RL have been occupied, Community Visitors' reports indicate that residents of the demountable units rely on the existing SRS facilities (i.e. meal preparation and dining) provided by RL.

Reservoir Lodge has resisted efforts by Community Visitors to visit residents in the demountable units when Community Visitors routinely visited the SRS.

The Public Advocate was particularly concerned that the demountable units posed a fire safety risk to all RL residents as the demountable units do not have fire suppression equipment (i.e. a fire sprinkler) installed.

She brought these matters to the attention of DHHS in 2019 and a compliance notice was issued to the SRS in early 2020.

Internal fitting and fixtures

Community Visitors frequently reported on SRS with broken furniture and inadequate bedroom furnishing. For example:

> *"The door to a bedroom was open. Apart from a chair there was no furniture at all. Clothes were on the floor and three mattresses made up the bed base. Community Visitors could see the bed linen was dirty. Cigarette butts were on the floor as well as in an ash tray."*

Disability access

Community Visitors were concerned about a ramp used by residents at one SRS. Residents said they had difficulty wheeling mobility equipment up the ramp and Community Visitors observed a resident in a wheelchair with the use of only one arm who was forced to go backwards up the ramp. The situation improved with the installation of a new handrail, but the building requires an accessibility review for residents with mobility aids.

Maintenance

A poor standard of maintenance was noted in several SRS, with basic repairs taking a long time despite persistent reporting. Poor maintenance included:

- an air conditioning outlet pipe dripping into a bucket near the food preparation area
- outside areas and gardens neglected and filled with rubbish and discarded objects
- a door falling off while Community Visitors were in attendance.

Cleaning

Many SRS have an effective cleaning regime, however, poor cleaning practices in some SRS over many years is particularly concerning for vulnerable SRS residents – and alarming during the COVID-19 pandemic. Issues commonly reported included dirty bathrooms with urine on the floor, evidence of mould and insufficient toilet rolls and soap.

Issues relating to incontinence were also commonly reported. For example, a resident reported to Community Visitors objectionable odours from used incontinence pads in a shared bathroom. This was later resolved with a range of approaches including increased cleaning of bathrooms.

Many SRS have reported to Community Visitors that they have significantly increased their cleaning practices as a response to the COVID-19 pandemic, at an additional cost for the business. Community Visitors are hopeful that a higher standard of cleaning will continue after the coronavirus pandemic.

Heating and cooling

Community Visitors again reported that several SRS are always cold and often have their heating turned off even during winter. One elderly resident reported wearing her clothes to bed because she was cold. This is an even greater concern for residents as they remain at home during isolation and lockdowns necessitated by COVID-19.

Bedding and linen

Two SRS in the same region experienced bed bug infestations. One bought new mattresses but the other denied there had been an infestation of bed bugs and cockroaches. However, residents at the latter SRS frequently showed Community Visitors the bites on their arms from the bed bugs. At the same SRS, residents consistently complained to Community Visitors of being cold at night due to insufficient bedding. These concerns were escalated to DHHS on several occasions and, although clean bedding has been provided, it remains an ongoing issue.

GOOD PRACTICES

In one SRS where the incontinence of the previous tenant resulted in the room smelling of urine, the SRS replaced the carpet with a flooring which could be cleaned more easily.

A resident's property was stolen during their absence. The SRS identified those responsible for the theft and secured the return of the property prior to the resident's return.

Two SRS developed relationships with local businesses to improve the garden and, therefore, resident amenity.

In the summer bushfires, a generator funded by SAVVI was used to provide power to the SRS during electricity outages.

Personal support

Staffing and support

The capability of staff is critical to the success of an SRS and the lives of residents.

CASE STUDY

Community Visitors understand that Child Protection placed a 12-year-old with her mother who was residing in an SRS.

The daughter was allocated her own room in the SRS, next door to her mother.

Management then complained to Community Visitors that the daughter was not attending school and spent her days smoking, sleeping and watching TV. The SRS was also having difficulties with young boys visiting to spend time with the girl and helping themselves to food from the kitchen.

Community Visitors notified the Public Advocate who escalated the matter to DHHS, and the mother was assisted to relocate to temporary motel accommodation which better suited their needs.

Community Visitors were shocked that Child Protection would consider such an environment appropriate where Working with Children Checks and other occupational health and safety checks may not have been undertaken.

At another visit, Community Visitors were unable to discuss matters of concern with a staff member due to their extremely limited English. The Community Visitors were concerned that vulnerable residents may not have been able to have their needs understood or even met and were concerned how an emergency would be managed by the staff member with poor language skills.

An incident report noted a staff member "smelling of alcohol". The staff member was stood down and subsequently dismissed.

Personal Support plans

Community Visitors report proprietors have differing attitudes to the development and use of personal support plans. Some see them as valuable tool in assisting residents, others merely as a bureaucratic requirement.

Community Visitors were impressed at the level of detail in the support plans at one SRS, particularly as they were written in the first person which conveyed a sense of empowerment and dignity for the resident. However, at several other SRS, Community Visitors queried whether the increasing care needs of residents were being adequately met, since the documentation in support plans was minimal or formulaic at best and often out-of-date.

Hygiene

Some residents of SRS present with very challenging behaviours in their hygiene.

A resident with open sores as result of diabetes, would not allow staff to clean his room and bathroom, change the bedding or do his laundry. Community Visitors, entering the room at the resident's invitation, observed blood-stained bedding and walls as well as a filthy floor, dirty dishes and rubbish.

The resident was ostensibly caring for his own wounds.

In response to feedback from Community Visitors, the SRS instituted a behaviour support plan, focussing on cleanliness and personal hygiene with reminders and encouragement. This has seen an improvement in the state of the room, the resident's personal hygiene, improved relationships with others in the SRS, and even some desired weight loss.

Other common challenges of some residents include incontinence and dental hygiene. Community Visitors reported instances of good support from SRS in these areas and support from SAVVI for some SRS.

Grooming and clothes

Personal grooming is a critical factor for many residents in maintaining a healthy mental state and most residents of pension-level SRS have very limited discretionary income. When clothes were lost in the laundry, one SRS, with advocacy by Community Visitors, paid a nominal amount to replace them, while another is yet to respond in a similar manner.

Food

Food Safety

Community Visitors remain very concerned about the poor food safety and hygiene practices in some SRS. This has included reporting to DHHS the presence of a cat and kittens in a kitchen, food past use-by dates and unhygienic food handling practices.

Community Visitors have been informed that DHHS does not regulate environmental health, however, the department has repeatedly failed to refer such issues to the appropriate authorities, such as local government. Community Visitors have requested DHHS increase its accountability for the provision of a safe living environment for all SRS residents.

Quality of food and special dietary needs

Community Visitors documented many concerns about the health and safety of residents due to the poor nutritional value of food, especially the lack of fresh fruit and vegetables, the lack of variety in menus and the inappropriateness of some menus for people with special dietary needs, for example, those with diabetes.

CASE STUDY

Community Visitors were concerned about the nutritional value of a dinner menu that included lasagne and chips, and chocolate Bavarian for dessert. No weekly menu was available to view making it difficult for them to assess the overall adequacy of the meals provided by the SRS.

At the same SRS, two residents reported vegetables were rarely available. Both were insulin-dependent diabetics and had amputated limbs. They indicated the food was not helpful for their condition. They also reported many meals included party pies and chips and that residents did not have access to fresh milk, only powdered. Their comments echoed concerns raised by Community Visitors about food in the SRS.

In another SRS, a resident, awaiting the fitting of dentures, had difficulty chewing. The manager explained she was offered Sustagen and a modified version of the main meal option, for example, white rice and curry sauce. She was, however, unable to advise how this meal requirement had been determined and what choice the resident had.

Community Visitors notified DHHS of their concerns about this resident's nutrition. DHHS subsequently advised that the SRS managed the nutrition of the resident appropriately, given 'the behaviour of "the resident and the decline of the resident's health".

In one SRS, residents were asked to supply their own cups for drinking. Community Visitors frequently observed no potable water available and, on a very hot day, were told "residents can always ask for water if they need it".

Resident choice

In some SRS, residents are given no choice in relation to food. One resident said bread for toasting was not provided, while another resident at the same SRS said they preferred pasta and better meat dishes. The SRS Manager said lamb was served as a special dish.

In one SRS, residents complained that the menu lacked variety. One resident said they could not request menu preferences and sandwiches were provided if a meal was not acceptable. Community Visitors spoke to the manager who advised that a food survey was being conducted and a relatively new cook would receive training. The manager was aware of some resident's issues with food. Subsequently this issue was resolved.

NDIS staff support

For the third consecutive year, the Board undertook a project to assess the number of SRS residents who have accessed the NDIS.

This year, 74 SRS participated in a survey conducted by the Community Visitors on their visits representing 58 percent of SRS residents in Victoria.

The proportion of eligible SRS residents with NDIS is much higher at 70 per cent compared with 51 per cent last year.

At one SRS, no eligible residents were receiving NDIS or had applications in progress.

In another SRS, one resident applied for an NDIS plan but declined to accept once she discovered she would not be getting the funding paid directly to her.

At an SRS in the West Metropolitan Melbourne area, where Community Visitors have raised several serious complaints about a residents' treatment, the proprietor explained that no one was actively working with residents and, if they had no plan, there was no other support available.

GOOD PRACTICE

Over half the residents in one SRS have case workers. SRS staff worked collaboratively with services and now 90 per cent of residents have an NDIS plan, a significant increase from last year.

Residents, many of who have psychosocial disabilities, need targeted information and assistance to access the NDIS. This requires additional funding. Some proprietors providing both SRS and NDIS services to the same residents appear to have no additional staff or increased services available to provide the NDIS services.

Community Visitors have documented that SRS proprietors and staff throughout Victoria lack knowledge and understanding of NDIS service provision - even when they are also an NDIS provider. Some seemed "out of their depth" when detailed questions were asked about their NDIS services to residents. Community Visitors question what information and services are actually being provided to residents by the NDIS services.

While dual registration by a proprietor with DHHS and NDIS is a lawful practice, a key concern of the Board is the potential for a conflict of interest when an SRS proprietor operates an NDIS business that provides services to residents in their SRS. Community Visitors have received feedback from residents and OPA guardians that residents can feel they have little or no choice or control when this occurs. For example, one SRS advertised a 'partnership' with an NDIS provider which was very misleading as it was the same people running both businesses.

For some time, Community Visitors have been extremely concerned about the potential for residents who have an NDIS plan to be charged for services provided by staff at the SRS from their SRS fees and, at the same time, via funding from their NDIS plan. It is very difficult for Community Visitors to substantiate these concerns because they may not have access to the residents' NDIS plans and residents are not always aware of what their plan contains. Nonetheless, the lack of transparency around the use of NDIS funds combined with resident complaints about it and the neglected state of some residents with NDIS plans is cause for grave concern.

Some residents have claimed that their NDIS funds have "disappeared" and they don't know what happened to them. In one case, an SRS facility that had previously provided residents with showering assistance, now only provides 'shower reminders' with no reduction in SRS fees. Showering assistance is then only available to those who can pay separately for it via their NDIS plan. In another case, a resident with complex needs has an NDIS support worker who is also an SRS staff member. The worker sits with the resident when he isn't doing other work. Community Visitors question how a resident with a large NDIS package appears to receive little discernible benefit beyond 'personal care' and assistance with bathing, clothing and feeding which is also funded by SRS fees.

An emerging issue with the COVID-19 pandemic has been proprietors or their staff effectively locking other NDIS service providers out of their property, either by refusing them entry or making it very difficult for them to access their clients.

One example involved an NDIS support worker phoning an SRS every week over an extended period prior to their arrival to advise when they would get there. The worker then requested that the SRS staff organise the client (who did not have their own phone) to come out to the carpark to meet them for their two-hour session. However, when the worker arrived, their NDIS client was nowhere to be seen. The worker then made repeated phone calls to the SRS requesting the client be asked to come out to meet them, but nothing happened. It became clear that the staff were either not passing the messages on or there was a lengthy delay in this occurring.

Sometimes the client never arrived, on other occasions they came out after an hour so, then only had half their time with the support worker. If the support worker or SRS resident complained to the proprietor about this issue, they were advised that if they were using the proprietor's NDIS business then they would have none of these problems.

Conversely, some proprietors are building productive relationships with a wide range of NDIS service providers and support workers.

Some proprietors reported difficulties accessing information from NDIS workers who came to the SRS. On one occasion, the manager told Community Visitors it was helpful to have some information so that she could better look after residents. The support worker continued to come to the facility but made no contact with staff before dealing with the resident.

In many cases, proprietors had not set up their own systems to resolve the problem such as implementing a sign in/sign out book or a requirement that all service providers attending their facility wear identification including their organisation name as recommended by Community Visitors in last year's annual report.

SAVVI and PLP funding

SAVVI funding is critical to enhancing the lives of many residents in pension-level SRS through the provision of funding for social activities including bocce, cake decorating and the development of 'memories books'.

Community Visitors received several reports on the value of iPads provided by SAVVI which have enabled many residents to keep in touch with family during lockdown, attend tele-health appointments, continue activities, and access entertainment. Those vulnerable Victorian residents who live in a pension-level SRS not eligible for SAVVI funding sadly continue to miss out on this support.

Last year, the board advocated to re-open the PLP funding to all new eligible SRS. Its limited availability has created three categories of pension-level SRS: those funded under SAVVI or PLP; those that have refused both SAVVI and PLP funding; and new pension-level SRS that are ineligible to receive any additional funding.

The Community Visitors Program met with DHHS to reiterate the importance of combining the SAVVI and PLP programs across all pension-level SRS, with robust performance measures that ensure it is used to benefit residents. However, to date there has been no response to the meeting or the recommendation.

Where available, the additional funding is generally used to make a positive impact on the lives of residents. For example, a SAVVI-funded generator provided relief when used in a power outage in the Hume region and in the West regional area; SAVVI funding was used to provide improved facilities and activities for residents. However, in some SAVVI-funded SRS, Community Visitors could see no evidence that the funds were used to benefit residents, highlighting the need for the program to include performance criteria.

In the current environment, there is increased pressure on SRS. Many proprietors without access to SAVVI or PLP funding are supporting residents with complex mental health needs, Additional funding will assist these SRS to provide more effective support to their residents.

SRS Protocol

The SRS Protocol between the Community Visitors Program and DHHS expired on 30 June 2017.

A working party was established in early 2019 to update the protocol and to improve communication arising from increased tensions between the program and the department. It was disappointing that DHHS advised in July 2019 that it would not be in position to continue this work until its restructure was finalised, sometime in 2020.

DHHS indicated its preference to wait until the review of its regulation functions was completed before the protocol was revised. It is now three years past its review date and the Board believes there are many issues to address as a matter of urgency.

The Board will explore the options to bringing the review of the protocol forward.

Supporting Community Visitors in their legislated role

The Board repeatedly raised concerns about the treatment of Community Visitors at several SRS.

It is an offence to obstruct or threaten a Community Visitor, however, one SRS Manager berated and threatened Community Visitors on several occasions, accusing them of wasting time with 'useless questions'. He refused to answer many questions or discuss concerns raised by residents and told Community Visitors not to visit every month.

These matters were reported to DHHS and there was a consistent pattern of behaviour reflected in the evidence. DHHS efforts to remind the manager of his legislative obligations do not appear to have been effective.

In accordance with the SRS Act, Community Visitors can expect that proprietors and staff must not unreasonably refuse or neglect to give a Community Visitor any reasonable assistance or full and true answers, however, there were instances where managers did not provide information about incidents.

Community Visitors attend SRS where there have been serious incidents and, without prior notification, can be personally traumatised and unprepared to assist affected residents. In one SRS, a resident took his own life by hanging. Another incident involved injury to a resident who was hospitalised and subsequently passed away.

As DHHS has liaised with the SRS to manage these incidents, it agreed that in future, traumatic incidents at an SRS should be communicated to Community Visitors prior to them attending the affected facility. DHHS further agreed to include this in the much-delayed protocol.

Community Visitors asked detailed questions about the serious consequences to a resident following a medication error. When a proprietor complained to DHHS about the conduct of a Community Visitor, it took 12 months for the matter to resolved. The complaint was investigated by OPA and was unsubstantiated. The Public Advocate in her response restated the importance of proprietors respecting Community Visitors performing their legislated role.

DHHS' regulatory role and relationships with Community Visitors

Despite changes in 2018 to align and centralise regulatory functions across DHHS, the Board was informed of a further restructure in the regulatory area in February 2020 with further significant changes expected over the next two to three years.

In March 2020, over 50 per cent of SRS Regulatory Officers were temporarily redeployed to assist with the COVID-19 response, impacting on SRS regulatory activities. This area was already understaffed with three of four divisional managers leaving their roles just before the pandemic.

The Board believes the reduction in resources impacted on the ability to carefully monitor and investigate notifications made by Community Visitors. In particular, the Board is alarmed at the increase in abuse issues and what they perceive as the poor quality of responses to many notifications.

The Board notes the tension that exists between roles of the DHHS and the role of the Community Visitors. The purpose of SRS regulation is to protect the safety and wellbeing of residents and ensure minimum standards. The role of Community Visitors is to protect the safety and wellbeing of SRS residents and ensure they are free from abuse, have choice and control in their lives and are accorded dignity and respect. The lack of regular meetings between DHHS divisional staff and Community Visitors Regional Convenors contributes to misunderstandings, heightened tensions, a decline in engagement and fractured relationships.

The redefined regulatory role continues to be misunderstood. Proprietors and staff repeatedly tell Community Visitors that they see DHHS's role being to assist them and their residents navigate an increasingly complex and challenging social care system. In response, the sector formed a Supported Residential Services Association Inc. to advocate collectively for its needs.

CASE STUDY

An SRS, housing more than 30 residents in a two-storey terrace house in Melbourne's inner south, 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, three times more than the average number of issues reported for other pension-level SRS in the South Division.

Last year, Community Visitors identified 45 critical issues of concern about the living environment and support provided to residents, referring six formal notifications and accompanying visit reports about it to DHHS.

