



Office of the Public Advocate

Promoting the
human rights, interests
and dignity of Victorians
with a disability or
mental illness.



**Community Visitors
Annual Report
2013–2014**

Residential Services
Mental Health
Disability Services



Community Visitors Annual Report 2013–2014

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Cover

The cover of this annual report is an interpretation of an artwork titled 'Drifting Away' by Pina Natale. It has been painted in acrylics and was purchased by OPA at the State Trustees Ltd 'connected' art exhibition 2013. The annual exhibition celebrates the works of artists living with a disability or an experience of mental ill health.

This artwork reflects the role of families and carers which could be likened to being on the shore, watching the person they care for developing an independent life out on the lake sailing their own boat. Sometimes, the weather may be calm; sometimes not. Families and carers expect services involved with them and their family members will keep a weather eye out when they are out of sight. Sometimes this happens, sometimes it does not.

Community Visitors are independent volunteers monitoring these services and this report documents the year's findings about whether services have met, exceeded or failed in their duty.



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Office of the Public Advocate

Hon Mary Wooldridge MP
Minister for Mental Health
Minister for Community Services
Minister for Disability Services and Reform
Level 22, 50 Lonsdale Street
MELBOURNE VIC 3000

1 September 2014

Dear Minister

Re: Community Visitors Annual Report 2013–2014

In accordance with the *Disability Act 2006*, the *Supported Residential Services (Private Proprietors) Act 2010*, and the *Mental Health Act 1986*, please find enclosed the 2013–2014 Annual Report of the Community Visitors Residential Services Board, Mental Health Board and Disability Services Board.

This year, the findings have been drawn from 5079 visits by 443 volunteer Community Visitors across the state.

The report includes identification of important issues which cross the three Community Visitor Program streams.

The Community Visitors Boards commend the report to you and thank you for your support of the program.

According to the volunteers, the work ensuring Victorians with disability and mental illness can live their lives free of violence, abuse and neglect must continue.

They look forward to continuing to work with you towards that.

Yours sincerely,

Colleen Pearce
Public Advocate and Chairperson of the Combined Board

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Message from the **Public Advocate** and **Chairperson**

The importance of the **Community Visitors Program**

I am regularly reminded how important the Community Visitors Program is. I see it in the notifications I receive that lead to a vulnerable person being removed from a situation of risk. I see it in the quality and breadth of the contribution the Community Visitor Boards make in the many consultations they attend. Often it is simply comments made to me about how much a Community Visitor has changed someone's life for the better.

One positive comment I received this year via OPA's website read:

"I'd like to thank my community visitor for being so responsive...(they) acted immediately with a visit. And then was able to get action on a couple of

matters that I had failed to achieve a result with. I am enormously grateful for the help and...the service OPA provides."

The 5000 plus visits Community Visitors made this year are an ongoing testament to the care they extend on a daily basis.

Abuse and violence

This year, Community Visitors have continued their focus on abuse and violence because protection for those they visit is central to their role. Unfortunately, the pattern identified over recent years continues with the number of these incidents reported increasing. I am aware that what Community Visitors see is only the tip of the iceberg. Consequently, OPA actively champions zero tolerance of abuse and violence in the sector.

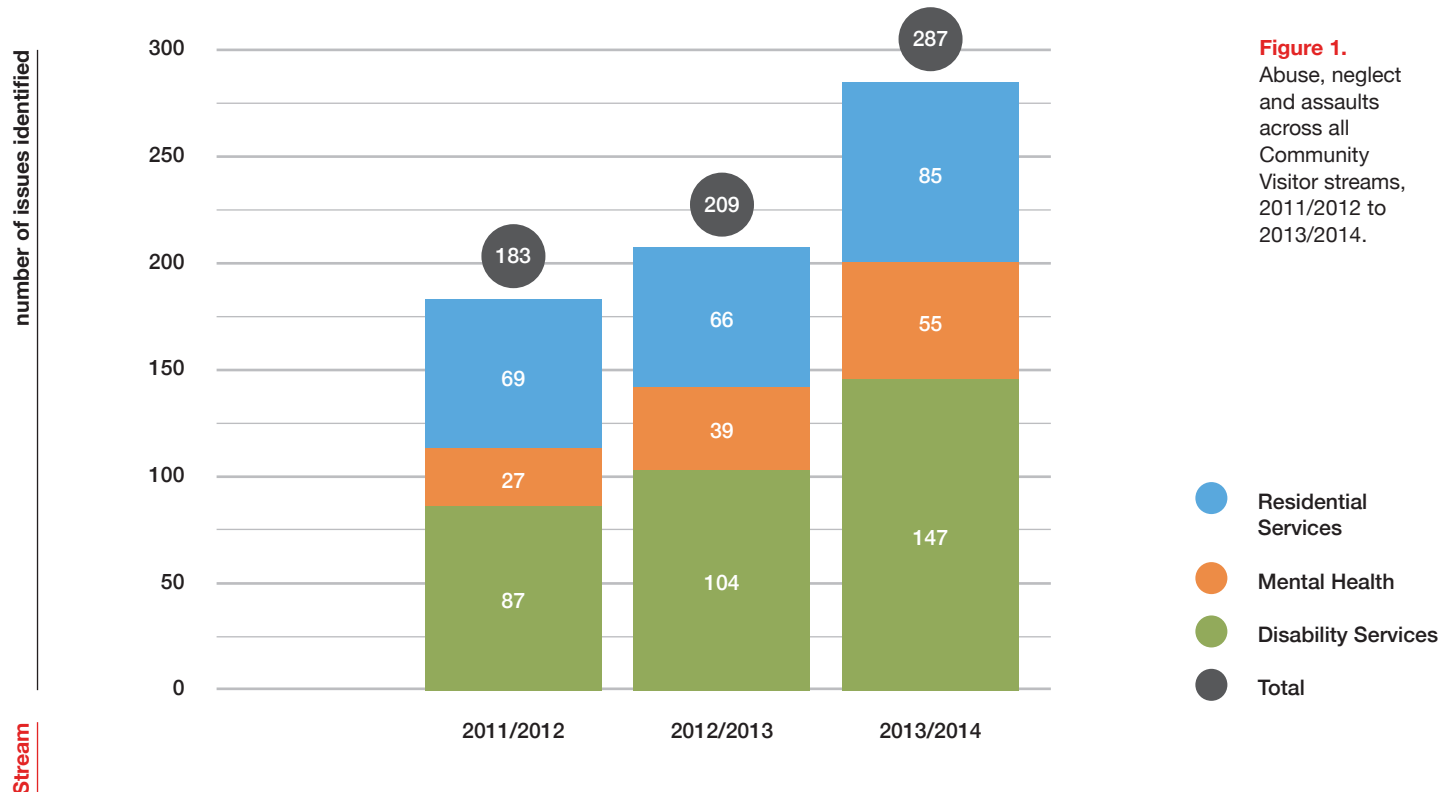


Figure 1. Abuse, neglect and assaults across all Community Visitor streams, 2011/2012 to 2013/2014.



The OPA-developed good practice guide, *Interagency Guideline for Addressing Violence, Neglect and Abuse* (IGUANA), is one step towards this cultural change. I am delighted to record that there are now 31 agencies signed up to IGUANA, including all the major Victorian mental health and disability Community sector organisations. However, it is a disappointment that the Departments of Health and Human Services are yet to follow suit. The government's response to last year's Annual Report recommendations advised that further discussions would occur on this issue and I am pleased to say that these discussions are now underway. The Boards have again recommended that the Departments of Health and Human Services endorse IGUANA and I am hopeful that in my next message I will be able to advise that this matter has finally been addressed.

The focus of much of this year's reporting of abuse and violence across the three streams is on inappropriate placement of individuals. Community Visitors have identified previously settled homes where the placement of a young person with challenging behaviours with older residents has caused significant disruption and led to ongoing violence. In mental health, problems arise when sexually vulnerable people, who may be disinhibited, are placed near those who are sexually aggressive. In Supported Residential Services, there are ongoing problems with the large number of residents in one location, the low staff to resident ratio, and the number of residents presenting with an increasing complexity of disabilities.

The Boards have reiterated the urgent need for a broader range of accommodation options to reduce these stresses in the system. This need is urgent and immediate to ensure that people with a disability or mental illness can live safely in their own home.

Whilst it is essential that abuse and violence is stopped, the mechanisms to instil such cultural change need to be sensitive enough to deal with a range of challenges. The case study that follows outlines a situation where the OPA Advice Service took calls from staff that had witnessed the assault of a resident, but wanted to remain anonymous

because they were fearful of retribution if they came forward. It was particularly disappointing to me that when these individuals were finally convinced to report their concerns to DHS management that disciplinary action against these 'whistleblowers' was proposed over their delay in reporting the abuse.

However, I applaud this Division for subsequently organizing a forum for direct care staff on abuse and neglect where I was one of a number of speakers on these issues

New Mental Health Act

I was pleased that the new *Mental Health Act 2014* was passed by the Victorian parliament, effective from 1 July 2014. This Act expands the powers of mental health Community Visitors including the welcome addition of the power to view Incident Reports. This change brings these Community Visitors in line with their volunteer counterparts in the disability and residential services streams of the Program.

The regional mental health reports document many instances where under the current legislation Community Visitors have been denied access to crucial incident reports. Unfortunately, this is often in the worst circumstances where there have been allegations of abuse or violence, despite Community Visitors having the written consent of the patient, and being ever mindful of their strict secrecy obligations.

Access to incident reports is therefore critical to Community Visitors being able to perform their role effectively and is a very positive change in the new Act.

Another welcome change for Community Visitors is the capacity to visit Prevention and Recovery Care (PARC) services so that they can see the total recovery journey.

The Program was very pleased to receive a one-off \$100,000 grant from Minister Wooldridge

towards Act implementation in the Program. However, the increased responsibilities it brings, such as the capacity to visit PARC services across the state, will be difficult to meet without increased recurrent funding.

Respite services

I remain concerned about people living long-term in respite facilities, particularly children. This year, Community Visitors reported on 34 people, including 15 children, who are living long-term in respite accommodation. Some of these people have lived in respite facilities for up to seven years, which is clearly unacceptable.

The challenges faced by these individuals on a daily basis include limited privacy, a rotating roster of new people in their home, no sense of permanency and potentially little active support to live a meaningful life. Many of these individuals are in respite because of an accommodation crisis or because their family is at breaking point and unable to continue the support they need. Their grief at such momentous life changes is compounded by the ongoing inability to re-establish any normal 'home' life.

This issue presents a double bind as for everyone living long-term in respite there are many families in desperate need of the break that respite provides who are then unable to access it.

The government needs to act swiftly to address the accommodation needs of these 34 people and to ensure that families needing respite can access it. However, forward planning processes are also needed to prevent others in future finding themselves in the same situation.

National Disability Insurance Scheme

OPA is dedicated to ensuring that the development of national safeguards under the National Disability Insurance Scheme (NDIS) does not diminish Victoria's existing quality assurance system and safeguards. Consequently, OPA was delighted to host a roundtable discussion on NDIS safeguards involving four key Victorian statutory agencies: the Victorian Ombudsman, the Office of the Disability Services Commissioner, the Victorian Equal Opportunity and Human Rights Commission and OPA itself.

One of those essential safeguards is Community Visitors and their Annual Report to parliament. This report details their observations and the issues identified over the past twelve months. Community Visitors are an early warning system highlighting where sector change is needed to protect and empower the vulnerable Victorians they visit.

Community Visitors have been active in the Barwon region trial site of the NDIS. Senior volunteers or Regional Convenors and Program staff meet with NDIA staff on a quarterly basis to raise the concerns they are identifying, as required by OPA's protocol with the NDIA. Some of the issues already raised include the short timeframe and rigidity of the initial planning process and the concern over whether there are adequate supports for people with cognitive disability to exercise choice and control. It is too early to receive feedback from participants in relation to their satisfaction with their plans and the outcomes achieved however, Community Visitors will be able to report more extensively on this in the coming year.

The Program remains concerned about the impact of the full rollout on volunteers' ability to visit accommodation facilities. Volunteers are apprehensive that their powers under current state legislative arrangements to enter disability services, supported residential services and mental health facilities may not continue to apply in the same way when the NDIS is fully implemented. In addition, it is expected new private accommodation providers will enter the sector. OPA worries that such providers may not possess the necessary skill base and experience required to provide an appropriate level of care to a person with a cognitive impairment or mental illness, and Community Visitors' ability to visit such accommodation settings into the future remains unclear.

The Community Visitors Program will keep a watching brief on the scheme's operation and will continue to actively advocate for the inclusion of Community Visitors as an essential safeguard under the NDIS.



Colleen Pearce
**Public Advocate and
Chairperson of the Boards**



Notification to the Public Advocate

An anonymous caller to OPA's Advice Service alleged that a senior DHS house staff member had abused a resident twice, resulting in a broken left leg the first time and a broken knee cap several months later.

These group home residents had previously lived at Kew Cottages and are non-verbal, frail and ageing.

The caller knew of others who had witnessed the abuse, however, they all wanted to remain anonymous for fear of retribution.

Community Visitors visited, and found no incident report about the most recent injury. Staff were concerned about the potentially adverse consequences for them if they discussed what had happened to the resident.

The Public Advocate was notified and referred the matter to DHS.

Community Visitors and senior program staff undertook a subsequent visit to get more details about the situation and encourage anyone who had further information to report it.

This eventually led to some staff coming forward with their concerns. However, it was disappointing that DHS management raised the prospect of disciplinary action against these 'whistleblowers' for their delay in reporting the abuse.

Subsequently, a staff member was suspended and police charges were instituted.

Introducing the Combined Board



Ms Colleen Pearce

Chairperson, Disability Services, Residential Services and Mental Health Boards

Ms Pearce is the Public Advocate of Victoria and, under legislation, is the chairperson of the Community Visitor Boards.

Ms Pearce has over 30 years experience in the community and health sectors and has spent her working life helping society's most disadvantaged people, and advocating for a better deal on their behalf.

She is currently a member of the:

- Victorian Equal Opportunity and Human Rights Commission Board
- Connecting Home Board, an organisation providing services to the Stolen Generations
- Dax Centre Ethics Committee.

In 2003, Ms Pearce received a Commonwealth Centenary Medal for her contribution to community services in Victoria.

She commenced as Public Advocate on 8 September 2008.

L-R: Mike Hadley (MH) David Roche (DS), Pauline Musgrave (RS), Public Advocate Colleen Pearce (Chair), Fay Richards (DS), Dr Carol Morse (MH).

Residential Services Board



Ms Pauline Musgrave

Ms Musgrave has a background in education spanning 37 years as a teacher, consultant, teacher educator and, finally, a principal of a special developmental school for 15 years within the Victorian Education Department.

She is a Regional Convenor Residential Services for outer Southern Region as well as an Independent Third Person supporting people with a disability in interviews with Victoria Police. Ms Musgrave continues her vast experience working for community organisations and has recently been appointed as a member of the Mornington Peninsula Shire's Disability Consultative Committee.

Pauline has just completed her seventh year on the Residential Services Board.



Dawn Richardson

Ms Dawn Richardson

Ms Richardson has a background in telecommunications, training and disability. She has served on the committee of management for the Communications, Electrical and Plumbing Union and has spent six years in a voluntary position managing Food Relief.

She joined the Community Visitors Program in 2006 in the Western Region in the disability stream and is now a Residential Services Community Visitor and Regional Convenor in the Barwon Region.

This is her fourth term on the Residential Services Board.

Mental Health Board

Dr Carol Morse

Dr Morse has spent over 30 years as an academic psychologist engaged in health research and teaching at universities in Victoria and New South Wales. She has published widely on issues in lifespan development and positive ageing of Australian-born and migrant peoples. Dr Morse is also an experienced psychotherapy practitioner in mental disorders and relationship counselling.

She joined the mental health stream of the Community Visitors Program in 2008 and has completed her second term on the Mental Health Board.

Mr Mike Hadley

Mr Hadley was born in Birmingham, England, and spent most of his working life as a metrologist in the aircraft engine industry in Coventry.

He arrived with his family in Australia in 1981 to take up the position of Chief Inspector Special Projects (turbine blades) at ANI National Forge

in West Footscray, and has held various senior inspection and quality assurance positions since. After retiring his quality assurance consultancy, and looking for a way by which he could contribute something to the community, Mr Hadley joined the Community Visitors Program ten years ago and is a Regional Convenor in the Mental Health Stream.

He joined the Residential Services Board in 2013.

Disability Services Board



Ms Fay Richards

Ms Richards has been involved in advocacy for people with an intellectual disability since 1981. This includes serving on boards of management and negotiating with ministers and departments.

Ms Richards completed a Bachelor of Applied Science (Intellectual Disability) in 1994. During and after this course, she was employed to find placements for students in that course and supervise them at the extensive range of service providers. She was then employed by a Community Service Organisation to create a pilot program for DHS, working with families whose parents were over 65 years of age.

Ms Richards was the Community Visitor Regional Convenor (Disability Services) at Kew Residential Services from 1994 until its closure in 2008 and previously served on the Disability Services Board from July 2000 to June 2003.

Mr David Roche

Mr Roche has qualifications in public policy and management, business management, project management and training. He is an Associate Fellow of the Australian Institute of Management and a member Gippsland Regional Council of Adult Community and Further Education.

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

This is Mr Roche's second term on the Disability Services Board having served in 2009-2010. He is Chair of the Combined Board's Policy Review Steering Committee, a Panel Secretary and a former Regional Convenor.

Introducing Community Visitors

Community Visitors are independent volunteers who safeguard the interests of people with a disability.

The Community Visitors Program is part of OPA.

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

- Residential Services – visits are made to people who reside in supported residential services (SRS) and require additional support
- Mental Health – visits are made to consumers and residents in mental health facilities providing 24-hour nursing care
- Disability Services – visits are conducted to institutions and community-based facilities for people with disability.

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

- *Supported Residential Services (Private Proprietors) Act 2010*
- *Mental Health Act 1986*
- *Disability Act 2006*

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

Community Visitors are appointed for three years by the Governor in Council. They are empowered by legislation to visit specified facilities, to make enquiries of residents and staff and examine selected documentation in relation to the care of people residing at the facilities. Community Visitors usually make unannounced visits and visit in teams 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 DHS or DH 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 the Volunteer Programs Unit.

Stream	Visits 13/14
Residential Services	882
Mental Health	1262
Disability Services	2935
Total	5079*

Table 1. Community Visitor visits by stream 13/14.

* The number is slightly lower than last reporting year because of the early cutoff for data collection to meet the revised annual report tabling dates due to the impending state election.

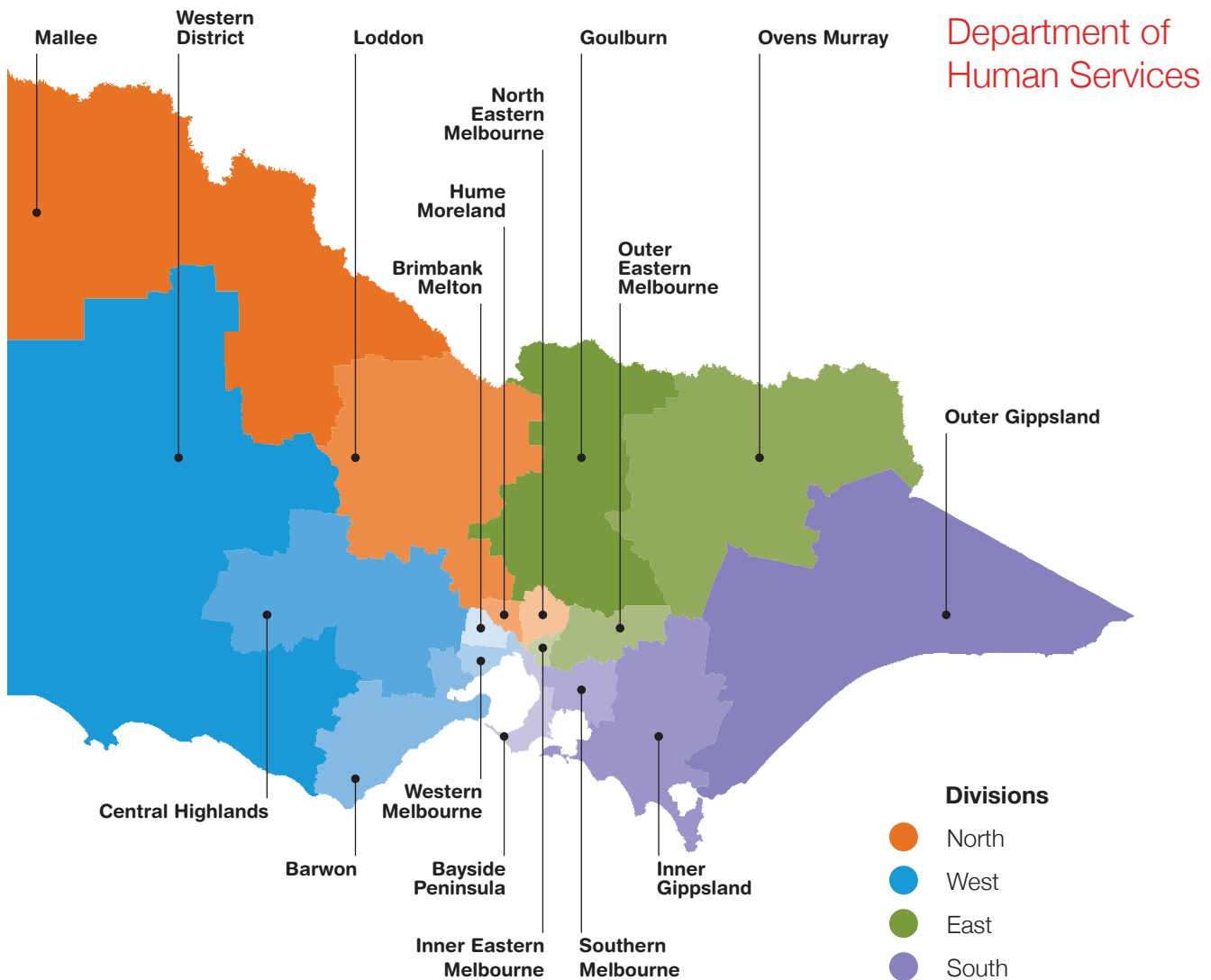
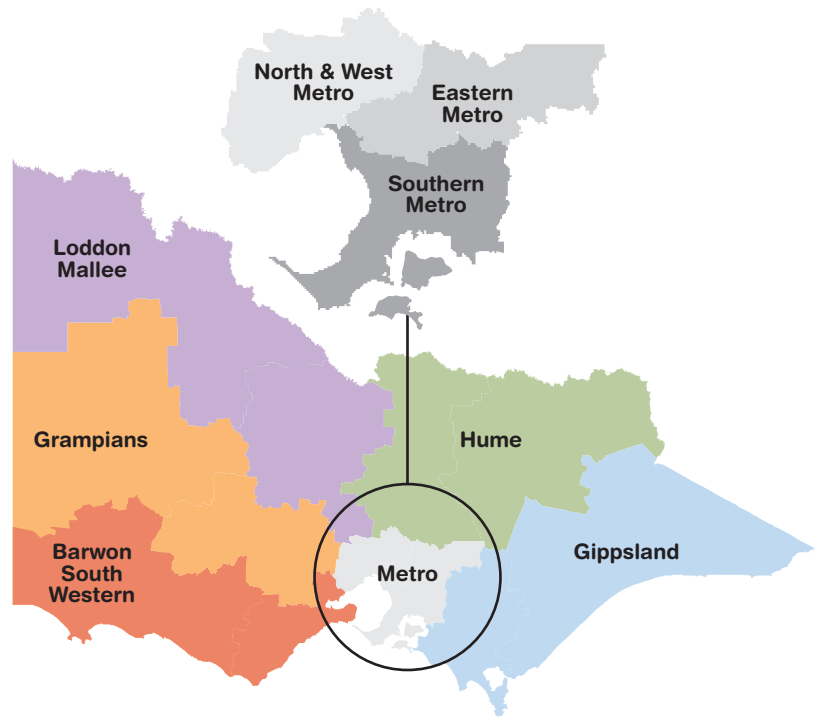
Stream	Community Visitors 13/14
Residential Services	87
Mental Health	80
Disability Services	276
Total	443

Table 2. Community Visitors by stream 13/14.

Reporting Regions/ Divisions

Department of Health

Regions



Residential Services

Statewide Report and
Recommendations



Recommendations

Residential Services

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

1. work with the Office of the Public Advocate (OPA) to evaluate the effectiveness of the *Supported Residential Services (Private Proprietors) Act 2010* and the impact it has had on the quality of life for Supported Residential Services (SRS) residents
2. finalise the review of the SRS and mental health service protocol with the aim that it translates to additional local supports for SRS residents with mental health issues
3. establish a team of behaviour management specialists that support proprietors to maintain a safe, home-like environment to minimise abuse, neglect and violence and ensure that training continues for proprietors and staff that develops the skills necessary to defuse these situations
4. immediately endorse the *Interagency Guideline for Addressing Violence, Neglect and Abuse* (IGUANA) developed by OPA and encourage all SRS to adopt this good practice guide to safeguard residents with a disability or mental illness from abuse.
5. develop a notification protocol with the Public Advocate of incidents or allegations of violence and abuse in order to reduce the risk for SRS residents
6. clarify and simplify the SRS incident reporting requirements and ensure they are backed up by a comprehensive education program for proprietors and staff
7. amend the SRS regulations to allow Community Visitors to be able to inspect any document pertaining to their role, such as communication books and progress notes
8. extend the Pension-Level Project funding for the next 12 months as the first step in addressing the funding inequity between Supporting Accommodation for Vulnerable Victorians Initiative (SAVVI) SRS and non-SAVVI SRS; with the ultimate aim of extending SAVVI funding to all pension-level SRS so that resident need is the driver for additional support and not the SRS at which they reside
9. increase the recurrent funding for the Community Visitors Program to enable OPA to recruit, train, support and reimburse sufficient numbers of Community Visitors to visit all SRS on a regular basis and liaise effectively to address the issues identified on visits.

Residential Services

Statewide Report

During the year, 87 Community Visitors in the Residential Services stream conducted 882 visits to 154 SRS across eight regions of Victoria. Fifty of these visits were because of a referral from OPA's Advice Service.


The visit number is less than last year, due to an early cut-off for data entry. This was because of the early tabling deadline for the annual report in light of the impending state election. In addition, a shortage of Community Visitors in some regions reduced visit numbers and the lack of program funding meant that vacancies in some hard-to-recruit areas went unfilled, as there were no funds to advertise for volunteers.

Statewide findings

The following tables and figures provide an overview of visits made by Community Visitors and the issues of concern they raised. During the year, Community Visitors identified 494 issues that affected the lives and wellbeing of people living in SRS. A number of common themes were identified and are reflected in this year's statewide report.

The impact of the new Act on SRS residents

The Board welcomed the new *Supported Residential Services (Private Proprietors) Act 2010* when it was introduced. The year has seen the finalisation of some of the substantial changes brought by this Act, such as the closure of fourteen SRS, many due to the new legislative requirement that SRS operate under only one Act rather than under several Acts simultaneously. Consequently, SRS that previously operated under this Act and the aged care or retirement villages legislation were required to elect to operate under only one.



Region	No. of units visited	No. of CVs	Requested visits	Scheduled visits	Total
Barwon South Western	9	9	5	68	73
Eastern Metropolitan	42	14	14	196	210
Gippsland	6	5	2	21	23
Grampians	11	7	0	83	83
Hume	2	5	0	23	23
Loddon Mallee	7	7	4	44	48
Northern Metropolitan	19	10	8	91	99
Southern Metropolitan	46	21	15	234	249
Western Metropolitan	12	9	2	72	74
Total	154	87	50	832	882

Table 3. Total visits Residential Services Stream 13/14.

This has led to a rationalisation of SRS beds in some areas with the consequence that the Board continues to be concerned about bed loss in the sector.

The changes to the Act around extension of residents' rights and incident reporting were welcome improvements. Community Visitors were particularly pleased with the incident reporting provisions, including their capacity to view the reports. The Board also endorsed the Department of Health (DH) focus in the first 12 months on education about the Act, rather than prosecution. However, the past year has seen two instances where SRS proprietors have treated Community Visitors in an intimidating and abusive manner. In the first situation, in the view of the Board, DH responded too slowly however, once taken, the action was very positive.

The second situation is ongoing and is documented in more detail in one of this year's regional reports.



The Board is very critical of DH response to this situation particularly as the proprietor owns a number of SRS. Senior DH officers seem unwilling to recognise the seriousness of the situation nor the distress caused for the Community Visitor volunteers involved. DH persist in pushing mediation with the proprietor as the only option despite the program's repeated efforts to arrange this, over a considerable period, having failed.

DH continues to characterise the situation as a dispute between the proprietor and the program, rather than accepting that it has the regulatory responsibility for enforcing the Act with SRS proprietors. The new Act provided DH with an expanded range of regulatory tools, however, none have been used to date. Despite the invidious situation in which the Community Visitors find themselves, they have persisted in visiting because of their concerns for the vulnerable residents at these SRS.

Consequently, OPA is planning to undertake a review of the effectiveness of the new Act and its impact on the quality of life for SRS residents. The Board hopes that DH will work collaboratively with OPA on this project.

Health and personal care

Across Victoria, Community Visitors report that they are broadly satisfied with the standard of health care afforded to residents of both pension-level and pension-plus SRS. Many Community Visitors reported that General Practitioners regularly visit SRS to assess and treat residents.

One issue of concern is medication errors; several regions reported this problem and there are positive Community Visitor reports of staff training being implemented to address it. However, the number of medication errors at some SRS continues to concern the Board, particularly as the consequences for residents can be dire.

The sector accommodates a high percentage of people with chronic mental ill health, as there are few accommodation alternatives for people discharged from inpatient mental health care with

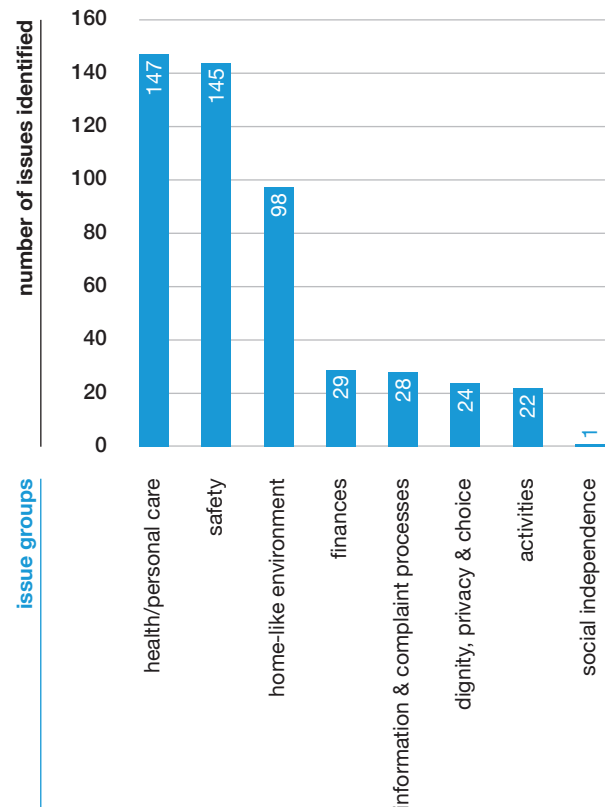


Figure 2. Residential Services Stream by issue groups 13/14.

high personal support needs, other than SRS. Many have no option to return home or have little or no relationship with family or friends who could provide regular care and support.

Proprietors report that they have a close working relationship with local area mental health Crisis Assessment Teams (CAT) and can summon assistance for assessment and treatment of residents who may be suicidal or at risk of harming others. Continuing Care and Mobile Support Teams also visit SRS to administer the contraceptive injection, depo provera, and oral medication.

The process to review the protocol between SRS and the mental health sector has already taken a substantial period of time and the Board is unaware of the proposed timetable to finalise the review and update the document. Consequently, the Board

urges DH to expedite the process in the hope that the outcome is a much shorter and more focussed protocol that translates to increased support services for SRS residents with mental health issues.

Many people diagnosed with chronic mental illnesses have other co-morbidities, such as drug and alcohol dependence or an intellectual disability. Consequently, a high percentage of SRS have a no-alcohol policy inside the facility, however, are tolerant of resident substance abuse, provided it occurs off-site and they are not abusive or violent to others on their return.

This year, Community Visitors are reporting on an enormous age range in SRS that can present resident-mix issues. The Eastern Region's report discusses 30 residents under 30 years of age they visit, and that SRS vary in their capacity to meet the needs of this client group.

Other regions highlight older residents who have lived at an SRS for many years and are now ageing. Consequently, their needs are changing and some SRS are struggling to meet them, particularly with their low staff-to-resident ratio. Ageing residents may not wish to leave an SRS where they have lived for many years and have friends. Similarly, many proprietors want to continue to support these residents rather than see them move to the unfamiliar aged-care environment. This year's regional reports document a number of these challenges that have been met with varying levels of success.