Issues raised included:

- ongoing infestations of bed bugs and cockroaches, and bites on a resident
- on one visit, almost all toilets had no toilet paper and no soap or hand towels
- poor hygiene practices related to food preparation, including the presence of cats in the kitchen and open cat food tins in the fridge
- poor food quality, with limited adaption to residents' health needs, or personal choice
- poor levels of personal hygiene and clothing
- residents complaining about being cold, particularly at night.
- broken and stained furniture and parts of the property in disrepair
- the death of an elderly resident
- resident's reporting assaults and of being afraid of other residents with one resident accusing a staff member of hitting her
- intimidation of residents, family and visiting professionals, including threats to evict
- inappropriate and abusive behaviour towards Community Visitors and OPA staff.

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.

The SRS has a number of single rooms, double rooms and shared rooms housing up to three residents in a room. Some shared rooms have chipboard barriers between the beds in an attempt to provide residents with privacy while others do not. Bathrooms are communal and in extremely poor condition. There is a small lounge room with a TV and a dining room where meals are provided. The facility has no wheelchair access.

The male and female residents range from 20 to 70 years old. Most are long-term residents, but short-term respite is available when there is a vacancy.

Many of the SRS residents have multiple conditions and complex needs and are among the most marginalised members of our community. Community Visitors have frequently reported seeing residents in a dishevelled and neglected state.

The residents are supported by a local health service which manages the SAVVI Supporting Connections Program, and provides allied health services, if required.

Under the SRS Act, residents have "the same rights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities".

The SRS claims its staff, including Personal Care Attendants, are Certificate III qualified and have a police check, and that it was passionate about caring for residents in a family atmosphere.

Evidence from the Community Visitors, however, paints a vastly different picture.

Concerns about the SRS are longstanding, with issues identified by Community Visitors during unannounced visits, and individual concerns raised with OPA.

It is noted that a DHHS authorised officer has the ability under the SRS Act to take enforcement action against an SRS proprietor such as issuing an infringement notice (s.155) or compliance notice (s.160).

In September 2019, Community Visitors were concerned about the wellbeing of an elderly resident who died five days later. The resident lived in a shared room with two other people and was well-known to Community Visitors as they had visited her on multiple occasions. Prior to her death, Community Visitors had been appalled at the dirty condition of her room, the stained linen on her bed, and the lack of warm coverings on her bed. She told Community Visitors that she frequently wore her clothes to bed because she was cold.

Community Visitors were gravely concerned for the welfare of other residents.

In November 2019, the Public Advocate wrote to DHHS about the inadequate responses to the notifications made in 2019, highlighting the apparent ineffectiveness of any enforcement action taken.

In January 2020, a Community Visitor notification raised concerns about emergency planning and processes, insufficient and poor-quality bedding, overflowing rubbish bins, dirty floors, food safety, the sale of cigarettes in the dining room, and the inadequacy of personal support plans.

The state of personal support plans was particularly concerning as almost all were out of date, incomplete, frequently did not list medication or dietary needs, were not in residents' files, and appeared to contain generic information rather than addressing the specific needs of residents. In one case, Community Visitors provided DHHS with photographic evidence of a support plan for a diabetic that showed no attempt to understand or address specifically the resident's dietary or other needs. This support plan simply said "...is a diabetic. Enjoys all her meals. Loves drinking cola".

In late March 2020, following the suspension of unannounced visits due to COVID-19, Community Visitors instituted a remote safeguarding initiative in an attempt to keep in contact with residents and proprietors.

As part of this initiative, numerous attempts were made to arrange a phone visit with the proprietor.

In late April, during a phone visit, the manager refused to answer questions or provide reasonable assistance despite the SRS Act stating that SRS staff or management must not unreasonably refuse assistance (s.188) or not give "full and true answers" (s.189) to Community Visitors.

On 18 June 2020, the Public Advocate again wrote to DHHS advising that interventions with the proprietor had not adequately addressed the ongoing issues at SRS which included the manager's verbal abuse of Community Visitors and his refusal to assist them with their enquiries.

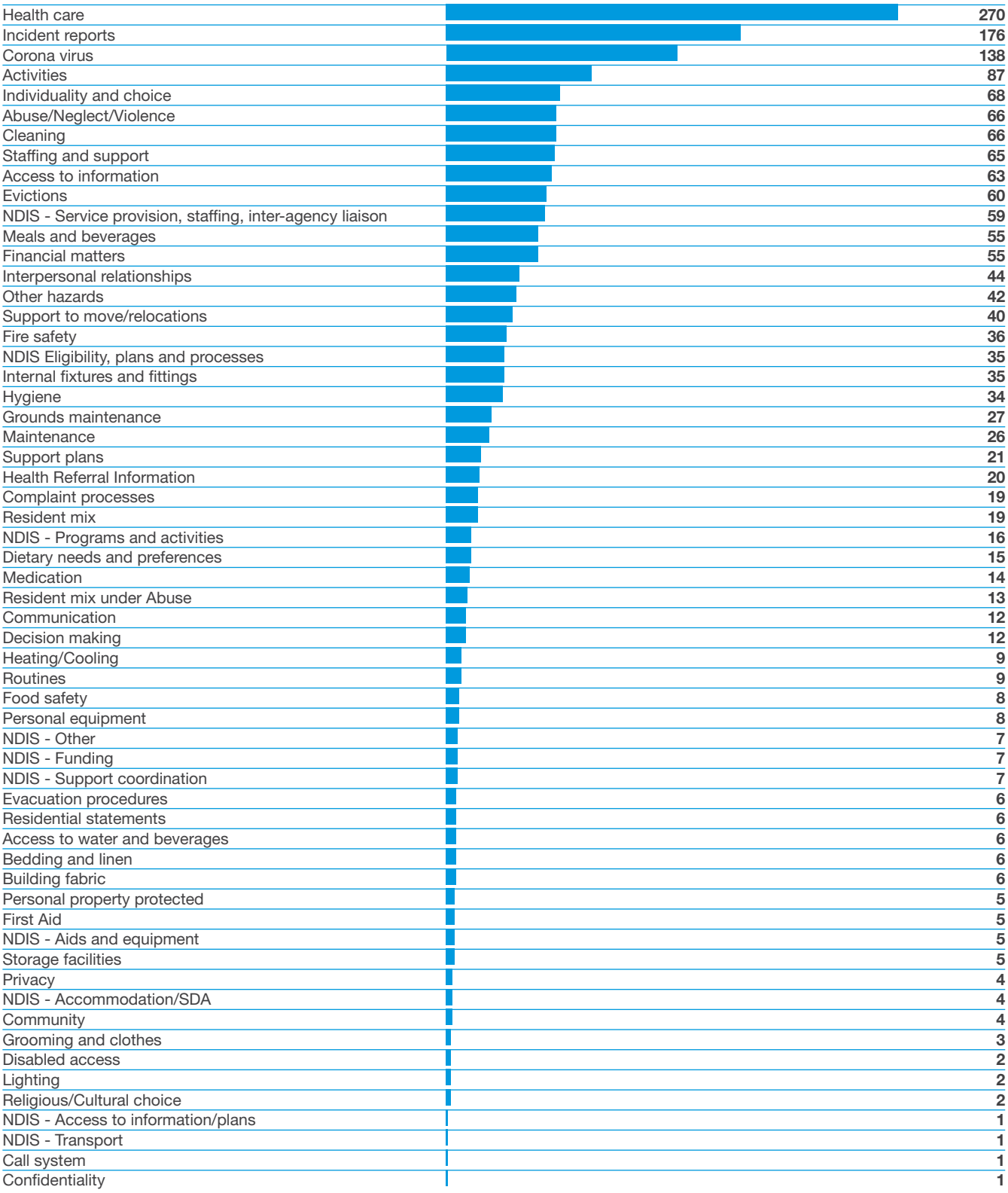
All six Community Visitors and OPA staff that visited the SRS last year reported being verbally abused by the manager. It included being told that they were "trouble-makers", that the SRS was none of "their business", that they were "not welcome" and to "get out". Their care was also questioned.

Intimidating behaviour included yelling, pointing fingers at their chest and ranting. The volunteer Community Visitors felt obstructed from exercising their statutory role. Under the SRS Act s.190: "SRS staff or management must not obstruct a Community Visitor in the performance or exercise of any power or function."

The persistent and serious concerns raised by Community Visitors indicates that there continues to be an ongoing high risk to the safety and wellbeing of the residents of the SRS, despite any action taken by DHHS. The Community Visitor reports, notifications and photographs show the proprietor was consistently unable to meet minimum standards of accommodation and personal support in accordance with the SRS Act and regulations.

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, while volunteers and OPA staff have been exposed to unacceptable abuse, impeding their important safeguarding role.

Figure 4. Disaggregation of issues reported by Community Visitors, 19/20



Disability Services

> Reports of residents being fearful of emotional and physical harm from other residents in their group home continued to be made with alarming regularity."

Recommendations

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

1. respond to all Community Visitors annual reports and recommendations in a prompt and timely manner
2. extend the scope and funding of the Community Visitors Program to provide independent monitoring of NDIS-funded, non-SDA shared supported accommodation
3. advocate for a stronger NDIS Code of Conduct to reflect the Victorian Government's zero-tolerance approach to abuse and continue to support cultural change training for disability service providers to counter violence, abuse, neglect and exploitation within services
4. consider 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*, and advocate for the NDIA to implement its recommendations
5. ensure all behaviour support practitioners and SIL workers have a competency standard equivalent to Certificate IV in disability to ensure consistent and safe supports across the system and to help prevent potentially harmful behaviours
6. advocate for an amendment to the NDIS Act to include reference to legislation authorising the Community Visitors Program as a key component of the NDIS safeguarding arrangements. Amendments should ensure that:
   - Community Visitors are entitled to see copies of a participant's NDIS plan, any documentation related to a participant's Specialist Disability Accommodation tenancy arrangements, as well as the documents they are currently authorised by legislation to see when visiting
   - Community Visitors are entitled to share information to the extent necessary to advocate for participants and raise concerns with relevant complaints bodies
7. further fund the Community Visitors Program to enable it to recruit and support adequate numbers of volunteers and continue to support the use of technology to efficiently carry out its critical safeguarding role
8. ensure statewide consistency and timely upkeep and maintenance of houses.

Statewide Report

Introduction

Now, more than ever, Community Visitors are crucial to safeguarding the rights of Victorians residing in disability accommodation.

The rollout of the NDIS in Victoria has led to significant amendments to the *Disability Act 2006* and the transfer of tenancy rights regulation in most cases to Consumer Affairs Victoria (CAV). Disability residential services that were operated by the Victorian Government are in the process of being transferred to five Community Service Organisations (CSOs), a process that was expected to be finalised by 1 July 2019 but that is still ongoing.

The legislative amendments to the Disability Act mean that the Act now empowers Community Visitors from the disability stream to visit a wider range of accommodation types: disability 'residential services', NDIS 'SDA enrolled dwellings where there are SDA residency agreements in place', and NDIS 'short-term accommodation and assistance dwellings' (STAA).

The increased complexity in the market and its safeguarding arrangements make the role of Community Visitors in improving the lives of residents and eliminating abuse and neglect even more important.

As part of the transition to the NDIS, people with disability living in residential accommodation are adapting to a new model where funding for physical premises in which they live, Supported Disability Accommodation (SDA), is distinct from funding for personal care required for everyday living, Supported Independent Living (SIL). The intention of the separation is to increase the choice and control of participants by allowing them to more readily change either their SDA or SIL provider without having to change the other.

Community Visitors, through their relationship with OPA, are aware of other new models of accommodation evolving which effectively operate as a shared SDA-like accommodation for people with complex and challenging support needs. Community Visitors are concerned that this model of service provision lacks almost all the safeguards available to people with similar support needs living in SDA, including the independent oversight provided by Community Visitors.

Community Visitors have not always been advised about the opening of new SDA. There is the need for clearer communication and information-gathering processes around SDA identification between the Department of Health and Human Services (DHHS), CAV and the National Disability Insurance Agency (NDIA) in Victoria. This will ensure that the safeguarding function provided by Community Visitors is available to every SDA resident.

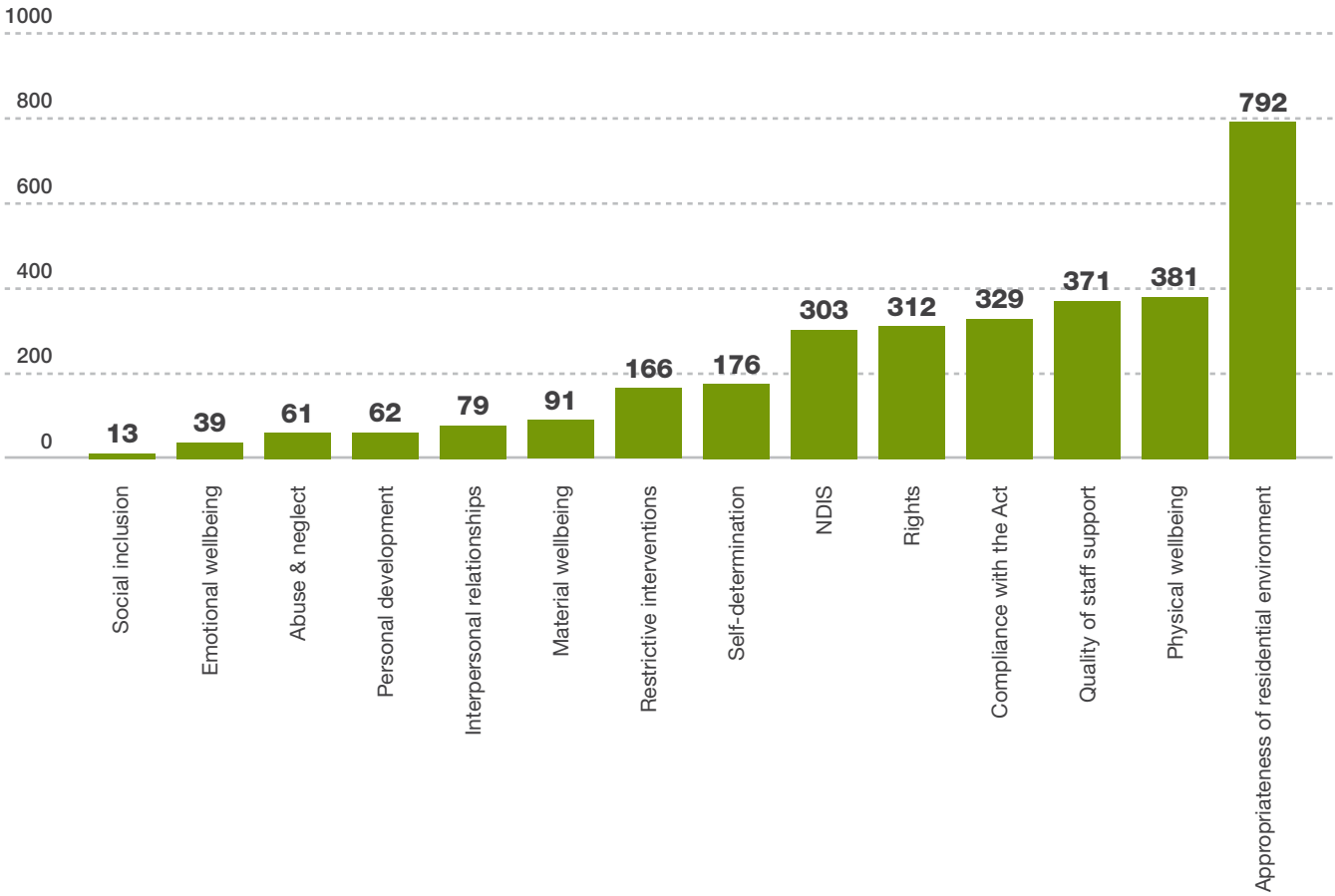
Community Visitors eagerly await the decision of disability ministers across the country on determining the parameters of its safeguarding role in the context of the National Disability Insurance Scheme (NDIS) Quality and Safeguards Framework.

This annual report reflects the work of Community Visitors, who identified 3175 new issues impacting residents, ranging from allegations of abuse—notably resident-to-resident violence—to concerns about the quality of staff support, emotional and physical

Table 3. Total visits Disability Services stream, 19/20

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	335	77	29	581	**610**
North Division	291	52	28	324	**352**
South Division	272	68	25	535	**560**
West Division	270	51	18	539	**557**
Total	**1168**	**248**	**100**	**1979**	**2079**

Figure 5. Issues reported by Community Visitors, 19/20



wellbeing, behavioural support, healthcare, incident reporting and participation in the NDIS. Issues resolved during visits and not requiring further follow-up are not included in this figure.

Figure 5 shows the categories of issues reported by Community Visitors. Figure 7 (at the end of this report) provides a further disaggregation of these issues.

Disappointingly, as has occurred in the previous two years, the State Government has yet to respond to last year's Community Visitors annual report recommendations prior to preparation of this report.

In 2018, in its response to the *Community Visitors Annual Report 2017-2018*, the Victorian Government stated its "continued commitment to supporting quality improvement and safeguards for vulnerable Victorians" and that it tabled its response "in Parliament addressing each of the recommendations raised". An important aspect of the response is that it indicates initiatives undertaken by the Victorian Government which respond to the themes raised in the Community Visitors annual reports. For the Disability Services Stream, in particular, given its changing and increasingly complex regulatory and operating environment, the lack of a government response compromises the capacity of the program to contribute to ongoing systemic reform in the disability services environment.

Consequently, the recommendations contained in this report were drafted without the benefit of incorporating the State Government's response to the previous year's recommendations.

COVID-19

The onset of the COVID-19 pandemic in early 2020 and subsequent restrictions significantly impacted the Community Visitors' safeguarding work.