Community Visitors consider the provision of accurate contemporaneous support plans as vital for SRS staff to provide appropriate resident support. This reporting year, Community Visitors have found that support plans at SRS are often out-of-date or that staff are unable to locate them when requested. In addition, they report on residents who are unaware that they have a formal support plan. All these issues mean suboptimal outcomes for affected residents. Support plans need to be an ongoing focus of training to ensure staff understand their role, as living documents that can assist staff to meet the complex and often changing needs of residents.

Abuse, neglect and violence

This year, Community Visitors continued to document an increasing pattern of abuse and neglect, a situation they have been reporting for several years. Resident incompatibility in SRS often leads to verbal abuse, aggression and, in too many instances, violence. Many of these instances have required police or medical intervention to deal with these behaviours and their consequences.

An emerging trend this year has been increased, aggression and violence from female SRS residents.

In 2013, OPA developed the *Interagency Guideline for Addressing Violence, Neglect and Abuse* (IGUANA) following detailed reporting in the *Community Visitors Annual Report 2011-2012* of these issues. IGUANA is a good-practice guideline for organisations like SRS and staff working with adults at risk of violence or abuse.

The guideline's endorsement by 31 Victorian disability and mental health agencies, also sends a message to the sector of a zero tolerance approach to abuse. It is for this reason that the Board recommended last year that the State Government and DH endorse IGUANA. The State Government's response to this recommendation was that there were some policy inconsistencies between IGUANA and DH, however, consultations would occur in an effort to resolve them. To date, the Board has seen no action on this. Consequently, it again recommends the endorsement of the IGUANA guideline in the hope of eliminating abuse and neglect for SRS residents.

The Board notes this year that there have been allegations of sexual assault where it has been unclear what action staff have taken to respond, or where staff have advised Community Visitors that they are unsure of what their response should

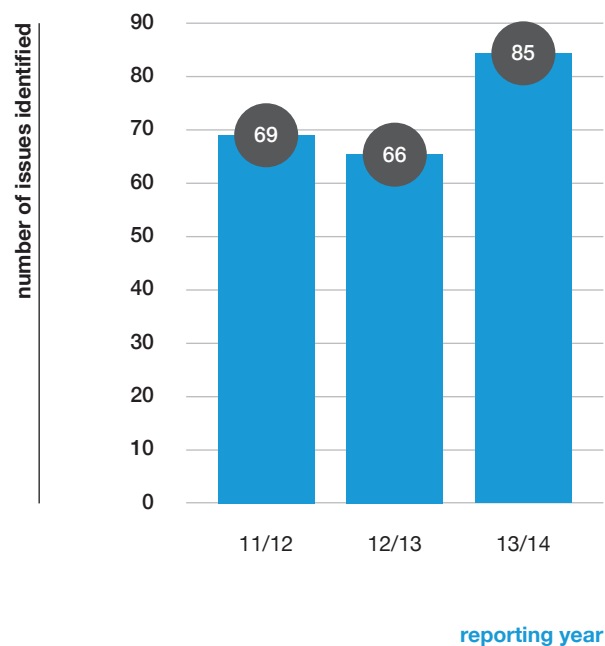


Figure 3. Residential Services Stream abuse, neglect and violence 11/12 to 13/14.

be in such situations. The Board was delighted with the ministerial and DH acceptance of the recommendations in OPA's May 2012 report *Sexual assault in Supported Residential Services: Four case studies*. However, it is now clear that this work needs to be reinforced. Consequently, the Board would like to see a renewed education campaign highlighting the correct staff response to such incidents, such as the importance of keeping the staff action checklist in a prominent place where everyone can see and use it.

The amendments to the protocol between DH and the program, needed in light of the new Act, have finally concluded. Consequently, work can now commence on the agreed recommendation, detailed in OPA's report, that a notification protocol be developed. It would be based on the existing disability services protocol between OPA, the Department of Human Services (DHS) and Community Service Organisations where instances of serious risk of abuse are advised to the Public Advocate. The Public Advocate then takes immediate action by contacting the appropriate service provider to ensure that the risk to the vulnerable person has been addressed and action taken to ensure the situation will not reoccur. The Board looks forward to working with DH to develop this protocol over the next reporting year.

Incident reports

Community Visitors have welcomed the introduction of incident reporting in SRS as a requirement under the new legislation. It has provided the opportunity to capture a range of information succinctly that can give Community Visitors a clear picture of what is happening in SRS, particularly between visits.

Naturally, a change of this magnitude presents a range of challenges for proprietors, staff and Community Visitors. The disability sector has utilised incident reporting for many years and there is still the necessity to fine-tune its processes from time-to-time, as well as constant reinforcement of staff training on the system. So it is not surprising that there have been teething difficulties in SRS. The first issue that Community Visitors are regularly reporting is that proprietors and staff, mainly in pension-only SRS, are having difficulty understanding the difference between 'reportable' and 'recordable' incidents.

A recent regional liaison meeting where these differences were discussed with DH Authorised Officers generated several pages of notes about how that region was interpreting different situations

and the fine distinctions being made within classes of incidents, for example, resident injury. The Board was so concerned about the potential for confusion in the sector, resulting in key issues going unreported, that it raised this issue in its subsequent statewide liaison meeting.

Other concerns reported by Community Visitors include where, how and whether incidents are recorded. DH provided all SRS with an initial incident record book, however, once these were full, it was up to the SRS to determine what mechanism they would utilise: they could continue to use the original book at a cost or they could develop their own paper-based or electronic system. Consequently, Community Visitors have seen many different systems emerge across the sector.

One disturbing development is the recording of incidents in residents' progress notes, which Community Visitors have been denied access to. The reason given for this information being withheld is that progress notes are not a document that Community Visitors can automatically access under the Act. However, this method of recording incidents is concerning from a number of standpoints, as it may be used as a device to avoid documentation, to avoid scrutiny or it may simply be ignorance. The Board sees the need for the SRS regulations to be amended to ensure that Community Visitors are not denied access to information required to undertake their role effectively.

In several regions, Community Visitors have been informed about serious issues for which they can find no incident record. One example in a country region involved a female resident reporting that a male resident came to her bedroom door and exposed himself to her. The incident was immediately reported to the SRS manager who undertook a range of actions to address the situation. However, no incident report was prepared until after Community Visitors raised the issue.

DH needs to address these problems as a matter of urgency. Otherwise there is no clear overall picture of incidents in SRS or whether they are being effectively managed, while in some instances, Community Visitors are being denied access to the information they need to perform their role.

Additional funding for non-SAWI SRS

The Board has advocated for a number of years that residents living in pension-only SRS should not be discriminated against simply because of the

SRS in which they reside. The majority of pension-only SRS took advantage of the SAVVI program when this funding became available in 2006. The funding has been used to upgrade the physical buildings and facilities, and buy recreational equipment as well as the purchase of additional activities or supports. However, some pension-only SRS chose not to take up SAVVI funding and, in other cases, the business model has changed from pension-plus to pension-only since that time. Residents living in these SRS have suffered compounding disadvantage.

Consequently, for the past two years, the Board has recommended to government that additional resources be allocated to address such situations. The Board was delighted and very grateful that DH took up this issue and introduced the Pension Level Project this year. This initiative provided \$250 per resident, to a maximum of \$10,000, for facility upgrades and additional supports. The only drawback is that it is time limited, only lasting 12 months. The Board is keen to see this funding extended beyond the initial twelve months and would like to see it become ongoing and eventually merged into SAVVI funding, or, at the very least, extended for several years to meet the level of disadvantage needing to be redressed.

National Disability Insurance Scheme (NDIS) and SRS

The plan development process for SRS residents who come under the NDIS in the Victorian launch site of the Barwon South West Region has not been without obstacles.

Many residents, families and proprietors found the information provided by the National Disability Agency (NDIA) confusing. Proprietors and staff were initially excluded from any discussions around resident support needs, nor were existing support plans consulted. This led to some plans not meeting essential resident needs and requiring extensive rewrites.

There was much participant confusion around the likely outcomes of an NDIS plan because of one of the questions posed was whether SRS residents wanted to live independently. Some SRS residents expected this to be an automatic outcome and told Community Visitors that they would soon be living independently, irrespective of their capacity to do so.

The Board was heartened by the support provided by the regional DH Authorised Officer and the willingness of the NDIA to engage with SRS

proprietors and staff. A meeting was organised between the agency and proprietors so that teething problems around the process could be openly discussed and options for future engagement agreed.

Community Visitors will continue to monitor the impact of the NDIS for SRS residents as the scheme moves into its second year of operation in the Barwon South West Region.

Program funding

It was pleasing that the State Government continued to fund the Consumer Price Indexation of Community Visitors honorariums. However, no action has been taken in relation to addressing the Board's recommendations over the last few years about the inadequacy of program funding.

It is a constant struggle to meet the program's legislated roles, responsibilities and functions in light of the absence of adequate funding. The Community Visitor role has become much more complex and demanding over the last 25 years, which means that volunteers need additional support, training and resources. This does not come without cost.

Societal changes have led to a substantial reduction in the volunteer pool and the time available to devote to volunteering activities. Consequently, there is an incredibly competitive market for volunteers; many estimates are that there are at least three volunteering opportunities for every potential volunteer.

A relatively small investment in the Community Visitors Program from the overall state budget would generate a very big return for Victoria. It also provides greater protection for the most vulnerable and disadvantaged people in our community as well as hastening the speed of systemic sector change. Consequently, funding to the program, for both its short and long-term needs, is again recommended by the Board in order to ensure it can continue to be one of the most effective statewide advocacy programs in Victoria.

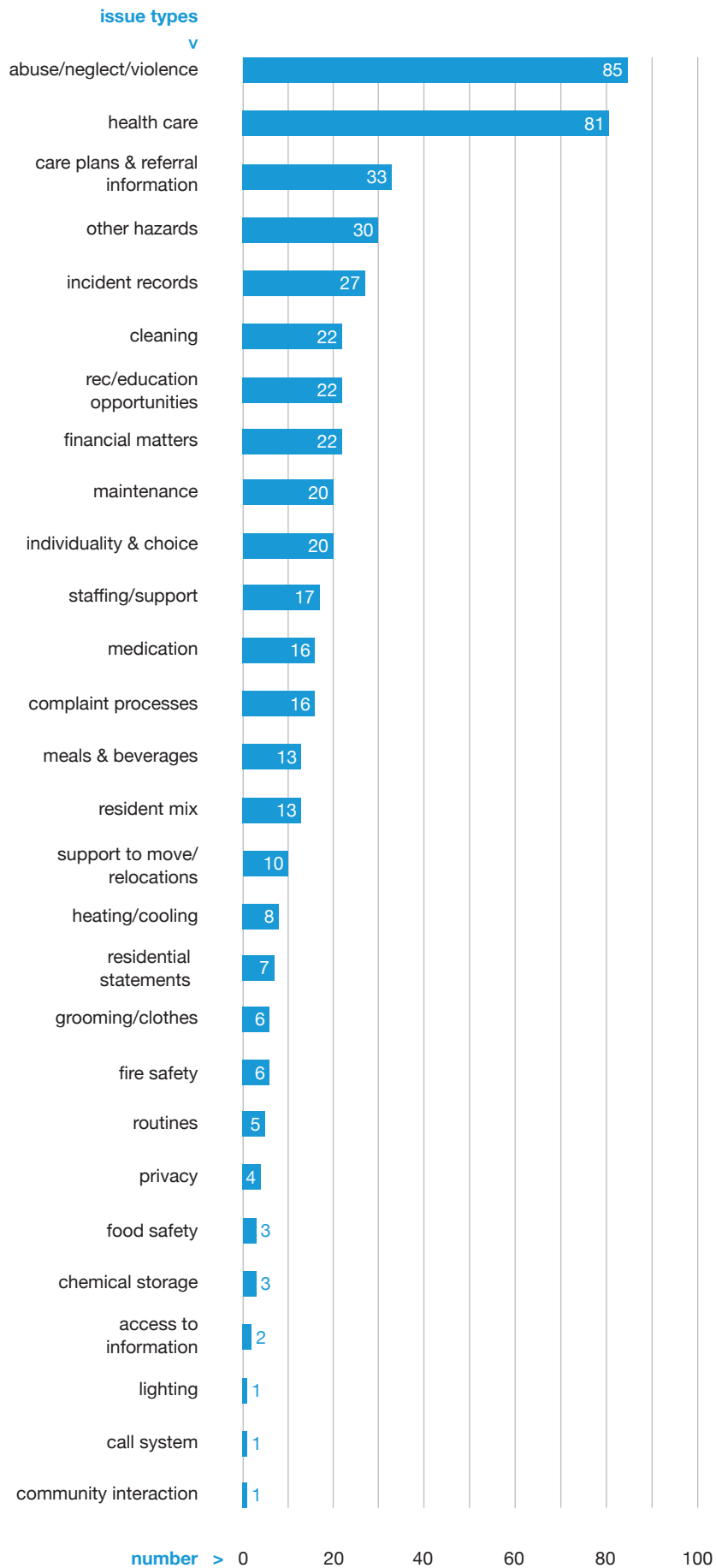


Figure 4. Residential Services Stream number and types of issues identified 13/14.



Barwon-South Western Region

In this region, five SRS are pension-level (provide accommodation based on payment of a high percentage of the pension) and four are pension-plus (charge a fee higher than the pension).

Community Visitors, Supported Residential Services (SRS) proprietors and the Department of Health's (DH) Authorised Officers take great pride in working collaboratively to ensure the very best outcomes for residents.

Health and personal care

Community Visitors believe that residents' health needs are well-supported by SRS staff. When there is a need for specialist assessment or for more care, residents are usually moved to a local mental health provider and/or the local hospital.

One elderly resident was admitted to hospital following her third fall related to her heart condition. The person's condition was well-managed by the SRS and she was able to return there, rather than having to move to aged care.

A resident with a mental illness refused to have her regular depo provera injection, despite the repeated efforts of the proprietor to encourage compliance. The resident's behaviour, which was related to her mental illness, started to upset other residents. Subsequently she was evicted. Another SRS now provides support to this person. However, her challenging behaviour remains an ongoing issue.

A female resident who was sharing a room with her partner became pregnant. It was intended that the couple would stay at the SRS until the baby was born to receive support from the proprietor. However, the resident vacated the SRS when she was six months pregnant and did not return.

Abuse, neglect and violence

Two residents at a pension-level SRS were frequently reported to bully other residents. It was alleged that they would meet outside the front of the building and plan who they were going to target next. A meeting of residents and staff was held at the facility, at which the 'SAWI Connections Worker'

warned all who attended about the consequences of bullying. The outcome was that one of the men was evicted and a caseworker assigned to the other. While the bullying by this resident ceased for a period, Community Visitors later reported that it had re-started. This led to the second resident being evicted. The first resident to be evicted is now reported to be 'stalking' staff at this facility.

A resident at a pension-level SRS attacked a staff member and a resident, so another resident intervened to restrain the resident from attacking them. He was subsequently hospitalised at the local mental health acute unit, the Swanston Centre.

Home-like environment

Community Visitors have observed that all SRS in the area provide a homely atmosphere for their residents, with fresh hot meals provided daily and appropriate heating and cooling.

During last summer's heatwave, residents at one SRS were given a different flavoured icy pole on each of the very hot days; all facilities were reported to provide additional cold drinks for residents' comfort.

One pension-level SRS was observed paying particular attention to residents' grooming; this was reflected in their good presentation and clothes that were clean, tidy and well-cared for.

One resident complained that hot water was not hot enough. The proprietor had this checked by a plumber who found the hot water system to be working normally.

Incident reports

A resident at a pension-level SRS left one evening at approximately 8pm. Police were informed at 10pm when staff rang 000. The following day, as police had not attended, staff rang local police, who attended promptly. The resident had been at the facility for 16 years and enjoyed a positive relationship with staff. The man was known to enjoy going for walks, but was not reported to 'wander'. Police checked the residents' bank accounts, which remained unused. To date, the resident has not been found.

This incident prompted a procedural change at this SRS, such that, if a resident has not returned to the facility by 10pm, the night supervisor completes an 'Incident Report', advises local police and requests that the person be listed as a missing person.

Activities and social independence

Residents participate in a wide range of social and occupational activities in the region.

Six residents from a facility in Warrnambool went on a holiday to the Gold Coast with the facility manager. They stayed in a beachfront apartment with a heated pool and enjoyed many outings including a visit to the casino. A great time was, reportedly, had by all.

Vision Australia has provided an electronic reading machine for one SRS. This is a great asset for visually impaired residents, enabling them to read the paper and do crosswords.

A guest speaker has attended one pension-level SRS to promote empowerment of women through positive thinking. The session covered topics including anxiety, depression and bullying. Residents were then given the opportunity to read 'confidence poems' at meal times and discuss their best/worst experiences, speaking up and out to gain confidence.

Two residents from a pension-level SRS are attending a 'Diverse Attack' school where they are concentrating on mathematics, English language and literacy. One resident, who attends classes once a week, is attending their first-ever daytime activity. A fellow resident who attends classes three times a week is now reported as being a great deal more positive about life.

After many years of recommending that all pension-level SRS receive SAVVI funding, the DH Pension-Level Project Funding was introduced as a one-off initiative in this reporting year. It provided up to \$10,000 to benefit residents of pension-level SRS that do not receive SAVVI funding.

Community Visitors were very disappointed that the Geelong Lodge proprietor declined to take part in this initiative, thereby disadvantaging its residents.

One pension-plus SRS has, what Community Visitors believe to be, an excellent program involving students from nearby colleges and residents, usually carried out in school terms three and four of the school year. High school students interview residents and compare their different experiences of growing up, as well as participating in activities with the residents such as bingo and gardening. All participants report that this program benefits both residents and students greatly.

Community Visitors wish to commend the local residents of Queenscliff for their interest and contributions to the local SRS at Christmas.

Every resident received Christmas gifts from local service organisations last year, while other local people donated Christmas food. Fish and chips are donated once a month, facilitating very good interaction between residents and members of the local community.

Brooklyn House won an award for business quality in 2013.

Residents at Geelong Lodge were paid a visit by the former Governor-General Ms Quentin Bryce. She spent approximately 45 minutes at the facility. Residents commented that Ms Bryce was very friendly and 'down to earth'.

Viability of the program

Both Community Visitors in Warrnambool have retired. Financial pressures on the Community Visitors Program prevent advertising in local newspapers to recruit new Community Visitors.

Consequently, the program explores free opportunities to attract new volunteers, which is time consuming, takes staff away from their support activities for existing volunteers, and often does not generate potential volunteers.

If no new volunteers are recruited in the Warrnambool/Portland area, the program will struggle to visit the two SRS in the area due to distance and cost.

Eastern Metropolitan Region

Community Visitors in this region have divided it roughly into two geographic areas for ease of visiting. In the inner part of the region, most SRS are pension-plus, with many specialising in support to elderly residents. In the outer part of the region, eleven SRS are pension-level with the remaining pension-plus, so a diverse range of support needs are being met.

Health and personal care

SRS provide some personal care, from assisting with bathing and personal hygiene when necessary, washing clothing, cleaning rooms, to changing linen and towels. Most residents' medication is administered by qualified staff.

In the outer east, it was noted that one facility recorded twelve instances where personal care assistants left prescribed medications with

residents who did not take them. Staff training rectified this situation. Another SRS is ensuring all staff achieve a Certificate IV in Aged Care.

Community Visitors have identified that some SRS in the region have actively facilitated residents with age-related disabilities moving to aged care. The exception is where twelve of the 21 residents are Chinese speakers or of Chinese background, some with high-care needs that are being met at this SRS.

Most proprietors are very supportive and understand their clients well. Community Visitors have noted staff assisting people to help themselves, such as providing a phone and private place to call mental health services and ensuring a GP is available to see residents at agreed times. Staff have been observed reminding residents to keep appointments with hospitals and case managers.

In the inner east, Community Visitors have observed comprehensive health care support, particularly those with registered nurses on staff or who are proprietors. In addition, many have doctors who visit regularly, so health progress notes are recorded as being detailed and up-to-date.

On one occasion, a resident disclosed to Community Visitors that they felt suicidal and needed a case manager to assist them to manage their mental illness. This situation was discussed with the staff on duty and Community Visitors were told that the staff had known the resident for many years and that it was common for them to say such things. The matter was escalated to the proprietor, who took very swift action to arrange a medical appointment for the resident, resulting in a referral to a mental health service.

Abuse, neglect and violence

Community Visitors comment that many instances of conflict appear to be because of residents displaying behaviours consistent with the features of an undiagnosed mental illness. The SRS environment may not suit such individuals, however, the paucity of alternative accommodation options often means that they have no other choice.

Home-like environment and safety

The age range in some pension-level SRS is wide. In one, it ranges from 18 to 70 years. This may pose problems for some people where their life experience and interests are vastly different from others, for instance, the English graduate who reads poetry and has no-one with whom to share

this interest. Most people, however, develop close friendships and socialise within those groups.

Routines in facilities are fairly fixed with several meals or snacks a day. Most have their main meal in the middle of the day although, facilities where people are more independent, may have theirs in the evening. While food is always contentious, as opinions differ, Community Visitors report that menus appear well-balanced and proprietors seek support and advice through dieticians at DH's Supporting Connections Program. While some pension facilities offer menu choice, this is rare in pension-level facilities, although vegetarian and diabetic needs are usually met.

The expectations and demands of some residents cannot be met, or staff find them very difficult to cater for. The family of one person expected the bathroom to be refitted to suit their requirements, refused continence aids and demanded a new mattress. Another resident was noted as demanding an "hour-long" shower, with a support worker to scrub her back, feet and shampoo her hair. This person informed staff that she was being discriminated against when these demands were not met. Situations like these lead to some facilities insisting on a trial period of two weeks to see if new residents settle in with the others.

At one facility, a resident had returned from attempting to live alone as she found she was unused to the quiet and having to manage her own affairs.

The SRS are generally clean, comfortable and well-maintained.

In the inner east, many have multiple lounge areas where people can sit quietly or entertain visitors, and some have attractive garden areas. Kitchens are reported as being clean and orderly, while meals seem to be varied and nutritious, with individual dietary requirements and personal preferences accommodated. Cooling and heating are generally well-regulated. The hot summer tested some SRS, though some supplied portable fans in addition to air-conditioning. Most SRS were reported as being cool and comfortable on the very hot days and warm in the colder months.

The majority of SRS in the inner part of the region have regularly reviewed, detailed and up-to-date support plans. In one SRS, however, support plans were a year out-of-date. Visitors noted that the staffing levels seemed to be inadequate as the manager said they did not have time to address the problem. At the next visit, support plans had been revised.

Community Visitors noted on two visits to one SRS, that the 'chemical cabinet', in which residents' medications were kept, was unlocked. However, on the third visit it had been resolved.

Another SRS had its food safety assessment downgraded because the kitchen needed to be painted and have tiles replaced.

Incident reports

In the outer part of the region, incident reporting remains poorly understood, particularly in relation to DH's definition of recordable and reportable incidents.

One proprietor informed Community Visitors that her facility is not a hospital and, so, very few incidents are recorded. However, other facilities keep very comprehensive incident report records, particularly where the manager or proprietor is a nurse. Most proprietors advise a formal record would be made when skin is broken, someone is found on the ground, medication is missed or there is a behavioural concern such as an argument between residents or with a staff member.

One SRS records actions or activities concerning new residents or those which are out of the ordinary for a resident. The result is that, if a person develops behavioural issues or an illness, these records can assist professionals, such as mental health staff with diagnosis and treatment.

There are few issues with incident reporting in the inner part of the region. Many SRS use the incident report book provided by DH. In one SRS where the report book was not used, Community Visitors reported that the records lacked sufficient detail. They discussed this with the manager who was very responsive and undertook to ensure that the required standard for incident reporting was met.

Activities and social independence

One SRS in the outer east ensures that all residents are involved in some way in the 'life' of the facility and assists residents to access activities in the community wherever possible. Minutes of a house meeting showed much discussion about food and whether to order soft or crisp crust on pizza night, demonstrating resident involvement and choice. The proprietor of this facility was observed teaching a resident how to manage the laundry, a role she had wished to take on.

In several facilities, people assist with vacuuming, setting and clearing tables, peeling vegetables and tidying the garden.

There is a diverse range of activities on offer for people living in SRS in the inner part of the region, including sing-alongs, exercise classes, discussion groups and day trips. On one visit by Community Visitors, the activities coordinator was reading a play by Chekov, with residents taking parts in the reading. One SRS has cable TV for residents who speak languages other than English, so they can enjoy programs in their rooms. Community Visitors were very pleased to report this year on an SRS where two people were allowed to have pets.

The availability of postal and early voting meant that residents who wished to do so, voted in last year's Federal election where proprietors contacted the Australian Electoral Commission or candidates to obtain voting papers. Some had mobile booths – both pension and pension-plus. One facility has already requested the Victorian Electoral Commission to update the electoral roll for the forthcoming State election

Financial matters

Community Visitors reported on a resident who wanted to open a bank account but was unable to provide the required 100 points to prove her identity. She did not have a drivers licence, passport, loan record, birth certificate, credit cards nor had she ever owned or rented a house in her name. In addition, living in an SRS meant she did not have any utility accounts in her own name.

Community Visitors conducted a visit in response to a request by an anonymous caller to OPA's Advice Service. The caller said that they had overheard a resident tell other residents that they had loaned money to a staff member and that, when they asked for it back, the staff member denied having borrowed it. The caller also heard the resident state that some of her jewellery had gone missing.

They spoke to the resident who confirmed what the caller had said and reviewed the incident report book. It included an entry detailing the loss of jewellery, which was later located and the offer of a reward to the staff member who found it. A notification for investigation was prepared and sent to DH.

The departmental investigation found that the allegations were not verified and requested a referral to the resident's GP for a psychiatric assessment. The resident's family were notified by both facility staff and the resident's GP.

Children and young people in SRS

The Community Visitor team in the outer east conducted a brief survey in March-April 2014, which identified thirty people less than 30 years of age at nine pension-level SRS. Some moved from DHS shared supported accommodation, others from foster care or their parental home. All had an intellectual disability and/or a mental illness.

Community Visitors are concerned about the disparity in care for young people with an intellectual disability residing in disability accommodation versus those in the SRS system. The former have formal plans focussed on skill development compared with the ad hoc nature of the support available in SRS being able to meet their specialised needs.

good practice



Warranvale SRS welcomes and works positively with its five young residents.

They are supported to develop living skills and self-discipline by looking after their rooms, helping to prepare their own breakfast and clearing up after meals.

Warranvale is assiduous in ensuring referrals from hospitals include details of the person's mental health history, medications and case management prior to acceptance at the facility.

Gippsland Region

The region has one pension-level and five pension-plus SRS. The majority of these facilities have caring staff who work hard to cater for the needs of their residents, including providing appetising, nutritious meals in their accommodation, which is of a satisfactory standard.

Abuse, neglect and violence

Aggressive incidents between some residents at one SRS were of such concern to other residents that one person stated their intention to leave the SRS if the behaviour continued.

Various alleged incidents of sexual assault/harassment have been reported at one facility and

are being investigated. One alleged victim self-harmed due to the trauma she had experienced and needed to be admitted to hospital.

Residents at a facility complained that another resident was constantly entering their rooms and taking belongings, usually cigarettes. This occurred over a long period and her behaviour did not change despite the regular involvement of a case manager working with her.

Visitors have noted that, one SRS, where there is little or no resident involvement in activities, has the most allegations of violence and abuse.

Home-like environment and safety

There are serious health and safety issues for some residents at one SRS, which was the subject of four investigation notifications to DH.

Community Visitors received reports that, on numerous occasions, one resident wandered around the locality, late at night or early morning, sometimes visiting the local police station to enquire about lost items.

Another resident attempted to self-harm and was hospitalised before returning to the SRS. Community Visitors noted that her support plan stated that she had no behavioural problems.

Incident Reports

A female resident reported in detail to the manager about an alleged incident of sexual harassment. The manager spoke to the alleged perpetrator; however, they neglected to write an Incident Report regarding the disclosure or involve the police.

Activities and social independence

Community Visitors note that, in all but one SRS, there seem to be genuine efforts to involve residents in recreational and occupational activities. The acting manager at the one exception informed Community Visitors that they had attempted to motivate residents to take part in local community activities, however, it was their view that no-one was interested.

Viability of the sector

Unfortunately, one SRS that, over many years, has provided excellent care for frail, aged people is

closing down. This leaves only one SRS to cater for this client group with the remaining four having residents of mixed ages and disabilities including intellectual, mental health and drug/alcohol issues.

Grampians Region

There are seven pension-level and four pension-plus SRS in the region. Most are well-managed where residents receive good quality care.

Health and personal care

A podiatrist from a regional hospital was visiting an SRS on a monthly basis, which meant that only four residents were able to receive this service, rather than the many that needed it. Community Visitors notified DH of the situation, which resulted in the local hospital increasing the podiatry visits to every fortnight. This has resulted in a much-improved quality of life for many more residents.

Abuse, neglect and violence

A fight occurred between two residents, both allegedly intoxicated, which resulted in one being hospitalised. Community Visitors made a notification to DH in order to ensure better management of similar problems in future as such behaviour greatly distresses other residents.

Home-like environment and safety

A resident was found in the grounds of an SRS. It was first thought she had fallen from the balcony of the residence. However, following investigation, it was ascertained that she had fallen while walking.

However, this incident resulted in an agreement between the SRS and DH to raise and strengthen the balcony railing to minimise the future risk to residents.

Viability of the sector

One SRS will cease operation this reporting year as it has chosen to move to the federally funded aged-care sector.

good practice



Community Visitors noted that, in one SRS, management twice arranged for residents to see different shows in a nearby regional city that involved a 200-kilometre round trip.

Community Visitors believe this demonstrates a wonderful commitment to their residents and affords them every opportunity for community inclusion.

Hume Region

There are two SRS in the region, both are pension-level and are providing good care for residents.

Health and personal care

This year, there is evidence that residents at both SRS visited in Hume received improved access to general health care. The most common health need is for mental health support with a number of residents receiving inpatient and outpatient treatment at regional mental health facilities. One resident at each SRS has moved to aged care due to their support needs no longer being able to be met.

Abuse, neglect and violence

There was one reported allegation of sexual abuse by several residents. Victoria Police's Sexual Offences and Child Abuse Investigation Team (SOCIT) investigated but it was not proven. Another incident involved a male resident making inappropriate sexual advances towards a female resident. Police were called and the Centre Against Sexual Assault offered support.

Home-like environment and safety

Community Visitors regularly check Support Plans and found updates completed regularly. However, there was one report of vital information missing when a new resident moved into a facility.

One SRS resident lit fires on two occasions, one of which caused extensive fire and water damage to their room and adjoining ones. Community Visitors were pleased to note that alarms and evacuation

procedures worked and there was no injury to residents or staff. Another resident lit a fire in a nearby pine forest.

Activities and social independence

Residents' meetings occur at one SRS where complaints and suggestions are discussed.

Community Visitors are still concerned that, though recreational activities are said to be on offer in each individual Residential Statement, very few seem to interest residents. Both SRS have a regular swim/gym session.



One resident died in hospital of health complications.

Community Visitors were pleased to note a letter of thanks from the resident's family about the positive and happy experience they felt their brother had experienced as a long-term resident.

Loddon Mallee Region

The region has four pension-level and three pension-plus facilities. All pension-level facilities have shared bathrooms and bedrooms with between two and four beds to a room.

Health and personal care

A large number of residents with a history of mental illness live in pension-level facilities in the region. This reflects the lack of other affordable accommodation options. When these residents are depressed, distressed or unwell this often affects other residents.

A variety of other physical health and mental health issues were noted during the year including several medication issues. Some residents required hospitalisation. At one pension-plus SRS with 56 registered beds, there were 30 falls in one quarter and 38 in another. Community Visitors also reported stained drinking vessels and a water cooler containing debris.

Abuse, neglect and violence

One resident made several calls to OPA's Advice Service to report bullying by another resident and the cook at the facility. The SRS complaint book showed resident allegations regarding verbal abuse by other residents. The Authorised Officer met with the resident, proprietor and staff member. It was agreed that the resident's mental health case manager would provide training to staff to try to improve staff-resident interaction.

Home-like environment and safety

Support Plans are sometimes not available to Community Visitors; others contain minimal information or are inaccurate. Review dates are also not always adhered to. Missing dates on Residential Statements and other details have also been noted.

Other hazards include an urn sitting on a refrigerator, water leaking on the floor, a bathroom door being unable to be locked, a crack in a shower screen, and a back door not closing properly, so it could not be secured for the safety of residents at night.

At one SRS, a septic tank system was not functioning correctly and there was a strong odour. It was noted in subsequent Community Visitors reports that the septic tank had been fixed. Community Visitors have also noted unclean bathrooms and strong urine smells at facilities. Flies have also been noted in the dining room at one SRS on several occasions.

Incident Reports

At some facilities with large numbers of residents with complex needs, very few incidents are recorded. At one SRS, a staff member said a resident had held a fork to her face and threatened her, however, this was not recorded as an incident.

At another, incident reports were not signed, and did not have a date or time noted. One unexpected death, recorded in an incident book, had not been reported to DH.

Financial matters

Some residents have told Community Visitors that their VCAT-appointed administrator is not providing them with enough money. One resident evicted from a facility in another region said they had only

been given 24-hours notice and their money was withheld. He claimed the facility, not a registered SRS, owes him money and was continuing to charge \$315 per month for personal belongings storage. The Authorised Officer enquired into the matter, but could find no evidence of this having occurred.

Service Provider relationships

This office wrote to a proprietor after Community Visitors were spoken to in a rude and intimidating manner during a visit. The proprietor denied he was rude to Community Visitors and the Department did not find his behaviour a breach of the *Supported Residential Services (Private Proprietors Act) 2010*. Community Visitors hope that they will be treated with respect in future.

The program believes that the Department should take legal action where Community Visitors or residents are subjected to aggressive or bullying behaviour by SRS proprietors.



At one pension-level SRS, Community Visitors found only one shower available for 23 men and one bathroom including a toilet for seven women.

Following an Authorised Officer inspection, two showers are now available in the men's section and the proprietor is obtaining quotes to create another bathroom.

Residents also told Community Visitors a wood heater and bar heaters in the men's section had not been used for some years. Staff advised that residents had used the heaters to light cigarettes and this posed a fire risk.

However, there was only lino on the bedroom floors and some residents had only a thin doona or one or two blankets on their beds at the start of winter.

Community Visitors notified the Authorised Officer who met with the SRS proprietor which led to a new heater being installed and new doonas purchased.

North and West Metropolitan Region (North)

There are twelve pension-level SRS and six pension-plus SRS in this region. There are very cordial relationships between Community Visitors, the DH Authorised officers and all but one proprietor which has substantial benefits for residents.

Health and personal care

Community Visitors are noting more people with mental illness and complex needs entering SRS, as there are few other accommodation options. Some of these residents cause disruption and situations of concern to other residents and staff due to their behavioural issues which may be related to their mental illness, ABI or cognitive disability.

Abuse, neglect and violence

There have been several serious incidents, including a resident inappropriately touching another resident, verbal abuse, theft and property damage.

At one SRS, two residents were sleeping on mattresses on the floor, with no beds in their room. At the same facility, another resident was asleep on a bed without sheets. Their room was filthy with food scraps and other mess lying on the floor. The manager insisted that the residents preferred these arrangements and that the facility was cleaned every Monday. DH is investigating these matters. Another SRS was noted as previously having experienced a bedbug infestation.

Home-like environment and safety

In general, Community Visitors report that Support Plans are kept up-to-date. However, they are concerned that many residents who state they are unaware of their Support Plan or cannot recall participating in update discussions.

At one facility, Community Visitors noted the evening meal was finished for most residents by 4.45pm, which was the time of their arrival. Practices such as this where meal times do not match normal community expectations belie the expectation that an SRS provides a home-like environment. Residents complained that they had no more to eat until breakfast though the staff said supper was provided.

Concern regarding both the quantity and quality of meals, especially evening meals, continue for some facilities.

Community Visitors noticed that a proprietor of multiple facilities prepares food at only one facility and transports meals across the suburb to their other facility. This matter was raised with DH which notified the local council, so they are undertaking routine visits to this SRS to ensure food safety and hygiene.

Incident Reports

At one SRS, Community Visitors noted with great concern that Incident Reports were recorded on loose sheets of paper and not numbered. A formal notification was made to DH which resulted in the pages being numbered sequentially after Authorised Officer follow-up.

Finances

There were no adverse financial issues with any SRS in the region. However, many residents in pension-level facilities complain of not having enough money and blame their VCAT-appointed administrator for this predicament.

Information access

DH has circulated information about residents' rights, however, Community Visitors note that often residents are still very ignorant of their rights so the information does not seem to be getting to them.

Service Provider relationships

Community Visitors attempt to maintain positive working relationships with proprietors and staff.

However, one proprietor who runs a number of facilities has endeavoured to obstruct and intimidate Community Visitors on several occasions over the past year. In addition, this proprietor has made complaints to various agencies about Community Visitors, which were unsubstantiated.

On one occasion, a staff member refused to sign the report until the proprietor was consulted. The report was finally signed by a staff member after its contents had been reviewed by the maintenance person. Community Visitors were very unhappy about this situation and question whether this individual has the right to view confidential resident

records; particularly as two of them could be identified by the information in the report.

North and West Metropolitan Region (West)

There are seven pension-level and four pension-plus SRS' in the region. The relationships between Community Visitors, DH and proprietors have improved, which has led to improved outcomes for residents.

Health and personal care

Community Visitors have noted improvements over time across facilities in the provision of health and personal care to residents. One SRS was commended for the support staff provided to an individual in addressing their personal hygiene issues.

Concerns were raised at one pension-level SRS where most residents appeared unclean and dishevelled. Community Visitors also questioned the support and care provided to a young male resident with very complex issues including an acquired brain injury, mental illness and restricted mobility. This resident spends most of their day in bed and their feet appeared blue and cold on one visit. Reassurances were given by the proprietor that the resident was receiving sufficient care, including regular visits from the Royal District Nursing Service and podiatry.

Case management provision is a key factor for ensuring that many SRS residents receive adequate health and personal care. In particular, concerns were noted about two residents in relation to the lack of contact with their allocated case managers.

Abuse, neglect and violence

Community Visitors noted changes in resident mix at one SRS appeared to reduce conflict between residents. Incidents of abuse and violence appear to be significant across facilities, as indicated by multiple incidents recorded and frequent requests for police involvement.

Home-like environment and safety

Community Visitors believe that Support Plans must be clear and accessible, so staff can effectively meet the needs of the residents.

Deficiencies in support planning have been highlighted as an ongoing issue in the case of one pension-level SRS. These plans are difficult to understand and inaccessible. In the case of one particularly complex resident, the Support Plan was amended after Community Visitors intervened and indicated that particular support services were not included but needed to be in their plan.

Despite this issue being flagged in previous annual reports, little appears to have been done by this SRS to rectify this situation.

The boundary fencing at one pension-level SRS remains a safety concern; it is badly damaged and requires repair and replacement in some places. At another facility, the heating and fire panel were tampered with and the fire hose turned on in the corridor on more than one occasion, requiring the attendance of a fire brigade.

Incident Reports

Community Visitors reported that they have been able to access Incident Reports and other required records without issue. In some facilities, Incident Reports indicated that police have been called on multiple occasions because of violence.

Activities and social independence

Community Visitors have continued to note the positive impact of SAVVI funding in upgrading amenities and facilitating access to recreational and educational opportunities. For instance, a vegetable garden created at one SRS has been a huge success with residents.

Finances

Concerns were raised at one pension-level SRS when fees increased over and above the pension and additional charges for services such as laundry were levied.

Children and young people in SRS

A resident at one pension-level SRS had her son, 4, staying with her initially for overnight access visits and, subsequently, for lengthy day visits. Community Visitors were concerned about this arrangement in regard to the child's safety and the fact that other residents were complaining about the noise and the child's behaviour. The matter was escalated to DH which liaised with child protection

and foster care services to work through the issues to find a suitable outcome to this difficult situation.



A resident at a pension-plus SRS threw a rock at the front door of the facility and threw a chair at a group of residents. The proprietor sought a review of the resident's medication by her mental health services and placed her on a three-week good behaviour trial.

The proprietor then called a meeting of all residents to update them about the situation.

Southern Metropolitan Region

The Community Visitors in this region have divided it roughly into two geographic areas for ease of visiting. In the inner part of the region, six SRS are pension-level and five are pension-plus. In the outer part of the region, eighteen SRS are pension-level with the remaining five pension-plus.

Health and personal care

Community Visitors report that most pension-plus SRS provide excellent health and personal care to ensure their residents can remain in their place of choice for as long as possible.

Pension-only facilities face more challenges due to the type of resident seeking accommodation as many have mental health illnesses or other complex needs and often lack alternative accommodation and support options.

The case study, 'George' featured in last year's Annual Report had a happy conclusion with agreement for him to move to aged care rather than being forcibly evicted due to his morbid obesity. Community Visitors see issues for pension-only SRS with people who are morbidly obese due to their high-care requirements, as a pension-level SRS may only have one or two staff on duty for 30 residents.

The issue of morbid obesity is becoming more prevalent and the occupational health and safety considerations for care staff means that facilities without lifting equipment may be reluctant to admit people classified as morbidly obese.

Two residents at a pension-plus SRS were observed by Community Visitors not having their high-care needs met as their next-of-kin refused to support recommendations regarding enhanced care support. Community Visitors advocated on behalf of these residents, pressing proprietors to continue the dialogue with families regarding the need for enhanced medication and equipment to better meet residents' needs.

Community Visitors were most concerned when visiting one facility that a resident recovering from hip surgery was observed to have no liquid near her chair, or easy access to a buzzer to summon staff, if necessary.



John, 47, suffering from Multiple Sclerosis was placed in a pension-only SRS.

Many of the older residents and those with less-ebullient personalities resented his manner. However, another resident, Vera, 97, formed a very close bond with John and enjoyed his company. John's mother visited regularly and formed a close relationship with Vera.

John took ill very suddenly and subsequently died in hospital. Staff decided to tell residents that John had gone to higher care, as they did not want to upset anyone. The family were very distressed, as they wanted Vera and any other friends among the residents to attend John's memorial service.

Staff continued to refuse to inform residents about John's death so John's mother visited the facility and informed Vera. Subsequently, staff agreed to take Vera to John's memorial service.

Abuse, neglect and violence

Community Visitors continue to report many acts of violence among residents and towards staff, particularly in pension-only SRS. Incident reports, which have been made available to Community Visitors, highlight that physical confrontation between residents often require police intervention and medical support. Threats and attempts of suicide have also occurred, particularly at pension-level SRS.

On occasion, SRS residents who have been violent are evicted and move to other SRS. This may be facilitated by case managers from mental health services. Repeated incidents of violence by the same perpetrators highlight how SRS may be inappropriate accommodation options for people with complex needs, including alcohol and substance abuse.

Community Visitors in the inner south noted three significant events at a pension-plus facility, where resident behaviours affected other residents and staff.

A female resident became aggressive, throwing glasses, chairs and tables and attempted to self-harm with a knife in front of other residents. Police and ambulance attended and the resident was taken to hospital.

A male resident became aggressive, attacking staff and residents. Police had to remove him.

A male resident became aggressive and attacked other residents: biting, hitting and throwing cups.

Community Visitors reported that none of these three incidents were reported to DH as required.

Home-like environment and safety

On 7 April 2014, Community Visitors visited a pension-plus facility and found that a person with profound physical disabilities who had been recently admitted had attempted to shower himself. This caused flooding of his bathroom and bedroom. The person was in receipt of case management from DHS's Disability Services, which facilitated the placement.

Community Visitors have observed that residents' Support Plans are usually well-documented, however, on several occasions, they have found ones that have not been updated for sometime.

In some instances, Community Visitors have not been able to access Support Plans nor were staff able to locate them.

Information regarding the referral of residents with complex needs continues to be of concern to Community Visitors.

Pension-plus facilities have a largely older resident-mix. However, the equilibrium of such a facility can be compromised when a proprietor accepts a younger person with complex needs and associated behaviours.



In one SRS, where there is a mix of pension-only and pension-plus residents, a proprietor reluctantly bowed to external agency pressure to allow an elderly person with a cat to be admitted on a Sunday for two nights. This was subsequently extended for a further two nights. On the fourth night, the woman let her cat out of the bedroom, opened the cage door of the SRS pet lorikeet in the residents' lounge room and allowed her cat to eat the lorikeet. This incident caused much distress among the resident group, in particular for one resident who was very attached to the bird.

On 13 March this year, Community Visitors noted that a resident at a pension-level SRS did not have a Support Plan completed within 48 hours of her becoming resident. The Authorised Officer shared the Community Visitors' concerns regarding timely and appropriate admission documentation for all residents at that SRS, including those for short-term stays. In addition, there were questions about whether education on the prescribed standards had been provided to this staff team. Maintenance and general cleanliness of facilities remained an issue throughout this reporting cycle.

Community Visitors noted, during five separate visits to five different SRS where bathrooms were not cleaned and at one pension-plus facility, there was a pervasive smell of urine.

Hazards created by poor maintenance remain a concern including worn carpet and vinyl flooring. In one facility, electrical cords in a bicycle shed were tangled among bikes and posed a health risk.

Community Visitors regularly find rooms heavily cluttered by residents' possessions impeding the ability to clean the room efficiently. One resident kept a cat in her already-cluttered room and rarely showers, as the cat's litter tray is kept in the shower recess

At one pension-plus SRS, carpets and handrails were dirty and sticky and the towels looked very old.

One issue raised by Community Visitors was excessive condensation at a pension-plus SRS. The SRS proprietor leases the property, however, the property owner who has statutory responsibility for maintenance, refuses to rectify the problem. The situation is further complicated by the inability of Authorised Officers to place pressure on third parties to comply with the legislative requirements under the SRS Act, in this case the building owner and landlord.

Community Visitors observed Sandra seated in a princess-like chair in an SRS day area. She was very distressed, calling out loudly and repeatedly that she wished to die and that "God should let her rest".

Residents sitting near her appeared affected and Community Visitors found her calls concerning to hear. Sandra advised Community Visitors that she was very unhappy, as she was unable to do anything or think straight.

Sandra's Support Plan appeared current.

The proprietor advised Community Visitors that Sandra's next-of-kin had ruled out any change or increase in medication. Community Visitors stressed the need to raise the matter again with her next-of-kin.

Incident Reports

Community Visitors have welcomed the change to the Act that requires proprietors and staff to complete Incident Reports and that these records are available for them to inspect.

However, there are a range of issues with them as the methods used by SRS to record and report incidents vary between facilities. It is often difficult for Community Visitors to locate incident reports and, at times, staff have even been unable to find them.

Community Visitors have found that proprietors frequently do not understand the difference between serious incidents they need to report to DH or those that are recordable in their files.

In addition, Community Visitors have observed proprietors using residents' progress notes to document incidents, to which Community Visitors have been refused access. This access refusal relates to claims by proprietors that either these documents contain medical information or they are not a document under the Act to which Community Visitors are deemed to have access.

On six occasions, Community Visitors identified a failure by proprietors or staff to correctly record incidents as required.

Community Visitors were particularly concerned about three instances of significant violence by residents at one pension-plus facility between

December 2013 and March 2014 where they failed to complete Incident Reports to DH.

During a visit in July 2013, Community Visitors found no record in the Incident Report book of a resident falling and breaking her foot. The staff member on duty informed Community Visitors that they were unsure how to record incidents.

During a visit to a pension-level SRS in November 2013, Visitors noted that a resident had been reported missing from the facility. The person subsequently fell in the street, was initially held by police and eventually taken to hospital. This incident was recorded in the person's Support Plan rather than the required Incident Report being completed.

A proprietor in the outer south, using a new SAVI-funded computer program, refused Community Visitors access to electronic progress notes, which may have contained Incident Reports. The proprietor who designed and implemented the computer program has verified that the recording of incidents in this computer program occurs.

Similarly, on 4 October 2013 at a pension-level SRS, Community Visitors noted an incident of a male resident being aggressive towards a female resident, which had been recorded in the facilities' communication book and not recorded as an incident.

Abuse, neglect and violence are the most common incidents recorded in pension-only facilities. In pension-plus facilities, most incidents relate to falls. These are usually monitored and supports put in place for residents.

Financial issues

Residents in pension-plus facilities rarely complain about financial matters. However, residents in one facility sadly lost all their bond money because of very poor management. The facility was placed in administration and many residents moved out. The business was eventually sold to a new proprietor and is gradually re-establishing itself. The new Act has much more stringent requirements about funds allowed to be held by proprietors on behalf of residents and this example illustrates why this is necessary.

Residents in pension-only facilities regularly complain about lack of disposable income as most of their pension is absorbed by rental and medical costs.



Alan, a pension-level SRS resident, has been moved between SRS despite agreements between DH and DHS that this would not occur.

Alan's support worker raised concerns about his behaviours and his support hours having been decreased. Community Visitors notified DH.

The proprietor stated that Alan's behaviour was being managed and that the strategies in place had resulted in measureable improvements.

There continues to be disagreement about how effective the current processes are to manage Alan's behaviour.



Mental Health

Statewide Report and
Recommendations



Recommendations

Mental Health

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

1. monitor and evaluate the implementation of the new *Mental Health Act 2014* in Victoria to assess the impact of the Act on the participation of consumers and carers in the decision-making and delivery of treatment and care
2. publish data on the Department of Health (DH) website on:
 - the number of patient and staff assaults
 - the number of abscondings
 - readmission rates for inpatients
 - the length of stay of people with a dual disability (intellectual disability or acquired brain injury and mental illness) as compared with the general population in mental health facilities
 - the number of people subject to assessment orders and treatment orders
3. ensure patient safety and wellbeing through staff training, building improvements and gender sensitive practice
4. expand treatment and accommodation support options for:
 - people with a serious mental illness
 - people with a dual disability
 - people with substance abuse disorders
 - young people who need extended time in a secure environment
5. increase the number of acute inpatient beds in areas of high growth and where the length of stay in an emergency department regularly exceeds Federal Government targets
6. expand regional specialist options such as eating disorders and mother and baby beds
7. produce guidelines that require services to provide meaningful and therapeutic activities and advocate for the Federal Government to amend the national standards for mental health services accordingly
8. increase the recurrent funding for the Community Visitors Program to enable OPA to recruit, train, support and reimburse sufficient numbers of Community Visitors to visit all mental health facilities on a regular basis and, then, effectively liaise with service providers to address the issues identified on visits.



Statewide Report


The Board acknowledges the dedicated work of many staff within Victoria's mental health system and the high standard of care provided by many mental health services. The Board also acknowledges the continued expansion of community-based mental health services as well as positive developments and facility improvements in many services.

However, during the year, Community Visitors have enquired into and reported on a diverse range of issues of concern which are the focus of this report. They include serious incidents and assaults, pressures from limited bed availability and accommodation options, boredom due to lack of activities, and struggles with the no-smoking policy. Medication complaints, lack of access to psychiatrists, discharge and involuntary status issues, and the slow resolution of maintenance issues are also of great concern.

Many of these concerns are reported by Community Visitors year after year.

Visits

This year, the total number of visits made to mental health facilities was 1262. This includes both scheduled visits and visits in response to 120 calls to OPA's Advice Service. Because patients are sometimes in acute facilities for only a few days, Mental Health Community Visitors often respond to calls initially by phone, then



Region	No. of units visited	No. of CVs	Requested visits	Scheduled visits	Total
Barwon South Western	5	5	3	10	13
Eastern Metropolitan	18	14	26	188	214
Gippsland	6	3	4	66	70
Grampians	8	6	7	83	90
Hume	9	9	2	108	110
Loddon Mallee	7	8	14	71	85
Northern Metropolitan	22	11	13	204	217
Southern Metropolitan	27	12	27	172	199
Western Metropolitan	23	12	24	240	264
Total	125	80	120	1,142	1,262

Table 4. Total visits Mental Health Stream 13/14.

a visit as required. All facilities visited by Mental Health Community Visitors in 2013-14 are public services providing 24 hour nursing care.

The new Mental Health Act

The Mental Health Board paid close attention to the progress of the new *Mental Health Act 2014* during its various stages with particular attention on the role of Community Visitors.

Several months of advocacy achieved some significant changes to the draft bill. Community Visitors will be able to commence visiting the 21 Prevention and Recovery Care Services (PARCS) in Victoria and facility staff will now be required to provide "reasonable assistance" to Community Visitors, although the penalty for not so doing has been removed.

A key function of Community Visitors is to report on the compliance of service providers with the requirements of the new Act. Community Visitors will be able to inspect any document including incident reports, though clinical records will require the patient's consent.

These important changes will enable Community Visitors to better understand the patient's experience while being treated in a public mental health facility. The Community Visitors Mental Health Board is pleased with these additions, although it is concerned the new Act does not require facilities to be visited monthly as was the case under the old Act for the last 28 years.

However, without extra recurrent funding, regular visits to PARCS will not be possible as the Board wishes to maintain the present frequency of visits to patients and residents in facilities already served.

Serious incidents and assaults

People with a mental illness, their families and carers and the wider community expect people receiving treatment to be safe from all forms of abuse and violence.

Community Visitors reported 55 serious incidents involving physical and sexual assaults, intimidation and other forms of aggressive behaviour, most of which occurred in acute units and most of which involve patients threatening other patients.

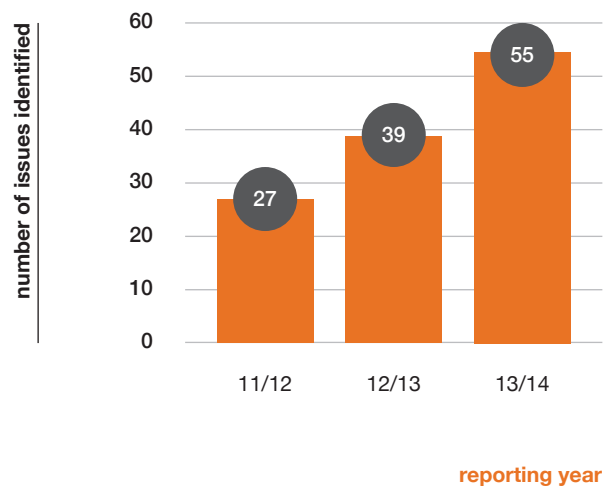


Figure 5. Mental Health Stream assaults and violence 11/12 to 13/14.

At the Bendigo Hospital acute unit, a patient could not sleep because another patient who wanted her cigarettes had threatened to kill her.

At the same service, a young male resident felt unsafe because another patient was following him and exposing himself. Another patient alleged he had suffered an anal injury during a previous admission. Although the patient's file states that he had reported this to a doctor and nurse, and the service said the matter was thoroughly investigated, Community Visitors could not obtain an incident report or find any evidence of an examination or police referral.

The Department of Health (DH) has funded a number of initiatives related to gender sensitivity and patient safety and is to be praised for what has been achieved to date.

Despite these initiatives, the harassment of women continues. Patients in an eating disorders unit at the Austin Acute Unit told Community Visitors they had unwelcome hugging by male patients and one male patient had told them: "You should all be raped". Community Visitors in the Grampians Region have expressed ongoing concern that females at a Community Care Unit (CCU) in Ballarat have no separate lounge so they tend to stay in their bedrooms and feel unsafe as there are no locks on doors.



During a 'bed-check' in the adult acute unit at Northern Hospital, a male patient and a female patient who was unable to give informed consent were found together in the male patient's bedroom.

Victoria Police and the Centre Against Sexual Assault were contacted and the female patient received an appropriate medical examination.

The alleged offender was moved to another unit and a hospital transfer sought for the female patient. It wasn't until several days later, that the hospital informed the female patient's guardian. This should have occurred concurrently with the police notification.

The service has reviewed its procedures since the incident and it reports that special attention will be given within the unit in future to the placement and management of female patients.

As a result of patients assaulting staff, serious staff injuries were noted as well as staff stress at the number of assaults occurring. There have also been allegations of staff assaulting patients and serious damage to property by patients. Suicides and attempted suicides were also noted at the acute inpatient units in Traralgon and Bendigo.

Patient abscondings are a serious challenge with a patient in Hume Region dying after being hit by a train and a patient in Bendigo escaping serious injury after being hit by a car. Abscondings were also noted in the Grampians and Northern and Southern Metropolitan Regions.

Restraint and seclusion

Legislation requires services to provide treatment which least restricts the patient. Twenty-seven issues relating to this have been reported by Community Visitors. Both the Public Advocate and the Minister for Mental Health have made public statements stating that the current level of restraint and seclusion is unacceptable, and \$2 million has been provided to help services reduce these practices.



A patient in the Swanston Centre Acute Admissions Unit in Geelong reported bruising on his wrist due to five staff members physically restraining him. This allegedly occurred when he tried to leave the facility, even though he was a voluntary patient.

The patient, who has an intellectual disability, was apparently suicidal and the service told Community Visitors that they were in the process of changing his status from voluntary to involuntary when he tried to leave the service.

Frequent 'lock downs' of units and the locking of doors which lead to gardens, patios and other outside areas have also been noted, usually after a patient has exhibited aggressive behaviour. While Community Visitors support efforts to reduce the use of restraint and seclusion, and praise the efforts of services to create alternatives such as quiet or 'sensory modulation rooms', they are concerned that the reduced use of seclusion rooms may have led to an increase in the locking down of whole units.

Bed availability

The demand for beds is a perennial issue.

Community Visitors report that Eastern Health has 2000 mental health calls to its triage services and assesses approximately 400 patients each month.

In September 2013, at the Bendigo Base Hospital, there were 36 emergency department presentations in four days, resulting in three patients being kept on trolleys for more than 24 hours while waiting for beds. In November 2013, three patients waited at least 10, 18 and 20 hours.

In the Western Metropolitan Region at Werribee Mercy Hospital, Community Visitors noted waits

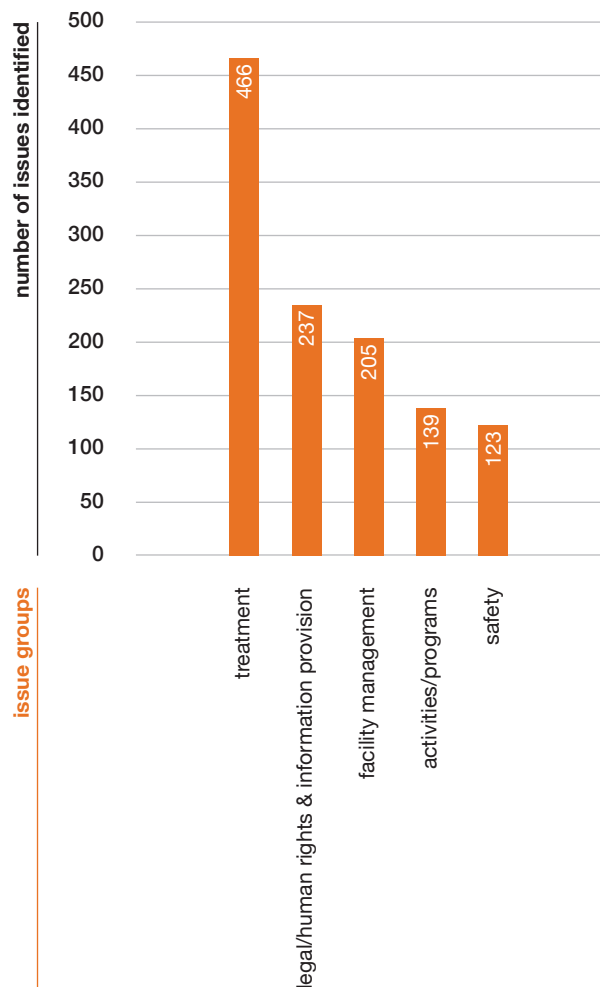


Figure 6. Mental Health Stream by issue groups 13/14.

of 19 hours in February 2014, 12 hours in August 2013 and up to 48 hours in July 2013.

At Sunshine Hospital, waits of 11 and 18 hours were also noted. Two patients a day are required to be discharged from some facilities after a psychological assessment. Unit managers, using a twice-daily telephone link-up, assess bed availability based on daily discharge figures.

A male patient at the Bendigo Hospital acute unit was awakened and moved to another room in the middle of the night so a female patient could have a room with an ensuite. A staff member was reported as saying patients were “treated like cattle because of the pressure on beds.”

In the Hume Region, Community Visitors successfully advocated for the reinstatement of two beds lost after the Rosewood Aged Care Unit closed and beds were transferred to the Wanyarra acute unit in Shepparton.

Private aged care beds were found for patients when Weighbridge aged mental health facility in the Western Metropolitan Region was closed with the loss of 30 publicly funded aged-care beds.

In Southern Metropolitan Region, Peninsula Health is proposing to sell 48 beds in two aged-care residential facilities, stating that current residents will continue to receive care during the transfer of ownership process. Community Visitors are concerned that, as a result of this, there will be no public health beds for aged people and substantial financial resources may be required to access beds in the private sector. In an area with a high proportion of people aged over 60 years of age, Community Visitors view this as an entirely unsatisfactory situation.

Community Visitors in the Northern Metropolitan Region learned from a young adolescent woman from Bendigo that she had been admitted to the Austin Adolescent Unit as there were no adolescent beds in Bendigo. She wanted to go home as it was hard for friends and family to visit. The husband of a woman located at the Werribee Mother and Baby Unit while the Monash unit was renovated, had to travel over an hour to visit his wife and baby adding to the family’s financial problems.

Treatment and care

The highest number of issues in this category concern the adverse effects of medication either previously experienced (and ignored) or currently experienced.



Figure 7. Mental Health Stream number and types of issues identified 13/14.

Delays or lack of patient engagement in the development of treatment plans, and unanswered requests to speak with treating doctors were also noted. Community Visitors reported that treatment for medical conditions, physical ailments and electroconvulsive therapy (ECT) are often not addressed for patients until queried by Community Visitors.



The wife of an aged-care patient stated that she found his mouth full of unswallowed food and a broken tooth.

The service stated that the patient's wife often assisted her husband at meal times, but, at the time of the tooth being found, she had not immediately alerted staff.

Dental care of the carer's choice was arranged.

Treatment plans, required by law for all patients, are not always prepared on time. One Bendigo Health patient did not have a treatment plan after two months, another after 18 days, and a third after two weeks.

The low provision of allied health and social services in many facilities remains a concern. Patients frequently require assistance from social workers to explore accommodation opportunities, assist with financial matters and organise family conferences. Psychological services are necessary to provide intensive psychotherapy and counselling with individual patients, their partners or groups to support medication regimens. This is especially important in units providing care for patients with eating disorders and mothers experiencing perinatal mood disorders. Lack of access to dieticians and occupational therapists is also concerning.

At the Austin Hospital, mothers and their infants are provided with a multi-disciplinary treatment program that includes maternal and child health nurses assisting in developing strong mothercraft skills, dance therapy activities and part-time psychology sessions for learning emotional and relationship skills.

At the Monash Medical Centre, the eating disorders unit is a joint operation between the hospital's departments of medicine and psychiatry;

a Nurse Practitioner provides liaison between the two. The model of care includes access to an outpatient psychology clinic within a structured weekly program. However, at weekends when the patients are cared for by regular nursing staff instead of the specialist staff, the understanding of the complex needs of the patients is less certain and patients have complained about the lack of empathy and low level of informed care they receive.

In the perinatal and infant unit at Monash Medical Centre for mothers experiencing post-natal mood disorders, the model of care has become so generalised as to exclude allied services entirely. The philosophy is that staff of any discipline, such as occupational therapy, speech pathology, or nursing can provide all that is required to support distressed mothers in their recovery. While the focus on developing strong mothering skills and enhancing mother-infant bonding is necessary, the lack of psychological services is concerning. It is well known that anxiety and depression experienced in young mothers is often repeated in subsequent pregnancies and, without specialist care, the development of infants is disturbed well into their early years.

While many patients appreciate the care they receive, issues related to dignity are also reported. Patients sometimes complain that they are not treated with respect or are spoken to in an insulting manner. Patients in several regions reported they had no fresh change of clothes and, in one instance, a patient was very distressed as no clean underwear was available. Complaints about money and personal belongings going missing were also frequently recorded.

Complaints about food, catering and the availability of water are also common. Patients with specific dietary preferences for vegetarian, kosher, dairy or gluten free food complain about the lack of variety in food received. Patients have also complained about not receiving food they ordered. In one instance, this was within an eating disorders unit.

Legal rights and information provision

Patients and residents often express frustration when they lack information about their treatment, leave arrangements or discharge. Community Visitors are asked about access to second opinions, legal aid and advocacy, Mental Health Review Board (MHRB) hearings, wills, financial matters, and guardianship.

Some services are excellent at providing information on notice boards and in booklets to patients on admission. At Mary Guthrie House, Austin Health's unit for people with neurocognitive disorders, there is a display chart of photos of five interpreters and the languages in which they provide translation services.

Unfortunately, at other services Community Visitors have noted patient's rights booklets and posters about the Community Visitors Program are often missing. Lack of staff knowledge of the Community Visitor role is also a problem, particularly among emergency department staff.

Community Visitors find it difficult to meet with some unit managers to discuss issues raised, but realise staff are busy. Access to incident reports has been an ongoing problem but, hopefully, this will be resolved with the implementation of the new Mental Health Act.

Discharge issues

Finding suitable, affordable accommodation for people awaiting discharge is a frequent challenge, particularly if the person has a dual disability.