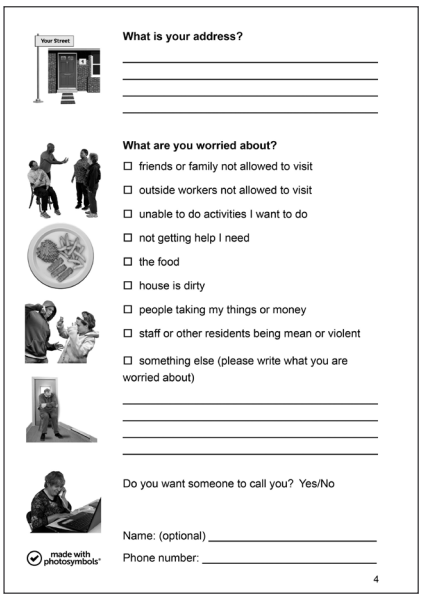
To reduce the risk to residents, volunteers, and staff, face-to-face visits were suspended by the Public Advocate in March. The 'do no harm' principle was adopted by the United Nations Subcommittee on Prevention of Torture and replicated across the world, as governments sought to manage the very real risk of widespread transmission of the virus, particularly in closed environments.

The increased importance of oversight and monitoring by relevant bodies due to the pressures and restrictions bought on by the pandemic encouraged innovation. The Community Visitors Program pro-actively sought alternative safeguarding arrangements to ensure it could continue its work. With the suspension of face-to-face visits, the program developed guidelines on how the safeguarding of residents could be ensured remotely to allow them to continue to perform their role by conducting visits by phone and video conferencing. Volunteers were provided with various types of support to enable them to do this.

The guidelines tried, wherever possible, to replicate the strengths of the face-to-face visits and regular processes. As the integrity of the program and safety of volunteers remained paramount when conducting phone visits and video visits, two Community Visitors would be on each phone call or at each video visit. This would mean that both Community Visitors could independently verify the information given to them by staff initially and, where possible, by residents.

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.

What is a Community Visitor?
Easy Read resident survey



Additionally, a brochure was included with details for the Office of the Public Advocate's (OPA's) Advice Service and it was noted that there was an increase in calls to the service seeking unscheduled visits from Community Visitors.

The response so far has been positive, both from the Community Visitors' point of view and residents and staff in houses. Community Visitors consider that the learnings gathered by remote safeguarding during the pandemic will supplement face-to-face visits when they are reinstated.

The program was also successful in obtaining funding from DHHS for 50 computer tablets to assist it with conducting video visits to high priority group homes.

The program contributed to OPA's submission to the Disability Royal Commission *Emergency Planning and Response Issues Paper*, articulating the particular vulnerability of residents living in congregate care settings, and the challenges they faced in accessing services and supports in the community and their homes.

Violence, abuse and neglect

This year, 218 issues were recorded by Community Visitors. The most serious incidents lead to notifications to the Public Advocate, the Office of the Disability Services Commissioner and/or the NDIS Quality and Safeguards Commission.

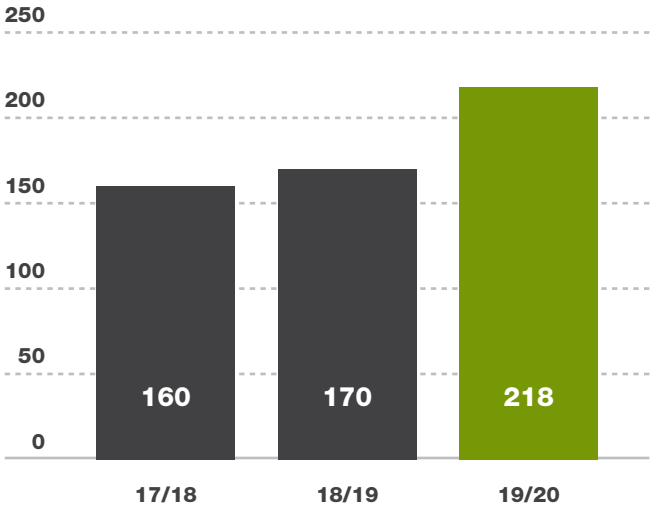
The total number of issues of abuse, neglect and violence continues to trend upwards from previous years. While this may be a by-product of improved reporting practices, the overall increase is concerning.

OPA's Interagency Guideline for Addressing Violence, Neglect and Abuse (IGUANA) provides the following definitions:

- Violence is behaviour towards a person that is physically, sexually, emotionally, psychologically or economically abusive. It also includes behaviours that are threatening or coercive, or in any other way control or dominate the person and cause that person to feel fear for themselves or another person.
- Neglect includes intentionally or negligently failing to take care of a person's physical, psychological or financial wellbeing in breach of a duty of care.
- Abuse is the violation of an individual's human rights resulting from the act or actions of any other person or persons.

This section of the report includes numerous examples of instances of violence, neglect and abuse perpetrated against residents in disability services in Victoria.

Figure 6. Issues of abuse, neglect and violence identified in Disability Services stream, 17/18–19/20



Resident-to-resident violence

Resident-to-resident violence accounts for the majority of reported cases of abuse, an ongoing issue which Community Visitors continue to highlight year after year:

> *"Resident-to-resident violence and abuse remains a significant concern. Community Visitors continue to receive reports from residents living with others whose behaviours of concern place them at ongoing risk" (Community Visitors Annual Report 2018-2019, p 17).*

This year saw the commencement of the Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability. Periodic public revelations of the violence, abuse, neglect and exploitation of people with disability and people with a mental illness continue to shock the Australian community and provoke governmental responses. The Royal Commission is one such response to continuing reports and calls for action.

Community Visitors believe that the Royal Commission can be a catalyst for lasting social change, so that the right of people with disability and a mental illness to lead a fulfilling life, free of violence, abuse, neglect and exploitation becomes fully embedded in the Australian community.

Community Visitors from all three streams, but particularly from disability services, provide critical information that is used by OPA in its engagement with the Royal 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 year of Community Visitors reporting incidents of violence and abuse within services to the Victorian Parliament in its Annual Report.

I'm too scared to come out of my room identifies five key systemic factors of resident-to-resident violence in group homes, all of which have been repeatedly raised by Community Visitors. They are:

- choice and control in accommodation
- workforce
- responding to and reporting allegations of violence and abuse
- relocation and eviction of residents
- justice system responses.

The Disability Services Stream Board commends the report to the Victorian Parliament and urges implementation of its 38 recommendations.

Following the publication of *"I'm too scared to come out of my room"*, the Royal Commission invited two Community Visitors and the Public Advocate to appear as witnesses at its December 2019 hearing on this topic. Community Visitors Board member, David Roche, and Regional Convenor, Cindy Masterson, attended the hearing. Together, they spoke about their work as Community Visitors and the practical difficulties they often face in undertaking their role, such as access to incident reports. Community Visitors highlighted the important part played by management within services in responding to serious incidents.

"As a Community Visitor, you might see something there that is really – well, it concerns you. It's about the care and dignity of an individual. (…) You know what should be done – I mean, person in the street like myself knows what should be done. But to get it done is a completely different – it becomes very, very complex" (p.149 of transcript)

Community Visitors will continue to contribute to OPA's systemic advocacy in its ongoing engagement with the Royal Commission.

For many people with disability, the right to choose where they live and who they live with is so constrained that they are left feeling unsafe and fearful in their own homes.

CASE STUDY

Police and ambulance services attended a house in regional Victoria several times after one resident, following a medication change, became aggressive and assaulted another. The victim temporarily moved to a metropolitan location, returning to the house after the offender was relocated to another facility following treatment in a mental health unit. An intervention order was instigated.

Another resident at the same house, which is home to offenders and clients on supervised treatment orders, threatened to "smash in the head" of a staff member, using a hammer. The resident is now on remand for breaching bail conditions.

Since these incidents, staffing has been increased and resident vacancies have not been filled.

Reports of residents being fearful of emotional and physical harm from other residents in their group home continued to be made with alarming regularity.

A number of these issues remain unresolved due to the unavailability of more suitable accommodation for those engaging in violent behaviour, or alternative accommodation for their victims. One resident who was assaulted by a co-resident had to return to living with an elderly parent after no suitable alternative accommodation could be found. Residents who felt threatened by other residents in their homes reported they stayed in their room or spent time outside their homes, where possible, to avoid further physical or emotional abuse. In one case, a resident who had been assaulted by a co-resident, slept in the corridor of another unit on site as she felt unsafe returning to her own.

Often those engaging in violence have been placed in inappropriate accommodation where they have no choice or control over who they live with. Community Visitors have repeatedly reported that incompatibility between residents is one of the main risk factors for violence between residents. While the solution is to grant residents greater choice, it is not so easily implemented as there are many systemic hurdles. Vacancies in accommodation are now advertised online and no one entity provides a central coordination role. The intention is to give choice and control back to all participants, but in practice, providers do not always consult existing residents on applications made by incoming tenants and compatibility with existing residents has not always been considered by the providers managing the vacancies. Community Visitors are concerned that SDA providers will prioritise tenants who do not have high support needs or complex behaviours over those who do.

Residents engaging in violence are often attended by staff who are not properly trained in dealing with their specific needs. In one incident, a 21-year-old was placed in a home with long-term residents who were all in their 50s. The younger resident engaged in ongoing threatening behaviour including verbal abuse and property destruction. Community Visitors noted that the younger resident's behaviour was a result of frustration at his living situation, yet he remained at the home because no alternative accommodation could be found. Situations like this place perpetrators at great risk of being evicted and becoming homeless.

The NDIS has not yet solved the shortage of disability accommodation options and choice and control over where one lives and with who is still somewhat limited. Even when SDA funds are allocated in an NDIS plan, a participant may not be able to source a suitable or willing provider. With the transfer of the operation of State-owned group homes to CSOs, residents are less and less able to count on the Victorian Government to step in or intervene where there are no available accommodation options. It is unclear where the duty of care to ensure people with disability are afforded safe accommodation sits in the NDIS marketised world.

These serious incidents of violence between co-residents in group homes receive little practical attention, despite a number of inquiries around violence against people with a disability. Community Visitors were pleased to see the Royal Commission take an interest in this issue. Residents who experience violence in their own homes by co-residents do not receive the same consideration as others in family violence situations. Protective measures are rarely put in place to ensure residents' ongoing safety in their own homes, and many are forced to navigate the situation on their own or with little practical support.

CASE STUDY

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 guardian will be able to advocate to improve John's circumstances and, when necessary, make decisions to promote his personal and social wellbeing.

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.

Since these incidents, staffing has been increased and resident vacancies have not been filled.

CASE STUDY

Suitable long-term accommodation is yet to be provided for a particularly violent and disruptive resident at a group home, who has been the subject of multiple notifications to the Public Advocate. The situation was noted in last year's annual report but ,12 months on, no alternative accommodation has been found. The resident is currently in temporary respite accommodation.

Staff-to-resident abuse

There were also concerning incidents of staff-to-resident abuse, often with multiple reports coming from certain homes. While this continues to be a serious issue, there were some incidents this year where swift action was taken, and staff were stood down pending investigation.

Some staff-to-resident abuse issues appear to relate to reliance on less-experienced casual staff and high staff turnover. Community Visitors note the employment of appropriately trained and skilled staff, along with careful planning and clear behavioural support strategies, has a significant positive impact in creating safer households.

However, some incidents of staff abuse were reported by casual staff. In one case, a casual staff member raised the alarm at a group home where staff locked a resident in a cold bathroom a response to behavioural issues and limited their access to food by putting locks on the cupboard. In this case, all the group home staff involved were stood down pending an investigation.

GOOD PRACTICE

Staff in one group home worked very hard to address a resident's serious ongoing behavioural issues by proactively engaging behavioural therapists and support practitioners and developing specific procedures and protocols. This led to an improvement in the resident's behavior and stability within the home.

Neglect

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.

CASE STUDY

Community Visitors hold grave concerns for two residents who live in a house on a rural property, several kilometres out of a country town.

The service provider has not addressed issues which continue to be raised around the residents' wellbeing, despite the situation being referred to the Disability Services Commissioner (DSC) for a second time due to reports of abuse and neglect.

For two years, the residents have been told they will be moving to alternative accommodation, but this has not happened. They are now further isolated due to COVID-19 restrictions.

Community Visitors are very concerned that the residents' needs are not being met and that decisions are being made without taking into consideration the capacity of the residents to make those decisions.

One resident of the home has an OPA guardian, who temporarily also advocated for the other resident.

Nonetheless, Community Visitors have expressed ongoing concerns for these residents who have been subjected to many years of turmoil.

Another issue is the failure of some service providers to provide appropriate dietary requirements for those residents with high-risk health complications. Community Visitors reported that a resident with diabetes was gaining significant weight, largely due to spending their own money purchasing and consuming excessive amounts of unhealthy snacks. Community Visitors noted the service provider had a duty-of-care and, given the serious health risks, this should be an over-riding consideration.

Escalating issues

The Community Visitors Program continues to enhance its capacity to identify and report incidents of abuse and neglect and escalate these to appropriate bodies. The safeguarding environment is more complicated than ever. A new Community Visitors Operating Model provides guidance to Community Visitors on the appropriate escalation pathways within each of the services they visit. Key staff from DHHS and the Department of Justice and Community Safety have been pivotal in the development of the model.

Abuse and neglect matters to the DSC relating to government-run houses that are in the process of being transferred to non-government providers (i.e. Community Service Organisations). This year, Community Visitors referred 63 matters to the DSC.

There is a formalised information-sharing schedule with the NDIS Quality and Safeguards Commission, enabling the program to make referrals, which commenced in June 2020. To date, 52 matters have been referred to the NDIS Commission and the program has now established a process whereby it makes weekly referrals of high risk reports. Some practical challenges that remain to be agreed on include:

- consistent working definitions of abuse, neglect and exploitation
- expected or acceptable timeframes for response from the NDIS Commission and vice-versa
- extent of the information to be provided by the NDIS Commission in response to Community Visitors.

Another 47 medium and low-risk abuse and neglect matters were referred to the CEO or senior management of the relevant service providers.

Zero tolerance

Further abuse detection training was rolled out this year to Community Visitors to enhance their capabilities in this area.

Community Visitors strongly support initiatives targeting a zero-tolerance approach to abuse and neglect, as endorsed by the State Government some years ago. However, Community Visitors would like to see this stronger approach adopted federally via the NDIS Code of Conduct. The NDIS Code only requires service providers to make their best efforts by taking all reasonable steps to prevent abuse. The language of zero tolerance does not appear in the guidance for workers, which is a glaring omission. Community Visitors do not believe this is adequate to safeguard people with disabilities to live safely and free from abuse.

The rollout of the NDIS means there are now multiple service providers in the lives of residents. While this has achieved choice and control for some, it can also make them more vulnerable, due to safeguarding becoming more complex and challenging. The absence of individual case management means service providers are operating in an environment that is increasingly difficult to monitor.

CASE STUDY

Community Visitors have consistently raised concerns about the behaviour and impact of one service provider against another at a multi-unit disability accommodation site.

There have been competing actions taken by one service provider for their NDIS participants, for example, where a resident's emergency alert buzzer was removed, and where the resident also subsequently experienced a reduction in the provision of care.

Due to tensions between service providers at the site, Community Visitors were concerned at this apparent reduction in support and potential impact of limited access to this vulnerable resident in case of emergency.

Another resident's replacement wheelchair was not fitted with anti-tip brackets and had faulty brakes, which was of particular concern as the resident was prone to falls. Community Visitors sought information from this service provider regarding this inadequate equipment, however, the response received did not adequately address the matter.

Children in group homes

Access to appropriate schooling for residents under 18 years of age has also been highlighted as an issue. Service providers advised this was due to a lack of support coordination or case managers. In one instance, this led to a resident turning 18 years old before an education program was organised.

Physical wellbeing

Community Visitors frequently reported issues relating to errors made in the administration of medication and, increasingly, issues relating to the changing needs of ageing residents as well as delays in providing residents with the correct equipment required for mobility or safety.

In one case, there had been constructive suggestions from staff and family for pictorial communication aids. These aids would also be used by other residents in the home. However, they are yet to be provided.

Medication errors occur with some frequency and could be avoided with further training and more consistent staffing. Incidents included missed medications, medications administered at the wrong time, and incorrect medication administered. Some of these errors can have serious consequences. In one instance, diabetes medication was not administered, putting the resident at risk. Community Visitors also reported issues relating to safe storage of medication, including instances where medication was not locked away or secured and Community Visitors observing medication lying on the floor or under furniture.

Another concern noted again this year was the changing needs of residents as they age and experience issues such as the onset of dementia. While service providers face challenges in supporting residents to 'age in place', they also need to identify when a resident's needs have increased to the extent that a referral to aged care is required.

Residents over 65 years of age at the time of NDIS rollout were not eligible for NDIS plans, however, they are eligible for Continuity of Support (CoS) funding. Despite this, Community Visitors are concerned these residents may be disadvantaged compared to co-residents receiving NDIS plans.

It was noted that the COVID-19 lockdown restrictions had a significant impact on those residents who did not receive adequate support to exercise near their home or were not able to visit family.

CASE STUDY

Community Visitors responded to several calls from a resident in a group home who was very frustrated about his activities being curtailed during the COVID-19 lockdown.

On one call he was distressed about not being allowed to go to a shop to purchase Lego and on another occasion, he called about the purchase of containers to store his Lego. Other calls related to not being allowed to go to a lake to walk and being forced to exercise only near his house.

The House Supervisor told Community Visitors that agency policy was that staff were not permitted to transport residents by car, apart from taking one person at a time for essential personal shopping once a week or to essential medical appointments, during the Stage Three restrictions.

The service provider maintained they were acting in accordance with government restrictions at the time and highlighted there were increased health risks in group homes due to rostered staff and residents sharing accommodation. The service provider assisted the resident to purchase Lego online and, once the government restrictions were temporarily eased to allow it, the resident was also supported to walk around a local lake and to enjoy a coffee. He was also allowed to visit his parents' home and shops to purchase some of the requested items.

GOOD PRACTICE

Community Visitors noted that residents in a group home were calmer than they had been during previous visits. This was attributed to the staff introducing aromatherapy and relaxation music to the home.