One patient in the Southern Region was discharged to his grandmother's house (outside the network catchment) while awaiting suitable supportive accommodation. This raised concerns about compliance with his medication regime.



Finding appropriate accommodation for people leaving a forensic facility poses a particular challenge.

One patient due to be discharged in several months, told Community Visitors he had been on the public housing waiting list for over 13 years but there had been no offer of accommodation to date.

Community Visitors were told the patient had unrealistic expectations about the housing market and the reality of obtaining affordable accommodation in his preferred locations. He was allocated a social worker to assist him in his search.

One of the challenges for single patients is that families are often given priority to limited public housing stock.

Issues arising from discharge practices are also frequently reported: patients are not being discharged when they expect, patients are being discharged when they do not feel ready, and transferred when their condition has changed and a different type of facility is required.

Discharge decisions are sometimes made to free up a bed for a patient coming from the community or from the hospital emergency department. One problem with internal transfers is that the receiving unit may specialise on a different age cohort and the transferred person may not, then, receive age-appropriate programs. Carers understandably want patients transferred to facilities nearer their home, which can further delay a patient's placement.

Long-Stay Patient Project

Community Visitors have been reporting on long-stay patients in mental health units since 2007. They again collected information on these patients in April and May 2014. Long-stay patients are those who have spent more than three months in an adult acute unit and more than two years in a CCU or Secure Extended Care Unit (SECU).

This year, 61 long-stay patients were identified. This compares to 72 patients in 2013 when Community Visitors last collected the information. The reduction in numbers could be due to a range of factors including the development and expansion of PARCS and other housing and support programs such as the Mental Illness Fellowship's Doorway program, and the provision of support packages for CCU and SECU patients.

The project also used a different criteria for long-stay patients in aged mental health services where people will often be appropriately long-stay. Only those viewed as being 'inappropriately placed and ready for discharge' were included in this year's data. These positive developments and this project have played an important role in increased awareness of these problems and, in some instances, the resolution of them.

Since the commencement of the project in 2007, many long-term, former-institutionalised patients have been discharged to more appropriate accommodation. Many current long-stay patients in SECU and CCU settings have been there for relatively shorter periods of time than the original cohort of long-stay patients. These successes are in large part due to Community Visitors work in identifying them and OPA's advocacy on their behalf.

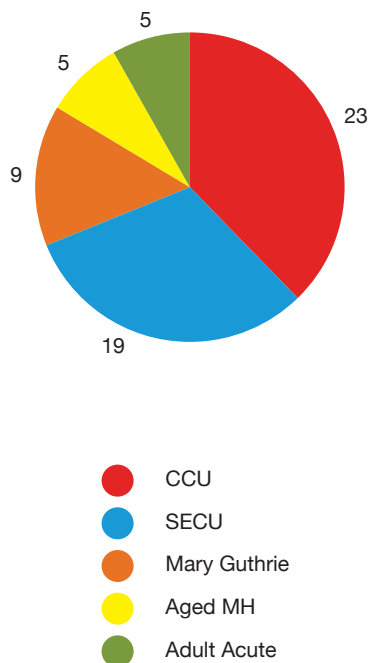


Figure 8. Total number of long stay patients identified by CVs in Mental Health facilities 13/14.

Adult acute inpatient units

Community Visitors identified five patients who had spent between three to nine months in adult acute units.

This figure does not reflect the number of long-stay patients in acute units during the year. It only represents the number of long-stay patients in acute units on the day Community Visitors collected the data.

Of the five patients identified in March and April this year, only one was ready for discharge and awaiting placement. Two patients were not ready for discharge and two other patients had housing or placement difficulties, illustrating that there are a range of factors beyond the services' control resulting in patients spending more than three months in acute care.

Community care units (CCUs)

Community Visitors identified 23 long-stay residents in CCUs, 17 who have been there for between two and three years, four between three and five years and two for 15 years.

Eight residents of the 23 identified were reported to be ready for discharge, six were not ready and, in nine cases, the information was not provided. Of eight residents ready to be discharged, accommodation was reported to be the main barrier.

Many long-stay residents were reported to be receiving other services including Psychiatric Disability Rehabilitation and Support Services (PDRSS) support (seven patients), Intensive Home Based Outreach (IHBOS) funding (four patients) and SECU diversion funding (one patient).

Secure extended care units (SECUs)

Community Visitors identified 19 patients in SECUs, seven who had been there for less than five years. Three patients had been in the SECU for seven years and four patients had been there more than eight years. In five cases, length of stay was not reported.

Similar to the CCU patients above, overall numbers and lengths of stay for long-stay patients in SECUs has decreased since the first comprehensive long-stay report. In the *Community Visitors Annual Report 2007–2008*, 34 long-stay patients were found in SECUs, 20 of whom had been there for between five and twenty years.

These decreases may be due to the introduction of the SECU diversion program and packages which have helped to divert people from SECU units and provide intensive support for recovery in the community.

This year, most patients remaining in SECUs for any length of time have enduring psychoses and are not able to function independently in the community due to risks to self or others. SECUs provide the only non-custodial setting in the system for patients with very complex needs. There is a need to consider alternative non-institutional models for long-stay patients requiring lifetime clinical care in a secure environment.

Mary Guthrie House

Community Visitors identified nine patients in Mary Guthrie House who had been there for between two and 22 years. All these patients have complex needs including mental illness and acquired brain injuries and some patients also have physical disability. Two have Huntington's Disease.

All patients receive packages from the government's Slow to Recover Program and other individualised packages. Two patients self-fund some support and all are identified as needing ongoing 24-hour support. Only two patients (with lengths of stay at six and nine years) are identified as ready for discharge.

While Mary Guthrie House provides specialised support for people with complex needs who require high-level clinical support, Community Visitors are concerned for patients who may spend the remainder of their lives there. Secure, individualised home-like options with the same level of clinical support are a critical gap in the current system.

Aged acute mental health units

Community Visitors were asked to use their discretion to identify long-stay patients in aged acute mental health settings where there are concerns about the suitability of placement. Five patients were identified.

Two patients, aged 83 and 84 years, have been in an aged acute unit for 15 years and seven years respectively but are not judged ready for discharge. One patient, 36, has been in the unit for one year and is waiting for community-based accommodation. Two further patients, aged 76 and 89 years of age, have recently been discharged to community-based accommodation.

Smoking

Most health networks now have non-smoking policies in acute units. Smoking is often a source of dispute, with many patients openly smoking and nurses resenting their policing role. Where patients can smoke in courtyards, other patients complain they do not have fresh air. As visitors bring in cigarettes and lighters, staff at Dandenong Hospital plan to provide lockers at the entrance for visitors to deposit smoking materials before entering.

A smoking exemption has been agreed at Wanyarra Adult Acute Unit in the Hume Region and appropriate interior areas have been designated. Patients are no longer allowed to carry lighters as fixed lighters have been fitted to walls.

The Policy Consumer Advisory Group at Thomas Embling Hospital noted in February 2014 that legal aid will be sought to support a challenge to the non-smoking policy to be introduced in July 2014 if the current exemption is discontinued.

Casey Hospital's Unit E has implemented the no-smoking policy effectively. However, Frankston Hospital does not restrain patients from smoking, accepting they are unwell when admitted, their stay is short-term and the risk of enforcing a smoking ban may exacerbate a patient's condition.

Rehabilitation and recreation opportunities

A persistently reported problem is the boredom of patients and residents in residential mental health facilities. Many patients cannot, or will not, readily engage in board games, quizzes, discussion groups, card games or visits to local places of interest.

Patients often find it difficult to find activities that hold their interest for more than a few moments. Staff are observed offering encouragement, which is pleasing. Many patients, however, appear to want to be left alone. They need meaningful therapeutic activities which increase their self esteem and sense of progressing while unwell.

In several services, including the adult acute units at Monash Medical Centre and aged persons acute unit at Frankston Hospital, structured activities were not operating as scheduled. At Monash Medical Centre in April Community Visitors noted that courtyards, gymnasium, games rooms and equipment were all locked down and patients had nothing to occupy them except television, drinking coffee and smoking.

However, some great initiatives have been reported. A Rebuilding Life Skills Program has started at Broadmeadows CCU. There is an information board for family and friends to view the schedule and residents are encouraged to decorate their rooms.

good practice



At Chestnut Gardens Monash Health aged mental health unit, each bedroom door displays a personalised name, in a foreign language if relevant, together with resident's photographs.

At other facilities, there are gardening, broadband for seniors, cooking, pet therapy, music and art therapy programs. Residents of the Benambra Unit in the Hume Region attend courses at TAFE.

Community Visitors who visit Dandenong Hospital's SECU and the units managed by St Georges Hospital have often commented on the comprehensive activities schedules providing interesting and engaging pursuits for patients. At the Steele Haughton Extended Care Unit for aged persons in Ballarat and the Marjorie Phillips Aged Psychiatric Unit in Bendigo, Community Visitors have noted the use of volunteers in activity programs.

Standard and appropriateness of facilities

Maintenance and cleanliness problems are widespread. The state of the acute adult unit at Monash Medical Centre deteriorated over several months. The courtyard bins required cleaning and bin liners were not available because plastic liners posed a safety hazard for patients. Paper liners are now used and improvement has been noted.

The general standard and appearance of the adult acute unit at Dandenong Hospital (Unit 1) was so poor that 12 patients composed and signed a formal letter to the Ombudsman protesting about the general appearance of the facility and lack of functioning equipment. There was no running hot water in the facility when visited, a washing machine had remained inoperable for over a month and the coffee machine was broken. These matters have since been addressed.

The cleanliness at the Bendigo acute unit was also criticised by patients. This was discussed with the nurse unit manager, who did some cleaning to assist. An additional half-time cleaner was then appointed.

Repairs often take an inordinate period of time, particularly when quotes from contractors are required. The Wanyarra Acute Inpatient Unit at Shepparton has not been painted since 1996. Twelve months passed before Monash Health arranged for replacement of soiled carpets in Chestnut Gardens, a unit for older patients with psycho-neurological disorders; it now has attractive wood-look vinyl flooring. Frankston Hospital has also replaced worn carpets in the common areas with wood-look vinyl flooring while retaining carpets in bedroom corridors and rooms.

Community Visitors at the Bendigo Health acute unit found a patient wrapped in a blanket saying he was freezing. Air-conditioning problems were also reported in the Northern Metropolitan, Southern Metropolitan and Hume regions. Many of these are longstanding issues.

At Dandenong Hospital adult acute unit, patients complain about the tired and unclean condition

of the unit and broken machines for washing clothes and coffee-making. The need to update older buildings has led to some health networks offloading facilities to dispense with maintenance costs. Peninsula Health has announced plans to relinquish two residential facilities to the non-government sector, currently for aged mental health residents and those experiencing advancing neuro-cognitive deficits. Similarly, Alfred Health plans to sell Namarra Nursing Home, a psychogeriatric facility on the Caulfield Hospital site and it is currently subject to an external tender.

At Broadmeadows CCU, 'Talgarno', substantial renovations are underway to restump foundations in three residents' units, replaster and repaint walls, create a new administration wing with interview rooms, offices and tea room. Community Visitors were impressed by the appearance of the Michael Court Hostel, managed by Peninsula Health; new clear signage helps residents find their way around. The facility and all houses were kept suitably air-conditioned during the extreme hot summer weather.

It is apparent that many facilities were not designed for their current use. This is indicated by the difficulties encountered with the retrofitting of gender specific areas, the segregation of smoking and non-smoking areas and the need to lock down all patients in a facility due to the confronting behaviour of one patient. Some new buildings show what can be achieved with thoughtful planning.

A new mental health wing at Dandenong Hospital opened in September 2013. It provides acute services for young people and adults and longer-term services for aged persons and those requiring long-term secure extended care. The bright facility with plenty of open air spaces and purpose-built infrastructure is a testament to innovative design. The Perinatal and Infant Unit at Monash Medical Centre also underwent lengthy renovation and refurbishment to create very attractive surroundings for six mothers and infants. Banksia Ward at the new Royal Children's Hospital also provides an excellent environment for mental health care for young people.

In the Northern Metropolitan Region, a new community rehabilitation facility, jointly managed by the Austin Hospital and Mind Australia, provides additional accommodation and psychosocial rehabilitation for 22 people with long-term mental illness in modern single and two-bedroom units of superb quality. Such options are urgently needed elsewhere.

Two facilities that would benefit from some renovation work are the Monash Medical Centre Acute Inpatient Unit and the Ballarat SECU.



● Barwon-South Western Region

The Barwon-South Western Region encompasses the area from Geelong to the South Australian border. Geelong area mental health services are provided by Barwon Health, with mental health services in the Warrnambool area administered by South West Healthcare.

The services consist of two adult acute inpatient units, one aged persons mental health residential unit, two CCUs, three emergency departments and one PARC. Community Visitors did not visit emergency departments in the region this year.

The number of visits conducted this year has been limited significantly by a shortage of Community Visitors, particularly in the Geelong area. OPA is hoping to rectify this in the coming year.

Treatment and care

Community Visitors spoke to a patient at the Geelong Hospital adult acute inpatient unit who reported bruising on his wrist due to five staff members physically restraining him, by pressing him down and holding his hands behind his back. The patient stated that he was admitted voluntarily to the inpatient unit, and the episode of restraint occurred while he was still a voluntary patient attempting to leave the facility.

Community Visitors asked Barwon Health to clarify why restraint was used when the patient was voluntary; they also wished to highlight a discrepancy in the recording of the incident: while the patient evidently has bruising on his wrists, the records indicated he had been restrained by the top of the arms. The health service responded, indicating that they reviewed the incident and found the patient's mental state had deteriorated rapidly and clinical advice about whether he should remain a voluntary patient or be detained involuntarily was being evaluated at the time of the incident. The health service acknowledged the discrepancy between the record and the observed evidence of bruising and reassurance was given that staff receive training in appropriate restraint techniques. The service is also striving to improve their documentation.

● Eastern Metropolitan Region

Eastern Health and St. Vincent's Hospital (incorporating St. George's Hospital and St. Vincent's Hospital) manage the mental health services visited in the Eastern Metropolitan Region.

The services comprise five adult acute units, two aged acute units, four aged persons mental health units and one adolescent unit, three CCUs and three emergency departments. The statewide specialised personality disorder unit, Spectrum, is also located in the region.

Serious incidents and assaults

There have been a number of violent incidents resulting in considerable damage to furniture and fixtures. One of these was caused by an older youth who had been admitted to the adolescent unit. No other bed had been available at the time. Following such incidents, the facilities have been upgraded but, at St. Vincent's Hospital, the nurses' station is locked for security reasons. New duress alarms have been installed in Normanby House and the Peter James Centre. Bells have been installed above external doors at Riverside House to alert staff of any resident walking outside after dark.

One patient who has a tendency to violence has been admitted to Maroondah Hospital several times this year. His care is complicated and requires a lot of staff time. The family has been closely involved in all decisions and everyone is to be commended on his management.

Patients with dementia illnesses on open wards cause anxiety in other patients because of some acts of aggression and intrusion into bedrooms. At Maroondah Hospital, a mother was extremely worried about her daughter staying in the HDU with a potentially aggressive male. Staff managed to rearrange beds to ensure safety. Other complaints have been about verbal abuse by fellow patients.

Daily assessments of physical and sexual assault risks are carried out in the acute inpatient settings. This includes deciding whether the facility should be locked or not. Every effort has been made to keep doors of acute inpatient units open and Upton House, particularly, is applauded for special efforts in this regard. Efforts to reduce seclusion and restraint have continued to good effect.

Difficulties arising from complicated behavioural issues such as the use of the drug ice have been reported at the emergency department of Box Hill Hospital.

Bed availability

Bed availability has not been a great issue, though the mix of patients at any one time is still a problem resulting in aggression and feelings of unsafety. One woman said that she would feel safer in HDU than in the gender-specific area of the ward.

A man with dual-disabilities was admitted to the Ringwood CCU after a time in Upton House. His management was complex and time-consuming but no other accommodation was available.

Recently, a woman was admitted to Maroondah Hospital far from her own home as there were no beds at Werribee, while a new mother was admitted to St. Vincent's Hospital and was separated from her baby. In both instances, staff tried to alter the situation but some time elapsed before the issues were resolved. An increase in the number of people under 65 years of age being admitted to Mooroolbark aged mental health facility has been noted.

Treatment and care

New electronic 'journey boards' are being installed in all adult acute units. These will help trace all services involved in a patient's treatment.

There have been numerous complaints about treatment received, regarding either medication or ECT. These are because of the concerns regarding side effects or the person's own perception of the best medication for them and may be exacerbated by an involuntary status.

Some concerns have been about treatment of simultaneous multiple conditions and the interaction of various drug therapies. Other complaints have been about low accessibility to treating doctors or a desire to change doctors. There have also been concerns expressed regarding a preference for transfer to other hospitals for treatment.

In the residential units, there have been visits by dentists, optometrists, physiotherapists and pastoral care workers; all appreciated by patients and residents. There was also a pharmaceutical review of all medication at Mooroolbark. At Normanby House, there has been an effort to provide a greater choice of food for patients.

During the year, there have been difficulties in filling the role of manager at the aged mental health facilities. It has been good to see the appointment of carer consultants in both the aged and youth areas.

Legal rights and information provision

There is usually a good range of information regarding medication, post-traumatic stress and help to find accommodation available.

In the gender-specific areas, information is available to meet client needs. At Maroondah Hospital volunteers maintain the information boards. A patient rights booklet is routinely given out on admission, though these have needed to be printed locally.

Despite this, Community Visitors often hear concerns expressed by patients wishing to know the process for applying for a MHRB hearing, in obtaining a second opinion or querying their involuntary status. One person was concerned about powers of attorney and was requesting to see a lawyer. Another did not understand the reasons for his admission, having been brought in by the police.

Information regarding carer and resident meetings is kept up-to-date and on display in the residential units. Some of the notices in the residential units could be printed more clearly for the older residents.

At Maroondah Hospital, new surveys have been carried out on patient experiences. The results have been largely positive and have echoed comments posted on feedback boards in the wards. Self-assessment of risk has been introduced by Eastern Health.

Discharge issues

The problem of finding suitable accommodation after discharge remains for many patients. Community Visitors often recommend that the patient seek the help of a social worker. Places in aged-care nursing homes can require considerable time to become available.

Rehabilitation and recreation opportunities

There have been some great initiatives in providing activities in all settings this year.

Broadband for seniors has been introduced at Riverside House and iPods are being trialled in the HDU at Upton House and at Mooroolbark. Riverside House, Auburn House and Normanby House, all aged

mental health facilities, have introduced behavioural management training for staff, in conjunction with new equipment, to assist those residents with dementia. The Northside aged mental health facility now has a garden area that is being used much more frequently than in the past. The activity program as a whole is being reviewed to provide more interesting activities to residents. A paid carer is being sought to take one person on outings. Auburn House is also providing more outings to suit individuals or groups. Bus trips are included in the program for Mooroolbark.

At Footbridge CCU, individually designed programs can include driving lessons. At St. Vincent's, 28 different programs are run each week including pet therapy, and there is an artist in residence. At Maroondah Hospital, sessions providing help and discussion on drug and alcohol issues and new programs are being run daily in the HDU. In the adolescent unit, the creation of a cooking program and the new emphasis on growing vegetables and herbs is applauded.

There have been difficulties in accessing the gym facilities at Box Hill Hospital. Some time is allocated for both Upton House and the adolescent unit. At the Ringwood CCU, there have been continual problems in using the computer in the common room as it is often out of order.

Rooms or trolleys with sensory equipment and sensory gardens are being used widely to good effect in calming difficult behaviours. While activities over the weekend are limited, some staff try to provide ideas for patients to use in their own time.

Standard and appropriateness of facilities

Over the very hot summer, deficiencies in cooling systems were noted and reviewed in all facilities.

At Footbridge CCU, the electricity supply is at present insufficient to allow for planned installation of air-conditioners. Due to safety factors, shower hoses at the Peter James Centre are removed during the day. This is very inconvenient and demeaning for patients wishing to shower at other times and needing to ask for assistance.

Access to courtyards at Upton House has been limited due to locked doors but access to gardens has improved in the adolescent unit. Shade cloths have been installed to make these areas more comfortable.

Renovations have taken place over the entire region. A carers' room at the Peter James Centre

is welcome. The Behavioural Assessment Room at St. Vincent's emergency department has been renovated to make it more attractive. Extensions to the walls of HDU at Maroondah are completed and they look good.

Maintenance

In all CCUs, there have been commercial cleaners employed to clean on a scheduled basis. A constant concern of the Community Visitors is the amount of cigarette butts littering the area, making for a very dirty environment, despite the existence of designated smoking areas. Exhaust fans at the Canterbury CCU need to be installed.

Repairs and maintenance of furniture is an ongoing problem because of high activity in each area. The HDU areas at St. Vincent's Hospital are in need of renovation. This is mostly because of the age and unsuitability of the facility. New furniture has been ordered to replace worn items in all facilities. Small repairs, or those needing quotes from contractors, can take a long time to complete.

Service-provider responsiveness

The service providers in the region have been extremely helpful in all their dealings with Community Visitors. All staff have been consistently helpful and courteous. Community Visitors have been impressed with the enthusiasm that has gone into planning new initiatives that will expand client access to improved programs.



One woman in the Northside aged mental health facility had been nursed almost continually in a tub chair and, because of her very noisy behaviour, was isolated from the other residents.

Though she appeared to be asleep at other times of the day, the Community Visitors encouraged staff to include her in all activities if possible. Changes to medication and management regimes have seen her progress considerably. Volunteers engage her in hand therapy and sensory activities and staff have lowered her bed and chair so that she is now able to move safely and independently from one to the other.

While still largely unresponsive to most of what is happening around her, her progress has been most impressive.

Gippsland Region

The Latrobe Regional Hospital manages the mental health services in the Gippsland Region. Community Visitors visit one adult inpatient unit which includes two dedicated adolescent beds, one SECU, one aged persons inpatient unit, one CCU and one emergency department.

Serious incidents

Community Visitors reported that a young man had committed suicide in the SECU courtyard following return from leave in a depressed state. A hanging point was subsequently removed.

Bed availability

Latrobe Regional Hospital reports the occupancy rate for the year to date is 98 per cent. Community Visitors question whether 26 acute inpatient beds for the region is sufficient and believe that sometimes patients are discharged earlier than they should because there are not enough beds to meet demand.

Legal rights and information provision

A long-term patient in the CCU received a recommendation from the MHRB that her future accommodation options be determined by her treating doctor. It took some months to resolve this issue.

Rehabilitation and recreational opportunities

A lack of educational and recreational opportunities was highlighted in last year's report. This issue has begun to be addressed in recent months since the appointment of a new occupational therapist.

Standard and appropriateness of facilities

The standard of the facilities is appropriate and Community Visitors were pleased to see the completion of a women's-only corridor during the year. Construction of a four-bed HDU and a mother and baby unit should be completed in September 2014.

Maintenance

Generally maintenance of the various units has been good, however, continual requests for the

replacement of torn furniture in the acute lounge and the removal of graffiti from the acute courtyard have not been successful.

Service-provider responsiveness

Community Visitors have been greeted pleasantly on each visit and quarterly liaison meetings with management have been well-attended and useful.

Grampians Region

Ballarat Health Services provides facilities and support to those requiring mental health assistance in the Grampians Region. Two nursing homes visited in Stawell and Nhill each have six funded beds for aged mental health patients.

There are six facilities in Ballarat; two acute inpatient units (one for adults and another for aged persons), one aged residential unit, a SECU, and a CCU. Visits are also made to the emergency department.

Ninety visits have been undertaken by six Community Visitors this year. The recent loss of two Community Visitors in the Wimmera has reduced the number of Community Visitors to four across the region.

OPA Advice Service

There were six requested visits by patients in the Ballarat adult acute unit and these have been responded to within twenty-four hours.

Little information is passed on to Community Visitors verbally at the time of routine visits regarding incidents and assaults. Statistical reports are provided, but these can be after patients have been discharged, when it is too late to follow up or access files.

Due to the possibility of patients absconding, the adult acute unit and the aged acute unit have been locked at times, preventing free movement and access to the external courtyard, as staffing does not allow for one-on-one observation.

A reduction in the use of seclusion has been noticeable with the use of the Psychiatric Intensive Care Area (HDU) increasing. When there was only one patient in this area, who was unable to leave due to locked external doors, Community Visitors questioned whether this could be considered seclusion, however, staff did not agree.

Appropriateness of facilities and recreational opportunities

The majority of facilities are well-maintained and resourced with adequate staffing and activities. In particular, the Steele Haughton Aged Residential Unit has a wide variety of outings and programs, the residents enjoying participation and the opportunity to talk with the volunteers who assist.

Over a long period, Community Visitors have indicated the need for an upgrade in the SECU and believe this unit is not conducive to recovery and wellness. As patients remain in this unit for prolonged periods, a more homely environment would augur well in meeting the human rights of the patients and assisting with their recovery.

There are particular concerns for the female residents in this predominantly male unit. Only one to three women are ever in the unit, and they have indicated feeling insecure. This is particularly the case at night when they are unable to lock bedroom doors. Nor is there any gender-sensitive area or lounge they can retreat to in the daytime.

A sensory room is being established in one of the bedrooms to assist patients with relaxation, and some individual time may be provided in the room when staff are able to provide support. Staff indicate that submissions for upgrade funding have not been successful and another funding submission is pending.

Over the years, Community Visitors have noted reduced occupancy of funded aged mental health beds at the Macpherson Smith Nursing Home in Stawell. A similar facility in Nhill rarely has a vacancy. Both facilities provide appropriate programs for the aged.

Service-provider responsiveness

Most issues raised are responded to or resolved at unit level.

Community Visitors are well-received and supported. Regular quarterly meetings are held with senior management and the opportunity is given for Community Visitors to raise any unresolved issues, queries or concerns. These meetings are informative, and assist in maintaining a positive rapport between Community Visitors and management.

Hume region

Mental health services are managed by Goulburn Valley Health, and North East and Border Mental Health Service. There are two adult acute units, two aged acute inpatient units, two aged residential units, two CCUs and two emergency departments.

Serious incidents and assaults

There were seven incidents involving violence and aggression within mental health services in the Hume Region. A staff member at the adult acute unit in Wangaratta suffered bruising in the rib area after attempting to restrain a patient.

In March 2014, Community Visitors were provided with timely information about the circumstances surrounding a female patient who absconded from the acute unit in Wangaratta and committed suicide on a local train line.

In January 2014, Community Visitors reported that the Shepparton acute unit managed by Goulburn Valley Health had sustained significant damage to the HDU area by a patient. Police were involved.

In April 2014, Community Visitors recorded that a patient absconded from the HDU in the Shepparton acute unit via the roof. Police retrieved the patient. Later the patient absconded in the same manner. The roof guttering has since been modified, preventing any further incidents.

Bed availability

In September 2013, Community Visitors reported there were two beds lost to the region after the closure of the Rosewood aged mental health unit and transfer of patients to the Wanyarra unit in Shepparton. These beds have since been reinstated.

Treatment and care

In November 2013, Community Visitors were advised that the Kerferd adult acute inpatient unit in Wangaratta was unable to comply with seclusion requirements on one occasion as the medical officer was unavailable due to emergency department demands. The service has ensured that this situation will not reoccur. After-hours telephone triage is now conducted by an outsourced agency.

The Wanyarra units at Shepparton are usually locked. Community Visitors also noted 'locked' fire doors at the facility in September 2013. Management subsequently advised that these doors unlock and open in an emergency.

A recent exemption to a no smoking policy at the Wanyarra unit in Shepparton is in part a result of Community Visitor reporting on behalf of patients.

Legal rights and information provision

Community Visitors reported difficulties accessing incident reports at the Wanyarra units on five occasions between September 2013 and May 2014. Since May, the Wanyarra Unit has provided a summary of incidents and has been willing to discuss matters with Community Visitors.

Discharge issues

Community Visitors reported concerns regarding delayed discharge from acute inpatient units, due to a lack of available supported accommodation.

Rehabilitation and recreation opportunities

Patients regularly complain about a lack of appropriate activities, so they appreciate activities when they are provided. There has been a marked improvement in recreational activities at some units in the region this year.

Community Visitors noted that two residents at the Benambra CCU were undertaking truck-driver training and food preparation training at a local TAFE. A sensory room and holidays, outings, walking, singing and music programs at other facilities have been noted.

Standard and appropriateness of facilities

Community Visitors reported that the facility and gardens at Blackwood Cottage, Grutzner House, and the Kerferd Unit looked homely and calming. The exceptional gardens at the Kerferd Unit are the work of a volunteer gardener.

Maintenance

Community Visitors reported that maintenance of some mental health facilities across the region remains poor. Carpets need replacing at the Kerferd acute unit in Wangaratta. The Wanyarra

units have not been painted since 1996, and the laundry at Grutzner House, the aged persons unit in Shepparton, needs upgrading.

The Willows CCU in Beechworth is undergoing major maintenance upgrades.

Service-provider responsiveness

Service providers and Community Visitors have met quarterly. This has provided a useful opportunity to raise issues and discuss funding submissions providers have made to improve units and patient safety. Goulburn Valley Health managers have advised that \$250,000 is available for upgrading facilities though new capital works are dependent on additional funding.

Loddon Mallee Region

Loddon Mallee Region mental health services are provided by Bendigo Health and Ramsey Health for two acute adult inpatient units, one aged persons acute inpatient unit, one aged persons residential unit, one CCU, one SECU and two emergency departments. Limited visits have occurred in Mildura because of a shortage of Community Visitors.

Serious incidents and assault

A female patient self-harmed with a razor blade on the open ward of the Bendigo acute unit following her admission via emergency department and HDU. Community Visitors were told her belongings were not thoroughly checked during the admission process.

A patient at the Bendigo acute unit told Community Visitors he wanted it known that, during a previous admission, he awoke following him being medicated to find he had an anal injury. He thought he had been raped while in the seclusion room. The unit manager advised that, although the patient had not made a formal complaint, the matter would be investigated.

After a further three months and several requests for clarification, it was confirmed to Community Visitors that the patient had, in fact, complained to his doctor and again 12 days later, to a nurse. No action was taken. The service said he had been assessed as delusional, there were significant discrepancies in his report and they concluded an assault had not taken place.



A female patient, 18, diagnosed with bipolar disorder and vulnerable in the inpatient setting, was admitted to the men's section of the Bendigo acute unit. She complained a male patient had taken sexual advantage of her as she was unable to make an informed decision.

Both patients were counselled by staff, and pregnancy and STD tests were negative.

At a later admission, she was again accommodated in the men's section. Staff were unaware of what had occurred at her last admission. The patient told Community Visitors she was scared and needed a room in the female section. Following Community Visitor advocacy, she was transferred.

The patient's mother had telephoned to complain about her daughter's placement in a male section following the initial serious incident, but it was five days before she was contacted by the unit manager. A written response took seven months.

Patient's files are now available to after-hours staff to facilitate communication of a patient's needs.

Another patient at the Bendigo acute unit said he felt unsafe when followed by a patient who was exposing himself. He said staff advised him to ignore it. Staff initially maintained the incident had not occurred but, at a later date, Community Visitors learned the second patient was volatile and he had removed his clothing.

Concerns of Community Visitors persist that the hospital sexual assault policy may not have been followed at the time of the complaint so patients may have been subject to unnecessary risk.

A patient claimed her clavicle was injured in a fall when pushed by another patient. The incident was witnessed by three other patients. The injured patient requested an incident report form, but did not receive one and was annoyed at how staff mishandled the matter.

In October 2013, a patient was hit by a vehicle after absconding over the fence of the Bendigo acute unit. Following a similar incident last year, the fence height was to be increased but delays occurred for several reasons, including the need to incorporate sails to ensure patient privacy from a new hotel next door.

Works commenced in May 2014 but a patient absconded over the temporary fence despite the

presence of a security guard. The unit manager contacted the security company and the security guard was removed.

Community Visitors are concerned about the number of incidents of patients absconding from the Bendigo Health acute unit. The number provided by Bendigo Health last year was 39, however, 67 were reported at a meeting between the hospital CEO and managers, the Acting Public Advocate and a Community Visitor.

Community Visitors are worried about health and safety issues of patients who have left the protection of the facility. Bendigo Health is reviewing their absconding policy to include clearer definitions and requirements for reporting in the Victorian Incident Health Management System (VIHMS).

Bed availability

Bendigo Health's first quarter performance in moving patients from the emergency department to an inpatient bed was only 52 per cent within eight hours, even though processes start well before 20 hours to ensure all bed options are identified.

More recently, Community Visitors have seen some improvement.

From July to November 2013, six patients remained in the emergency department for over 24 hours before being transferred and 33 patients waited over 20 hours. One patient waited over 23 hours in the emergency department and a further two hours in the Bendigo Adult Acute Unit for a room.