Appropriateness of residential environment

Over the past year, maintenance work and upgrades were undertaken in many houses to ensure that they met NDIS SDA design standards. While the majority of this work was completed successfully, there is ongoing evidence of poor workmanship and ill-conceived renovations, that have required further work to resolve issues.

CASE STUDY

During a renovation of a house required to be accessible to residents who use a wheelchair, a second kitchen sink was installed. Following completion and signoff of the renovation in 2018, the house now has two separate side-by-side sink areas with neither accessible by a wheelchair despite four of the five residents in the house using wheelchairs.

Community Visitors repeatedly raised this issue, but it has still not been resolved.

In at least one instance, Community Visitors observed that maintenance and upgrades could not address the inappropriateness of the physical environment.

CASE STUDY

'Margaret' has a long history of destroying property and now lives in a significantly damaged single-resident house. There is no working kitchen as she destroyed all the appliances shortly after moving in and the service provider considers it too dangerous to re-install them.

Staff have created a makeshift kitchen with a microwave in a lockable room that they also use as an office.

The house is unsuitable to meet the needs of the resident. While the provider has considered alternate accommodation, no viable alternative housing has been found.

In other houses, Community Visitors have reported many longstanding maintenance issues that remain unresolved, with the long delays impacting on residents' wellbeing. Often these issues relate to the fabric of the house as well as the upkeep of outdoor environments.

CASE STUDY

Following renovations, including placing a wall between the existing toilet and bathroom, it was found that a resident in a wheelchair was unable to access either the toilet or bathroom safely and with dignity.

On advice from an occupational therapist, there are plans to return the bathroom and toilet back to the original layout, however, after two years, this has still not been resolved.

Community Visitors are developing a closer relationship with DHHS in their SDA management role to identify and escalate issues and facilitate closer liaison to resolve maintenance queries.

Dual disability

Access to mental health services for residents who have a dual disability can be problematic. Barriers include different opinions offered from mental health services, inconsistent assessments regarding the identification of behaviours of concern and, at times, contrasting understandings of the symptoms of a mental health condition.

Disagreement among practitioners in relation to diagnosis can cause delays in the implementation of supports for residents. At the same time, the eligibility criteria for the NDIS are not articulated in terms of a specific disability, which means that a person can be eligible for NDIS supports where they previously would have faced service exclusion.

Quality of Staff Support

Some staff work diligently to consistently support residents to achieve their goals. However, there are other instances where residents appear to receive little input in the way of stimulation and skills development.

Retention of suitably qualified and skilled staff remains a significant, ongoing challenge for service providers. In many cases, frequent turnover of staff and the difficulty in covering shifts has led to a reliance on casual and agency staff, impacting on the consistency and quality of support that residents receive. The needs and preferences of residents are not always known or understood by casual staff. Community Visitors have also raised concerns about instances where there are no sleepover staff to attend to residents' needs.

GOOD PRACTICE

Community Visitors queried if more could be done to facilitate social activities for 'Danielle' and whether sufficient funding was available to do this. It stated in her Person-Centred Plan (PCP) that Danielle loved to go on outings on weekends with family and housemates.

The service provider responded that funds were prioritised to facilitate regular trips to visit family members who lived in a regional area and to maintain regular visits with friends. The Community Visitors were impressed with the efforts of staff to organise the visits.

CASE STUDY

Community Visitors requested information on how an induction checklist for new casual staff supported them in understanding specific communication strategies to engage the residents.

In response, the service provider indicated that the induction checklist was used as a handover tool to ensure new and unfamiliar staff are provided with direction as to where information about each resident is located. The induction checklist has now been updated to include information about the communication tools to be utilised with each resident.

At one house, staff proactively linked residents remotely to their local neighbourhood house and made efforts to facilitate family communication. In contrast to this positive approach, at another house, Community Visitors observed that few attempts were made to help residents keep in touch electronically with friends and family. There did not appear to be any use of technology to allow contact with friends from day placements or to encourage and support online group activities or develop individual interests.

Community Visitors are conscious that the onset of the COVID-19 pandemic has posed further challenges for group homes and continue to monitor the varied responses from staff to the associated restrictions and lockdown.

CASE STUDY

The impact of high staff turnover was particularly apparent in a house with residents who all have substantial physical support needs.

Only one resident can vocalise and she often gets the most attention. Client documentation is often disorganised and out-of-date.

Community Visitors are concerned about the detrimental effect of poor communication between a resident's day placement and home. One day, house staff were contacted to collect a resident who had just arrived at his day program which was cancelled without the house staff being alerted. In contrast, following a resident incident, the house staff sought a medical review, notified family and worked closely with day placement staff to facilitate greater communication between the two services.

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

NDIS

The rollout of the NDIS in Victoria has progressed in the last year. Community Visitors raised 303 matters relating to the NDIS over this period, relating to:

- treatment
- support coordination
- funding
- accommodation/SDA
- programs and activities
- service provision, staffing, inter-agency liaison
- other.

Places where Community Visitors can visit

In the NDIS environment, Community Visitors can only visit SDA where all residents have entered into an SDA residential agreement. Residents have the choice to enter an SDA residential agreement or a standard residential agreement, but all residents in the dwelling must have the same type of agreement. Where previously Community Visitors could obtain a register from DHHS of all the gazetted services where they were permitted to visit, the register is now split across two regulators, DHHS and CAV.

This also means that some residents who could benefit from the oversight of Community Visitors but who have chosen to enter into a standard residential agreement, rather than an SDA residential agreement, will not have access to Community Visitors unless they request them to visit. Community Visitors are unsure whether those residents are made fully aware of the safeguarding implications related to their choice of agreement. Moreover, the NDIS permits accommodation sites to be established outside of SDA properties that very closely resemble what was previously defined as disability 'residential services'. These settings will no longer benefit from the independent oversight of Community Visitors. This is a concerning shrinking of the remit of the program and a great loss of safeguards for those residents.

The future of Community Visitors

This year, the national evaluation of community visitor schemes across Australia was commissioned by the Australian Government and made public. The NDIS Quality and Safeguarding Framework ordered the review to assist the Disability Reform Council in determining what the continued role of visitors should be at full scheme. The national evaluation recognised the contributions of Community Visitors and recommended that they should continue to be provided by State and Territory-based schemes, pending the endorsement of disability ministers.

The Victorian Government has a long-standing commitment to maintain the program, which has been appreciated, but in the wait for a decision, the ongoing work of Community Visitors in an environment under federal legislation has become increasingly complex.

There is a need for state and Australian governments to clarify Community Visitors' role in the context of the national safeguarding framework, to ensure that they can fulfil their functions and duties under the Disability Act. Furthermore, federal legislative reform is required to ensure that Community Visitors have an ongoing role in safeguarding the wellbeing of NDIS participants.

SDA reassessments

As noted earlier, under the NDIS model, the physical premises in which residents live, SDA, is funded separately from the personal support required for everyday living, SIL. This is imperative in providing choice and control to residents by allowing them to more readily change either their SDA or SIL provider without having to change the other. However, not all of the benefits that the scheme is seeking to achieve will flow on to participants. All residents in Victorian Government funded disability accommodation were 'grandfathered' into SDA eligibility and their SDA provider is now one of the five CSOs.

There are concerns that the SDA eligibility of these residents will be put into question should they wish to move to another residence. In fact, Community Visitors had received advice from the NDIA that, for an SDA relocation to be enacted, a reassessment would be required. The intention, presumably, is to provide a participant with choice and control over the features of their next SDA, however, delays in obtaining reassessments can have adverse effects on participants, especially if the relocation is necessary in a situation of resident-on-resident violence.

There have been cases where residents had sourced an alternative SDA, thereby effectively 'reserving' a vacancy in another residence but could not move until the plan review had occurred. This meant that a single participant was effectively assigned two SDA vacancies. Community Visitors have numerous examples of this. While this is a necessary measure for a participant in the short-term, these situations can last many months during which other participants could benefit from accessing either of the vacancies. From the point of view of providers, these types of delays, which are not uncommon, cause a serious financial strain. In the long run, Community Visitors fear that administrative delays engendered by SDA reassessments could deter SDA providers from entering or remaining in the NDIS market.

The NDIA has now amended its policy that a participant plan must specify the appropriate SDA type and location so that participants can move without needing a plan review or reassessment.

Behaviour support

As the NDIS Commission has now been active for 12 months, all behaviour support plans established under the NDIS should now be registered with the national Senior Practitioner. However, Community Visitors observe that many behaviour support plans for residents have expired and there have been challenges developing new ones. A behaviour support plan is developed by a specialist practitioner in consultation with the person with a disability, their support network and implementing provider.

A comprehensive biopsychosocial assessment including a functional behavioural assessment is undertaken, where contemporary, evidence-based, behavioural strategies are identified to be implemented to ultimately reduce behaviours of concern and eliminate the use of restrictive practices.

There are significant delays for residents to access behaviour support practitioners, even when there is funding available in the resident's NDIS plan. This subsequently leads to challenges in accessing functional assessments in time for the annual review of a behaviour support plan, which leads to difficulties in justifying further funding requirements. Residents can be left with an inadequately funded NDIS plan and/or ability to utilise their plan. In one matter, advocates for a resident have been seeking funding for behaviour support services since 2017. Despite several reports from therapists recommending this support, additional funding has not been provided. In some cases, residents lose funding in reviews of their plans. More importantly, delays in assessments or reassessments are a missed opportunity to support residents to reduce behaviours of concern, decrease any inappropriate or unnecessary restrictive practices, in order to enable them to live a more flourishing life.

Planning

While many residents achieve positive and timely outcomes with regards to their NDIS plans, delays remain common and are more pronounced in regional areas. These relate to planning processes and reviews, the provision of services and accessing equipment; but also where local area coordinators are developing the plans with residents with complex needs, they do not have the authority to approve more specialised funding (for example for higher levels of support coordination) and further delays arise while an early plan review or appeal process has to be undertaken.

Apparent inconsistencies have also been observed where co-residents in houses who appear to have similar needs receive different levels of funding in their plans. Sometimes, goals in NDIS plans appear to be poorly framed, and are not specific or measurable. Difficulties with support coordination, including poor communication and delayed responses from support coordinators, also impacted on participants' access to funding for services and equipment.

CASE STUDY

A resident has a second-hand mobility scooter which is faulty, and Community Visitors were informed that he was getting poor responses from his NDIS support coordinator regarding assistance to purchase a new scooter.

He now has to pay $60 per week to rent a scooter.

At subsequent visits, the same resident reported ongoing problems and a lack of response from his NDIS support coordinator. He was informed any change of support coordinator would occur at the time of review of his plan, however, the support coordinator extended the plan for a further six months, preventing a review.

Community Visitors queried whether the resident understood the implications of this decision at the time of the extension. The SIL provider has made a complaint to NDIA about the support coordinator's actions and perceived lack of responsiveness to the resident's needs.

CASE STUDY

A resident had five different support coordinators in the last 14 months, causing an extensive delay in the review of his NDIS supports. Despite needing support to manage significant behaviours of concern, the resident's needs remained unfunded awaiting a review for many months. This contributed to a deterioration in his circumstances, leading to incidents requiring police involvement and resulting in him being evicted from his residence.

Delays in equipment

There were a number of reports by Community Visitors this year about delays in obtaining essential equipment required by residents.

In one case, Community Visitors reported delays purchasing a suitably sized change table required to assist a resident with personal care. NDIS was reluctant to fund it through the resident's plan as it could also be used by other residents. This issue is still not resolved.

Another resident waited more than 12 months for an appropriate wheelchair, relying on a borrowed piece of equipment that did not suit her needs to move around the house. A Community Visitor noted that a resident in a separate group home was also waiting on a wheelchair after a request had been made in February 2019 and funding approved. Community Visitors also reported a case where a resident at a group home had been waiting 18 months for his essential equipment – a commode, change table and wheelchair. NDIA claimed that it had not received the application for two pieces of the equipment.

In one case, a resident privately paid a large amount of money for wheelchair hire while waiting for their new wheelchair through their NDIS plan and for reimbursement for the costs incurred.

Community Visitors remain concerned about cases of poor communication between house staff and NDIS workers who come in to provide support to residents. This can have a detrimental impact on quality of care for residents. Sometimes NDIS support workers fail to appropriately identify themselves to staff when visiting residents.

There are also examples of NDIS support workers failing to arrive for appointments with residents and not communicating this to house staff, sometimes on multiple occasions, to the detriment of residents. An associated issue is the lack of transparency around the support provided to residents by NDIS support workers.

CASE STUDY

At one house, Community Visitors noted a number of 1:1 NDIS hours of support recorded as being provided to particular residents, however, there were no written records of where this took place, and what community access and participation had occurred.

They queried whether there could be a progress notes folder for the NDIS support worker to write in, to enhance continuity of care and provide greater accountability. The SIL provider responded there was a verbal handover at the beginning and the end of each NDIS support activity between the resident, NDIS Support worker and SIL provider staff.

The house supervisor agreed to contact the resident's individual NDIS service provider to request a copy of their progress notes.

Community Visitors were concerned to learn that one NDIS provider proposed charging residents a rate of $60 per 15 minutes to provide case notes. This cost potentially adds significantly to the amount required in NDIS plans for participants over the course of a year. The service provider responsible for SIL support at the house has encouraged family members and interested parties to take this issue up with the NDIS provider.

Access to NDIS plans

Community Visitors continue to be concerned about challenges in accessing crucial information regarding NDIS participants in group homes, including NDIS plans. In some cases, service providers kept plans at their head office. In others, the SIL providers themselves do not have access to this information, for instance, where family members do not disclose details of plans to them.

It is counter-productive for service providers to not know what other services are being provided. It hinders Community Visitors in their safeguarding role, as it is unclear whether supports in plans are being appropriately accessed and whether participants are making progress towards their goals.

Compliance with the Act

The Community Visitors Program has undertaken a great deal of work to liaise extensively with service providers and remind them of their obligations under the Disability Act.

While there has been a positive response from many providers, progress is still needed, particularly in regard to the timeliness of responses to issues raised, and access to key information relating to residents, including incident reports and care plans.

Access to incident reports

Incident reports provide an important source of information for issues that impact on residents' wellbeing, as well as recording the service provider's response towards addressing them.

Importantly, access to incident reports allows Community Visitors to assess whether a provider is under-reporting and/or incorrectly classifying incidents. Frequently, Community Visitors are unable to access this information. This is partially due to the shift towards electronic records management, and the failure to keep hard copy incident reports on site.

If Community Visitors are to perform their role, they must be granted access to incident reports, but this is one of the long-standing difficulties in the effectiveness of Community Visitors in fulfilling their statutory function. The advent of the NDIS further complicates the landscape as there are now multiple incident management systems operating in Victorian disability services.

Last year, Community Visitors could only access incident reports in 59 per cent of their visits to disability services.

CASE STUDY

Community Visitors expressed concern when they arrived for a visit to find a casual staff member contacting multiple phone numbers for assistance without success.

It transpired that the list of contacts was not up to date. In response to concerns, the service provider stated, inadequately, that the casual staff member had been given an appropriate handover at the start of their shift.

In some instances, Community Visitors had difficulty locating relevant records and documentation, such as resident routines. In one house, the content of the shift report book had changed and some information that was previously recorded was now omitted. Community Visitors believe that some of the omissions, such as meals provided to residents, should continue to be documented. In another house, staff were unable to provide Community Visitors with access to information on the computer, including incident reports, and weekly and quarterly fire checks and drill records. Resident files were sometimes out-of-date, incomplete or inaccessible. Casual staff sometimes did not have access to computers to retrieve information, which is problematic as services move towards complete digitisation of records, including client care plans and reports.

There are further concerns about the transition to the NDIS Quality and Safeguarding Framework and its incident reporting arrangements. Community Visitors note that the threshold for reportable incidents has been reduced: incident reporting is only mandatory for registered service providers in the NDIS. The extent of incidents that must be reported according to NDIS rules is also less than what has been previously recommended and implemented in Victoria. This is a backwards step from the commitment to zero tolerance and subsequent advancements made in the Victorian sector in recent years.

Staff knowledge of Community Visitors

Service providers need to ensure that their staff understand the role of Community Visitors to ensure that they provide them with appropriate assistance to fulfil their functions.

On occasions, because of the high turnover of staff and the introduction of casual staff, Community Visitors encounter staff who are unaware of their role and function. These staff sometimes query the Community Visitors' right to access information relating to residents. Community Visitors would like to see clear and consistent handover to casual staff, so that they are given this knowledge.

Reporting restrictive practices

NDIS service providers must meet their obligations in relation to both state and federal legislation for appropriately documenting and reporting of restrictive interventions where these occur. Sometimes these interventions may impact primarily on an individual (for instance, the use of medications as chemical restraint), however, on other occasions, such interventions may impact on all the members of a household (for instance, where kitchens and cupboards are locked to help manage the behaviour of particular residents).

Community Visitors have highlighted cases of undocumented restrictive interventions for follow-up by service providers. There are concerns that the NDIS guidance is not sufficient for explaining to workers and providers what constitutes a restrictive practice and when to report on its use. Providers are accountable for their actions and must demonstrate that they have developed appropriate plans to minimise and reduce the level of restrictions over time.

Rights

Concerns continues regarding those residents whose communication needs have not been adequately addressed. This restricts their fundamental right to communicate. Service providers must ensure that all residents with complex communication needs receive a communication assessment conducted by a speech pathologist and ensure strategies to support communication needs are documented in individual support plans.

Community Visitors also note that access to appropriate hardware to facilitate communication is a crucial component of support.

CASE STUDY

One resident has been waiting for an iPad to support her communication needs for more than 12 months.

In April 2020, her support coordinator advised there would be a further wait as a new agency was engaged to assess and address the resident's communication needs and subsequent modifications.

In the meantime, the resident demonstrates significant difficulty communicating with anyone other than regular carers and family who know her well. In recent months, she has become withdrawn and has exhibited some self-harm behaviours.