Bed shortages impact on gender specific needs. On one occasion, a staff member stated a male patient was relocated at night to allow a female patient to access the room which had an ensuite. It was reported to Community Visitors that the admissions/discharge co-ordinator felt under pressure to discharge patients early.

Lack of appropriate accommodation close to family resulted in one patient remaining in the aged persons adult acute unit for six months, still awaiting transfer to a residential unit in Melbourne.

Treatment and care

In Bendigo, staff advised Community Visitors that nursing shifts are commonly short-staffed. One patient was accommodated in the HDU of the adult acute unit as there was no 'special' nurse available to monitor him on the general ward.

Three long-stay patients, one in the aged adult residential unit, one in the SECU and one in the CCU, are still waiting for suitable accommodation. An agency worker for the homeless now attends clinical handover twice weekly at Bendigo health adult acute unit to identify housing needs at the earliest opportunity.

Written treatment plans are still not always provided in a timely manner. Patients in the adult acute unit have waited more than three weeks to receive a plan. One manager advised the timely provision of plans would be reviewed as a quality improvement measure.

There is a lack of community-based options for people in Mildura. There is no SECU, CCU or SRS in Mildura, however, funding for a new PARC has been allocated. There is also a shortage of emergency and transitional housing and few low cost supported accommodation options other than SRS in Bendigo.

The Bendigo adult acute unit seclusion rate of 34.4 per cent (first quarter) was the highest in the state, possibly related to a high number of drug and alcohol presentations (including for the drug 'ice'). There is an urgent need for a specialist detoxification unit in Bendigo. It is commendable that seclusion rates have reduced significantly in the last two quarters.

Patients and families were generally happy with good care at the aged mental health residential unit in Bendigo and a patient said very good service was provided at the Bendigo acute unit.

Legal rights and information provision

Since May 2014, a lawyer from Victoria Legal Aid has visited Bendigo mental health units weekly, offering free legal advice which is very good practice.

Bendigo Health senior management remains reluctant to allow Community Visitors to view incident reports on the VHIMS, despite written patient consent. Access to incident reports by Community Visitors in these circumstances is clearly supported by legislation and management is aware that Community Visitors are required to adhere strictly to privacy and secrecy provisions.

Rehabilitation and recreation opportunities

Limited provision of interesting and meaningful programs at the aged persons acute unit is an ongoing issue. Funding for a trained activities officer has been sought by the unit manager.

Standard and appropriateness of facilities

Poor maintenance of the fittings and environment, subjects patients to low standards of care and high levels of discomfort. The air-conditioner at the Bendigo adult acute unit does not adequately cool or heat bedrooms, as zoning was incorrectly designed and installed (reported since 2005).

The courtyard at the Bendigo adult acute unit remains unclean, with badly stained tiles often strewn with rubbish and no bin provided. Wall-mounted ashtrays have been installed. Carpets in the open ward are very stained as hospital cleaning equipment is inadequate.

The Mildura adult acute unit was upgraded creating a female wing with four bedrooms and ensuites.

Service-provider responsiveness

A new manager for the Bendigo acute unit was appointed in January 2014. She is very responsive to issues raised by Community Visitors and a calmer unit atmosphere has been noted.

At the same unit, two new nurses (to fill vacant positions) and 0.5 FTE cleaning staff were appointed following patient and staff complaints about limited time for patient and staff interaction. Since these measures, some patients have stated they receive "very good service". Conversely, three staff complained some shifts were understaffed at the aged residential unit. Further improvement measures are being undertaken.

North and West Metropolitan Region (North)

The region covers 22 specialist units.

Austin Health provides an emergency department, and Community Recovery Program (CRP), mother-baby, adult acute, SECU, child and adolescent, brain disorder, and veterans post traumatic stress disorder units.

Northern Area Mental Health Service (NAMHS) manages a CCU and two adult acute units in the Northern Hospital with oversight of four mental health beds in the emergency department.

North West Mental Health Service (NWMHS) manages two aged persons units: a residential unit and an acute unit.

Forensicare manages Thomas Embling Hospital, a seven-unit forensic mental health hospital.

Alleged sexual assaults at Northern Psychiatric Unit

Community Visitors were approached in December 2013 by a female patient who alleged she had been sexually assaulted by another patient in the Northern Psychiatric Unit (NPU) in 2007. The allegation had not been previously made to NPU staff or police.

The time delay in reporting the matter made it difficult to establish the relevant circumstances, although an investigation was undertaken. The patient was discharged prior to resolution of the matter. Follow up discussions between OPA and NPU resulted in contact with the patient's case manager to assist with her care. NAMHS subsequently reviewed and revised its protocols.

In April 2014, a sexual encounter took place between a male and female patient in the male's room at the same facility. This matter is discussed in the statewide report.

Bed availability

A 22-bed unit, the Austin Community Recovery Program, is a partnership between Austin Hospital and MIND Australia which opened in April 2014.

It provides 24-hour support and allows residents a stay up to two years. It has four double and 14 single beautifully established apartments that set a new benchmark in mental health accommodation. Support staff include a consultant psychiatrist and psychiatric registrar.

Treatment and care

Austin Hospital and its mental health units passed national accreditation under the National Registration Accreditation Scheme and provided the report to Community Visitors.

NPU recently introduced secure corridors and women only lounges in each unit. This has redressed a long-standing need and will contribute to the sense of security of the female patients.

Comments from patients about medication and second opinions have been many and varied. Each hospital has always responded promptly, reviewing medication, providing counselling and advice or arranging a second opinion.

good practice



The use of seclusion and restraint is generally decreasing. NPU implemented a 'refresh' approach to reducing episodes of seclusion.

Contributing factors were remarkably simple: they included discussion and review of seclusion episodes at nursing practice meetings and highly visible boards in the nursing station showing the number of days since the last seclusion episode.

Austin Psychiatric Unit seclusion episodes are consistent with the previous year's lower trend. The Brain Disorder Unit is considering converting their largely unused seclusion room to a sensory modulation room.

Legal rights and information provision

All units provide relevant information on recovery and treatment, program activities, patient rights, complaints procedures, contact numbers for Victoria Legal Aid, the Community Visitors Program and other advocacy and support organisations.

case study

During the year, an ABC TV broadcast was highly critical of alleged restraint practices in the Austin Child and Adolescent Mental Health Service featuring serious complaints by a parent about their child when they were a patient. Community Visitors were subsequently approached by some parents of children treated in the unit who condemned the TV report as inaccurate and misleading. These parents wrote a letter of protest to the ABC.

The service reviewed their seclusion and restraint practices and implemented reporting standards consistent with other units.

Community Visitors visiting the service consistently report praise of the unit by parents of children receiving treatment.

Service-provider responsiveness

Forensicare, Austin Health and NAMHS all participate in quarterly meetings with Community Visitors. The meetings are attended by senior operations and clinical staff, address issues raised and direct appropriate follow-up action. All services provide strong support to the Community Visitors Program.



Northern Hospital has continued to operate the Police, Ambulance and Clinical Early Response (PACER) project, though on a single weekly shift.

The PACER team provides a combined trained police and mental health nursing team response to critical incidents called in by police units.

Appropriate responses to mentally ill offenders are resulting in markedly reduced presentations to overworked emergency departments, direct admission to acute units and, in some cases, enabling a mentally ill person to avoid admission.

The Health Minister Health, David Davis, recently announced a \$15.1 million investment in the statewide deployment of PACER-like schemes.

Thomas Embling Hospital (statewide service)

The Victorian Institute of Forensic Mental Health, Forensicare, is a statutory authority responsible for the provision of adult forensic mental health services in Victoria.

Forensicare manages the Thomas Embling Hospital, providing 116 acute and continuing-care beds.

The average length of stay for a forensic patient is six to eight years and some patients remain in care for over 20 years.

Serious incidents and assaults

The recommendations arising from deaths at the unit in 2009, 2012 and 2013, are being progressively implemented by Thomas Embling Hospital.

A High Risk Assessment Panel, comprising senior clinical and management staff, a consultant psychiatrist, physical response team, and the Melbourne Assessment Prison consultant psychiatrist, now assess all prisoner transfers-in before their arrival.

This facilitates an assessment of staff capacity to safely manage their treatment. A detailed Ligature (Hanging) Point Review has been completed,

shift-handover protocols strengthened and patient observation practices improved.

Motion sensors for patient corridor observation during late hours are under review.

Barossa Unit low sensory room

Government funding of \$234,000 was allocated towards increasing women's safety. A low sensory room was created from a seclusion room to provide a low stimuli option for patients with growing agitation which may reduce aggression following a seclusion episode.

Treatment and care

Recovery and independence are fostered as treatment progresses. Patients move from receiving fully catered meals, to the independence of shopping and preparing meals. In the final stages of their treatment, patients can undertake part-time employment in preparation for discharge.

A no-smoking regime will be introduced from 1 July 2015. Management acknowledges this change will not be easy for smokers, staff and non-smokers in the current environment.

A new family visitor room has been established in the main campus for those visitors with children under 16 years old. The room is cheerful and comfortable with toys, tea and coffee-making facilities, a baby-change table and a toilet.

A Family and Friends Support Group meets monthly with the help of the staff, family and carer advocates. Forensic treatment extending over many years presents special challenges to families and carers. This group is a valuable component of the outreach program, assisting patients' progress.

Legal rights and information provision

In collaboration with support and advocacy organisations, the hospital provides information about patient rights, complaints procedures, recovery and treatment through notice boards, brochures, and briefings to patients and families.

Rehabilitation and recreation opportunities

A Consumer Advisory Group (CAG) meets monthly and includes social workers, management staff and elected patient representatives. The CAG

addresses patient concerns and directs questions to staff and contracted service providers such as the catering manager. Patients have actively participated in project teams reviewing models of care and recovery.

Service-provider responsiveness

Forensicare provides strong support and follow-up to issues raised by Community Visitors. Open communication, supported by staff and directed at developing patient independence and self-governance, has resulted in a greater sense of patient empowerment, assisting recovery.

A service charge for forensic patients was introduced in July 2012. A litigant from the patient group, with legal aid assistance, challenged the service charge at VCAT. Thomas Embling management decided to cancel the charge before the VCAT hearing and refunded all monies to patients.

North and West Metropolitan Region (West)

North West Mental Health Service, Inner West Mental Health Service, Mid-West Mental Health Service, Orygen Youth Services, Mercy Health Services and the Royal Children's Hospital manage mental health services in this region.

These services consist of four adult acute inpatient units, two aged acute inpatient units, three aged persons mental health residential units, one adult rehabilitation unit, four CCUs, one eating disorders and neuropsychiatric unit, one mother-baby unit, two adolescent units and three emergency departments.

Serious incidents and assaults

Community Visitors are sometimes alerted to assaults or incidents of aggression during their visits. Community Visitors may ask how such incidents are documented, and, in the case of serious incidents, whether they have been referred to police for investigation. They may also query what strategies are in place to reduce or prevent these incidents reoccurring.

While the health service may provide responses, often Community Visitors are limited in their capacity to follow-up with patients, as they may have been discharged or have limited recall of incidents. Access to incident reports is therefore critical to Community Visitors.



At the Werribee Mercy adult acute inpatient unit, two staff conducted an inspection of a bedroom as they believed a patient was smoking.

When staff removed a lighter from the patient, the confrontation escalated, and one of the staff members (an agency nurse) physically assaulted the patient, punching him in the head while holding a torch.

Community Visitors escalated the matter to their coordinator, who contacted the mental health service's program director to clarify the service's response.

The program director outlined the assessment and debriefing of the patient immediately after the incident. He also confirmed that the nurse's employment at the health service was terminated immediately, and the nursing agency informed that he was not to be sent to the health service in the future.

The incident was also referred to police for investigation. Community Visitors are still concerned that this nurse may be working in the mental health system at a different facility.

Excessive use of restraint is another issue of concern.

A patient at the Werribee Mercy Hospital complained of being manhandled when she asked for a cigarette, resulting in bruising. She also stated that she was shackled, and not allowed to use the toilet. At Orygen, another patient said she was handled very roughly by three security guards when being restrained, leaving bruises on her arms.

Following the report of an incident at Sunshine adult acute inpatient unit, Community Visitors queried the recording of incidents of aggression, and the strategies in place to deal with these incidents. This occurred after feedback from a patient that such incidents happened frequently but heavy workloads prevented staff from adequately responding.

In August 2013, Community Visitors spoke to a patient in the Sunshine adult rehabilitation unit who presented with red marks on his face and appeared to be in pain while moving around. He alleged he had been assaulted by two other patients and a staff member. The patient wanted the perpetrators charged. Community Visitors reported the matter

and queried whether it had been investigated. The service stated that the patient had a history of being delusional, abusive, threatening and aggressive and the unit is a locked unit treating complex, high needs and severely ill people.

Bed availability

Bed availability remains an issue in the region. This is indicated by the experiences of several patients waiting in emergency departments for acute beds for longer than 10 hours. This is certainly beyond the specified Federal Government target of four hours to treat patients and move them on.

In July 2013, Community Visitors recorded a patient being in the emergency department at Werribee Mercy Hospital for approximately 48 hours. At Sunshine, in November 2013, one patient was noted as having been in emergency for 18 hours, and in February 2014, two patients waited 16.5 and 19.3 hours, respectively.

Treatment and care

Staff in mental health services work in demanding roles; dealing with complex issues, heavy workloads and limited resources. Community Visitors enquire into how these pressures impact on the treatment and care of patients and residents. Patient concerns often relate specifically to mental health treatment, for instance, concerns about medication and the use of ECT.

While Community Visitors are not able to advocate on behalf of patients at MHRB reviews, they have a role in flagging issues with staff, as well as clarifying patients' rights.

Occasionally, patients complain to Community Visitors about the attitude or behaviour of staff towards them. Staff complain they are understaffed and the ratio of patients to staff is too high. However, Community Visitors also often report patients being happy with their surroundings and treatment, and they observe staff interacting well with patients at some services.

Several patients raised issues related to missing belongings. One patient had put her phone in trust, and later, after using it, claimed it was missing. Another patient reported that money being held in an office at the facility on their behalf had gone missing. Community Visitors asked to see an incident report and were refused. Two patients also raised issues about missing clothes. One resident at an aged mental health service said a suit she

wore to a wedding had gone missing and nobody was interested in finding it.

At another health service, a patient claimed a second patient had taken her spare clothes and staff had done nothing about it. Staff claimed that this patient often swapped clothes with another patient and they could then not remember who owned what. One patient also raised an issue about missing jewellery.

Discharge issues

Patients often talk to Community Visitors about their desire to go home and uncertainty in regard to discharge plans.

A patient was originally taken to St. Vincent's Hospital and put into HDU for her own safety. She was then transferred to the Royal Melbourne Hospital adult acute inpatient unit. She asked Community Visitors when she would be allowed to go home. The doctors stated that her placement would be reviewed in six days.

Community Visitors wonder if patients' mental health is being compromised when hospitals have a policy of discharging two patients a day.

One resident has been in a CCU for nine months and, although he is ready for discharge and can do his own cooking, finding appropriate housing for him is very difficult.

One nurse unit manager stated that they had been successful in finding accommodation for a long-stay patient with a discharge date set for the middle of December. A transition plan was developed with his mother and independent guardian to slowly allow him to become familiar and comfortable with his new environment.

It is the understanding of Community Visitors that, if a client is absent from public housing accommodation for more than six months, then that accommodation will no longer be available to them. Pressure is, therefore, on CCU staff to return clients to their homes, possibly before they are fully ready. Clients who lose their public housing could then be placed lower down on the public housing waiting list causing the CCU to house them for months after they are ready to live in their own home.

Rehabilitation and recreation opportunities

Patients frequently complain of boredom. In some facilities there are limited activities such as large

jigsaws. In others, there are a variety of activities such as music groups, gardening, walking, art, and cooking programs.

One patient told Community Visitors she would like to have more help with developing life skills. Other patients would also like counselling as part of their rehabilitation.

Residents at an aged care mental health facility were worried because the regular driver of the bus had been replaced. They believed her replacement was driving on a provisional licence and was not legally allowed to drive the bus. The patients wanted to know if anyone had been out in the bus since the original driver had left and what arrangements were being made to use the bus for residents. Community Visitors enquired into this matter, ascertained that all legal requirements were being met and the matter was closed.

good practice



As part of efforts to alleviate patient boredom in the Specialist Eating Disorders Unit at the Royal Melbourne Hospital, the volunteer coordinator told patients about movies that could be borrowed from the private collections of some nurses. A large number of DVDs are also now available.

The unit coordinator and manager have arranged for a hospital volunteer to visit the ward on Wednesdays to teach knitting, and for visits by Delta Society therapy dogs which seem to be a firm favourite with patients.

Donated books are also available in the unit. A further idea discussed between the volunteers and the unit manager is for the volunteers to take patients down to the hospital coffee shop, as patients can only do this when accompanied.

Difficulties arise when a patient is from the country, interstate or has both parents working. The volunteers engaged in this activity would have to be in possession of a Working with Children Check to accommodate young patients wishing to visit the coffee shop. Volunteers would also require some sort of basic training in the management of patients they may be escorting to ensure patient safety and compliance with treatment plans.

Maintenance

Maintenance problems often seem to take a long time to fix. This year, problems have included holes in the wall, a broken toilet, a television in need of repair, and filthy chairs. One bathroom required a ventilator, exhaust fan or window. This has been fixed.

In October 2013, the wire security door at a CCU was damaged so it could not close properly. The nurse unit manager submitted a request to the maintenance department for a replacement door. After a period of time, and the Christmas break, the maintenance department was asked if any progress had been made. Maintenance said they did not have a request for a new security door and, despite a vigorous search, no record of the request could be found. The request was resubmitted in March 2014 and Community Visitors noted, during their May visit, that the door had been replaced and was functioning well.

In February 2014, Community Visitors noted the air-conditioner at one HDU had been running too cold for at least two months. In March 2014, the nurse unit manager told the Community Visitor Regional Convenor that, since December, there had been no action on three requests to engineering for maintenance.

Community Visitors will try to ensure action before next summer.

Aged mental health service closure

Located in Ascot Vale Road and built in the 1980s, the Weighbridge aged mental health facility was beginning to show its age.

As internal ramps connecting clusters of bedrooms to the main building were becoming “springy” and mal-aligned, major works to improve access were commenced. Unfortunately, as the lower timbers of the building were unearthed, massive damage caused by termites was discovered. The estimated costs to remedy the situation escalated dramatically, and the only viable course of action was to abandon the works and close the facility.

Interviews were arranged with each of the 30 residents and a psychiatrist, carers, family members and guardians as appropriate. This enabled the best possible transition for the patients, with many being placed in mainstream facilities and a smaller number being placed in other residential aged care facilities. No-one was discharged to their family home.

While patients appear to have been relocated to suitable facilities, Community Visitors are disappointed in the loss of a substantial number of public mental health beds to the region.

Service-provider responsiveness

Many facilities do not respond in a timely manner, if at all, to written requests for information in Community Visitor visit reports.

Unfortunately, regular liaison meetings were not held in 2014 because of changes in service managers and Community Visitor ill health. Community Visitors hope to resurrect these meetings in the next reporting year.

Southern Metropolitan Region

Mental health services are governed by Alfred Health, Monash Health and Peninsula Health.

The services provide seven acute adult inpatient units, four acute aged inpatient units, four aged residential units, four CCUs, two SECUs, two adolescent inpatient units, one perinatal and infant inpatient unit and one eating disorders inpatient unit.

Serious incidents and assaults

Physical assaults and verbal abuse have occurred between patients and between patients and staff. Altercations may not result in actual physical injuries but patients have reported feeling fearful and unsafe around an aggressive fellow patient. Some incidents have resulted in physical harm to staff as well as emotional stress and psychological after-effects resulting in staff absenteeism.

Bed availability

The pressure for beds in all acute mental health facilities has been considerable throughout the year.

The adolescent mental health unit (Stepping Stones) at the Monash Medical Centre identified a marked increase in young people admitted with concomitant serious social issues and family dysfunction related to alcohol and other drug abuse.

At the Monash Medical Centre in February, a female patient remained in the emergency department for

over 17 hours from 6pm to midday the next day, waiting for an adult unit bed.

The patient was allegedly refused attention from a hospital doctor during the previous night as she was affected by drugs and was vomiting. The patient's husband was extremely critical of his wife's medical management, stating they were not provided with any information regarding his wife's treatment and that no food or drink was provided to her during her stay in the emergency department.

Treatment and care

The lack of simple individualised treatment plans remains a major concern in acute mental health services. Without a plan, the patient remains uninformed about their diagnosis and treatment. This results in increased anxiety and hopelessness superimposed upon their illness, exacerbating their passive acceptance of being controlled by powerful others.

Patients have complained that some treating psychiatrists disregard their advice about the adverse effects that some prescribed medications have on them. Some patients appear catatonic and unable to communicate.

When ECT treatment is prescribed, patients typically experience fears and anxieties. Often, the patient is given only a printed outline of the procedure that is not reader-friendly and only limited opportunity to talk through their concerns and ask questions.

Services from psychologists and social workers provide essential components to holistic patient care. Although social workers are available to most facilities, access to psychological services at the Perinatal and Infant Unit and the Eating Disorders Unit, Monash Medical Centre, is limited despite mood disorders being one of the primary features of patients admitted there.

When asked about this omission, staff respond that requests can be made to other units where allied health professionals work. This is grossly inadequate when mothers and young women are deemed seriously unwell, and require hospitalisation for these disorders.

Community Visitors also commonly learn from patients that their physical conditions do not receive attention and action. Examples include the need for dental care and denture management, podiatry services, cardiac assessment, and skin conditions. It appears that an over-focus on patients' mental health precludes attention being given to holistic

health and wellbeing. Conversely, psychiatric treatment seems to overly rely on drugs. Treatment seems to lack a broad psycho-educational therapeutic framework that addresses behaviour deficits and provides psycho-emotional skills training.

Legal rights and information provision

The range of legal issues affecting patients is considerable. These include seeking financial support through Centrelink, preparing for court proceedings, and issues with employers or estranged partners and children. Patients who wish to seek a second opinion or apply for a MHRB hearing are often unclear about the process, and often believe that the slowness of staff to respond is because they do not support their rights or are deliberately obstructive.

Patients frequently complain about the removal of personal mobile telephones on admission and controls exercised by staff over their use. Units have coin-operated public telephones but a damaged machine can remain inoperable for long periods of time, especially if there is a cost for repairs. The telephones are also in visible public areas and patients resent having to speak out loud about their personal affairs for all to hear.

Frequent complaints from patients include inadequate admission procedures with little or no provision of printed materials about the unit, its layout, and operations; lack of interpreters provided to patients of non-English speaking backgrounds; no clear understanding of the reason for admission and dissatisfaction at being made an involuntary patient under the Mental Health Act.

Some patients admitted into mental health services from the emergency department complained about being escorted by security guards through the hospital corridors to the acute unit at Frankston Hospital. This experience was undignified and could be perceived as violating their rights under sections 10 and 13 of the Victorian Charter of *Human Rights and Responsibilities Act 2006*.

Community Visitors also receive complaints regarding the lack of signage and pamphlets about the Community Visitors Program and their roles and responsibilities. It was pleasing that, in May 2014, Doveton Community Care Unit requested an information session for staff about the program with time for questions and discussion.

Discharge issues

The provision of suitable stable accommodation remains a significant challenge, as such options are extremely limited. Discharge cannot readily proceed when patients have no fixed abode, problematic relationships with family or friends, or additional disabilities including complex dual diagnoses.

Many others are discharged with no clear idea what is to happen once they leave the hospital. There does not appear to be a designated discharge planning officer who organises these complex arrangements and ascertains that patients understand the plans.

Rehabilitation and recreation opportunities

Regular scheduled recreational activities within acute mental health services have been variable across most facilities and this issue is frequently reported by Community Visitors across the three networks.

Dandenong Hospital SECU has consistently provided a range of indoor activities including cooking, painting, gardening and a men's group. Outdoor activities include accompanied walks around local parks, shopping, visits to the hospital coffee shop and visits to a local gymnasium. Community Visitors have also been most impressed with the comprehensive activity program offered at Unit 2 West at Frankston Hospital.

The two adolescent units at Monash Medical Centre and Dandenong Hospital provide courtyard games such as basketball, cricket or football as well as classroom lessons and indoor group work. The appointment of an assistant activities coordinator at Casey Hospital and at the Dandenong Hospital acute unit has helped alleviate the persistent boredom frequently reported by patients and residents.

In some aged mental health units, the continuous provision of interesting activities has been less certain and the activities provided may fail to capture patients' interest. Conversely, the Breakfast Club offered at Chestnut Gardens (Monash Health) and at Carinya Unit (Peninsula Health) are readily enjoyed as tasty treats are provided.

The lack of weekend activities when activities coordinators are off duty is onerous for those patients without family or friends visiting. Community Visitors have frequently reported on the lack of magazines, books, DVDs and DVD players across Monash Health and Peninsula Health inpatient units. The options for patients remain walking the corridors, watching daytime television, drinking

multiple cups of coffee, sleeping and, in Monash Health's facilities, flouting the no-smoking policy. Community Visitors perceive greater 'ambient tension' in the adult mental health unit than in other services, noticeably affecting staff and patients.

In April 2014, Community Visitors reported that the adult acute unit at Monash Medical Centre had performed poorly in providing a schedule of planned activities. It locked down one of the two open-air courtyards where carpet bowls and football had been played, permanently closed the gymnasium room and dismantled the weights equipment, locked away board games and other materials and kept a purpose-built kitchen closed where patients could engage in supervised cooking activities. Recently, reading materials have been provided and, for a while, fresh fruit was supplied by a patient's relative. This situation is totally inadequate.

Standard and appropriateness of facilities

Standards of maintenance of infrastructure and gardens fluctuate considerably across facilities. CCUs and hostels in the region consistently maintain high standards.

The condition of carpets in corridors and communal dining rooms has been inappropriate particularly in aged mental health units and adolescent units. Monash Health finally replaced stained odorous carpets in Chestnut Gardens after a year of critical reports from Community Visitors. Frankston Hospital's adult acute unit has recently received attractive wood-look vinyl flooring throughout the communal eating and lounge areas. Plans are also in-train to create an attractive outdoor garden area providing the opportunity for mental health patients to participate in vegetable and flower cultivation. Bunnings Warehouse are generously assisting in constructing raised garden beds, providing soil, compost, tools and plants.

Maintenance

It appears that budget constraints of health networks require funds to be found from elsewhere to meet the essential costs of maintenance, repair and replacement. While some health networks manage to fund repairs others do not.

A major obstacle to replacing essential machines or infrastructure appears to be the maintenance departments' scheduling of work and bureaucratic requirements for multiple quotations. At The Alfred Hospital it took nearly three years to replace and

safety test a clothes dryer in the acute inpatient unit. Community Visitors doggedly pursued the issue until it was eventually resolved.

Service-provider responsiveness

Written responses from health networks to Community Visitors' issue reports have been slow to arrive - if they have arrived at all. Explanations include changes in personnel or admission pressures.

Planned meetings with OPA personnel have not occurred with some Monash Health directors, with 'other urgent matters' cited for their non-attendance. Under these circumstances, it proves to be impossible to engage in meaningful dialogue so the advocacy efforts and time of Community Visitors is wasted and issues remain unresolved for lengthy periods.



In February 2014, 12 patients signed a four-page letter of complaint about the physical conditions of the Dandenong Hospital adult acute unit. The automatic coffee-making machine was broken, the coffee and tea-making area was covered in spills and discarded packets; one of the two washing machines was inoperable for over a month and filled with stagnant water; piles of dirty laundry lay under corridor sinks; the outside courtyards had discarded paper cups strewn about; bins were overflowing with rubbish; and patients continued to smoke in the courtyards in spite of the hospital's no-smoking policy.

The nurse in charge claimed that a request for repairs to the washing machine had been submitted over a month before with no response.

Disability Services

Statewide Report and
Recommendations



Recommendations

Disability Services

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

1. instigate a formal independent inquiry into abuse and neglect in group homes
2. provide full public reporting of all incidents and allegations of abuse and neglect, as well as the outcomes of these reports and any investigations
3. request that the Ombudsman inquire into the efficacy of the current system of incident reporting in group homes
4. embed the Community Visitors Program into the National Disability Insurance Scheme (NDIS) as a primary safeguard for residents living in group home facilities
5. endorse the Office of the Public Advocate (OPA) *Interagency Guideline for Addressing Violence, Abuse and Neglect*, and ensure that this guideline, and the relevant outcomes of the National Disability Services' Zero Tolerance project, form part of funding and quality requirements for disability accommodation and service providers
6. having resumed the Community Service Organisations (CSO) incident report training, continue to ensure CSO staff understand the Department of Human Services (DHS) *Critical client incident management instruction technical update 2014*, and that this training continues with involvement from Community Visitors
7. provide new and permanent accommodation to meet the specific needs of all people who are currently living long-term in facility-based respite accommodation
8. provide new accommodation options to address situations where people in group homes live at risk of assault and neglect due to incompatibility with others
9. immediately increase funding to the depleted maintenance budget for group homes in order to ensure the significantly high number of maintenance issues are addressed
10. ensure all housing for people with disabilities is of a satisfactory standard, including by replacing the former Singleton Equity Housing Limited properties, and finalising the audit of all DHS-owned group homes in order to refurbish or replace those deemed inadequate
11. immediately increase the vehicle fleet to ensure that every group home has a vehicle appropriate to the needs of its residents, in order to facilitate inclusion and participation in the community
12. ensure that all people with complex communication needs have a communication assessment conducted by a speech pathologist by June 30, 2015
13. ensure that all DHS Disability Accommodation Service (DAS) and CSO group home staff are registered and trained to a Certificate IV standard in order to provide a competent workforce who are able to meet the principles and objectives of the *Disability Act 2006*
14. urgently address shortages in the disability services workforce and progress the Community Sector Workforce and Education Strategy Report, particularly the focus on values-based training, as detailed in the State Government response to the *Community Visitors Annual Report 2011–2012*
15. address the inadequacy of institutional accommodation by: expediting the closure of congregate-care accommodation at the Oakleigh Centre; closing Colanda as part of the NDIS trial in Barwon; and determining the future of Plenty Residential Services
16. provide adequate funding to the Community Visitors Program to enable it to properly carry out its legislated functions.

Disability Services

Statewide Report

This year, Community Visitors reported on a range of serious issues in disability accommodation; many of which are significant and fundamental breaches of the *Disability Act 2006*, for which DHS, CSOs and group home staff should be held to account.

The Community Visitors Disability Services Board has made four new recommendations to the State Government focussing on crucial measures needed to address the abuse and neglect of people with a disability, including a formal independent inquiry into abuse and neglect in group homes.

The Board has also reiterated issues raised in the recommendations of its 2012-2013 annual report which are still to be met by the State Government.

Further to these recommendations, the Board strongly urges the State Government to commit resources to the disability services sector to ensure the objectives and principles of the Disability Act are upheld for all people living in group homes and institutions.

Disability Services Stream					
Division	No. of units visited	No. of CVs	Requested visits	Scheduled visits	Total
North Division	298	59	45	597	642
East Division	359	83	39	800	839
South Division	271	76	44	649	693
West Division	259	58	21	740	761
Total	1,187	276	149	2,786	2,935

Table 5. Total visits Disability Services Stream 13/14.

Abuse and neglect

Community Visitors' reports from across the state provide a compelling case for the Board to express real concerns that abuse and neglect of people with disability, including neglect of health care, is systemic in group homes.

The abuse and neglect is physical, sexual, emotional, and is also committed through inadequate funding. Abuse and neglect has been a continuing theme in Community Visitors annual reports in recent years. High-profile cases of abuse, and the subsequent dismissal of staff committing abuse, confirm the Board's concerns of a systemic problem.

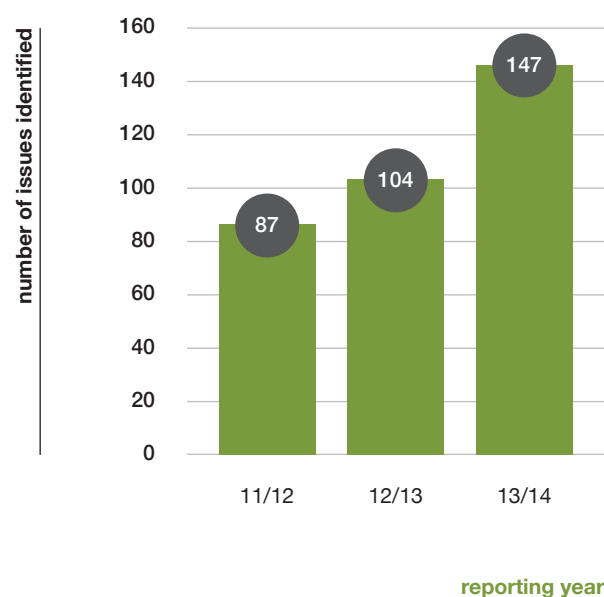


Figure 9. Disability Services Stream abuse, neglect and violence 11/12 to 13/14.

Community Visitors are regularly told that changing organisational culture is the way to eliminate abuse and neglect. The Board appreciates that both DHS and CSOs are working hard to achieve change. However, changing organisational culture takes time, during which group home residents continue to suffer.



Community Visitors also report serious abuse and neglect resulting from incompatible people being forced to live together in group homes because of a lack of alternative accommodation. This clearly illustrates the need for additional group homes to be established.

A key element in eliminating abuse and neglect is incident reporting. The Board considers that accurate, open and comprehensive incident reporting is integral to eliminating abuse and neglect. Community Visitors have reported on incidents where staff have assaulted or neglected residents; incidents where incompatible residents have assaulted each other; and incidents where residents have assaulted staff. However, the Board is concerned that incident reporting in DAS and CSO group homes has been inaccurate and lacked transparency. Community Visitors have again highlighted concerns with the efficacy of incident reporting, and the Board believes that if incidents are not reported, or are poorly reported, any remedial action is likely to be ineffective.

Incident reporting

The Board has expressed concern to DHS that there is no centralised or integrated system for incident reports in group homes. Introducing this would provide an oversight which, the Board believes, would improve work practices to minimise abuse and neglect of people living in group homes.

This year, Community Visitors participated in DHS critical incident reporting consultation and professional development for CSOs. The Board believe this was a good collaboration between the Community Visitors Program and DHS, and consider it essential that this training continue until all CSOs have a clear understanding of incident reporting requirements. This training must also cover Community Visitors access to incident reports, as required in the Disability Act.

Last year, the Board recommended DHS endorse the *Interagency Guideline for Addressing Violence, Neglect and Abuse* (IGUANA) developed by OPA, and encourage all funded agencies to adopt this good-practice guideline to safeguard people with a

disability from abuse. This year, the Board reiterates this recommendation and extends it to include the embedding of IGUANA, and the outcomes of the National Disability Services' Zero Tolerance project, in the practices of funded disability service organisations as a part of funding and quality requirements.

Respite care

People who live long-term in respite facilities are faced with limited privacy, daily changes in the people they live with, and no sense of permanency or 'home'. Every year, many people with a disability leave their family home and seek permanent accommodation. Forward planning would assist in providing suitable permanent accommodation for these people in crisis.

The Board believes it is unacceptable to accommodate people, particularly children, in facility-based respite on a long-term basis. This year, Community Visitors reported on 34 people, including 15 children, who are living long-term in respite accommodation. Community Visitors also reported that some adults had lived in respite facilities for up to seven years, which is clearly unacceptable.

DHS has informed the Board that a register of children with disability living in out-of-home care has been developed, and that DHS divisions are responsible for maintaining this register. Some of these children live in respite facilities registered under the Disability Act, and it is expected that the principles and objectives of the Act will be upheld in these facilities. However, Community Visitors report that this is not always the case.

Unmet need for accommodation

Inadequate forward planning and resourcing has led to a shortage of supported accommodation for people with disability. Because of this, people in urgent need of accommodation are often inappropriately placed in any group home where a vacancy can be found, regardless of their needs or the needs of existing residents. Community Visitors report that people urgently

requiring accommodation are often younger and require specific behavioural support, and that vacancies in group homes usually arise when an older person has died. The result is a high likelihood of incompatibility between the new resident and existing residents, which has an unnecessary and detrimental impact on all residents. Increased service capacity and support should be appropriately planned and resourced in future budget arrangements, in order to support residents with complex needs. The Board has raised this issue with DHS and has been informed that supporting complex clients is not yet clearly identified in future budget arrangements.

Upkeep of buildings and fittings

The Board continues to hold concerns regarding the significant number of maintenance issues that remain unaddressed. In one area, Community Visitors were told that “there is no maintenance money available except for bathrooms and kitchens”, but reported many maintenance issues in bathrooms that had not been addressed. In another area, several houses are more than 20 years old and urgently need upgrading or replacement, but Community Visitors were advised that DHS were “only approving urgent and essential expenditure on all maintenance”. The Board has not been able to identify any State Government strategies or budget resolutions to address maintenance issues in group homes, some of which have been outstanding for many years.

Community Visitors have been reporting for several years that some DHS-owned properties are unsuitable for people with disability, particularly as residents age and their needs change. This year, these properties were audited and the Board expects that required repairs and replacements have now been identified and will be addressed in the near future. Singleton Equity Housing properties are also becoming increasingly problematic for ageing residents, as the houses do not meet accessibility requirements or health and safety standards. The Board believes it is vital that the State Government implement a strategic plan, and allocate the necessary funding, to repair or replace these properties.

Individual planning

Community Visitors have reported many instances where individual planning and communication support for residents has not been adequately provided.

It is a requirement of the Disability Act that people with a disability are able to participate actively in the decisions that affect their lives, and that they are supported where necessary to enable this participation. It is vital that accommodation service providers have ‘living’, quality plans in place for all residents. These plans must be implemented and regularly reviewed to realise individual capacity for physical, social, emotional and intellectual development, and must be used as an effective tool towards the achievement of personal goals.

While some improvement has been noted, the Board believes the system of individual planning must be a serious focus in both DAS and CSO houses to improve the quality of life for people living in group homes. DHS should ensure that the principles of the Disability Act are met, in both their own services and in funded services, by implementing more vigorous quality control.

Residents who require support to communicate rely on staff to implement recommendations from communication assessments. Staff training is required to ensure these residents are able to seek, receive and impart ideas, opinions and feelings through their preferred communication style. The Board has been informed by DHS that, in accordance with the DAS Residential Services Practice Manual (RSPM), direct care staff must have practices in place to address residents’ communication needs in everyday interactions. The Board understands that CSOs are not required to adhere to the RSPM, however, they are expected to have comparable policies in place.

Community inclusion and access

Service providers are required by the Disability Act to advance the inclusion and participation in the community of people with a disability. Without this, residents are at risk of being socially isolated. It is critical that group homes maximise social inclusion, enabling people with a disability to lead full lives and take part in society. This year, Community Visitors reported lack of access to suitable transport, such as vehicles unable to accommodate people who use wheelchairs, was a barrier to community inclusion and participation. An increase in the vehicle fleet for group homes is required to address and reduce this barrier to community participation.

Staff support

The provision of a stable and skilled workforce is integral to the wellbeing of residents, and is central to enhancing their quality of life. This is even more

critical when supporting people with behaviours of concern. Community Visitors report the high use of casual staff in group homes creates instability and has a detrimental impact on residents' wellbeing.

Community Visitors report some group home staff lack important skills, while other staff teams can be dysfunctional. Ongoing changes or lack of a permanent house supervisor is also very problematic for residents, as this management position is essential in establishing a well-functioning environment.

The Board believes all group home staff should be trained to a Certificate IV level, and that this requirement should be better enforced in DAS houses, and extended to CSO houses. DHS should ensure that this training addresses the rights of people with disabilities, and the prevention of, and appropriate responses to, abuse and neglect.

Community Visitors continue to strongly support the concept of professional registration of staff working with people with disability. The Board believes this would increase professionalism of the workforce, provide better status, training, professional supervision and career structures for trained direct support staff - all of which are benefits DHS should promote.

residents with serious behaviours of concern continue to be placed there. This has caused dislocation for existing residents.

The Board is concerned that vulnerable people living at PRS are being placed at risk by the introduction of new residents who have behaviours of concern, and some with involvement in the criminal justice system. The Board believes many long-time residents at PRS could easily live in the community, rather than at this 'cluster' site where they are at risk because of new residents.

Community Visitors Program funding

The Community Visitors Program remains inadequately funded. This year, Community Visitors were required to reduce the number of visits to some group homes due to a lack of funding. For the third sequential year, the Board recommends that the State Government make what would be a relatively small investment in the program, in order to ensure that Community Visitors can meet their legislative obligations and continue to provide protection against abuse and neglect of people with disability.

Institutions

This year, the Community Visitors Program welcomed the announcement of the closure and planned redevelopment of congregate-care accommodation at the Oakleigh Centre.

At Colanda, residents await the assessments and outcomes of planners from the NDIS trial site in Barwon to enable access to improved accommodation. This is due to commence in September 2014.

While Plenty Residential Service (PRS) is not listed as an institution, it has cluster housing and a staff culture reminiscent of institutional practices, although some changes are presently being implemented to address this. There is still no specific clarification to determine the service model at PRS. New

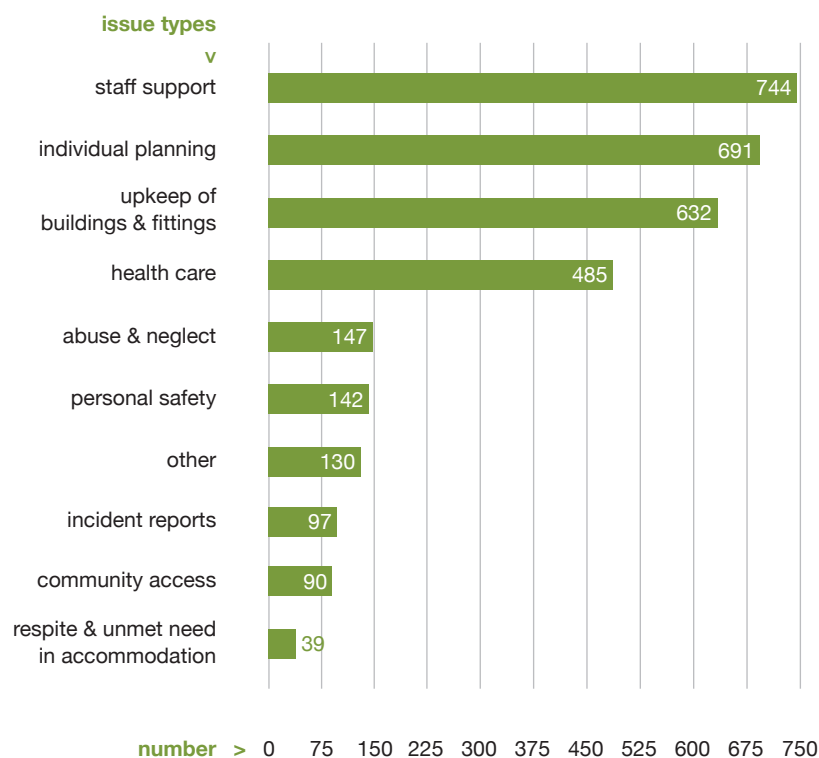


Figure 10. Disability Services Stream number and types of issues identified 13/14.



East Division

East Division includes the Eastern Metropolitan Melbourne area, which is made up of the DHS areas of Inner Eastern Melbourne and Outer Eastern Melbourne, and the regional Victorian areas of Goulburn and Ovens Murray. This year, 83 Community Visitors conducted 839 visits to 359 houses in this division.

There were four notifications to the Public Advocate regarding group home residents at serious and imminent risk of harm. These notifications are detailed throughout this divisional report.

Eastern Metropolitan Melbourne

Abuse and neglect

This year, Community Visitors reported two serious incidents where staff neglected to seek appropriate medical treatment for injured residents. These incidents of neglect are highlighted in the health care section of this divisional report.

Community Visitors raised concerns about bruising to residents in a number of DAS houses. At one house, progress notes for most residents indicated they had suffered bruising. DAS advised that each instance of bruising had been followed up, and future instances would be closely monitored, however no explanation for the bruising was provided. At another house, staff told Community Visitors that a resident attended hospital because of their tendency for bruising, but no diagnosis had been made. At another house, Community Visitors noted that a resident seemed to suffer regular unexplained bruising. The resident's doctor suggested this could be due to manual handling and recommended that the bruising be monitored and reviewed if it persisted. Community Visitors feel staff at these DAS houses need to take more care in supporting residents.

Notification to the Public Advocate

An anonymous caller to OPA's Advice Service alleged that a DAS house staff member had slapped a resident twice across their head and face, resulting in the resident having "a bit of black under [their] eye".

The caller said the staff member had also previously been involved in an incident where another resident sustained a "blackened" eye. The caller expressed concern that the staff member quite often used bullying behaviour with residents such as "standing over them" and not giving them dinner until they had drunk some water.

OPA's Advice Service notified the Public Advocate of the allegations and referred the matter to Community Visitors. The Public Advocate referred the matter to DHS and was advised that the staff member had been immediately suspended, an investigation had commenced, and that the allegation had been referred to the police.

Community Visitors were later advised by DAS that at the conclusion of the investigation, the allegations of abuse had not been substantiated and the staff member would return to work at the house in their usual role.

Community Visitors were alerted to an incident at a CSO house where it was alleged that a resident sexually assaulted another resident. As a result, the offending resident was medicated to restrain his behaviours of concern and an alarm was fitted to his bedroom door to alert staff when he left his room. However, Community Visitors raised concerns that these measures were not noted in his Behaviour Support Plan (BSP).

At one CSO house, Community Visitors reported that residents lock themselves in their bedrooms to avoid confrontation with another resident. At another house, residents eat their meals in their bedrooms and avoid a dominating resident. Plans to move this resident have been in place for nine months without any action.

Community Visitors witnessed a new resident at a CSO house seriously assault a staff member; the resident was later moved to other accommodation.

Inappropriate placement of residents with behaviours of concern has led to physical, sexual and emotional abuse and neglect of other residents' rights to feel safe in their home, as detailed in the following two notifications to the Public Advocate.



An agency staff member working at a DAS house picked up a resident from their day placement in the house vehicle, but did not return to the house for five hours. The agency staff member could not be contacted during some periods of this absence and house staff called the police. DAS management advised Community Visitors that, following the incident, police interviewed the agency staff member but no further action had been taken, as “they were not of the opinion that any crime had been committed.”

DAS management interviewed the agency staff member who said they had been lost, despite maps, directions and contact numbers located in the house vehicle. The agency staff member did not contact the house when they were ‘lost’ and could not explain several “time lapses” during the five-hour period. As a result, the staff member was dismissed by the agency and banned from all future work with DHS.

On the day of the incident, staff took the resident to a local medical clinic for an examination, but doctors refused to carry one out and referred the resident to a hospital. However, the hospital would not perform a forensic medical examination of the resident or their clothing without a police referral. A senior DAS manager contacted police at the Sexual Offences and Child Abuse Investigation Team to explain the resident’s situation, but was advised that police would not provide a referral to the hospital without evidence of a crime. The following day, the house supervisor took the resident to their own doctor, who reported no evidence of physical injury or trauma. House staff checked the residents’ clothes and reported no evidence of clothes being ripped or torn, but the DAS manager conceded they were “not experts in this field”.

Community Visitors believe this resident was failed by the very systems designed to protect society’s most vulnerable people. This resident’s care was entrusted to an unfamiliar person and, after an incident occurred, protocols and procedures denied the resident access to adequate health care and justice, because their disability affected their ability to advocate for their rights.

Notification to the Public Advocate

Residents and staff of a DAS house were threatened and assaulted a number of times by a resident with escalating behaviours of concern. In

August, a resident called OPA’s Advice Service to request a Community Visitor visit, and said they had felt fearful and unsafe for months and had resorted to locking themselves in their room for hours. Community Visitors raised these concerns and DAS advised a number of measures were in place to address the issue.

The same resident again requested Community Visitors to visit the house in October, saying that the situation had worsened and both residents and staff had been assaulted. Community Visitors again raised their concerns with DAS, and were advised measures had been implemented to keep residents safe and address the resident’s behaviours of concern and support needs. However, Community Visitors were not satisfied the situation had been adequately addressed and notified the Public Advocate, who raised the matter with DHS.

In December, DAS advised that the house had additional staffing and that support strategies were being developed by the East Division Behaviour Intervention Support Services (BISS) for the resident with behaviours of concern. In March, DAS advised that the resident’s behaviour escalated significantly and he was urgently moved to another DAS house where there was one other resident. Community Visitors were advised this was an interim measure and that, while the resident was happy at the temporary home, he needed to move again in June because of house renovations. This resident’s future remains uncertain.

Notification to the Public Advocate

Community Visitors repeatedly expressed concerns for the safety and wellbeing of residents at a DAS house because of a young resident’s behaviour, which had included assaulting others. The resident was reportedly very independent and wanted to live with people with whom he had more in common.

While DAS acknowledged Community Visitors’ concerns about residents’ safety, inadequate staffing and inappropriate accommodation for the young resident, it seemed nothing could be done to improve the situation. In December, DAS advised that another resident had been seriously injured, but there had been no witnesses to the incident. Community Visitors had previously reported the injured resident had been a target of the young resident’s behaviour. Community Visitors notified the Public Advocate, who requested a response from DHS.

In January, DHS advised an external investigation of the incident had begun. In June, Community Visitors were informed the investigation had found the injured resident was most likely assaulted by another resident while staff were attending to tasks and not observing the resident who was injured. Following this incident, additional staff resources were allocated to the house at “peak times”.

The young resident with behaviours of concern was allocated an Individual Support Package (ISP) and moved to his own home, where he employs staff for support. Because the resident now lives in private accommodation, Community Visitors are not legislated to visit and consequently cannot follow up on his wellbeing.

Two CSO houses have significant issues with resident incompatibility, resulting in assaults which stem from behaviours of concern. However, several months after the issues were raised, these residents had still not been moved to more appropriate accommodation. At one of the houses, a resident who intimidates others wants to move out, but alternative accommodation cannot be found. At the other house, an active resident with behaviours of concern has been inappropriately placed in a house with older residents for more than two years.

Incident reporting

It has become increasingly difficult for Community Visitors to access incident reports, as DAS and CSO houses are transitioning to electronic filing of records. In some CSO houses, Community Visitors can access incident reports on the house computer, but this is not always possible.

Staff at some CSO and DAS houses have been unable to find or access incident reports. At one CSO house, staff did not have keys to a locked office where incident reports were kept. At another CSO house, incident reports were not written in situations such as residents falling or being admitted to hospital, though they were noted in the residents’ progress notes.

DHS invited Community Visitors to participate in a presentation to East Division CSO staff on the DHS critical client incident reporting requirements. The presentation was well attended and Community Visitors hope to see improvement in the management of incident reporting by CSOs.

Respite and unmet need in accommodation

There is an urgent need for more houses to permanently accommodate people with disability. Community Visitors believe it is unacceptable for people to be accommodated long-term in respite facilities. These people are denied their right to a permanent home and the chance to develop community connections.

Community Visitors reported on a number of people with a disability who are living long-term in DAS adult respite houses, including:

- a person who has lived in a respite house for seven years
- a person living in a respite house for two years who also has to transfer to another respite facility on weekends
- a person living long-term in respite who frightens other residents to the extent they stay in their bedrooms.

Community Visitors are constantly advised by DAS that these people are a high priority for moving to permanent accommodation, but this rarely seems to eventuate.

Respite for children with a disability is in crisis. Children with a disability are living long-term in houses specifically designated as respite facilities.

This occurs for varied and complex reasons:

- families often require more support and assistance than they receive
- a child may have behaviours of concern that put other family members and their relationships at risk
- families may simply be unable to cope with their caring role any longer.

Community Visitors reported that DHS is aware of this crisis, but must continue to accept these children. Because of a lack of permanent accommodation for children with disabilities, respite facilities are sometimes the only option for accommodation. When respite facilities accommodate children on a long-term basis, this limits short-term or planned respite for many other families.

DHS advises that it formally reviews each child’s situation every six months.

Community Visitors commend respite staff who are dedicated to meeting the different needs of children from a broad age-range and who provide a homely environment, often with limited resources.

While some respite facilities are purpose-built, they are still not appropriately designed for the needs of children, including:

- fences that children can easily climb over
- communal indoor areas that are sparse and uninviting
- few quiet spaces for children to retreat to.

Community Visitors have reported in previous years that children were being 'shifted' between respite facilities, however, it appears this practice has ceased.

Upkeep of buildings and fittings

Community Visitors reported many ongoing maintenance and building issues at DAS and CSO houses. In some instances, issues have been reported for several years, and Community Visitors are greatly disappointed and concerned that property owners and service providers do not act to improve residents' living conditions.

At DAS houses, Community Visitors reported: holes in walls and broken bathroom tiles; dirty furniture and uneven floors; worn and stained carpets; mould and unclean bathrooms; piles of rubbish in neglected gardens; damaged fences and gates; broken appliances; inadequate lighting; and steep steps difficult for residents to use. In one DAS house, sloping pavements funnel water towards doors and staff have had to use rolled up towels to stop it seeping into the house.

At one CSO house, Community Visitors reported holes in the walls and exposed wiring; at another house the replacement of dangerous cork floors was delayed, and several other CSO houses were reported as poorly maintained and simply substandard. At one CSO house, a broken oven door was held together with tape until Community Visitors reported it and a maintenance request was made for an urgent replacement of the door.

Community Visitors are concerned that requests for maintenance are not made by house staff until Community Visitors raise issues in their reports. Maintenance and repairs are also delayed, or not addressed at all, at several houses where the service provider is not the property owner, such as houses rented from the Office of Housing (OoH).

At two houses managed but not owned by one CSO, Community Visitors reported on the urgent need for painting, replacement of damaged carpet that made manoeuvring wheelchairs difficult, and repairs to air conditioning and to hoist equipment. The CSO responded that these items would be included in its next submission for funding to DHS. Community Visitors reported that the carpet at one of the houses was replaced, however, other repairs are still outstanding.

Some houses are also not designed or fitted out to support residents' needs. Community Visitors reported that one OoH-owned CSO house is not purpose-built for residents who use wheelchairs. This is frustrating for the residents and greatly increases the amount of maintenance needed, as when the house is painted the condition of the walls soon deteriorates again. At one DAS house, residents have to use low, small, "kindergarten-like" toilets that were already in the house when residents first moved in. This is inappropriate and undignified for adults. Community Visitors have reported on this issue for a number of years and no action has been taken.

Personal safety

For more than 18 months, Community Visitors repeatedly asked for a safety rail to be installed in the bathroom of a DAS house. No action was taken until a resident fell in the bath several months after the issue was first raised. To date, the rail has not been installed, reportedly because an occupational therapist's report and recommendations are pending. Community Visitors question such resistance to installing a basic safety feature used by many people in the community.

Residents' personal safety is at risk when staff do not appropriately document and manage behaviours of concern. Community Visitors reported that at three CSO houses, residents' BSPs were not updated to reflect assaults or sexual behaviours of concern.

Community Visitors reported that maintenance and building issues that were not addressed, such as exposed wiring at a CSO house and dangerous paths and steps at DAS houses, also put residents' safety at risk.

Individual planning

Community Visitors reported varied standards of individual planning. Many DAS houses had

inconsistent filing of plans, out-of date records and reports, and incomplete Person-Centred Plans (PCPs) and BSPs. At some DAS houses, key workers had not been assigned for residents, despite this being common practice in most DAS group homes.

On a number of visits to both DAS and CSO houses, staff either could not find residents' individual plans, or the plans were stored on a computer inaccessible to Community Visitors. At one DAS house, staff could not tell Community Visitors where they could locate a resident's BSP on two visits that were seven months apart. This house had a locked kitchen to which only staff had keys, however, Community Visitors could not locate a current BSP authorising this restrictive practice or any documentation addressing its impact on other residents.

Individual planning for residents was delayed or not evident on a number of visits, including:

- a resident who had no ISP and had not attended a day placement for three years, which the DAS manager stated would eventually be addressed by the NDIS
- a CSO relocating a resident to another house a week before Christmas, with no transition planning, as a temporary measure to address resident incompatibility
- implementation of new behaviour support strategies for a resident with escalating behaviours of concern delayed by almost a year
- a resident unable to attend day placement funded for only two hours of one-to-one staffing each week
- residents affected by a reduction in their supported employment hours left with few activities while waiting for more funding for community activities and employment opportunities.

Community Visitors are concerned that a resident of a DAS house does not have enough support or engagement to address behaviours of concern, such as banging their head. The resident only has two days of one-to-one support each week.

Community Visitors were pleased to report that some houses kept residents' individual plans 'alive' by using photo-boards or iPads to document activities, and holding discussions with residents, staff and family members to keep plans up-to-date. Three residents of a CSO house were also supported to move into their own independent-

living flats, which has reportedly been successful and satisfying for these people.

One CSO has trialled an 'active ageing' project where residents who want to retire from work can take part in age-appropriate activities with friends from other houses. Residents have told Community Visitors that they enjoy the program. At some CSO houses, residents have been able to retire from day placement programs and be supported in their homes.

Staff support

Community Visitors questioned whether there was sufficient staff support to meet residents' needs at a number of houses, including:

- a DAS house where outings for three residents are restricted as there is only one staff member to support them
- a DAS house where the one staff member on duty must call a 'buddy' group home if they need help
- one staff member on duty overnight at a CSO house to support seven residents with high-care needs
- a DAS house where staff must justify why active night duty is required to support five residents with significant medical and support needs, instead of changing to 'sleepover' staffing.

Casual and agency staff are increasingly relied on in group homes, instead of permanent staff being recruited. Community Visitors reported that constant staff changes at some houses have unsettled residents, particularly those with behaviours of concern. Casual or agency staff are also often unable to adequately meet residents' support needs.

The quality of staff support for residents was questioned at one DAS house in "utter chaos" because the residents are poorly supported. Community Visitors witnessed the dignity and rights of one resident being breached when staff allowed the resident to walk naked from the carport to the house.

Other issues reported regarding staff support include:

- a staff member at a CSO house telling Community Visitors that a resident who is non-verbal did not need communication aids because they were able to indicate 'yes' or 'no'
- an under-utilised and uninviting sensory and recreation room at a DAS house, which was only restored after Community Visitors reported it had been used for storage for several years
- poor record-keeping jeopardising residents' care and support, including incomplete or missing paperwork and, in one DAS house, pages of residents' progress notes were missing
- residents left unattended during staff breaks, including one instance where Community Visitors knocked for more than ten minutes before staff answered the door
- delays in training staff at one CSO house to drive the house vehicle, limiting residents' community access and inclusion.

Staff encouragement of independence could be improved at many houses. At one DAS house, residents' plans state goals of learning new skills and participating in their household, but they are not given the opportunity to help prepare meals, reportedly because of their schedules and time constraints. At another DAS house, all residents cannot access the locked kitchen because of one resident's behaviour, and at a CSO house, staff told Community Visitors that meal preparation tasks were too complex for residents to help with.

Community Visitors reported a positive example of staff support at a CSO house where staff monitored residents' wellbeing and offered counselling after a resident, who had moved to an aged care facility several weeks earlier, passed away.

Health care

Community Visitors reported that poor communication between staff and medical professionals compromised the health and wellbeing of residents on some occasions.

A resident of a DAS house had delayed access to dental treatment, and staff told Community Visitors that this had occurred because the house supervisor neglected to fill in paperwork for the treatment to proceed. DAS responded that the paperwork was completed and the delay was due to waiting on the availability of three surgeons to do the work. This resident went on to have extensive dental treatment

and a number of teeth removed. Community Visitors report this resident may have had inadequate dental checks in the past and may have been in severe pain, which could have contributed to their behaviours of concern, such as biting others.

Community Visitors reported that a resident of a CSO house was in discomfort and suffered incontinence after waiting more than a year for house and hospital staff to arrange for an intrauterine device to be removed.

On at least two occasions, group home staff delayed or failed to call an ambulance for residents who had fallen. At one DAS house, a resident fell and injured themselves significantly; later requiring a hip replacement. Staff called a doctor to visit the house, but after a long delay, the doctor was unable to visit and an ambulance was eventually called. The second report of this nature is detailed in the following notification to the Public Advocate.

Notification to the Public Advocate

A resident of a DAS house suffered multiple leg fractures after falling from a chair while unsupervised. Staff did not call an ambulance, instead taking the resident to a doctor. Staff took the resident to have an x-ray and returned to the doctor for results. The doctor then advised staff to take the resident to hospital, where they waited for more than two hours before being transferred to another hospital for treatment. The resident's long and painful wait for treatment could have been avoided if staff had called an ambulance.

The house supervisor also incorrectly advised hospital staff that the resident did not have a family to consent to medical treatment. Consequently, the hospital resorted to a process of authorisation that can only be used when there is no person responsible, able and willing to consent to treatment. This incorrect statement became apparent when the resident's family, who had recently reconnected with the resident after a long absence, contacted OPA's Advice Service with concerns about the resident's treatment.

The house supervisor told Community Visitors that they believed the family members should not be allowed to make decisions for the resident because of their long absence in the resident's life. OPA has since provided the house staff and DHS managers with information and training on consent and medical decision-making.

Community Visitors reported several medication errors at DAS houses, including staff giving the wrong medication to one of only two residents in their care, and another house where a resident's medication was found on the floor. At another house, a resident was admitted to hospital because of the effects of being administered the wrong medication. Medication errors were also reported at CSO houses where Community Visitors repeatedly reported issues with unlocked medicine cabinets and medication left out or unsecured.

Community Visitors reported concerns that no action had been taken to prevent residents at several DAS houses from continuing behaviours that injured themselves, apart from staff documenting the behaviours.

A number of residents with epilepsy experienced increased frequency of seizures, but Community Visitors saw no evidence of plans or medical assessments arranged to address this.

Increased health needs of ageing residents were addressed with medical intervention at CSO houses. In some instances, residents moved to aged care facilities, but Community Visitors were satisfied that all options were explored before this action was taken.

Goulburn

Incident reporting

Community Visitors had difficulty accessing incident reports at several CSO houses, but this improved following discussions with management. The main problem was that staff told Community Visitors that they were unaware of how to access incident reports on the computer system.

Upkeep of buildings and fittings

Community Visitors reported several ongoing maintenance issues at one CSO house, and have now been advised that the CSO plan to demolish the house and rebuild on the site, while residents live together in alternative accommodation.

At another CSO house, Community Visitors reported staff were using a stick to close a broken oven door. After the Community Visitors' report, the oven door was fixed immediately.

Community Visitors reported that several long-standing maintenance issues at DAS houses in this area have now been attended to.

Personal safety

A resident's behaviours of concern prompted staff at one CSO group home to lock away all items that could be used as weapons, such as knives. Police have been called in the past because of this resident's behaviour, however, the resident's family have asked staff to contact them to diffuse the incident instead of calling police.

Community Visitors reported that 'buzzers' in the bathroom and toilet of a CSO house, used to alert staff in emergencies, had been broken for several months. The buzzers were fixed after the Community Visitors' report to the CSO.

Community inclusion and access

At one CSO house, Community Visitors reported that residents were restricted in their ability to go out in their community, as the house vehicle only accommodates one wheelchair. The house has three residents who use wheelchairs.

Staff support

Staff at a CSO house documented a number of incidents involving one resident's inability to balance, and the resident's subsequent falls. Staff manually assisted the resident to get in and out of bed, and to go to the toilet, as there was no hoist or other support equipment. File notes for the resident indicated that it could sometimes take more than an hour to assist the resident to use the toilet. Community Visitors reported that, on several occasions, the resident had been left in bed for extended periods of time because the one staff member on duty could not assist the resident to get out of bed, and also that that the resident had fallen out of bed several times. Community Visitors strongly believe more support, staffing and equipment is needed to prevent this situation from occurring and to protect this resident's dignity and rights.

Staff numbers were also raised as an issue at a CSO house where Community Visitors reported there was only one staff member, who was new to the house, rostered on in the mornings to support six residents.

Community Visitors reported that one resident of a DAS house had difficulty communicating with casual and agency staff, though this was not a problem with permanent staff. Community Visitors were advised that staffing and recruitment problems had increased the use of casual and agency staff at the house.

DAS advised that agency staff would be given strategies at the start of each shift to implement the resident's communication plan. As the resident had reportedly chosen not to use some of the communication aids outlined in their communication plan, DAS advised that a further assessment would be arranged to identify other options for supporting the resident's communication needs.

Health care

Community Visitors reported that many health care issues appear to be related to residents ageing, and in most instances, staff are taking appropriate steps to manage these needs.

An issue of concern is the significant amount of weight gained by one resident of a CSO house since moving in. Staff try to restrict the resident's food, however, this is hampered by the resident's negative reaction when food is not provided.

Ovens Murray

Abuse and neglect

Community Visitors have ongoing concerns for residents in some houses where incompatibility causes tension and anxiety.

Last year, Community Visitors reported on two residents who lived in the same unit for 10 years and were in constant conflict with each other. It is positive to see action has been taken to separate the two residents and to find alternative accommodation for one of them.

Incident reporting

Community Visitors reported an example of good practice at one CSO house where staff created an incident report folder for Community Visitors.

Upkeep of buildings and fittings

Last year, Community Visitors reported long-outstanding maintenance issues at Singleton Equity Housing properties. These issues are ongoing.

At CSO houses, Community Visitors reported maintenance concerns including a toilet leaking water on the floor, a broken freezer not fixed for at least four months, carpet which presented a tripping hazard, overhanging branches, and damaged fences.

At one CSO house, an overhead hoist is not aligned with the bath, meaning residents with impaired mobility cannot use the bath. The service provider does not see this as an issue and reported that the bath was not being used previously. However, staff have advised Community Visitors that it would be good for residents with impaired mobility to be able to have a bath.