Residents in group homes have a fundamental right to privacy, and it is particularly important that this is respected by all persons currently or previously interacting with residents in a professional capacity. The following case study highlights a serious breach of a resident's privacy.

CASE STUDY

Community Visitors visiting a group home in a regional town were alerted to the publication of a fictional novel written by a former staff member.

The book was self-published and launched in the town where the group home is located. While described by the author as fictional, the book appeared to be based on residents and staff at the group home where the author previously worked.

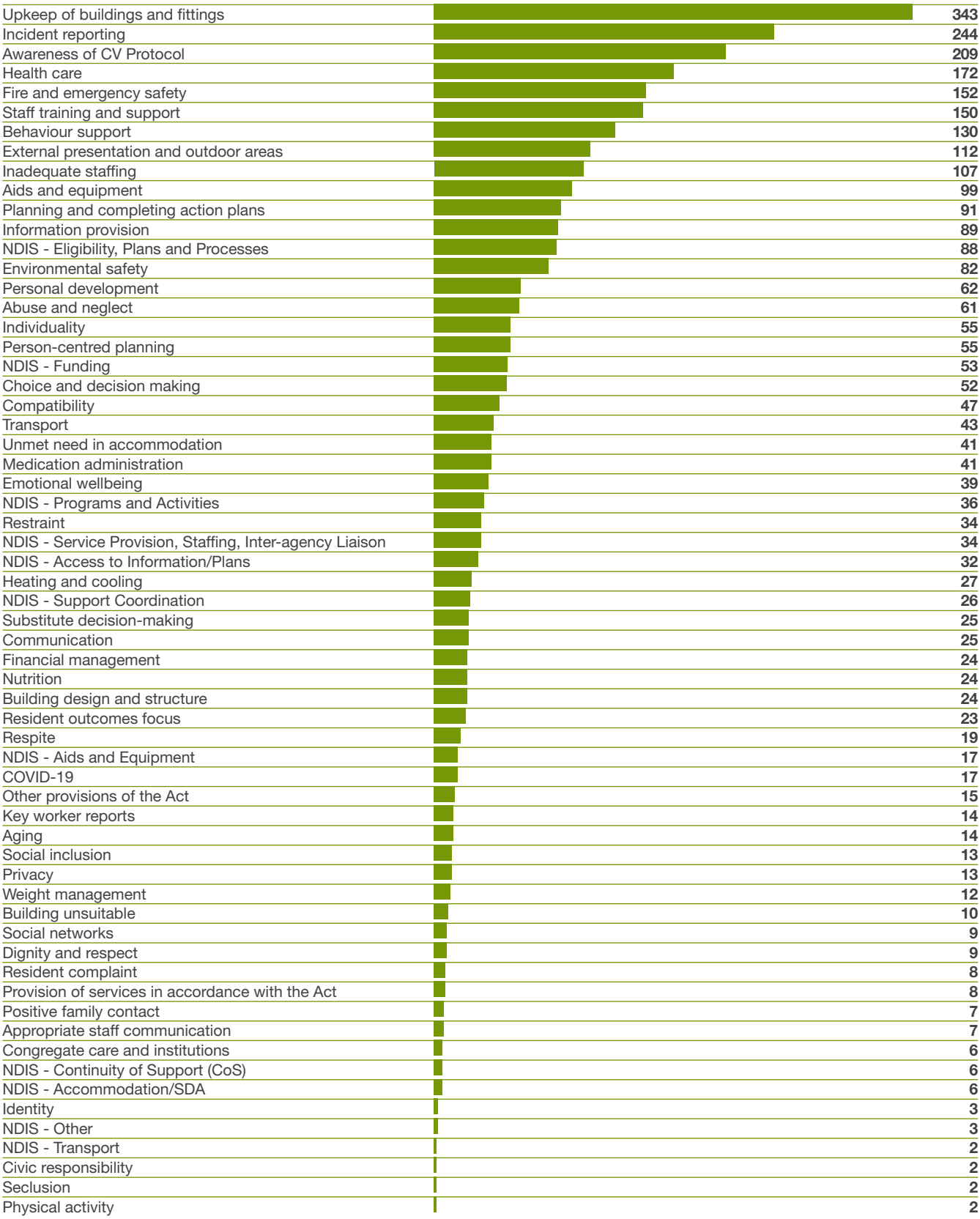
On reading the book, Community Visitors clearly recognised the main character as one of the residents in the group home. The afterword in the book implies that there will be a sequel.

Community Visitors were deeply concerned about the lack of respect demonstrated by the author for the residents and staff and queried whether the material was potentially defamatory. These concerns have been referred to the OPA Legal Unit.

Liaison with DHHS

Community Visitors are pleased to report that Statewide Liaison Meetings with DHHS have taken place more regularly this year. This has been important in keeping all parties updated regarding key issues, including the completion of transfer of government services to private providers, changes in tenancy arrangements in disability accommodation and, more recently, changes due to the COVID-19 pandemic.

Figure 7. Disaggregation of issues reported by Community Visitors, 19/20



Mental Health

> The management of consumers with complex mental illness and disability is a concern...the lack of availability of long term accommodation options makes discharge difficult."

Recommendations

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

1. substantially increase investment in beds in acute, forensic, and community mental health settings, particularly for consumers with complex needs
2. continue to invest in and expand strategies like the Safewards program, gender-specific units, and single rooms with proper security to promote health and safety within inpatient units
3. amend section 217(1)(c) of the *Mental Health Act 2014* to include specifically that Community Visitors have the power to inspect incident reports
4. develop a statewide strategy to address current gaps and improve access to eating disorder services, irrespective of where people live in Victoria
5. publish and implement a commitment to reduce and eliminate the use of restraint and seclusion in all mental health units
6. improve cleaning and timeliness of maintenance and repairs within mental health units and treat them with the same priority as other units within hospitals
7. increase fresh food options in mental health units, including the availability of fruit, and ensure that quality meals are served at reasonable times
8. provide suitable, daily therapy programs and activity options in mental health units
9. urgently undertake workforce reform and address workforce shortages, as recommended in the interim report of the Royal Commission into Victoria's Mental Health System
10. adequately resource the Community Visitors Program to:
    - undertake monthly visits to all mental health beds designated under the *Mental Health Act 2014*, including those in private hospitals
    - enable the use of technology to efficiently and effectively carry out its critical safeguarding role.

Statewide Report

Introduction

Mental Health Community Visitors play a vital safeguarding role for some of Victoria's most vulnerable people, through visits to facilities providing 24-hour care, such as mental health units in public hospitals, where they inquire into the adequacy of services and facilities provided to people receiving mental health services.

Under the *Mental Health Act 2014*, Community Visitors have considerable functions and powers and they may speak to anyone receiving mental health services who wishes to speak with them.

Community Visitors usually make monthly, unannounced visits to a wide range of state-funded mental health units in the public system including:

- hospital inpatient units
- Prevention and Recovery Care Services (PARCs)
- Community Care Units (CCU)
- aged persons residential care
- forensic services
- other specialist units prescribed under the Mental Health Act.

Community Visitors observe the daily operations within these facilities and listen to and document the experiences of consumers, their families and staff. As independent volunteers, Community Visitors are uniquely placed to offer valuable insights into what goes on behind doors which are often closed to the general community.

In addition to addressing individual issues, Community Visitors report on, and alert government to systemic issues within Victoria's mental health system.

This year, Mental Health Community Visitors reported 1927 issues from 1235 visits to 172 mental health units, compared with 1486 issues from 1670 visits to 170 units last year. Despite a 26 percent reduction in the number of visits, there was a 30 percent increase in issues identified.

The reduction in the number of visits was due to the suspension of face-to-face visits from late March, when COVID-19 restrictions were first introduced in Victoria.

Since then, Community Visitors have been making phone visits to facilities, completing 45 phone visits by 30 June. The Community Visitors Program is also exploring its capacity to make video visits.

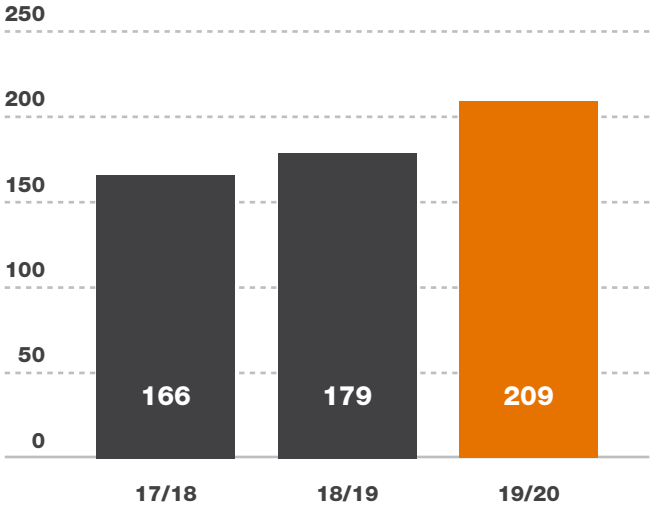
The increase in the numbers of issues identified may be due to more consistency in the entering of data and/or it may reflect an increase in the issues brought to the attention of Community Visitors this year, particularly once COVID-19 restrictions were introduced.

Community Visitors acknowledge that it has been an extraordinary year for everyone concerned and services have not only had to deal with issues related to the pandemic, but some rural services have also had to deal with bushfires, floods and computer hacking of some health networks. This has placed the whole system under stress.

Table 4. Total visits Mental Health stream, 19/20

Region	Units visited	Community Visitors	Requested visits	Scheduled visits	Total visits
East Division	33	17	15	237	**252**
North Division	33	14	7	227	**234**
South Division	49	25	21	266	**287**
West Division	57	26	19	443	**462**
Total	**172**	**82**	**62**	**1173**	**1235**

Figure 8. Mental Health stream assaults and violence, 17/18–19/20



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.

The number of assaults and incidents of aggression reported by Community Visitors increased from 179 last year to 209 this year, despite the number of visits being reduced.

These numbers vary from figures shown in Figure 10 of issue types as they were calculated by scanning all the data and noting issues related to aggression that were recorded under another category, for example, “Hazards/safety issues”.

Community Visitors acknowledge that most health workers are extremely committed to the safety and wellbeing of consumers, but they are sometimes operating in volatile and resource-constrained environments. Despite their best efforts and, in some cases, an increased presence of security personnel, there were still many incidents of assault by consumers in inpatient settings, on both other consumers and staff. This highlights continuing underlying systemic issues that still need to be addressed.

There was a small increase in the total number of reported suicides, attempted suicides and self-harm within facilities or within 28 days of discharge, from 27 last year to 30 this year. Tragically, these figures include three deaths. These numbers only represent a snapshot of serious incidents according to the incident reports that Community Visitors were permitted to access.

The largest number of issues documented are related to treatment (685) and safety (452). There were also a significant number of issues relating to legal rights and information provision (269), facility management (262), activities and programs (226) and the NDIS (33). It should be noted that, in previous years, issues related to Community Visitor access to incident reports were included in the category ‘Legal rights and information provision‘ but, this year, they were recorded under ‘Safety’ which may account for the sizable increase in the number of safety issues and a decrease in the number of issues related to legal rights and information provision compared to last year.

Positive changes

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. For example, the PARC model of care has been praised by both consumers and carers for providing a supportive environment which assists recovery.

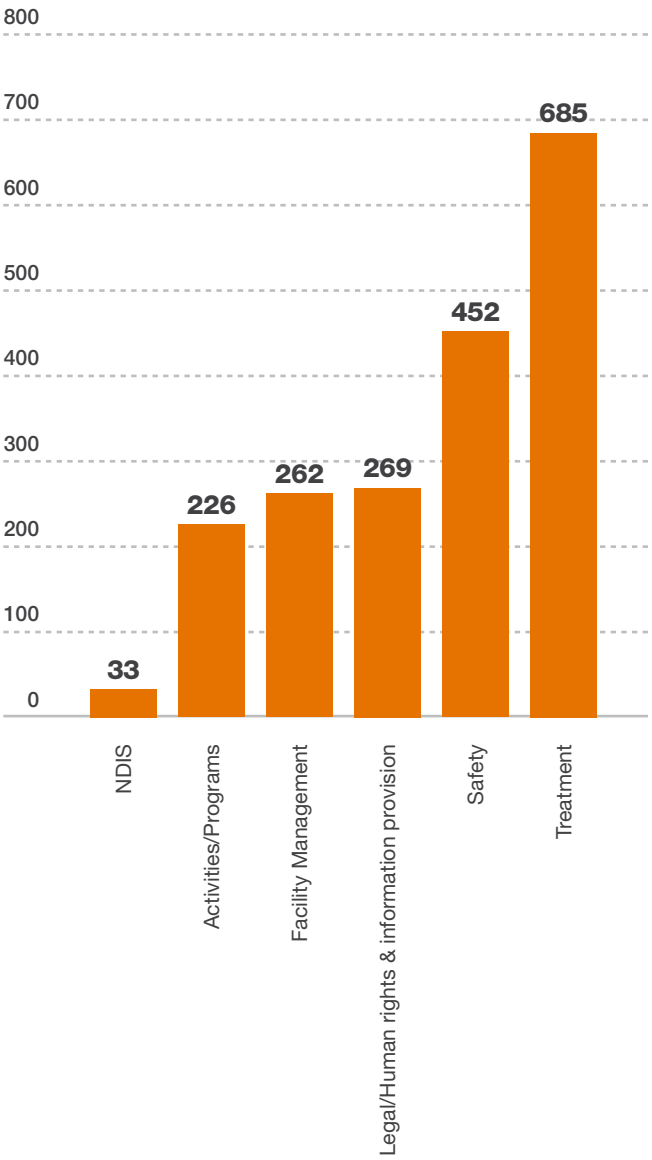
The mental health system in Victoria is at a crossroads, with the Royal Commission into the Mental Health System in Victoria due to deliver its final report in February 2021. The Commission is charged with providing the community with a clear and ambitious set of actions that will change Victoria’s mental health system and enable Victorians to experience their best mental health now and into the future.

The Board hopes that this report will help alert the Commission and government to areas where action is required.

Table 5. Facilities visited, number of visits and issues identified, 18/19–19/20

	18/19	19/20	% age change
Facilities visited	170	172	+ 1.2%
Number of visits	1670	1235	- 26.0%
Issues identified	1486	1927	+ 29.7%

Figure 9. Issues reported by Community Visitors, 19/20



Serious incidents, assaults and safety

This year, Community Visitors reported 452 safety issues, an increase from 179 incidents of assault and aggression last year. The increase may be partially due to the inclusion of issues related to incident reports (242) in this category for the first time.

Safety issues identified by Community Visitors included issues in the categories of hazards/safety (58), aggression, intimidation, harassment (42), assaults including sexual assaults (37), dignity (29), security of possessions (27), environmental hazards (18), self-harm (17), gender sensitivity (16) and suicide and attempted suicides (13).

Assaults including sexual assaults

Serious assault of both consumers and staff, particularly in acute units, is a continuing concern. Community Visitors reported multiple issues of alleged sexual assault. These issues mainly concerned allegations of inappropriate touching or exposure by other consumers. Some incidents were reported to the police, while other sexual safety notifications and reports were sent to the Chief Psychiatrist. On one visit, a Community Visitor noted three alleged "breach of sexual activity" incidents involving two females and one male consumer. Protocols were followed, including notification to the police.

Eight incidents involving sexual harassment or assault were recorded in August 2019 at Bendigo Health's Adult Acute Inpatient Unit. Community Visitors advocated for the implementation of the Mental Health Complaints Commission's (MHCC) Right to be Safe practices to be strengthened at the hospital. An in-service review led to the creation of an improved secure female area, and a revised protocol on sexual assault and activity was approved by the hospital's Quality and Risk Committee to raise awareness and guide staff in relation to legislation and best practice regarding sexual abuse.

At Upton House in Box Hill, Community Visitors repeatedly observed male consumers admitted to the gender-specific areas of adult acute units due to a lack of beds, increasing the risk to vulnerable female consumers. Shared rooms also exposed vulnerable consumers to greater risk and compromised treatment. Pleasingly, Eastern Health is renovating the adult acute unit at Upton House to offer increased flexibility with the allocation of beds for consumers, particularly with respect to gender safety and aggression. The service also reports that they have operational processes to support safe patient care.

CASE STUDY

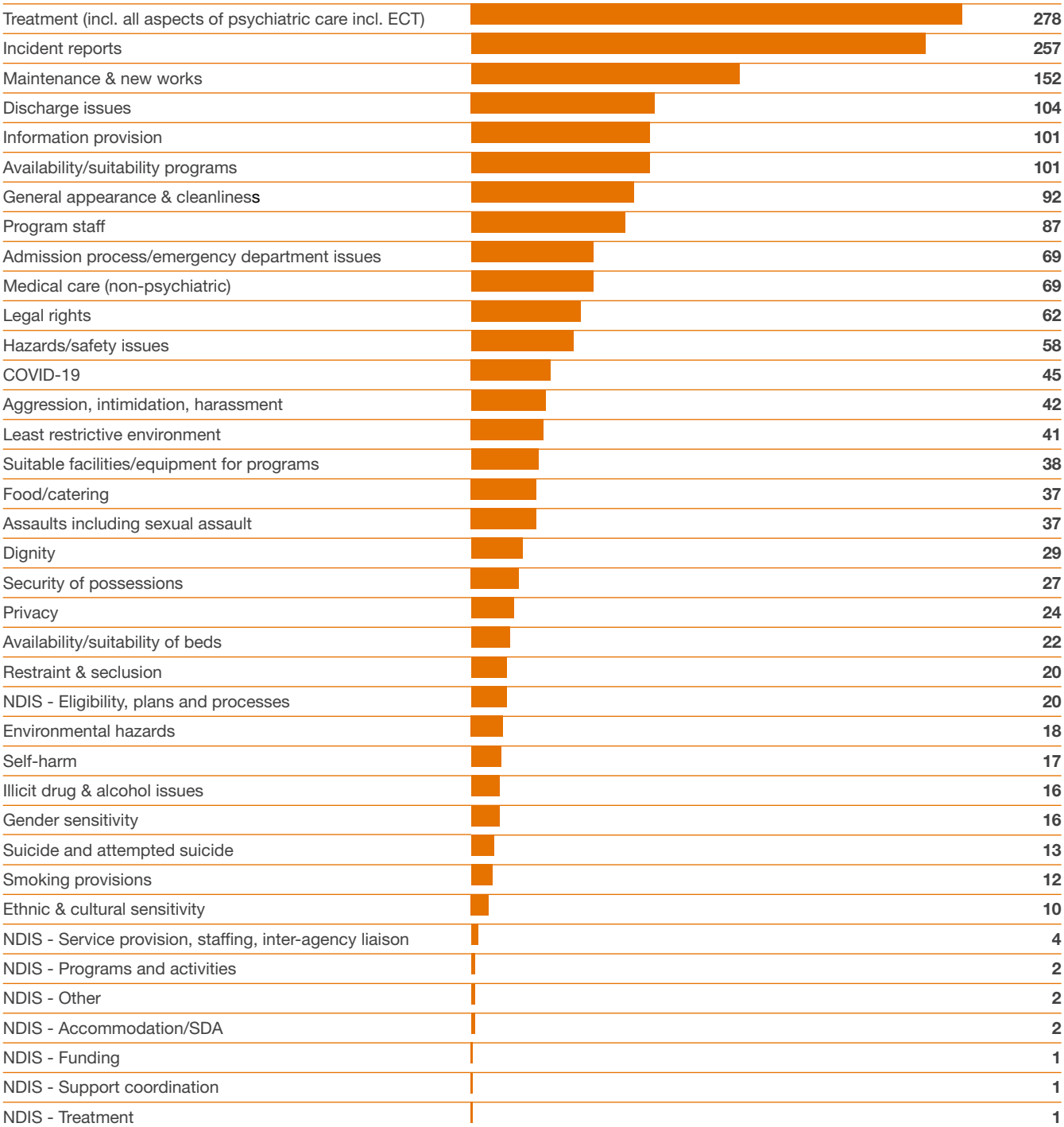
An anonymous call to OPA advised of a sexual assault on Kala, a female consumer in an acute inpatient unit, who alleged she had been disturbed at night by a male consumer entering her room and standing over her while she slept. She woke up and yelled out, and the male left the room. A short time later, he re-entered the room, naked and sexually aroused, and approached Kala, who was lying on her bed. She screamed and the male hastily left the room. 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

the matter. Community Visitors were told by the service director that the OCP was satisfied that the incident was managed as required. The facility advised it was installing a patient room-access bracelet system. The OCP requested and received the services' guideline and asked to be informed once the installation of the system was completed.

The facility continues to use the gender sensitive area for male consumers. Sensor lights and swipe access are now operational and planned refurbishment to the inpatient unit includes the installation of an additional set of doors in the gender sensitive area and nine additional mental health beds, providing greater flexibility.

Figure 10. Disaggregation of issues reported by Community Visitors, 19/20



Aggression, intimidation and harassment

Unfortunately, a high number of incidents continue to be reported in acute inpatient settings. For example, at Box Hill Hospital, Community Visitors noted 60 incidents in a month. There were a small number of medication errors but most of the incidents involved aggression between residents or towards staff. This number of incidents is not unusual in acute inpatient units but remains totally unacceptable. The use of furniture as a weapon resulted in one high dependency unit having furniture removed for two weeks before being returned.

Community Visitors also reported aggression in aged persons mental health units, as they did last year.

CASE STUDY

John, a 68-year-old consumer in an aged persons acute unit, attacked a nurse during the night by attempting to choke her and hitting her head against the wall.

Security personnel were not present and other nursing staff came to her assistance. Further assessment indicated that John would be better managed in an adult inpatient unit, before later returning to the aged persons acute unit.

Although John initially met the criteria for admission to the aged persons unit, Community Visitors were concerned that his unpredictable aggressive behaviour was incompatible with the safety of older and more fragile consumers. John has returned to the community with follow-up treatment at home.

Community Visitors have annually reported on the positive impact of the Safewards Program and the use of de-escalation techniques by staff to reduce agitation. At Eastern Health's Peter James Centre, Community Visitors observed a consumer being taken to the sensory room and calmed with the use of massage chair. At St Georges Hospital's Normanby House an occupational therapist was observed brushing a patient's hair as a calming technique.

Safety issues

Community Visitors are concerned by reports of concealed knives and illicit substances being smuggled into inpatient units and have advocated for the installation of lockers for visitors to secure their bags and other personal items, to curb such instances. They believe this will be effective, noting that when entry of visitors to the main ward area was suspended during the pandemic lockdown, such occurrences stopped.

In another incident, a staff member left the code to a safe containing medication on a post-it note, allowing a consumer to access excess medication. Fortunately, the consumer was not harmed and procedures have now been strengthened.

GOOD PRACTICE

During a routine visit to Broadmeadows CCU, a consumer, Aaron, expressed concern about an intruder peering into his bedroom window in the early morning. He then described another "two attacks" the following day stating there was a "gang of youths" armed with a metal pole, damaging the fence at the rear of the property, ripping away metal sheeting.

Community Visitors observed numerous puncture holes and dents and brought these to the attention of the facility's management.

The fence damage and a person looking in windows was reported to the police who attended in response to a group of youths known to them. The fence was repaired, and a safety audit of the premises and grounds undertaken. Increased lighting, an electronic gate and CCTV have been installed.

At the time, consumers said they were shaken by the experience but they felt safe due to prompt actions by staff.

Self-harm

Community Visitors continue to be concerned about the level of self-harm and adequate of supports for affected consumers.

In one case, a consumer was discharged from hospital after a serious self-harm incident only to be re-admitted the following day with a further and more serious self-harm incident.

Elsewhere, at the Eastern Health adolescent acute unit, Community Visitors observed in one month, more than half of the 20 self-harm incidents were attempts at self-strangulation. In response, a staff member advised that many were attempts to attract attention. Community Visitors were concerned with this response.

Eastern Health has since advised that they take the issue of self-harm very seriously and the unit has written a practice guideline to promote best practice in relation to the prevention and management of self-harm.

GOOD PRACTICE

A resident at one of Latrobe Regional Hospital's units has ongoing, complex, self-harm issues when stressed and anxious. Each incident is reported. They have a treatment plan and now self-report to the nurse on duty and any minor injury is addressed without consequence. This has led to a significant reduction in the severity and frequency of the self-harm.

Suicide and attempted suicide

Four recorded incidents of attempted suicide were reported in the Eastern Metropolitan area.

A female consumer was found in her room at night, not breathing and with a sheet around her neck. In another case, a consumer attempted to strangle herself during a visit with her mother in an interview room. There was no nurse present at the time. The woman was discharged two days later. She had a history of admissions with suicidal ideation after multiple suicide attempts.

An attempted hanging in an adolescent unit, with the consumer using the sprinkler system as a suspension point, resulted in the Austin Hospital replacing all sprinkler heads to comply with "design to fail" criteria.

These examples demonstrate that risk cannot be eliminated in all instances for people with serious mental illness and ongoing suicidal ideation. However, risk assessment and treatment plans must be strengthened, and interventions provided to support the person's individualised recovery.

CASE STUDY

Paul, a young consumer at a facility in the western suburbs, attempted to smash his skull by dropping a bed leg on his head. He sustained a deep laceration above his right eye. After initial treatment in the unit, staff facilitated a transfer to a hospital emergency department for further medical intervention.

Following this, the service completed an audit of all beds, prompting further discussions and team-based reviews as to whether all beds within their mental health areas should be fixed to walls.

Hospital beds are extremely heavy and some can reportedly hold 250kg. The Board raised this issue with DHHS which sent the Board the building guidelines for information. However, it is still unclear why some newly built services attach their beds to walls and others do not.

Community Visitors have been advised that there is no consistent standard regarding fixed or freestanding beds. Services reportedly strive to achieve a balance regarding patient comfort and safety while attending to ergonomic safety when cleaning or bed-making. NorthWestern Mental Health's new three-bed Intensive Care Area and three-bed Youth Justice Unit have fixed, plinth-type beds.

Eating disorders

At the Austin Hospital, consumers with eating disorders are co-located with acutely unwell consumers diagnosed with other mental health conditions.

Community Visitors are concerned that consumers with eating disorders, who often have diminished stature and anxiety due to their illness, are at risk of intimidation and harassment from other consumers. This issue has been discussed at length at the hospital Quarterly Liaison meetings and the monthly Safety Quality and Risk Committee. A detailed review of Community Visitor data from the past two years, revealed that there had been no reports of aggression or intimidation involving eating disorder consumers but often Community Visitors do not know the diagnosis of consumers.

While consumers with eating disorders at the Austin Hospital have a room exclusively for their use, this can lead to isolation and reclusion. Best practice is unlikely to recommend the co-location of consumers with eating disorders and consumers with other diagnoses because of increased vulnerability.

Treatment and care

'Treatment and care' was the leading category of issues documented, with 685 issues this year, an increase of 150 over last year.

A wide spectrum of issues was reported by Community Visitors ranging from medication concerns (errors, medications not working well, over-medication, preferences for oral rather than injected medications and concerns about side effects); to concerns about the impact of Electroconvulsive Therapy (ECT) treatment, advance care statements not being followed, wrong diagnoses, leave delays and concerns about the effectiveness of treatments.

GOOD PRACTICE

At an aged persons mental health facility, Alex was concerned staff were not adhering to his Advance Statement. When Community Visitors raised his concerns with the Nurse Unit Manager, the treating team agreed to investigate triggers of infections or pain first and then progress to comply with his Advance Statement.

Admissions and emergency department issues

Community Visitors raised 69 issues relating to admission processes and emergency departments. A number related to people with disabilities from group homes who presented to emergency departments and were admitted without group home support.

CASE STUDY

Colin, a person with disability living in a group home, was admitted to a hospital emergency department after exhibiting behavioural issues (violence and faecal smearing).

The group home reportedly refused to take him back until his mental health behaviours were "fixed" as they believed it was unsafe for him and his co-residents if he returned. Colin was observed by clinicians for two days in a general unit and it was determined there were no mental health issues.

They became aware that his medication had not been administered appropriately – a long-acting pill had been crushed to administer, thus, making the medication less effective and shorter-acting.

After follow-up by Community Visitors in the disability stream and the service, Colin returned to his disability group home.

The lack of mental health beds in regional areas remains an ongoing issue, with consumers and their families travelling long distances to be admitted to hospitals in metropolitan areas. Community Visitors reported cases where referrals from Albury-Wodonga were received by Box Hill Hospital's Adolescent Inpatient Unit, a three-hour drive away.

Bed availability and discharge issues

Community Visitors continue to report issues relating to bed availability and discharge across metropolitan and regional hospitals. They include a shortage of forensic beds and limited discharge options, contributing to longer stays as well as affecting the delivery of services and consumers' rights. Staff at both metropolitan and regional hospitals reported there were times they had to discharge the consumers who were the least well, rather than when they were clinically ready for discharge.

One metropolitan health network advised Community Visitors that bed occupancy hovers around 100 per cent and there are often 25-30 consumers awaiting admission in the three emergency departments under their management. An average length of stay for their acute admission is nine days. There is a gross mismatch between capacity and demand for acute beds.

Some services have had to limit the number of consumers supported or were unable to open new beds because of difficulties in recruiting enough suitably trained nurses or medical officers.

Hospitals also experienced temporary bed shortages due to property damage. In one case, only 'low-risk' consumers could be accepted for seven days due to property damage by another consumer, resulting in no seclusion space being available and beds remaining empty until the unit had been repaired.

Community Visitors reported that Ballarat Health was only running a five-day service from their parent-infant unit. The Board raised this issue with DHHS and it was confirmed that the service had funding for seven days. The unit is now in the process of becoming a seven-day-a-week service. A new PARC service, now on site, allows a higher level of support and safety for consumers and staff.

A lack of suitable community options for consumers with complex needs continues to affect discharge planning. At a liaison meeting with Community Visitors in November 2019, St Vincent's Hospital reported that they had five or six consumers with complex needs within the inpatient setting because there were no other services available to support them: they were effectively stranded. This had been reported to the Office of the Chief Psychiatrist.

CASE STUDY

Lee remained in an acute unit for 253 days under a treatment plan monitored by the Chief Psychiatrist in conjunction with the DHHS Multiple and Complex Needs Initiative.

In October 2019, Community Visitors reported that Lee was confined to his room by two security guards and a nurse, with 15-minute observations. In November, Community Visitors reported he had moved to 60-minute observations and he only came out of his room for meals.

A plan to relocate Lee to transition accommodation in a rural area was cancelled in February and there are currently no other accommodation options. However, he has started to engage in community activities with the support of two NDIS workers.

Positive developments have been seen in the last year, with several units expanded or refurbished to accommodate more beds. The opening of additional beds in Bendigo Hospital's Extended Care Unit has enabled more people to be transferred out of the acute unit.

The Mercy Mental Health Perinatal Mother-Baby Unit developed a bed substitution service to support more mothers and families to receive treatment at home during the COVID-19 pandemic. This service is being evaluated. The perinatal service also increased clinical psychology within its outpatient services.

New acute beds in the north and west of Melbourne have been announced but these are still at least 20 months away.

GOOD PRACTICE

The family of a consumer seeking transfer from another psychogeriatric service was reluctant to agree to admission because only a shared room was available.

The consumer had previously been admitted to five different facilities because of aggressive behaviour. Another resident agreed to swap from a single to a shared room and staff supported the consumer continue activities that were important to him including drawing and playing his guitar.

Food and catering

Community Visitors raised 37 issues relating to consumer dissatisfaction with the quality, variety and food choices available.

In one service, fruit previously freely available on a table in the common area was replaced by a vending machine containing soft drinks and packaged snacks. Consumers who want fruit need to request it on their daily menu. In another service, a consumer described the food as bland and there was not enough to eat. This person requested that more fruit be made available.

The timing of the serving of meals in some facilities was also an issue, with late lunch and early dinner leading to a short period between both meals. Consumers complained that reheating meals delivered earlier in the day resulted in food that was dry or overcooked. There were also issues relating to the accommodation of specific dietary requests.

While these issues can be easily addressed, some require more attention before they are resolved.

CASE STUDY

Last year, Community Visitors reported that a Mercy Mental Health facility served microwaved, pre-packed meals, small in portion sizes.

There was limited choice, and health and cultural considerations were not being appropriately met. The issue was complicated as the hospital did not operate the centre on a Mercy Health campus, and the arrangement for meal provision was included in a memorandum of understanding.

A year and a half later, fresh hospital food is now delivered. The Nurse Unit Manager advised that there has been positive feedback from consumers.

Restraint and seclusion

Issues related to restrictive environments almost doubled from 22 last year to 41 this year. Restraints and seclusion can have a traumatic effect on consumers and can result in injury or even death. Consumers sometimes report distress and disorientation to Community Visitors after seclusion, seeking more independence and freedom of movement.

The main reason given for the application of restrictive and seclusion practices is 'consumer safety' – of both the consumer and others.

At Box Hill, in one month, there were 17 instances of physical/mechanical restraint and 17 instances of seclusion reported. Most of the episodes involved a small number of consumers. Community Visitors were informed that a consumer with autism and intellectual disability had required four-point mechanical restraint. The consumer had been admitted from a group home after a history of increasing agitated behaviours.

The management of consumers with complex mental health illness and disability is an ongoing concern for Community Visitors. These consumers often need access to disability support workers to ensure that they get comprehensive treatment. The lack of availability of long-term accommodation options makes discharge difficult.

Some situations involved violent behaviour. For example, at St Vincent's Mental Health Adult Inpatient Unit, staff reported using seclusion when a consumer was kicking holes in the Extended Care Unit bedroom walls. Staff attempts to de-escalate the situation were unsuccessful and in discussion with the afterhours consultant, staff said they made the decision to use seclusion to avoid further escalation to a violent incident. Discharge from the unit was discussed, however, this would have placed the consumer at increased risk as they were homeless at the time.

CASE STUDY

Rob had only just been admitted into Western Health 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.

Restrictive clothing

In some aged persons mental health units, Community Visitors observed the use of all-in-one suits with fastenings down the back. Staff advised this clothing was used to promote dignity for consumers who frequently disrobe or to support incontinence management, when used overnight with adult diapers.

Community Visitors were told there is no policy or procedure regarding the use of dignity suits but consumer needs were reviewed shift by shift according to the consumer's behaviour and involved family members.

This is an emerging issue and Community Visitors request that consideration be given to adding the practice as a restrictive and reportable item.

GOOD PRACTICE

An improved high dependency area has been created at the Mildura Base Hospital Acute Unit and, in South Gippsland, senior nurses engage with emergency departments to educate staff on restraint and reducing restrictive practices. Community Visitors note Latrobe Regional Hospital in Gippsland reportedly has one of the lowest seclusion rates in the state.

Thomas Embling Hospital is also contributing to mental health research in developing a Safewards Secure Program - adapting the Safewards Program to forensic mental health settings.

Research projects are also to be undertaken at the hospital in the follow areas:

- evaluation of Aboriginal social and emotional wellbeing
- evaluation of the neuropsychology service
- evaluation of the Reflective Practice approach.

Legal rights and information provision

Community Visitors reported 269 issues relating to legal rights and information provision, a decrease from 355 last year, largely due to issues related to incident reports being included in the 'serious incidents, assaults and safety' category.

Community Visitors continue to meet staff who are unaware of OPA's role and that of the Community Visitors Program. This year, Community Visitors continued to raise awareness of the program, presenting sessions tailored to hospitals and staff.

Information provision issues raised by consumers included access to WiFi, concerns about family welfare, pets, accommodation, Centrelink payments, medical records accuracy, discharge and treatment plans and Mental Health Tribunal hearings.

CASE STUDY

Sam, a deaf and non-verbal consumer at a CCU was unable to access interpreters who would visit. Staff communicated with him by using picture cards and phone apps. Staff at the unit are trying to find appropriate accommodation to meet his needs.