Community Visitors reported on DAS houses with maintenance and building issues including: bedrooms in need of adequate heating and cooling; rotting posts, ramps and doors; and faulty door locks.

Personal safety

Community Visitors reported that support rails were needed at a DAS house to ensure residents' safety.

A CSO resident has not been able to use a trampoline at the house because the safety net has been damaged and not replaced for more than a year. The service provider does not see this as an essential need. However, Community Visitors believe this is an activity the resident enjoys and should be supported to do safely.

On three occasions, Community Visitors reported to DAS and CSO houses that overgrown grass needed to be cut because of the risk of grass fires or snakes. In each instance, the grass was cut following Community Visitors' reports.

Individual planning

DAS houses are addressing issues raised with residents' BSPs, however, Community Visitors believe placement in appropriate accommodation is crucial to improving residents' lives, and this process can take time.

Community inclusion and access

Community Visitors reported that staff at two CSO houses were using their own cars to take residents to appointments and on outings, as there was no vehicle available at the house. When Community Visitors raised this issue, the service provider stated that staff had been advised not to use their own cars to transport residents, and stated that a house vehicle would be located at the unit every night, except one day per month. However, this has not been the case on the last two visits to the house, including over Easter when the vehicle had reportedly broken down.

Staff support

Staff at one DAS house are commended for their initiative in developing a 'communication needs' list for staff to better understand a resident who sometimes experiences language difficulties. The list indicates to staff what the resident may be trying to communicate when they use hand gestures, point or use facial expressions. Community Visitors believe this is a very valuable communication aid, and has reduced much of the resident's frustration. It is also a valuable tool for new staff working with the resident.



A young resident with multiple disabilities, complex care needs, and significant behaviours of concern, lives alone in a house with varied levels of staff support throughout the day and night. The resident's extreme behaviours, including violence and self-harm, make it difficult to live with other residents. A housemate was moved from the house due to the young resident's violent behaviour, including throwing furniture and damaging the property. When the resident throws furniture, staff members lock themselves in the staff room and do not intervene.

The resident receives significant behaviour support from DHS Disability Services.

In November, Community Visitors requested information from DHS as to what actions were being taken to reduce the resident's behaviours of concern, and the plan for long-term accommodation. To date, a response has not been received. In April, Community Visitors were advised that an engineer had been employed to plan the reinforcement of the walls at the house.

Community Visitors believe this resident requires specialist accommodation where walls cannot be damaged, and a team of staff specifically trained in behavioural intervention, not staff with only basic training in working with people with disabilities.

Community Visitors reported concerns that a resident's dignity and rights had been breached by staff at a CSO house where a notice was displayed about staff contacting police because of the resident. Staff could not explain why the notice was there, or whether it was part of a behaviour support strategy. Staff also could not access the resident's file, because it was in a locked office. Four months after Community Visitors raised this issue, the CSO advised that the sign was used as a deterrent for the resident. Community Visitors are dissatisfied with the CSO's response and question whether this is a valid and effective behaviour support strategy.

Fire safety and emergency preparedness are important staff responsibilities in group homes. At one CSO house, Community Visitors raised concerns regarding missing equipment in evacuation packs, an exit blocked by rubbish bins and only one fire extinguisher in the house.

Health care

Community Visitors are concerned about the welfare of a CSO resident whose weight is compromising their health. The resident is breathless, fatigued and has difficulty managing personal hygiene because of their weight. The engagement of an outside agency has improved the resident's living conditions and community access, however, Community Visitors feel this resident is at risk of further deterioration.

Community Visitors reported that staff procedures at a CSO respite house meant a respite-user could not be given pain relief for a headache, because it was not on their medical authority. If the respite-user becomes unwell in the future, their family will need to take them home, or to hospital, as the respite service staff cannot support respite-users to hospital.

Medication errors were noted at two CSO houses. At one house, the medication packs in use were reviewed after residents missed medication. At the other house, 17 of the 27 incident reports recorded over a three-month period related to medication errors. The remaining 10 incidents related to residents falling or assaults. The CSO service manager responded that a pharmacy was responsible for three medication errors; another three errors related to 'missed' medication; two errors involved staff or residents dropping medication; and one incident report related to medication missed at a resident's day placement. The service manager also told Community Visitors that staff had unnecessarily filed incident reports on several medication errors, which had inflated the number of incident reports. Community Visitors were advised that staff had undertaken in-house medication retraining to reduce the number of medication errors.

North Division

The North Division includes Northern Metropolitan Melbourne, which is made up of the DHS areas of Hume Moreland and North Eastern Melbourne, and the regional Victorian areas of Loddon and Mallee. This year, 59 Community Visitors conducted 642 visits to 298 houses in this division.

There were eight notifications to the Public Advocate regarding residents at serious and imminent risk of harm. These notifications are detailed throughout this divisional report.

Northern Metropolitan Melbourne

Abuse and neglect

This year, Community Visitors reported an incident where two residents were sexually assaulted by another resident, as detailed in the following notification to the Public Advocate.

Notification to the Public Advocate

Community Visitors visited Plenty Residential Services after a caller to OPA's Advice Service reported that a resident, who had been left unsupervised, had been sexually assaulted by a resident from another house. Community Visitors later learned that another resident had also been sexually assaulted by the offending resident on the same day. Staff responded appropriately to the incidents, however, it took five hours for staff to notify one resident's family of the assault.

Community Visitors notified the Public Advocate who referred the matter to DHS North Division Executive Director. DHS responded that a range of strategies were developed in response to the incident, a number of which are still being implemented, and that the offending resident was being closely monitored.

Community Visitors raised concerns at a number of houses where residents with behaviours of concern physically attack each other, and there are no plans in place to address these issues.

Notification to the Public Advocate

Community Visitors have raised serious concerns regarding the wellbeing of residents at a CSO house who have complex needs and behaviours of concern.

Throughout the year, Community Visitors reported that the health of a resident with a history of mental illness had been deteriorating. When the resident was no longer able to attend a day program, they began to self-harm; assault and intimidate others; and leave the house in a dishevelled state, only to be returned home by police. The resident was admitted to hospital twice after setting fire to the dining room table and assaulting two staff members. The resident was discharged to another house with two-to-one staffing because of the risk the resident's behaviour presented to other residents.

Meetings were held with a range of parties to try to develop a plan for the resident's future, however, options were limited and a satisfactory solution is yet to be found. An OPA guardian was recently appointed to make decisions in the resident's best interests.

Community Visitors continue to hold concerns about the health and wellbeing of residents remaining at this CSO house.

Notification to the Public Advocate

Last year, Community Visitors reported on a CSO house where there had been incidents of violence and verbal abuse between residents. Following a notification to the Public Advocate, additional staffing hours and strategies were introduced at the house, but incidents continued to escalate.

A parent of a resident contacted OPA in July 2013 and said their adult child and another resident had been physically assaulted and verbally abused a number of times over a three-month period. Community Visitors notified the Public Advocate who contacted DHS to express ongoing concern for the safety of residents at the house.

In a response, DHS detailed actions that had been undertaken to address safety concerns in the house, and alternative accommodation was found for one of the residents. In May 2014, Community Visitors reported the house had "a much happier and more settled feel", and staff reported there had been no critical incidents since the resident's relocation.

Community Visitors also reported instances of staff neglecting residents' support needs.

A staff member at a CSO house told Community Visitors that another staff member had deliberately moved a buzzer out of the reach of a resident with complex medical needs, stopping the resident from seeking staff assistance at night. Community Visitors were advised that the staff member had been stood down pending the outcome of an external investigation.

Community Visitors reported concerns that the support needs of a resident at a DAS house were being neglected. Community Visitors felt it was unacceptable that the resident had been lying in their urine-and-faeces-soaked bed and night-clothes for many hours, despite staff encouraging the resident to get up. Community Visitors advocated for an assessment for the resident to improve their quality of life and health, and to protect their dignity. DHS advised they were aware of the resident's 'lack of motivation' and that a mental health plan was in place for the resident. Community Visitors did not feel this response adequately addressed the seriousness of the issue, and questioned whether more could be done to support this resident. The resident has since moved to another house and is reportedly doing well.

Incident reporting

DHS invited Community Visitors to participate in a presentation to North Division CSO staff on the DHS critical incident reporting requirements. The presentation was well attended and Community Visitors hope to see improvement in the management of incident reporting by CSOs.

Respite and unmet need in accommodation

Community Visitors believe permanent and age-appropriate accommodation must be found for two young residents living at an adult respite service. The residents, who are 17 and 18 years old, have both lived in child and adult respite facilities for long periods of time since being placed into the care of DHS. Community Visitors question what long-term strategies are in place to find suitable permanent accommodation for these young people.

Notification to the Public Advocate

Community Visitors reported on two children with disabilities who were placed in a DAS respite house in June 2013 following the death of their mother in early 2013.

Respite staff told Community Visitors that the Victorian Child Protection Service had been appointed as the legal guardian for the children, but that more than two months after arriving at the respite house, the children had still not been seen by anyone from child protection, nor was financial assistance provided.

The children arrived at the respite facility with no belongings, apart from the clothes they were wearing. Respite staff said they had sought vouchers from the Salvation Army and clothes from opportunity shops for the children, and the children's school had provided taxi money to enable them to attend school.

In September, Community Visitors notified the Public Advocate of the children's circumstances, and the matter was referred to DHS senior management.

In October, DHS responded that, on the advice of the Making a Difference Program, child protection had no direct contact with the children as it would be detrimental to their emotional wellbeing to be introduced to a stranger so soon after their mother's death. DHS was also advised that, given the children's disabilities and vulnerabilities, there should be a slow introduction of any new professionals in the children's lives, and that a child protection case manager would be introduced in a planned manner.

DHS also stated that it had funded items and medical costs for the children, and engaged with Centrelink to obtain health care cards. It is not clear when these actions were taken. Community Visitors were also advised DHS would work with child protection to ensure permanent placements for the children.

Community Visitors were later advised that the two children had been placed in foster care.

A number of Singleton Equity Housing properties have closed in this area over the past two years, and residents have moved to other houses where there were vacancies. Community Visitors are seriously concerned this will decrease the accommodation options for others requiring supported accommodation. This also does not allow residents who have lived together for up to 30 years, to choose whether they want to remain living with their housemates. Residents may also lose contact with staff who have supported them for many years and have a good understanding of their needs.

Community Visitors have raised concerns for a number of years that Plenty Residential Services (PRS) has been used as accommodation of last resort for residents who are incompatible with others. In some instances, people have been inappropriately placed with co-residents who have significantly different support needs. Similarly, residents who are unhappy where they live, and want to move to a house in the community, off the PRS site, face long delays because of the number of people waiting on the Disability Support Register (DSR) for accommodation opportunities.

Community Visitors are concerned that there are not enough respite places in this area. One CSO-managed respite house, which caters for high-risk respite-users with complex behaviours, is only contracted to support people between the ages of 15 and 25 years. Another house, managed by the same CSO, supports people with complex medical needs under 25 years. The CSO would like to extend the upper age limit at these houses to 30 years of age, so respite-users do not need to travel long distances to use a respite facility suited to their needs. The CSO is negotiating with DHS about a possible expansion of the current age limits. Another CSO has 59 families accessing a five-bed respite facility in Preston, which is set to be replaced by a six-bed facility in South Morang. Community Visitors believe an analysis of respite services in the area is needed.

Upkeep of buildings and fittings

Community Visitors reported on a number of maintenance issues at DAS and CSO houses. Reports include: carpet and linoleum in need of replacement; inadequate heating and cooling in residents' bedrooms; broken or missing cupboard doors; water damage in bathrooms; homes in need of repainting; broken and rotted boards on a fire escape ramp; a broken dishwasher; poor fencing; a collapsing retaining wall, and an overgrown garden blocking a side gate.

A number of maintenance issues were identified at the Disability Forensic Assessment and Treatment Service (DFATS), which were still not addressed four months later.

Maintenance is a particular issue at houses that are due to be replaced, even though residents who are still living there have a right to a home-like environment. This is also the case where the service provider does not own the house, such as for Singleton Equity Housing properties.

Community Visitors reported on unsafe bathrooms at one Singleton Equity Housing property managed by DAS. Six months later, Community Visitors were told repair work would be undertaken, however, nine months on from the initial report, the work was still not done. Rodents, cockroaches and a number of structural issues were also reported at this house. DHS has since advised residents and their families that this house will close once new accommodation for each resident is found within existing vacancies in this area.

Community Visitors reported that some houses are not designed to support residents' needs and provide a home-like environment. Issues reported include:

- a DAS house with no power points in the kitchen where residents have to walk across the room to use appliances that are kept on a bench
- privacy issues for adults at a DAS house where staff walk through a resident's room at night to access one of the two toilets in the house
- a DAS house which is too small for four residents and in need of replacement.

Personal safety

Community Visitors reported concerns for the personal safety of a number of residents, including a resident who regularly leaves the house unexpectedly, a DAS resident who has engaged in self-harm and a DAS resident who has fallen at night while staff are asleep.

Safety concerns were also raised regarding a resident of a CSO house who has poorly-supported behaviours of concern, and at another CSO house where a resident has said they feel unsafe because of the actions of another person at their day placement service.

Individual planning

Community Visitors reported that many important planning documents were out-of-date or not created for residents, including in at least three houses where files were several years out of date.

Some PCPs were unclear, meaningless or had unachievable goals. In some houses, Community Visitors could not find documentation as to how staff were implementing residents PCPs. Many key worker reports for residents in DAS houses were also reported as being out-of-date, unavailable, or not updated on residents' files.

Individual planning issues reported include:

- a resident who did not have a BSP despite allegedly being involved in an incident of sexual abuse and behaviours of concern regarding alcohol abuse
- out-of-date or non-existent BSPs for several residents subject to chemical and mechanical restraints
- a DAS house where food was locked away with no documentation available to explain why the restriction was needed, or what impact it had on residents
- a resident's repeated requests to move home not recorded in their file or in their out-of-date PCP, despite the resident's constant conflict with their housemate.

Community Visitors raised concerns regarding planning delays affecting a resident of DFATS who was due to finish a three-year court order. Accommodation for the resident had still not been found three weeks before the end of the order, which affected the resident's ability to plan for their future and apply for work. Community Visitors were advised the resident had received support for their transition to the community, but a decision on accommodation had been delayed as the resident was reluctant to accept supported accommodation options because of the level of supervision involved. Community Visitors question why this planning was left so late, given that the resident's future depends on finding suitable accommodation.

Planning of a high standard was reported in some houses: at one CSO house staff demonstrated good practice by making daily notes that link back to goals stated in residents' PCPs.

Community Visitors reported that some older residents want to have a day free from placement during the week; it is unclear how service providers will support these residents in transitioning to retirement.

Community inclusion and access

Community Visitors reported that one CSO house does not have a vehicle for staff to support residents to access the community, and staff are not allowed to use their personal vehicles to transport the residents. At two DAS houses, Community Visitors reported that residents spend large amounts of money on taxi fares because three houses share a vehicle. Sometimes residents have missed out on recreation activities because they cannot afford a taxi.

Staff support

Community Visitors reported that many DAS and CSO houses are understaffed, or rely heavily on casual staff who have varied levels of skill and training. Community Visitors believe all staff working in group homes should be sufficiently skilled to care for the individual needs of each resident.

Community Visitors report that there are some CSO houses that lack adequate management support, as they only have one team leader or house supervisor for two or three houses. This is particularly problematic when the houses are far apart. Lack of consistent management is also an issue for staff and residents, particularly at one CSO house where Community Visitors reported there were four different house supervisors in an 18-month period.

Some service providers have advised that they have had difficulty filling vacant positions, or now require additional staff support to manage residents' changing needs, but do not have sufficient funding for this.

Community Visitors raised concerns about the impact of staffing levels on residents, including:

- two residents of a DAS house who have no choice but to go to bed at 8.20pm each night before staff finish their shift, as two staff are needed to use the hoist to assist them into bed
- a DAS house where residents with high support needs have two staff during the day, but only one staff member is rostered on overnight

- a CSO house where staff lock an adolescent resident with behaviours of concern in a separate part of the house to other residents at night, as there is insufficient funding to provide active night staffing
- a casual staff member working a 'sleepover' shift alone overnight, despite it being their first shift in the DAS house
- two residents, who require one-to-one staff support, are limited in their community access because whenever they go out, another resident requires support from two of the three staff on duty.

Community Visitors reported inadequate quality of staff support at some houses, including: staff failing to enable community access for residents who have little family contact; staff at a DAS house failing to plan for residents to take holidays; and a lack of engaging activities for residents in some houses.

Community Visitors also raised concerns about several houses where there were no staff or resident meetings, and a DAS house where there was little interaction between staff and five residents who are non-verbal and have complex needs. Community Visitors noted a need for a 'relationships and sexuality policy' at a CSO house to clarify residents' rights and the support that staff could offer. A policy has since been developed at this house.

A significant sum of money was bequeathed to a CSO house, but residents were not involved in planning how the money would be spent, and requests for small purchases were denied until Community Visitors raised this issue.

At another CSO house, residents were restricted in their access to food, as money to purchase food had to be collected by staff members from the CSO head office, which is about 25 kilometres from the house. Community Visitors reported that house staff were not given extra time in their shift to collect this money, and staff often took one resident with them to reduce the number of residents in the house for the remaining staff member to support.

Health care

Community Visitors reported that a resident of a CSO house complained that they were unable to have pain relief medication prescribed by a hospital two weeks earlier, as it had been destroyed. Community Visitors raised this issue with the CSO and, after waiting several months for a response, were advised that medication storage procedures

would be reviewed and residents' consent sought before destroying medication.

Concerns were also raised at a CSO house where Community Visitors reported that there was no evidence that staff were monitoring a resident's significant weight gain.

Community Visitors met with a DAS resident and the resident's family after they contacted OPA's Advice Service to report unfair treatment by staff related to the resident's eye infection. Staff had placed a sign on the resident's door warning of infection risk, and had damaged the resident's clothes by washing them at a high temperature. Staff reported that they had contacted a disease control centre for advice because some staff had been infected while caring for the resident. However, the resident's family said the infection was being treated by medical professionals, and that no medical advice had been given suggesting infection control procedures were needed.

Community Visitors asked staff to respectfully discuss the procedures with the resident and the resident's family, and to provide a copy of the advice given by the disease control centre. Neither of these actions had been taken before the infection control procedures were implemented. Because of this lack of consultation, Community Visitors supported the resident's request for an apology and compensation for damaged clothes, and also asked staff to develop a plan ensuring appropriate care and support for the resident.

Notification to the Public Advocate

A hospital worker contacted OPA's Advice Service to report staff at a DAS house had failed to provide adequate care for a resident with a fractured leg. The resident was admitted to hospital with a necrotic wound, which hospital staff said was caused by staff at the DAS house failing to remove a leg splint.

Community Visitors enquired into the matter, but could not find any evidence that house staff had failed to care for the resident. Community Visitors spent several hours viewing health progress notes and other records at the house and talking with staff, and reported that staff had done everything in their power to provide very good care to the resident. Community Visitors also reported that the Royal District Nursing Service, the resident's doctor and an occupational therapist were also actively involved in the resident's care.

Notification to the Public Advocate

Community Visitors visited a DAS house after a resident's family member contacted OPA's Advice Service with concerns about the resident's care. The resident reportedly had a number of unexplained injuries which required hospital treatment, including a hip fracture.

In their response, DHS said staff believed the resident's mobility was deteriorating. DHS admitted there was a delay in seeking medical assistance for the resident on one occasion, and advised that a number of actions had been taken to try to reduce potential risk to the resident. These actions included an occupational therapy assessment and the installation of handrails.

Loddon

This year, Community Visitors received very few responses from CSOs within the timelines agreed in the Community Visitors protocol. This has impeded Community Visitors' ability to follow-up on issues.

Abuse and neglect

Community Visitors reported several incidents at the Sandhurst Centre where three residents from one unit have verbally abused or physically assaulted other residents or staff, or caused property damage. At times, police had to intervene, as detailed in the following notification to the Public Advocate.

Notification to the Public Advocate

A Sandhurst Centre resident was struck on the head with a kettle, causing an injury which required five stitches.

The next day, staff spoke to the resident alleged to have caused the injury, who said that another resident had told him to commit the assault.

When this resident was questioned, he became agitated, assaulting and verbally abusing staff. He also smashed nine windows before police arrived and he was interviewed and charged.

Community Visitors reported instances of abuse at two CSO houses. At one house, a resident said that they were scared after being hit, kicked and bitten by another resident. At another CSO house, Community Visitors reported instances of abuse which are detailed in the following notification to the Public Advocate.

Notification to the Public Advocate

Community Visitors visiting a CSO house enquired about scars on a resident's face and were told that one resident was aggressive toward others, and had bitten and scratched residents and staff. Community Visitors noted that the resident's BSP was out-of-date and that it listed prescription medication without the resident having seen a doctor.

Community Visitors also reported issues at the house including: residents burning themselves on the oven and stove; the need for safety barriers in the kitchen; a chained and padlocked refrigerator; and lack of resident information in the house evacuation packs.

Following the Community Visitors' visit, representatives from DHS and the CSO met with residents' families to discuss the concerns raised by Community Visitors. A number of actions were taken to try to ensure the safety, health and wellbeing of the residents, however, Community Visitors remained concerned about residents' safety.

On a subsequent visit, Community Visitors were pleased to report that the strategies implemented appeared to have improved life for the residents who were reportedly much happier. Community Visitors also reported that the resident who was aggressive toward others had seen a new doctor and their health needs appeared to have been met.

Incident reporting

Community Visitors were unable to access incident reports at two houses in this area that are managed by the same CSO.

At another CSO house, Community Visitors raised concerns that there were no incident reports written on two occasions when a resident had fallen. On one occasion, the resident required stitches after a fall, and a month later, the resident suffered a blood

nose and a cut lip after another fall. The CSO responded that incident reports had been written, but the acting house supervisor had not put them in the correct folder.

Upkeep of buildings and fittings

Community Visitors have reported on very few maintenance issues at DAS houses, however there are ongoing issues at several CSO houses.

Community Visitors reported concerns that hoists at a CSO house were not safe. A hoist service technician on site during a visit advised that at least one of the hoists at the house was not 'legal'. Community Visitors requested that the CSO rectify the issue immediately, and later reported that the hoists were fixed within the next few days.

A resident who lives alone in a CSO unit has been without furniture in their kitchen for more than a year after damaging it, but the CSO advises Community Visitors they are reliant on State Trustees to release the resident's monies to replace the furniture. Community Visitors have also reported problems with a flywire screen door at one of the CSO units for at least twelve months, and have also routinely noted dirty windows at the units.

At other CSO houses in the area, Community Visitors reported issues with the cleanliness of toilets and bathrooms, cobwebs around houses, and drapes not hanging properly.

Personal safety

Staff at a CSO house told Community Visitors that safety barriers were needed in the kitchen to ensure residents' safety. Staff also said they did not feel safe transporting residents in the house vehicle because one resident could attack others. Community Visitors do not believe this issue has been resolved as yet, but are aware that the Office of Professional Practice (OPP) and DHS are working with staff to better manage this situation.

Individual planning

Plans for the closure of the Sandhurst Centre in June 2016 are underway. Community Visitors were invited to attend several forums held by DHS to inform and consult with residents' family members about the redevelopment process. Individual plans have now been developed for each resident, and drawings of new accommodation options

have been drafted on the basis of individual plans, assessments and knowledge of resident compatibility. Community Visitors feel that staff support of residents at Sandhurst has remained constant during this period of planning and redevelopment.

At some houses, Community Visitors have noted positive effects when iPads have been purchased for residents, and believe this technology could help other residents with communication.

Staff support

At a CSO house, Community Visitors witnessed a resident using a chair to lock a staff member out of the house while the staff member was trying to encourage the resident to come back inside. Community Visitors are concerned that this is a dangerous situation for both the resident and staff.

Staff at two CSO houses in this area were not aware of the role of Community Visitors, although staff at one of the houses were able to locate the Community Visitors poster.

Community Visitors reported on incomplete evacuation packs with no resident photos at two CSO houses in this area. This issue has since been resolved at both houses.

Health care

Community Visitors have expressed concerns about several residents who are obese, and believe that staff could assist residents more with menu planning and exercise. However, this may be challenging when residents do not like healthy foods.

Five reports of medication errors, such as missed medication, were noted at one CSO house. In one instance, a resident's medication was missed two days in a row and the resident later had a fall at night, which may have been related to the missed medication. In another incident, a resident's medication was missed in the morning but was not reported until the evening, and the resident later missed their medication again because it had not arrived from a pharmacy.

At a DAS house, Community Visitors reported that three new wheelchairs sit unused in a garage because they are not suitable for residents. This issue has been ongoing for more than a year, but there is still no decision as to what to do with the new wheelchairs.

Mallee

This year, there was a critical shortage of Community Visitors available to visit houses in Swan Hill. The small number of Community Visitors in the area visit as many houses as possible, but simply cannot provide this important service to all Swan Hill residents living in group homes without the assistance of more volunteers.

This year, Community Visitors received very few written responses from DAS and CSO agencies in the Mallee area in a timely manner, which subsequently impeded Community Visitors' ability to follow-up on issues.

Respite and unmet need in accommodation

Community Visitors reported that there is a waiting list for respite at the only respite facility in Swan Hill. The house provides respite for all ages, but presently can only have three people at one time, and only on weekends. Community Visitors believe DHS should consider funding more respite places in this area for both adults and children with disabilities.

Upkeep of buildings and fittings

Community Visitors reported maintenance problems at one CSO house where they noted: mould on a wall outside a resident's room; a broken couch residents had difficulty getting up from; an inaccessible bath without a hoist or rails; and a toilet with no assistance rails or sufficient space for staff to help residents.

Personal safety

A CSO house in this area has a swimming pool, which Community Visitors report residents enjoy using. However it presents safety issues as the gate does not automatically lock when it is closed, and there is no shade over the pool to protect residents from the sun.

Individual planning

Residents of a CSO house have little or no equipment in their sensory room and backyard, despite their need for this. Two residents who like to relax by watching TV use an old video and DVD player and Community Visitors feel they should have a better entertainment system in their home.

Health care

Community Visitors reported that a resident in a CSO house required a water filter as part of managing multiple allergies which are exacerbated by unfiltered water. Staff tried boiling water for the resident, but this was not successful, and they resorted to purchasing bottled filtered water.

Community Visitors also reported that one resident of a CSO house has a bed which is too low for staff to assist in lifting the resident.

South Division

The South Division includes the DHS areas of Bayside Peninsula, Southern Melbourne, Inner Gippsland and Outer Gippsland. This year, 76 Community Visitors conducted 693 visits to 271 houses in this division.

There was one notification to the Public Advocate regarding a resident at serious and imminent risk of harm. This notification is detailed in the Public Advocate's introduction to this report.

Bayside Peninsula

Abuse and neglect

For many years, Community Visitors reported concerns that residents at one CSO house were subject to emotional abuse due to a house supervisor's autocratic style. The supervisor was placed on a six-month performance contract after Community Visitors raised concerns with the CSO, and left the service last year. New staffing is in place and the house now has a relaxed and homely atmosphere. One resident no longer requires weekly health treatment for an issue possibly related to poor emotional wellbeing. New staff told Community Visitors that serious breaches of the resident's rights had occurred in the past.

This year, a DAS house staff member was charged by police following an investigation into the assault of a resident. The staff member had been stood down while the incident was investigated. Community Visitors noted that counselling was provided to the resident following the incident.

At one CSO house, a resident repeatedly attacked other residents and staff, as documented in at least 25 incident reports. Community Visitors reported that staff were frightened to come to work, and residents were so fearful they would not be in the same room as the resident. The resident was

placed on the DSR and alternative accommodation was provided in another group home.

At a CSO house, Community Visitors reported that one resident had intimidated, verbally assaulted and physically assaulted residents for six years. The resident shouts and assaults other residents who use walking aids, and also throws residents' meals in the bin. Other residents back away to their bedrooms when the resident is in the main living areas of the house. While staffing at the house has increased in the evening, when most incidents occur, Community Visitors remain concerned that residents do not feel safe and comfortable in their own home. Community Visitors raised the matter with the organisation's Chief Practitioner who responded that several discussions had taken place with the resident's family about the resident moving to alternative accommodation with more appropriate support, and that this was an ongoing matter. However, the CSO's management had not informed Community Visitors of these discussions, despite Community Visitors raising their concerns consistently for several years.

At another house, one resident's ongoing dispute with a service provider has had an impact on the wellbeing and rights of other residents. Residents have been harassed and staff have been assaulted while assisting other residents. Community Visitors believe residents are living in a destabilized environment despite staff and management efforts to support them.

Incident reporting

On a number of visits, Community Visitors were unable to access incident reports. Reasons given for this included reports being with management for consideration and casual staff being unfamiliar with accessing incident reports electronically.

The Disability Act requires that service providers make documents available for inspection by Community Visitors, but not all CSOs are doing so. Two CSO houses have moved to electronic systems of storing incident reports, but Community Visitors' access is reliant on staff being both available and able to use the computer. Community Visitors have been offered passwords to access incident reports, but are not comfortable with this level of access to an organisation's management systems.

DHS invited Community Visitors to participate in a presentation to CSO staff on the DHS critical client incident reporting requirements. The presentation was well attended and Community Visitors hope to see improvement in the management of incident reporting by CSOs.

Respite and unmet need in accommodation

Community Visitors reported ongoing concerns about the placement of a young resident in a house with four elderly residents who have impaired mobility and vision. This inappropriate placement impacts on the quality of life for all residents. Community Visitors understand the young resident has waited on the DSR for 18 months for other accommodation.

Upkeep of buildings and fittings

Problems with maintenance, repairs and replacement of furnishings and fittings are widely-reported, particularly in ageing houses. Issues include stained carpets, water damage and mould in bathrooms, inadequate lighting, and outdated houses not suitable for residents with disability.

Community Visitors have reported that one DAS house has needed painting for the past 10 years with no result. At one CSO house, residents' families and staff resorted to holding a sausage sizzle fundraiser to pay for paint.

One DAS house with multiple maintenance and design issues is now being rebuilt following Community Visitors persistent advocacy, and some houses are being renovated or have had worn furniture replaced.

Community Visitors report that residents' dignity and privacy is compromised in some houses where toilets are located in open-plan bathrooms. After persistent advocacy from Community Visitors, two of these houses now have screened areas or doors in bathrooms for privacy, but in other houses bathrooms remain institution-like.

At one CSO house, five residents have to share one bathroom as staff have locked the second bathroom for their own use, and the OoH refuses to pay for another toilet to be added. Stronger toilet seats are needed at another CSO house, in order to prevent one resident from removing them.

Individual planning

On many occasions, Community Visitors reported residents' PCPs had either not been developed or were incomplete, which Community Visitors feel is unacceptable. Responses from DAS were that plans were in progress or had been completed following the Community Visitors' visit.

Staff methods of recording residents' plans, implementation of plans and residents' progress,

vary. In some houses the concept of a 'living plan' is not evident, and plans are not reviewed or updated. Community Visitors reported that a 'universal' system of documenting residents' plans is needed.

Community inclusion and access

The increasing use of taxis to enable residents' access to the community is having a serious impact on residents' finances, and often means long waiting times. A number of houses have inadequate access to vehicles, which restricts residents' access to the community or transport to appointments and day placements.

A caller to OPA's Advice Service reported that a resident of a CSO house, who had become increasingly unsteady and needed to use a wheelchair, was no longer able to go out in the house vehicle because it did not have a hoist. The resident had stopped attending their day program because of the transport issue and risk of falls. Community Visitors raised concerns the resident was becoming socially isolated, and questioned the level of staff and day program support for the resident's changing needs.

At a CSO house, which does not have a permanent vehicle, Community Visitors were concerned to learn that a resident, who missed a bus on the way home from day placement, was driven home by a passing stranger who called the house for permission to do so.

Staff support

Community Visitors reported two issues regarding staff attitude towards residents. At one house, staff openly discussed residents in an insensitive and demeaning way, and were asked by Community Visitors to move their discussion to a private location.

Residents at a CSO house told Community Visitors they were unhappy with the support and attitude toward them expressed by a staff member. The staff member, who was unaware of the issue, now takes more care with communication and meets with residents weekly to ensure they are satisfied with the support they receive.

Community Visitors reported concerns regarding staffing levels at some houses, including:

- a CSO house where an application to DHS for additional staffing was refused, despite insufficient staffing to support residents during meal and bathing times

- a DAS house where staff spend four hours each day transporting residents to and from day programs, detracting from time spent supporting residents
- some houses where frequent use of casual staff is affecting staff ability to meet residents' needs.

At houses where residents are not engaged or enabled to make choices, Community Visitors note residents are bored or frustrated. This is in contrast with other houses, where motivated house supervisors and staff working in a person-centred active support model have benefited residents and reduced behaviours of concern. Community Visitors reported that communication assessments are also an important part of encouraging resident independence and choice.