GOOD PRACTICE

Many consumers are very concerned about their pets when they are admitted to residential services. Latrobe Regional Hospital has a program where consumers, on admission, are asked about pets and, if necessary, support is arranged. Staff will sometimes look after the pets themselves in the short-term if it is brought to the hospital.

Privacy

There was a slight increase in privacy concerns reported by Community Visitors with 24 issues compared to 18 last year. A number related to staff or other consumers accessing consumer rooms unannounced. Some female consumers reported they felt compromised when they were supervised while they undressed or showered, particularly when this practice had not been explained to them.

CASE STUDY

Joan, a resident of an aged persons facility, reported that another resident was constantly coming into her room, knocking items off her table and sometimes getting into her bed.

Joan felt scared and powerless to remove the other resident. She reported she was worried she would be trapped in the room with the person and felt humiliated when staff laughed at her complaints. Staff advised Community Visitors that it would not be appropriate to lock or block a resident's door as this would be considered a restrictive practice. Joan felt that staff were not addressing the problem or taking her concerns seriously, leaving her feeling dismissed and ignored.

Gender sensitivity

Reports relating to gender sensitivity increased from seven last year to 16 this year, with the majority relating to male consumers in gender-sensitive areas, which are usually used for female consumers.

Ethnicity and cultural sensitivity

Community Visitors reported 10 issues relating to ethnicity and cultural sensitivity. Issues related to the support of consumers from Aboriginal or non-English speaking backgrounds. In one report, staff of different cultural backgrounds and their interactions with consumers was raised as a concern, particularly nurses of Indian origin who misinterpreted consumer hand gestures.

CASE STUDY

Larry, a consumer at one facility, told Consumer Visitors he was worried about Thant, another consumer, who did not speak English very well. Thant had not been eating because he thought he had to pay for the food, and he didn't have any money. Community Visitors advised unit staff about Larry's concerns for Thant so they could follow it up.

GOOD PRACTICE

Mildura Base Hospital has gained one of two registered training posts for Aboriginal Mental Health commencing in 2021. Currently, Aboriginal consumers can contact an Aboriginal liaison officer or receive visits by a community service.

Facility management

Community Visitors raised 262 issues related to facility management this year. Community Visitors reported 152 facility management issues related to maintenance and new works, with this being the third highest category reported by Community Visitors. Issues related to general appearance and cleanliness of facilities (92) with environmental hazards (18) also included in this category.

Maintenance and new works

Delays in maintenance and new works were commonplace, with 34 issues identified in one inpatient unit. Community Visitors observed that serious hazards were generally resolved within a reasonable time, however, many maintenance requests and general outdoor maintenance issues at facilities have taken months to action.

Last year, Community Visitors noted the need for soundproofing to ensure the privacy of patients and confidentiality of Mental Health Tribunal hearings held at Goulburn Valley Health's Wanyarra Acute Inpatient Unit. Despite advocacy by regional Community Visitors, and the Board raising this with DHHS at several liaison meetings, this issue remains unresolved. In June 2020, Goulburn Valley Health was still awaiting approval for the funding of this work. The Board raised this issue at the Statewide Liaison meeting and DHHS agreed to follow it up.

CASE STUDY

At a Northern Hospital Acute Inpatient lounge, Community Visitors reported in November 2019, January 2020 and February 2020, that cushions needed to be replaced as they were stained and torn.

The service said they would remove the worn couches and relocate furniture from elsewhere as a temporary option until replacement furniture could be purchased. Highly offensive graffiti and unhelpful statements related to recovery on the walls of a unisex toilet was also reported over three months.

These issues were unresolved when Community Visitors last visited in March 2020.

Graffiti on a wall in an outdoor courtyard was also reported by Community Visitors at Goulburn Valley Health's acute unit in August 2019 and January and February 2020. It had reportedly been cleaned by April 2020.

General appearance and cleanliness

Community Visitors reported foul odours including urine smells as well as mould and other substances in bathrooms. The issues were raised with Alfred Health for several months until they were finally resolved. Cleanliness issues have been raised in a further two services in lounge areas and bathrooms. Towels, soap and rubbish were on the floor, with Community Visitors told cleaning would not occur until the afternoon.

Cleanliness of bathrooms and lounge areas were also raised at other services. After Community Visitors raised these issues at one facility, additional cleaning was arranged to comply with cleaning standards.

At the Royal Melbourne Hospital, Community Visitors observed that there were fewer dedicated cleaners and they were shared between two floors. Community Visitors were told that the unit had also lost kitchen staff. Nurses have had to perform cleaning tasks and, in June, a solution was still in progress. Melbourne Health says the cleaning and food service functions were re-designed to ensure separation between the two tasks and this was for reasons of efficiency as well as hygiene.

GOOD PRACTICE

Community Visitors at the Austin Hospital and Thomas Embling Hospital reported: "All units in both hospitals are consistently noted for the cleanliness of their units. This is also commented on by the patients."

Activities and programs

Overall, there were 226 issues related to activities and programs raised by Community Visitors this year including general issues regarding the availability and suitability of programs (101), suitability of equipment and facilities (38), and program staffing (87).

Availability and suitability of programs

Community Visitors argued for activities to help alleviate boredom, especially in High Dependency Units, to cater for patients who are more physical as well as to respond to consumers needing physical rehabilitation to recover from injuries. Community Visitors raised issues about the small number of activities scheduled on weekdays as well as a lack of activities on weekends in both high and low dependency units.

Community Visitors reported out-of-date or incomplete activity programs and others that did not occur as advertised. Delivery of some programs was reliant on the availability of students. On one occasion, Community Visitors observed "bed making" listed as a group program.

However, some examples of good practice were reported around the state. At Royal Melbourne Hospital's John Cade Unit, weekly music therapy was introduced after many years of advocacy by Community Visitors. Broadmeadows Community Care Unit has also employed an exercise physiologist.

At the Peter James Centre, Mooroolbark, a therapeutic pony was a great success. At the Maroondah Hospital, Community Visitors observed a pet therapy dog, a large Great Dane, moving about with consumers. The dog is provided by a volunteer who receives no financial support for transport costs, despite travelling from Warragul fortnightly to provide the service.

GOOD PRACTICE

Community Visitors were greeted by new occupants of Jardine - five brown chickens! The Jardine rehabilitative unit is the lowest security unit at Thomas Embling Hospital. Community Visitors reported: "Chickens laying eggs are a great addition to the unit as well as the atmosphere and calming effect of free-range chickens in the unit."

Facilities and equipment

Reported issues included insufficient space for activities, equipment not available or in poor condition, and communal rooms or courtyards being locked. Access to equipment such as headphones or gym equipment has also been raised by consumers. Sometimes such equipment has been restricted because it was perceived to be a ligature risk.

Other issues arise because buildings are not fit for purpose. For example, the Ballarat Hospital building is at the end of its life span and does not meet contemporary standards. Courtyards are small due to the footprint of the site and do not provide line-of-sight into the main unit area.

Program staffing

Community Visitors raised issues relating to staff shortages for occupational therapy positions, resulting in a decline in activities offered. In one unit, there was no occupational therapist and the nurse unit manager had tried to manage activities through nurse allocation, as an interim measure. Community Visitors remain concerned about the lack of organised activities and were informed by the service that an occupational therapist is available only one day a week for assessments, and not for activity coordination.

In one low dependency section of an acute unit, there appeared to be only two sets of headphones available. Community Visitors were surprised to hear that an occupational therapist assessment was required for consumers to use headphones. There had been none at the unit for three weeks. Community Visitors asked whether the Nurse Unit Manager could make such assessments.

Some rural services lacked access to occupational therapists for most of the year, and faced other ongoing staffing issues. At Wanyarra Acute Inpatient Unit in Shepparton, this led to a lack of staff for activities and patient-escorted leave, especially in 2019. Many activities were listed on the board, but did not always run, due to staff shortages. Nursing staff now run various activities.

Attracting and retaining appropriately skilled staff is an ongoing issue for some rural services that struggle to fill advertised positions.

NDIS

Community Visitors recorded 33 NDIS-related issues in their visit reports and these issues were frequently discussed at service liaison meetings. Many issues related to eligibility or the rejection of necessary items from their plans. Some consumers were ineligible because they are not Australian citizens while others would not consent to the assessments necessary to provide the evidence of permanent disability.

Many consumers need assistance to apply for the NDIS and navigate their way through the system to obtain funding. Staff have told Community Visitors that this process can take up to six months.

CASE STUDY

Justin had been a patient at a rural adult acute unit since November 2018.

In July 2019, Community Visitors reported that Justin was without an NDIS package or plan and he was unable to be discharged to community care without funded supports. They identified that he needed advocacy assistance to access the NDIS.

Community Visitors followed up on another four occasions throughout the year, but the issue remained unresolved. Sadly, Justin required palliative care and, in March 2020, he passed away, while still residing in the acute unit.

One psychogeriatric nursing home in a rural area has four residents under 65 years of age, one who is only 41 years old. Two are receiving services from the NDIS, one is awaiting NDIS approval and another had her plan declined.

Community Visitors questioned the appropriateness of their accommodation and advocated that a specialist NDIS planner be consulted given their complex needs and lack of accommodation options. The health service agreed to arrange referrals to Independent Mental Health Advocacy for advocacy support and the NDIA for a Local Area Coordinator which resulted in individualised age-appropriate activities.

Another consumer, in a metropolitan PARC, told Community Visitors she had made three applications for funding which had all been declined. She had also been told that a previous agency that had provided outreach services to her was no longer able to do so because of changes in the sector related to the NDIS. Given she has been deemed ineligible for the NDIS, she wondered how she would obtain support when she left the PARC.

Staff reported that this is a common issue; that people currently receiving services cannot access NDIS funding. When they then move to the community, they struggle to obtain case management or other supports for daily living.

Community Visitors note that most health networks now have dedicated mental health workers who can support consumers with their NDIS applications and assist in liaison with Support Coordinators and the NDIA about the progress of applications and funding packages. Social workers also assist with these tasks.

Under the NDIS, some previous services within facilities are no longer available, including a music therapist at one service.

Even when a consumer has access to NDIS funding, there is no guarantee that appropriate accommodation, such as a specialist service with overnight support, can be found. As a result, some consumers have remained living in adult inpatient units for many years.

CASE STUDY

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 was declined. Unit staff are assisting John to appeal this decision.

The NDIS has enabled some consumers to move on from forensic and extended care facilities and to participate in community activities with support before discharge.

COVID-19

Face-to-face visits to mental health facilities were suspended in March 2020 on the advice of the Chief Health Officer.

Calls from mental health consumers and carers to OPA's Advice Service were responded to by phone, initially by staff working from home and then by Community Visitors.

The Community Visitors then commenced scheduled phone visits. While the program is keen to have contact with consumers via other platforms, such as Zoom, there have been challenges. These include a volunteer workforce with varying technological abilities and ensuring their security as well as the safety and confidentiality of consumers using shared equipment in a congregate setting.

In the initial stages of the restrictions, consumers had reduced access to family and significant others as well as professional service providers such as case managers, peer support workers and NDIS services which impacted on consumer wellbeing and, in some cases, discharge planning. Some services reported unexpected positives including reduced contraband coming into the facility, less aggression and a drop in the number of suicides in the community. While some consumers were uncomfortable with telehealth or video consultations, the majority seemed happy with them.

Community Visitors noted that service providers were forced to rapidly adjust their practices to ensure consumer and staff safety. Actions included:

- development of COVID-19 response plans
- initial closure of units to visitors, non-essential contractors and allied health professionals but then reopening in line with changes to government restrictions
- promotion of social distancing and hand hygiene
- temperature checks and screening of consumers, staff and visitors
- providing staff and residents with flu vaccinations
- increasing availability of PPE, cleaning equipment and sanitiser dispensers
- increased education of staff about hand hygiene, PPE and COVID-19
- supporting consumers in using iPads for conversations with family and friends as well as connecting with the Mental Health Tribunal, online church services, allied health professionals, Independent Mental Health Advocacy and Legal Aid Victoria
- creation of areas for patients who might need to quarantine
- reconfiguration of services with the suspension of some face-to-face community services.

CASE STUDY

Community Visitors to the Swanston Centre in Geelong were very concerned about the impact of lockdown on consumers in the acute inpatient unit.

Many consumers are smokers and, with all leave suspended, there was an increased risk of behaviours of concern as frustration levels grew.

Leave arrangements were reviewed and new leave plans established to allow consumers time limited leave while maintaining public health directives for COVID-19 restrictions.

Stakeholder relationships

Regional

Community Visitors report productive interactions and good working relationships with most mental health providers across the state. Regular quarterly liaison meetings are held with the various health networks in most areas. These have continued via Zoom or other virtual platforms during COVID-19 restrictions. However, several Regional Convenors have advised that written responses are not automatically provided to issues documented on visit reports despite clear indications where responses are required. This has required follow-up by Regional Convenors via meetings and email despite a statewide protocol that requires responses to be made within seven days, where possible.

In some regions, relationships with emergency department staff and managers have required work, with some staff being unaware of the Community Visitor role or forgetting that Community Visitors were on site and waiting to be informed about mental health consumers. In the Barwon South West area, Community Visitors presented an information session to the emergency department team that was reportedly well-received. Protocols have been established that streamline the entry of Community Visitors into emergency departments and mental health incidents in them are included in the monthly incident report summaries from the service.

In the Northern Metropolitan area, the Regional Convenor regularly attends the Quality and Risk Committee meetings to gain a greater understanding of the service's analysis and response to incidents. They have found these meetings very valuable.

CASE STUDY

From October 2019 to March 2020, consumers and staff at Latrobe Regional Hospital were impacted by a cybersecurity attack which took months to fix. For much of this time, staff were offline with no emails, internet or, in some cases, phones, and no access to the incident-recording program, Riskman.

Community Visitors were unable to access incident reports for a few months. Records needed to be manually entered into the repaired system, which only gradually came back online.

Maintenance issues were affected as the hospital could not access orders or make payments.

Consumers and staff were also adversely affected by the bushfires over summer, especially those at the PARC Bairnsdale.

In addition, COVID-19 has impacted on protocols and practices at the hospital, including moving to Zoom for the May 2020 liaison meeting.

The cybersecurity attack also affected services in the Barwon and South West region.

Restricted access to incident reports in some parts of the State is a continual source of frustration to Community Visitors, with some services like Monash Health insisting that full reports can only be viewed on site or summaries provided once all names have been removed. Some services such as St Vincent's and Austin Health provide good access on site and other services like Bendigo Health and Mercy Mental Health provide Community Visitors with electronic summaries on a monthly basis. Eastern Health and Goulburn Valley Health have also provided information electronically since Community Visitors ceased face-to-face visits.

The volume of incident reports can be overwhelming, whether they are accessible in hard copy or via computer during a Community Visitor visit. Electronic summaries allow Community Visitors to consider the reports in their own time but reports from metropolitan health networks often run to hundreds of pages and can take hours to analyse. The content of these reports can also be harrowing.

If Community Visitors are to fulfil their role in reporting on the adequacy of mental health services and facilities and compliance with the Act and Regulations, they must be made aware of the incidents occurring within services. If the DHHS cannot provide meaningful reports from the Victorian Incident Health Management System, then additional resources are required to assist the analysis of incident data from individual health networks.

Where mental health services work collaboratively with Community Visitors and provide incident summaries, some excellent outcomes can, and have been achieved.

GOOD PRACTICE

Bendigo Health is providing password-protected electronic incident report summaries monthly, enabling Community Visitors to identify trends which are then taken up with the service management.

A cluster of sexual assaults in the adult acute unit over several months was referred by Community Visitors to the Director of Nursing. Community Visitors understand this contributed to the improvement of security of gender separation in the facility and clearer information to consumers on admission.

Recently, Community Visitors were alerted to instances of repetitive self-harm in the unit and engaged with nursing staff to ensure optimum treatment therapies were implemented. An at-risk consumer involved in these incidents appeared to respond to the enhanced trauma-focused care and was able to be successfully discharged to community care.

Statewide

The Community Visitors Mental Health Board has continued to engage in informative and productive meetings with DHHS and sincerely appreciated the support of the Chief Psychiatrist, Dr Neil Coventry and his staff, not only in the follow-up of issues, but also in the delivery of training on eating disorders to our Community Visitors.

Systemic issues discussed at liaison meetings this year have included:

- incident data and Community Visitor access to incident reports
- facility design issues
- sexual safety strategies
- restrictive practices in aged persons mental health services
- services for people with eating disorders
- Transition Support Units and the needs of people with a dual disability
- parent-infant units
- the availability of meaningful therapeutic activities in facilities
- accommodation for the families of adolescents and children in units out of their region
- workforce issues
- peer support initiatives
- NDIS.

Other systemic issues raised by Community Visitors in the preparation of this report include:

- a shortage of forensic beds
- concerns about the suitability and flexibility of available resources to care for consumers at heightened risk and high acuity
- the large number of people in prison who need mental health care but were unable to obtain this, who then came into mental health acute units directly after their release.

Some of these issues were included in OPA's submission to Victoria's Mental Health Royal Commission.

Going forward

The Mental Health Royal Commission released an interim report with priority recommendations to the State Government in November 2019.

They included the funding of an additional 170 youth and adult mental health beds to help critical demand pressures. This includes allocating 135 additional acute inpatient public mental health beds or equivalent to Barwon Health and Melbourne Health, in alliance with Western Health and Northern Health, and an additional 35 acute inpatient mental health beds or equivalent from a private provider for the clinical treatment and support of public patients.

The Board commends the funding of these much needed beds and other programs to support people with mental illness in the community. Two new innovative Hospital in the Home programs will enable consumers to receive clinical treatment from home and avoid hospital admission. The Hospital Outreach Post-Suicidal Engagement (HOPE) program is also to be expanded to Shepparton, Epping and Bairnsdale, with it continuing at existing sites. The Board urges that these programs are implemented without delay.

Community Visitors understand they will be able to visit public beds in private settings funded under the Mental Health Act in future and await details of these facilities, hopefully, with additional resources to enable the program to effectively recruit, train and support additional Community Visitors to regularly visit and report on services in a changed COVID-19 world.

Appendix 1

Community Visitors 2019–20

OPA acknowledges and thanks Community Visitors in all streams who stood up for the rights of people with a disability or a mental illness during the year.

Marta Acton
Deanne Ades
Ian Alexander
David Allen
Jo Allen
Jenny Allen
David Anderson
Arthur Apostolopoulos
Gudrun Argyropoulos
Karina Au
Kim Baker
Joyce Ball
Wendy Baneth RC
Christine Barbuto RC
Jan Barker
Ricky Bartolo
Cheryl Beatson
Efi Bellchambers
Judy Berry
Judith Bink
Franciska Blanc
Rose Blustein RC
Marion Blythman RC
Dominic Boland
Walinda Bonne
John Bowen
Kathleen Bragge RC (Deceased)
Rebekah Braxton
Fiona Breedon
Robyn Brewin
Sheena Broughton RC
Deidre Brown
Geoff Brown
Lorraine Bryant
Ian Buckles RC
Ronald Butler RC
Andrea Cahill
Don Cameron
Kevin Campbell
Heather Campbell
Ken Castanelli
Joan Castledine
Pat Cerra
Julie Cesal
Chris Chapman
Carol Chenco
John Chesterman
Shri Chitale
Coleen Clare
Belinda Clark RC
Pamela Clarke
Jo Cohen
Peta Collet
Terry Collison
Kim Conder RC
Sandra Cooper
Carmelo Corrente
Stefania Cortecci RC
Jeanette Coulter
Adele Coutts
Joanne Coverdale
Erin Cowley
Vicki Cowling
Bryan Crebbin RC
Fiona Cromarty RC
Patricia Cross RC
Graeme Crutchfield
John Cull RC
Robyn Cunningham RC
Philip Dalliston
Doreen Dalrymple RC
Wendy Davies
Pat Davison
Meryl Dawson
Geraldine De La Harpe
Melissa Debono
Tracey Denby
Bev Devidas RC
L'Shae Dib
Graham Dickinson RC
Christine Dimer
Di Dixon
Alex Dobes
Kerrie Dobrzynski
Diane Doherty RC
Jenny Donaldson
Diana Donohue RC
Francine Dudfield
Jan Dunbar
Ian Dunn
Jennifer Dunn
John Dunn
Inez Dussuyer
Anne Eddie
Megan Edwards
Daisy Ellery
Elizabeth Elms
Pam Evans
Anne Fahey
Eveline Fallshaw RC
Mary Farbrother
Elizabeth Faulkner
Gillian Fawcett
Jennifer Fenwick
David Ferguson RC
Deborah Field
Jeanette Findlay
Roger Findlay
Trudy Firth
Judy Fitzgerald
Maureen Fontana RC
Daphne Foo
Marilyn Forbes
Christopher Forde
Jan Forsyth
Debbie Fowler
David Frame
Paulette Fraser
Ian Freeman
Judith Freidin
Anne Freudenberger Kay
Emma Frisch
Dale Furey
Jayne Gallo
Joanne Garrett
Sandra George
Dylan George
Ken Gibbs
Louisa Gibson
Pamela Giles RC
John Gleeson
Daysie Goldenberg
Karyn Golumbeck
Yan Gorrie
Swati Gossain
Mark Goy
Audrey Grace
Ruth Graham
Eddie Graham
Brian Granrott
Mandy Gray RC
Avril Green
Kay Gregory
Alan Grigson
Bill Grint
Gerard Grogan
Henry Grossbard
Alan Gruner RC
Suzanne Gubby RC
Wendy Guy
Frances Haberfield
Michael Hadley RC
Ghassan Haidar
Gail Haley
Linda Haller RC
Sam Haouchar RC
Sally Hargrave
Susan Harraway RC
Lynette Harris
Ian Harrison
Vera Hartelt
Lynette Hayes
Barbara Hayes
Carol Haynes
John Heath
Coral Heazlewood
Linda Helal
Neil Henderson
Jennifer Henry
Sue Herbst
Judy Heron RC
Pradeep Hewavitharana
Robyn Hickey
Bill Hickey RC
Glenys Hill
Colin Hinckson
Geoffrey Hoare
Jennifer Hocking
Wendy Holland
Pat Horan
Stephane Howarth
Mary Howlett
Natasha Hunt
Carolyn Hutchens
Giordana Ienco
Paul Iles
Kim Inglis
Chris Ingram RC
Dallas Isaacs
Felicity Jack
Beverley Jacob
Thomas Jambrich
Mary James
Robert Jeffree
Val Johnson
Lyn Johnson
Ray Johnson
Prue Jolley
Heather Jones RC
Barry Jones
Lynda Judkins
Don Juniper
Ivan Jurisic
Peter Kadar
Soula Katsaros
Karamjeet Kaur RC
Julie Kelly
Paul Kent
Jenny Kerr
Liam Kershaw-Ryan
Saima Khan
Sarah Khor
Brian Kiley
Debbie King
Mary King
Lisa Kirton
Julie Klok
Sandra Knorpp
Alan Kohn
Shiv Kumar
Amanda Kunkler
Justyna Kurzak
Tineke Lagerwey
Suzanne Lau Gooey
Pauline Lavars
Paul Lavery
David Lawrence
Susan Lawrence
Debra Lee
Robyn Leeman
Lawrie Leeman OAM RC
George Lefroy
Annie Lenanghan
Rob Lewis
Mark Lewis

Beverley Libbis
Margaret Lippold
Vashti Lloyd
Lam Loi
Louise Long
Jennifer Lush
Virginia Mack
Paul Mackaness
Colleen Macqueen
Umberine Madan
Carole Maher
Jenny Maiolo
Sandra Manitu
Kaye Manners
Jessica Marie RC
Linda Markowiec
Rohan Marlow
Valerie Martin
Jenny Martin
Sandra Martin
Brooke Mason
Pamela Masters
Cindy Masterson RC
Julian Maugey
Wendy Mayne
Ian McBeath
James McCarthy OAM
Kaye McClure-Leckie
Carole McElvaney
Stephen McElwee
Paddy McGennisken
Irene McGrath
Pamela McGregor
Deborah McLachlan RC
Heather McLeish
Brenda McMinn RC
Romy McNally
Louise McPhee RC
Laurie Messenger
Neil Michael
Alex Miller
Sonia Miller-Randle
Frank Miragliotta
Nina Mobach
Joanne Moore
Asher Moses
Rachel Mulder
Marj Munro RC
Alan Murphy
Gerald Mutubuki
Philip Myers
Danielle Neal
Rodna Nedanoska
Andrew Needham
Craig Ng
Connie Ngu
Sue O'Brien RC
Judy O'Brien
Kim O'Donoghue
Janine O'Neill
Joanne Page
Gloria Parker
Dave Parker RC
Wendy Patchett
James Paterson RC
Judith Pauwels
Cheryl Paxton
Betty Pearce
Stephen Peterson
Daniel Petrasek
Wendy Pfeifer
Lyn Phelan
Max Pietruschka
Sally Polack
Regina Prakash
Nancy Price
Dame Price
Robert Proudlock
Margaret Purves
Rose Randall
Helen Rawicki
Ann Ray RC
June Rea
Keren Reeve
Edith Retemeyer
Sue Rewell RC
Maureen Rhodes RC
Kathy Richards
Brian Richards
Dawn Richardson
Julie Ritchie
Dany Roberts
Sebastian Roberts
Ryan Robertson
Hugh Robinson
David Roche
Vivienne Roche RC
Jo Rodger
Mick Rosier
Pam Roth
Ainsley Rozario
Linda Rubinstein
Frances Schepisi
Lina Schonfeld
Bill Scott
Diane Seren
Debra Sevastianov RC
Nimit Shah
Rosemary Shaw OAM
Awtar Singh
Mohini Singh
Puvana Sivakumar
Jenni Smith
Rebekah Smith
Joanne Smout
Nicole Smyth
June Soutar
David Stafford
Glenn Staunton
Nola Stavely
Ray Steadman RC
Gideon Stein
Margaret Stevenson RC
Gavin Stewart
Graham Stickland RC
Suzanne Straney RC
Susan Strohfeldt
Bernadette Sullivan
Sheryl Summons
Bill Swannie
Robert Swiger
Anne Tait RC
Alan Talukdar
Suzanne Tatchell
Tanjilia Tayeb
Mark Thompson
Graeme Thornton
Rosslyn Thurrowgood RC
Cherie Titman
Julia Tivendale
Rosemary Tomkins
Nam Tran Nguyen
Betty Trayling
Meryle Trentini
John Trevillyan
Helen Tribe
Julie Trompf
Stephanie Tufft
Merrill Tunstall
Kathy Turcan
Gary Turner
Jordan Turner
Diane Tymms
Malcolm Urquhart
Luke Van Den Dikkenberg
Linda van Draanen
Adam Veitch
Antonia Veneracion
Alexa Viani
Lynn Wallace-Clancy RC
Sylvia Walton AO
Sebastian Waluk
Betty Waters
Melinda Watt
Jennifer Weber
Christine Weetch
Sally Wellard
Wendy Wereta
Calvin White
Michael White
Susan Whitehead
Liz Whyte
Susan Wilcox
Dianne Wilde
Carole Williams
John Williams
Beverley Williams
Ros Williamson
Linda Wilson RC
Elaine Wilson
Sheila Winter RC
Columbia Winterton
Lyn Wood
Tricia Woodcock
Rhonda Woodrow
Ying Yew
Stephen Young
Ping Yu
Annie Zahra
Susan Zammit
Ignatius Zanetidis
Alison Zylenberg

Appendix 2

Facilities eligible to be visited

Disability Services Providers

AAA Nextt Group Pty Ltd
Ability Assist
Able Australia
Accommodation and Care Solutions
AGAPI Care Inc
Alkira
Amicus
Annecto Inc.
Araluen Centre
Aruma
Aspect Australia
Asteria Services
Australian Community Support Organisation (ACSO)
Australian Home Care Services
Bayley House
CareChoice
Carinya Society
Colac Otway Disability Accommodation Inc.
Community Living & Respite Services Inc.
ConnectGV
Cooinda Terang Inc.
Department of Health and Human Services
DPV Health Ltd.
Expression Australia
Encompass Community Services
Epworth HealthCare
Ermha
Focus
Gateways Support Services
Gellibrand Support Services
genU
Golden City Support Services Inc.
Healthscope Independence Services
Home@Scope
IDV Inc.
Independence Australia
Jesuit Social Services
Jewish Care Victoria
Kirinari
Kyeema Support Services
Life Without Barriers
Mallee Family Care Inc.
Mansfield Autism Statewide Services
McCallum
Melba Support Services
Melbourne City Mission
Merriwa Industries
Mind Australia Limited
Mirridong Services Inc.
MOIRA
Monkami Centre Inc.
Multiple Sclerosis Limited
Nadrasca
Nepean Centre
Northern Support Services
Noweyung Ltd.
OC Connections
OzChild
Possability
Providing All Living Supports (PALS) Inc.
Scope Australia
Southern Stay Disability Services Inc
Southern Way Direct Care Service Inc.
St John of God Accord
Statewide Autistic Services (SASI)
Sunraysia Residential Services Inc.
ONCALL Group Australia
Trio Support Services
Uniting (Victoria & Tasmania) Limited
Villa Maria Catholic Homes (VMCH)
Vivid
Wallara
Woodbine Inc.
Yooralla

Mental Health Providers

Albury Wodonga Health
Alfred Health
Austin Health
Ballarat Health Services
Barwon Health
Bendigo Health
breakthru
cohealth
Eastern Health
Ermha Ltd.
Forensicare
Goulburn Valley Health
Latrobe Regional Hospital
Life Without Barriers
Lyndoch Living
Melbourne Health
Mercy Health
Mind Australia Limited
Monash Health
Neami National
NorthWestern Mental Health
Peninsula Health
Ramsay Health Care
Royal Children's Hospital
South West Health Care
St Vincent's Hospital Melbourne
Stawell Regional Health
Wellways Australia Limited
West Wimmera Health Service
Western District Health Service
within Australia

Supported Residential Services

Aaron Lodge
Absalom
Acacia Gardens
Acacia Place
Achmore Lodge
Acland Grange
Adare Supported Residential Care
Alexandra Gardens
Allbright Manor
Alma House
Angus Martin House
Arnica Lodge
Balmoral
Bamfield Lodge
Belair Gardens
Bella Chara
Belmont Manor
Berwick House
Bignold Park
Blue Bells Crofton House (Registered 20 October 2019, formerly Crofton House)

Blue Willows Residential Aged Care
Brooklea Lodge
Brooklyn House
Browen Lee Home – Ballarat
Browen Lee Lodge – Brown Hill
Brunswick Lodge
Burwood Lodge
Caulfield House
Caulfield Manor
Chatsworth Terrace
Chesterfield
(Closed 28 February 2020)
Chippendale Lodge
Coorondo Home
Corandirk House
Covenant House
Cranhaven Lodge
Crosbie Lodge
Crystal Manor
Darebin Lodge
Doncaster Manor
Dorset Lodge
Dunelm
Eagle Manor
Edwards Lodge
Elgar Home
Eliza Lodge
Eliza Park
Eltham Villa
Fermont Lodge
Ferntree Gardens
Ferntree Manor
Finchley Court
Footscray House
Galilee
Glenhuntly Terrace
Glenville Lodge
Glenwood Assisted Living
Golden Gate Lodge
Gracedale Lodge
Gracevale Grange
Gracevale Lodge
Grand Villa Mentone
Grandel
Greenhaven
Greenslopes
Hamble Court
Hambleton House
Hampton House
Harrier Manor
Hawthorn Grange
Hawthorns Victoria Gardens
Hazelwood Boronia
Heathmont Lodge
Hillview Lodge
Hollydale Lodge
Homebush Hall
Iris Grange
Iris Manor
Jasmine Lodge
Kallara Residential Care
(Closed 30 July 2019)
Kallara Care (Bendigo)
(Opened 10 July 2019)
Karinya
Kilara House
Kooralbyn Retirement Lodge
Kyneton Lodge
L'abri
Landora Care
(Closed 27 July 2019)
Lilydale Lodge
Manalin House
Maroondah House
Mayfair Lodge
Meadowbrook
Melton Willows
Merriwa Grove
Mont Albert Manor
Mornington House
Mt. Alexander
(Closed 14 February 2020)
Mulvra Aged Care
Mulvra Place
Northern Terrace
Oakern Lodge
Parkland Close
Pineview Residential Care
Princes Park Lodge
Queens Lodge
Raynes Park Court
Reservoir Lodge
Rosewood Downs
Rosewood Gardens
Royal Avenue
Sandy Lodge
Seaview House Residential Care
Southcare Lodge
St James Terrace
Stewart Lodge
Strabane Gardens
Sunnyhurst Gardens
Surfcoast Supported Accommodation
Sydenham Grace
Themar Heights
Trentleigh Lodge
Vermont Gardens
Viewmont Terrace
Warranvale Gardens
Wattle-Brae
Waverley Hill
Westley Garden
Whitehaven

Appendix 3

Acronyms

AAU Adult Acute Unit
ABI Acquired Brain Injury
ACSO Australian Community Support Organisation
BD Brain Disorder
BSP Behaviour Support Plan
CAG Consumer Advisory Group
CALD Culturally and Linguistically Diverse
CAT Crisis Assessment and Treatment
CCU Community Care Unit
CDDHV Centre for Development Disability Health Victoria
CHAPS Comprehensive Health Assessment Plans
CPAP Continuous Positive Airways Pressure
CRF Community Rehabilitation Facility
CRP Community Recovery Program
CSO Community Service Organisation
DAS Disability Accommodation Service
DCS Disability Client Services
DFATS Disability and Forensic Assessment and Treatment Service
DDSO Disability Development and Support Officer
DHHS Department of Health and Human Services
DSC Disability Services Commissioner
DSR Disability Support Register
DWES Disability Worker Exclusion Scheme
ECT Electroconvulsive Therapy
ECU Extended Care Unit
ED Emergency Department
GP General Practitioner
HCA Housing Choices Australia
HDU High Dependency Unit
HSR Human Services Regulator
IGUANA Interagency Guideline for Addressing Violence, Neglect and Abuse
IHBOS Intensive Home-based Outreach
ISP Individual Support Package
LGA Local Government Area
MACNI Multiple and Complex Needs Initiative
MHRB Mental Health Review Board
NAMHS Northern Area Mental Health Service
NDIA National Disability Insurance Agency
NDIS National Disability Insurance Scheme
NGO Non-government organization
NPU Northern Psychiatric Unit
NUM Nurse Unit Manager
NWMHS North Western Mental Health Service
OCP Office of the Chief Psychiatrist
OPA Office of the Public Advocate
OPP Office of Professional Practice
PACER Police Ambulance Crisis and Emergency Response
PAPU Psychiatric and Assessment Planning Unit
PARC Prevention and Recovery Care
PCP Person-Centred Plan
PDRSS Psychiatric Disability Rehabilitation Support Services
PEG Percutaneous Endoscopic Gastrostomy
PRN Pro Re Nata (medication provided as needed)
PRS Plenty Residential Services
RMH Royal Melbourne Hospital
SAVVI Supporting Accommodation for Vulnerable Victorians Initiative
SDA Specialist Disability Accommodation
SECU Secure Extended Care Unit
SIL Supported Independent Living Provider
SOCIT Sexual Offences and Child Abuse Investigation Team
SRS Supported Residential Services
STO Supervised Treatment Order
TEH Thomas Embling Hospital
TSU Transition Support Unit
VCAT Victorian Civil and Administrative Tribunal
VDDS Victorian Dual Disability Service
VEOHRC Victorian Equal Opportunity and Human Rights Commission
VIHMS Victorian Incident Health Management System
VSA Victims Support Agency
VSDP Victorian State Disability Plan
YPARC Youth Prevention and Recovery Care

Office of the Public Advocate

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