Community Visitors reported positive examples of staff support including:

- a resident in a CSO house who has become very independent and could benefit from moving out of a group home
- a DAS resident encouraged to attend activities outside of the house to distract from obsessive eating behaviours
- staff at a DAS house trained to work with residents with dementia following a suggestion from Community Visitors.

good practice



A shy, young resident has become confident and settled in a DAS house with the support of staff. The resident has learnt to train and care for pet birds, enjoys relaxing with housemates in a new 'games arcade' room at the house, and is embracing new challenges.

Community Visitors report that mandatory weekly fire safety checks of equipment need to be enforced to increase staff awareness of this important safety requirement. Community Visitors' access to information on evacuation and fire drills is dependent on staff members on duty knowing how to access records on the computer. As a result, Community Visitors are sometimes unable to verify staff compliance with safety requirements.

Community Visitors reported that evacuation packs also need to be updated with residents' details and equipment at some houses.

Health care

Residents' health care needs, including assessment, preventative dental care and management of behaviours of concern, are generally well-managed by staff and residents' families. Community Visitors noted that a resident of one CSO house had consulted a specialist for treatment of an ongoing medical condition, however, the resident's family does not want invasive medical procedures to be performed. Community Visitors questioned whether an application for guardianship would be a suitable method of promoting the resident's best interest with regard to making medical decisions on their behalf.



Community Visitors reported a number of issues concerning the health and wellbeing of residents at a CSO house where one resident's repeated screaming was distressing all residents.

Community Visitors first raised the issue in October 2012, and were advised that a medical review for the resident had been organised. In April 2013, Community Visitors reported that the OPP had assessed the resident's health, and that medical investigations had been undertaken and medication altered.

In August 2013, Community Visitors requested an urgent solution be found, as the resident's behaviour had further escalated. The CSO responded that they had sought to move the resident out, as all recommendations from professionals involved had been followed for 14 months without success.

The CSO also agreed with Community Visitors that the resident would benefit from individualised support and accommodation. In February 2014, a notice to vacate was issued, however, in May 2014 Community Visitors reported the issue was still unresolved. The CSO advised that the resident continued to show improvement in their wellbeing, which was attributed to a new psychiatrist and medication, and the commencement of a transition process for the resident to return to day placement.

Community Visitors noted nine separate errors involving medication administered to residents at one CSO house. The CSO advised that this was due to confusing procedures and pharmacy errors, and on a later visit Community Visitors reported that the situation had improved.

Increased referrals to the Centre for Developmental Disability Health (CDDHV) for a second opinion on medication has reportedly resulted in a decrease in residents' medications.

Southern Melbourne

Abuse and neglect

A notification of abuse and neglect was made to the Public Advocate regarding the alleged abuse of a resident by a DAS staff member. This notification is highlighted in the Public Advocate's introduction to this report.

Community Visitors report that an incident report is still not available regarding the alleged abuse of a resident by a staff member at a CSO children's respite service. The allegation was referenced in staff notes, but no incident report appears to have been written. Community Visitors have not been able to establish what is alleged to have occurred, and only have information from the CSO and DHS that the staff member has been stood down pending a police investigation.

Incident reporting

Community Visitors reported difficulty in accessing incident reports at a CSO house as they were stored on an intranet. Community Visitors' access is reliant on staff being both available and able to use the computer. Community Visitors have been offered passwords to access incident reports, but are not comfortable with this level of access to an organisation's management systems.

Community Visitors have been unable to access incident reports at a CSO house on several visits, as they are stored electronically. Service managers insist staff are willing to show Community Visitors how to log in, however staff on duty at the time of visiting often tell Community Visitors they don't know the passwords or how to access the computer.

On one visit Community Visitors asked staff to access incident reports on the computer and were told the staff member did not know the password, however, later in the visit the staff member used the computer to provide information on fire drills. When this issue was raised with management, the response received stated the system for incident reports was not working on the day of the visit. A brief summary of incident reports is sent to Community Visitors. However, Community Visitors believe this is

insufficient and that the CSO is not fulfilling its obligations to make incident reports accessible to Community Visitors at all times.

Respite and unmet need in accommodations

Community Visitors are concerned that families, who need respite to cope with the demands of being carers, are not able to access respite services when needed.

More funding is needed for a CSO children's respite house, which only has three respite places available because of funding cuts and accommodation of long-term residents. There are 13 families who use the respite facility, and a further seven families waiting to access respite.

Another CSO children's respite facility in this area underwent a change of management and is now underutilised, as families do not seem to be using the service on weekdays. The house is well-appointed, has good amenities and two vehicles. However, due to a lack of funding for staffing, the vehicles cannot be used to transport children to school during the week.

There is still a great need for accommodation for people who are waiting on the DSR. Community Visitors are aware of a unit in Pakenham unoccupied for more than two years which could have provided accommodation for at least two residents. At another house, Community Visitors note there is a large room with an ensuite and private entrance which could be used as independent living accommodation for a resident with minimal support needs.

Upkeep of buildings and fittings

Painting is needed in several houses in this area, and Community Visitors have also noted a bedroom window at one CSO house that has been boarded up for more than three years.

Community Visitors reported that some houses in this area are not suitable for people with a disability. In one DAS house, five residents now require bigger wheelchairs than their house was designed to accommodate. This raises the question of whether residents can continue to be safely cared for in this house.

In a CSO house, five residents must share one toilet, which is located in the bathroom, as the other toilet at the house is locked for staff use only. This leads to numerous problems for the residents,

especially during busy times such as in the morning, or when the bathroom is occupied. CSO management has advised Community Visitors that the OoH and DHS will not fund the provision of an additional toilet at the house.

During the February heatwave, Community Visitors were called to attend a DAS house where the air conditioning had broken down and the heat had compromised residents' health. Community Visitors also raised concerns regarding a similar issue at a CSO house in January.

Individual planning

Community Visitors raised concerns regarding a resident who was moved from their home of 16 years following an altercation with another resident. The resident does not want to live in the house they have since been placed at, and, as a result, is displaying behaviours of concern.

Community Visitors reported that overdue review dates for residents' PCPs were still a concern in this area.

Community inclusion and access

A DAS house has residents who are ageing and need transport to medical appointments. Often they do not have a vehicle available. This limited access to transport impacts on residents' rights to access their community for vital health care. Community Visitors were advised that a proposal had been forwarded regarding a suitable vehicle. Given that this issue was first reported in 2009, Community Visitors are concerned that it is still unresolved.

Staff support

Community Visitors reported that a CSO had difficulty retaining permanent staff for one house and required agency staff to fill shifts. On one visit, Community Visitors reported that a new staff member was rostered on to work alone on an 11-hour overnight shift supporting residents with high-care needs.

At other houses, Community Visitors reported concerns that there was insufficient time provided for staff handover and for casual staff to understand residents' support needs.

Community Visitors in this area had an additional focus on emergency management this year, and reported that evacuation packs needed to be updated with residents' details at several DAS and CSO houses.

Health care

Community Visitors raised concerns at two houses that residents were not receiving medical treatment in their best interests. At one CSO house, staff reported difficulty arranging for a resident to have blood tests and dental work due to resistance of family members. A resident at another CSO house refuses medical treatment, and Community Visitors question whether a guardian is needed to ensure medical decisions are made in the resident's best interests.

Inner Gippsland

Abuse and neglect

Community Visitors reported a concerning case of neglect and the abuse of a resident's dignity and rights in a CSO house. A resident's friend requested, through OPA's Advice Service, that Community Visitors visit the house. On the visit, the resident complained to Community Visitors that for many months, they were not assisted to get out of bed before 9am. This resulted in the resident soiling themselves, causing them great embarrassment and stress.

House management advised that three staff were needed to help the resident get out of bed, and that they were trying to employ more staff and to work with the resident's family to address the issue. However, Community Visitors report the situation is still ongoing, and is an example of inadequate staffing having a serious impact on residents' wellbeing.

Incident reporting

Community Visitors have raised concerns that staff may be unintentionally miscategorising incident reports. Follow-up after incidents can also be difficult if BSPs are not put in place for residents and if the incident in question has not been well-documented for other staff.

Upkeep of buildings and fittings

Upkeep of buildings and fittings continues to be a major concern, particularly in ageing houses where appliances often break down and general maintenance is required. Community Visitors reported issues including broken stoves, dryers and dishwashers, and damaged floors. These issues affect residents' daily routines and the support they receive from staff.

Community Visitors reported that one CSO house had a bleak, stark and unhomelike environment, and were advised that the CSO would work with DHS to improve the structure and living environment at the house.

Personal safety

Community Visitors report that residents' personal safety can be placed at risk because of other residents' behaviour, making it crucial that residents' BSPs are effective and regularly reviewed. Consequently, it is problematic, and a safety risk, when the development and implementation of residents' BSPs are delayed. Staff can also be at risk because of residents' unsupported behaviours, and may require management to put other strategies in place to protect residents and staff.

Individual planning

Some CSO houses in this area are failing to create, update and review residents' support plans. This is of particular concern for Community Visitors, as the Disability Act requires that residents' support plans be developed and updated. This is also a condition of service providers' funding from DHS.

Staff support

Community Visitors reported that, at some houses, there was insufficient staffing to manage residents' support needs and behaviours of concern.

Community Visitors reported concerns about a staff member at a CSO house "shaking their behind" in front of a resident, and also questioned the adequacy of support provided to two residents displaying behaviours of concern. CSO management responded that it was making changes to practice, culture and personnel at the house, including the appointment of a new manager and eight new staff. The manager stated that the staff member's "dance" was not suggestive, and it was intended to engage with the resident based on an activity the resident enjoys. The manager also stated that behaviour support strategies for residents displaying behaviours of concern were being developed.

Health care

Community Visitors reported on an ongoing conflict between CSO house staff and a resident's family, who are reluctant to consent to medical treatment

to address a problem which is causing the resident significant pain. While staff are working to find an advocate to support the resident, and are continuing discussions with the resident's family about the issue, Community Visitors are concerned that the resident's health care needs are not being met.

Community Visitors raised concerns regarding the nutritional value of meals at one DAS house, however, staff have advised that meals are appropriate and are chosen by residents on particular days of the week.

Outer Gippsland

Incident reporting

Community Visitors were not able to view incident reports at one DAS house, as they were kept on a computer. Hard copies were not kept on residents' files, despite this being a requirement.

Upkeep of buildings and fittings

Several houses in this area are not fitted with air conditioners. At one DAS house, residents were required to pay for air conditioning to be installed, but it is unclear whether the residents now own the air conditioner and can take it with them if they leave. At another DAS house, air conditioning cannot counter the heat in some rooms and Community Visitors believe an outside awning is needed to address the problem.

At a DAS house, Community Visitors reported that a shower had leaked into an adjoining wardrobe, causing mould and rot in the woodwork.

Community inclusion and access

Community Visitors reported that a wheelchair-accessible vehicle is shared between four DAS houses in this area. Residents of one house only have access to the vehicle for three days each month, seriously limiting their right to participate in their community.

Health care

At one CSO house, a resident sometimes has seizures, however, staff are unsure what has caused them. Community Visitors have requested that the resident's family and medical professionals be engaged to address this issue.

West Division

The West Division includes Western Metropolitan Melbourne, which is made up of the DHS areas of Brimbank Melton and Western Melbourne, and the regional Victorian areas of Barwon, Central Highlands and Western District. This year, 58 Community Visitors conducted 761 visits to 259 houses in this division.

There were four notifications to the Public Advocate regarding residents at serious and imminent risk of harm. These notifications are detailed throughout this divisional report.

Western Metropolitan Melbourne

Abuse and neglect

Community Visitors notified the Public Advocate of three incidents of abuse and neglect in this area, as detailed below.

Notification to the Public Advocate

Community Visitors notified the Public Advocate that a DAS staff member had allegedly assaulted a resident. The incident report stated that the resident was allegedly kicked, choked and pinned to a counter by a staff member, who reportedly stated, "this is how we should deal with behaviours". The Public Advocate escalated Community Visitors' notification to senior DHS management.

DHS advised that the staff member had been suspended from duties and instructed not to have any contact with residents or staff at the house. Police had also reportedly requested that a DHS investigation be delayed until after a police investigation.

The Public Advocate was advised that the resident's BSP did not include physical interventions, and that the staff member had worked with the resident for several years and had been trained to manage the resident's behaviours of concern. DHS also advised that other staff witnessed the alleged assault, but delayed reporting it because they were intimidated by the perpetrating staff member. Work practices at the house were also to be reviewed by DHS.

On later visits, staff advised Community Visitors that the resident had initially been subdued and less trusting of staff, but that this had since improved.

Notification to the Public Advocate

An adolescent living in a CSO house with adult residents alleged that they had been sexually assaulted by a staff member. Community Visitors were satisfied that staff and management of the CSO had followed correct procedures in reporting the allegation and supporting the resident. However, Community Visitors were concerned about the appropriateness of the resident's placement at the house and the adequacy of their case management.

Community Visitors notified the Public Advocate, who requested that DHS advise what steps had been taken to provide the resident with adequate care and age-appropriate accommodation.

The resident later retracted their allegation of sexual assault and acknowledged that they had made a false statement. In its response to the Public Advocate, DHS stated that case management for the resident had ceased when they had settled in at the house. DHS acknowledged that, given the resident's age, continuing case management would have been more appropriate, and advised that the resident and their family would be re-engaged to assess accommodation and support options.

Notification to the Public Advocate

Community Visitors reported that a resident of a CSO house has waited seven years for an ISP, and has become increasingly isolated. The resident has very specific communication needs, and spends most of their time at home alone. CSO management advised that the resident loves to socialise, but has suffered a decline in their emotional and mental wellbeing, motivation and independence because of their isolation.

Community Visitors raised the issue with the DHS division in which the house is located, and also with the West Division which funds the CSO. However, there was no change in the resident's circumstances. The Public Advocate was notified and raised the issue with the CSO management.

The CSO advised they were working to engage the resident in activities, teach them to travel independently, and had enquired about the cost of a day service, which DHS advise the resident's family may have to pay for if the resident is not allocated an ISP.

Community Visitors first raised concerns about this resident's isolation in 2010 and, given that other residents are funded to attend day placement, believe this is discriminatory and a breach of this resident's human rights and the principles of the Disability Act.

Incident reporting

Incident reports are not always accessible to Community Visitors, despite this being required by the Disability Act. Staff have advised Community Visitors that incident reports are on the house computer and hard copies are not available, or that reports are at another office.

It is important that Community Visitors have access to incident reports as the reports can show a pattern or issues that require attention. At one CSO house, Community Visitors were informed of a serious incident involving a resident that required the evacuation of other residents. The incident report could not be found at the house, but Community Visitors found nine other incident reports relating to the same resident. Community Visitors would like also to see the recommendations and outcomes following incidents, and that the completed incident reports are returned to the resident's personal file.

Upkeep of buildings and fittings

Community Visitors reported that many houses in this area needed repairs for issues such as: holes in walls; broken toilet seats and showers; unsafe fences; dangerous and unusable ramps; rotting pergolas; and much-needed painting.

Community Visitors are repeatedly told repairs are delayed, or denied, due to lack of funding, and report 'buck passing' between agencies and government departments as to who bears responsibility for this funding.

Community Visitors report many maintenance problems in bathrooms, and in one house an unsafe shower has still not been repaired two years after Community Visitors first reported the issue. At one DAS house, toilets were built to accommodate commodes, however Community Visitors reported that work on flooring had not been completed and toilets were not suitable for one resident who does not use a commode.

At one DAS house, staff and residents use a toilet in one resident's ensuite, which Community Visitors feel is a breach of the resident's privacy. DAS has advised that another toilet cannot be added because of the design of the house, and that staff and residents had decided to continue using both the ensuite toilet and the other toilet in the house. This house has been identified for replacement.

Community Visitors reported that residents at two CSO houses could not use their own backyards because of maintenance issues. At one house, this is because of poor fencing to protect residents from a dog that leaps at the fence, and at the other house because funding is not available for a locked gate.

Personal safety

Community Visitors reported safety concerns at several houses including:

- unsecured knives at a house where a resident had threatened others with a knife
- a resident who had fallen getting out of bed but had no way of alerting staff
- a power point close to a resident's pillow which was only moved after two reports from Community Visitors that the resident often hit their head on it
- a house where steps at the front door are difficult for residents to use as there is no handrail for support.

Safety concerns regarding uneven footpaths at one house were referred for a maintenance assessment, and matters regarding poor-quality photos of residents in evacuation packs and old machinery in a house backyard were rectified once they had been raised by Community Visitors.

Community Visitors reported concerns at some CSO and DAS houses where chemicals were not stored safely or laundry cupboards had no locks.

Individual planning

Community Visitors reported that some houses have well-written PCPs and BSPs for residents, but others have out-of-date plans. In some instances, staff were slow to develop and implement PCPs for new residents.

Key worker reports, which are crucial to reviewing planning, are often misfiled, incomplete, or not written at all. At one house, reports were still not completed after six months, and some houses

report a lack of permanent staff means some residents do not have staff members nominated as key workers, which is common practice in most DAS group homes.

At one DAS house, food cupboards were locked, but there was no indication of this restrictive action written in residents' BSPs.

Improved quality of PCPs in one DAS house has meant residents are now happily taking on new household activities, including one resident who grows vegetables and helps to prepare them for dinner. Some houses document residents' PCPs in creative ways, such as using photographs of residents doing household tasks and activities, which, Community Visitors reported, has encouraged residents to try new activities and made residents proud to show their plans to visitors and family.

Communication assessments are still not available to all residents, due to long waiting times of up to two years for assessments through DHS, and the high cost of private assessments.

Community Visitors believe residents have a right to communicate, and that assessments are crucial in enabling residents to communicate their needs, choices and decisions to staff.

Community Visitors also made a number of requests to staff at both DAS and CSO houses that asset registers be updated.

Community inclusion and access

Community Visitors reported that staff ability to support some residents to go out in their community is limited by the availability of vehicles. One DAS house has access to a vehicle only every third weekend, as it is shared with two other houses. DHS advised Community Visitors that a vehicle was available on the weekend and residents could use public transport or taxis if needed. At another DAS house, two residents who use wheelchairs cannot use the house vehicle as it is not designed to accommodate wheelchairs.

Staff support

Community Visitors reported that one DAS house has been without a house supervisor for more than 18 months, which has affected the stability of management in the house. At another DAS house, staff advised Community Visitors that unfamiliar staff and changes at a day placement contributed to one resident's aggressive behaviour towards another resident.

Community Visitors reported that staffing levels on weekends were problematic at two CSO houses, and that additional funding was being sought so residents could be supported to go out.

Community Visitors reported concerns with staff attitudes at two CSO houses. At one CSO house, a resident complained about the way a staff member had spoken to another resident, as witnessed by Community Visitors on two visits. At another CSO house, a staff member's inappropriate attitude was also of concern, as she referred to residents as being "not all there"; said a shy resident was a "snob"; and said residents couldn't ask to go outside, because they could not "talk." In its response, the CSO stated that the staff member's comments were "in jest with no malicious intent", that residents who are non-verbal could indicate 'yes' or 'no' with gestures and sounds, and that the staff member would be offered training on positive interaction with residents. Community Visitors are concerned that residents, either do not have effective communication assessments and strategies, or staff are failing to use these strategies to communicate with residents.

Community Visitors reported that many houses have committed and dedicated staff who interact well with residents and involve them in the running of their house.

Positive examples of staff support include:

- meetings between house staff and day placement staff to discuss issues and develop BSPs
- staff and residents creating themed gardens and placing a water feature near a resident's window so they could enjoy the sound and movement of the water
- a resident encouraged by staff to use their iPad to take photos and email family and friends.

At one CSO house, casual staff were not aware of the role of Community Visitors, even though the house management said it was included in an induction checklist for casual staff. A number of DAS and CSO houses also did not have a copy of the Community Visitors protocol at the house.

Health care

Community Visitors reported a number of medication errors, including staff failing to check correct medication was provided by a pharmacy, inconsistent medication storage, and medication stored in unlocked cabinets. Community Visitors feel it is important that residents' photos be attached to

their medication packs to prevent errors when staff administer medication.

At two DAS houses, residents' health summaries and health plans were out-of-date until Community Visitors raised the matter.

Community Visitors in this area had a particular focus on emergency management this year, and reported that some houses had out-of-date first aid kits in evacuation packs. At the houses where Community Visitors reported this issue, staff purchased new kits or designated a staff member to regularly check the kits.

Barwon

Abuse and neglect

Community Visitors reported that inappropriate placement and residents' poorly-supported behaviours of concern have resulted in residents and staff being abused at two DAS houses. At one DAS house, a resident is continually physically and verbally assaulted by another resident, and at another DAS house two residents encourage each other to behave violently and damage property, upsetting other residents.

Incident reporting

Incident reports are stored on a computer at some houses, and are not available to Community Visitors as required. When asked for incident reports, staff at one CSO house phoned a manager who incorrectly advised them Community Visitors were not allowed access to incident reports.

It is crucial that Community Visitors have access to incident reports as these can indicate a pattern of incidents that require attention and whether incidents have been reported properly and action taken.

Respite and unmet need in accommodation

Community Visitors reported ongoing problems at a DAS respite facility used to accommodate a person with behaviours of concern. This person's long-term stay restricts others from accessing short-term respite. Incidents at this respite facility were the subject of the following notification to the Public Advocate.

Notification to the Public Advocate

A person staying long-term in a respite facility assaulted other respite users and staff in July 2013, and attempted to assault them again in August. In both cases police were called and in one instance, staff moved other respite users to the staff room for their safety.

Community Visitors raised safety concerns with DAS, and were assured that action was being taken. DAS acknowledged that staffing issues at the facility had compromised the quality of care expected at a DHS facility. These issues included the resignation of three staff whose conduct, DAS stated, had contributed to the interactions between two respite users.

In December, the person went missing, damaged a staff member's car and injured a staff member by throwing stones. The Public Advocate requested DHS take immediate action to address this person's support needs and to protect other respite users' safety and rights.

Between January and May, a BSP, alternative support strategies and staffing changes were introduced; these reduced the person's behaviours of concern and use of medication.

Upkeep of buildings and fittings

Community Visitors reported maintenance concerns in several houses including holes and cracks in walls and ceilings, unsafe bathroom flooring, mould in showers, leaking toilets, no flyscreens on doors and dirty carpets.

Some houses have inadequate toilet facilities, while others have corridors and bathrooms that are not suitable for residents using wheelchairs. One house needs bathroom equipment such as hoists, and a CSO house does not have air conditioning.

Personal safety

Community Visitors reported three incidents of residents injuring themselves through behaviours of concern, including one resident who ate fabric and foam and was taken to hospital. Community Visitors questioned what strategies would be developed to prevent this happening again.

Community Visitors reported that a resident at Colanda had suffered a black eye, but staff did not

know how it had happened. Staff told Community Visitors that they were busy that day because they were short-staffed.

Individual planning

In some houses, residents had up-to-date PCPs and BSPs, but other houses were still updating plans.

Community Visitors reported concerns that the interviews and assessments of residents taking part in the NDIS trial were very brief and included little or no input from people involved with residents' daily care and support. Some residents are non-verbal and their needs have been assessed on approximately one hour of observation. Community Visitors believe this is inadequate and are concerned that years of care, consultation and understanding of residents' needs are being ignored in NDIS planning.

Community inclusion and access

Additional vehicles would help staff support residents' access to the community. Some houses share vehicles which restricts outings, and other vehicles need to be adapted to provide wheelchair access.

Staff support

Community Visitors reported that staffing at several houses may be inadequate to support residents with high care needs. At one DAS house where a resident requires the assistance of both staff on duty to have a shower, other residents are left unsupervised, and Community Visitors question whether a third staff member is needed to support residents. At a CSO house, a resident with epilepsy is increasingly experiencing falls, including one fall which resulted in serious injury and required hospital treatment. Staff told Community Visitors that they can no longer meet this resident's needs with the current level of staffing.

Community Visitors also reported that residents at one DAS house had been "unsettled" by the number of staff changes, and also noted that in some houses, staff may need specialist training to support residents with behaviours of concern.

Health care

Community Visitors reported that health care plans were in place for residents and appeared to be followed by staff at houses in this area. One resident's NDIS funding pays for night staffing to

manage bedsores, while at another house, a resident uses a pressure mattress to manage the same condition.

A resident who fell from a wheelchair was sent home from hospital with painkillers, but was later found to have a fractured shoulder. Community Visitors raised concerns that staffing was inadequate to assist this resident to recover from their injury.

Community Visitors reported that equipment to support residents' needs was not available in some instances. A resident at a DAS house has had the same wheelchair for seven years and it no longer meets their physical needs. The resident has been measured for a new wheelchair, but staff have told Community Visitors there is no funding to purchase it. A resident at another CSO house has waited more than 10 months for the installation of a bedroom hoist to help them out of bed and into a wheelchair.

Central Highlands

Abuse and neglect

Community Visitors reported several incidents where residents and staff have been assaulted or subject to abuse by other residents with behaviours of concern.

At one DAS house, a resident increasingly targeted two other residents, assaulting them and damaging property in at least 19 documented incidents. Moving the resident to another house is being considered, but Community Visitors feel this should be prioritised to protect residents who are frightened by this behaviour.

Community Visitors reported residents at another DAS house had verbally abused each other, damaged property and that one resident threatened another with a knife. One of the residents later assaulted a staff member. A new BSP was developed for this resident to address the triggers causing escalated behaviour. The resident's medication was also adjusted and an infection the resident had was treated. Community Visitors reported that the resident's behaviour has improved since the other resident involved in the incident moved from the house.

On a visit to another DAS house, Community Visitors witnessed a resident shouting and threatening staff, and were also advised the resident had threatened a housemate with a knife. Other residents were upset by this behaviour and Community Visitors raised the possibility of the

resident moving to other accommodation, however, additional staff and behaviour support stabilised the resident's behaviour in the following months.

Incident reporting

Community Visitors reported that some staff still have difficulty locating incident reports, however, filing systems are improving. Consistency of filing across all houses would be beneficial.

Respite and unmet need in accommodation

Community Visitors are concerned about the number of facilities being used for long-term accommodation, including:

- a respite house where four out of five residents are long-term and are waiting for accommodation
- two residents living in respite for a year and travelling long distances to attend day placement
- a resident who requires one-to-one care living in respite for one year and nine months while on a 'waiting list' for permanent accommodation.

Community Visitors reported uncertainty regarding continued funding for a respite house for four children. These children cannot live at home, and are deemed to be too young to live in a group home.

Upkeep of buildings and fittings

Community Visitors reported concerns with cleanliness and maintenance of bathrooms at several houses, including some where mould and rotting skirting boards were visible. Unsafe, buckled and damaged bathroom floors were eventually repaired in one CSO house, but no further work to patch or paint the bathrooms was completed. One resident was set to move to a new house as the unit she was living in independently was in poor condition with uneven floors and walls exposing sharp metal edges.

Community Visitors reported that the rights and dignity of residents at one DAS house are compromised by inadequate toilet facilities. The house has one toilet, located in the bathroom, for the use of five residents who have had to relieve themselves outside or in their bedrooms when the bathroom was occupied, as they could not wait. Community Visitors have asked for toilet facilities to be improved at this house, and at another DAS house in the area, which also has only one toilet.

Residents who use wheelchairs are unable to have a regular therapeutic spa at one DAS house, as the older-model spa has been broken for six months.

Personal safety

Community Visitors reported concerns for the safety of a number of residents who have left home alone at night, including:

- a resident found walking down the middle of a road after casual staff failed to set an alarm and lock the recently installed security door and gate
- a resident who left through a window and was brought home by police after being found some distance away wearing only pyjamas and thongs
- a resident who has left home several times despite a requirement to always be accompanied by staff.

Individual planning

Community Visitors reported that residents' PCPs have been updated at houses in this area and have been made more easily accessible to casual staff.

Staff support

Community Visitors reported positive examples of staff support including a DAS house resident being assisted to develop a plan for improving their independent living skills, such as travelling to work, shopping, carrying a mobile phone and accessing sporting activities independently.

A CSO house resident, who lives alone and requires high support, is gradually being prepared by staff to attend a day program at another house, and their progress has been well-documented.

good practice



A DAS house resident receiving palliative care wanted to die at home, supported by staff and fellow residents.

Following the resident's death, a palliative care organisation interviewed house staff and palliative care staff about their experience of providing care, and about the reactions and wellbeing of other residents. These interviews will form part of an education tool for other group homes.

Health care

Community Visitors reported that scales at a DAS house, used to weigh residents who use wheelchairs, have been broken for more than a year, which could have implications for residents' health. A hoist attachment is being investigated as a solution to this problem.

Community Visitors are concerned some residents may not be being treated fairly in the health system. A resident of a CSO house has reportedly waited several years for a procedure to investigate a health issue. This year, the resident went to hospital for the procedure, but it did not take place and no explanation was provided to house staff as to why it had not occurred.

Western District

Abuse and neglect

Community Visitors reported that a resident of a CSO house experienced increasingly regular 'cycles' of behaviours of concern that had a serious impact on other residents. The CSO had provided extra services to separate the resident from housemates for their safety, but funding shortfalls mean this additional service may not continue.

Community Visitors reported a number of instances where BSPs were used effectively to support residents with behaviours of concern, including:

- a DAS resident whose behaviours of concern continued despite moving to a new house, but were eventually addressed and reduced with the implementation of a BSP
- at a CSO house where two incidents of residents abusing others were well-managed when staff implemented procedures listed in the residents' BSPs
- a CSO house with potential resident incompatibility which has excellent management and staffing structures in place, such as the use of regular staff who are familiar with the residents, and consistent support practices which have had very positive outcomes.

Community Visitors reported that at one CSO house, a long-term resident has been subject to abuse by a resident who has lived in the house for two years. Despite a comprehensive BSP being in place for the resident with behaviours of concern, Community Visitors viewed 18 incident reports from 2014 relating to the abuse of the long-term resident.

Respite and unmet need in accommodation

After many years of Community Visitors reporting unmet needs at two respite facilities in this area, one facility has been replaced with a purpose-built group home and the other has addressed issues within its existing structure.

Upkeep of buildings and fittings

Many houses that were built for residents following the closure of institutions more than 15 years ago are showing signs of wear and tear, but Community Visitors are constantly told there is no funding available for building and maintenance.

DHS told Community Visitors at a meeting in June that as of July 2014 all group homes would be allocated an annual maintenance budget but there was no funding for cyclic maintenance, such as painting and replacement of carpets.

Community Visitors have repeatedly raised maintenance concerns such as bathroom drainage problems, broken kitchen appliances and poor fencing. At one DAS house, Community Visitors reported that kitchen cupboard doors needed to be replaced on six consecutive visits before maintenance work was undertaken satisfactorily. At one point, the cupboard doors were removed, exposing chemicals that should have been safely stored.

Community Visitors reported that a number of recently built houses in this area are well-designed and furnished, including rooms decorated to reflect residents' interests.

Personal safety

Staff at one house advised Community Visitors that the house vehicle often stalls, and that they were concerned residents would not be able to evacuate if this occurred, as their doors and seatbelts would not unlock.

At another house, staff reported concerns that a resident could undo their seatbelt when travelling on a bus at their day program. The house vehicle had a protective guard to prevent this occurring, and house staff planned to show the day-program staff the device for their consideration.

Individual planning

Community Visitors' regular checks of residents' PCPs have found they are up-to-date or about to be renewed. Well-written BSPs have been designed to improve residents' quality of life. Asset registers are also well-maintained and reviewed on a regular basis.

Positive examples of planning include a resident being assisted by staff to develop a plan for improving their skills so they can access the community independently; staff charting residents' behaviour at the end of their shift; and BSPs displayed for all staff to ensure they are familiar with them.

However, Community Visitors reported that there are inconsistencies in the level of support provided to residents at their day programs, particularly regarding residents' BSPs.



Community Visitors have repeatedly raised concerns regarding a resident of a DAS house who has not attended a day program for five years.

The day-program service provider initially stated that they did not have a suitable program to accommodate the resident's complex behaviour support needs. Over the five-year period, the resident's social skills continued to decline, particularly while the resident was living alone for more than a year with little social contact.

Community Visitors reported that house staff agree the resident has become "de-socialised" but believe with the right support, the resident could, and should, attend a day program.

In 2013, Community Visitors were advised that DAS had applied for more funding to assist with a day placement for the resident. However, Community Visitors are greatly concerned that despite assurance from DAS in April 2014 that the funding was authorised, no further action has since been taken. Community Visitors believe this situation is a breach of this person's rights and inconsistent with the objectives and principles of the Disability Act.

Staff support

Community Visitors had reported for several years that staff at one CSO house were unable to support residents' complex needs. Several initiatives have now been introduced with positive results, including one overweight resident losing more than 40kg.

Community Visitors continue to report on a lack of training for staff in both DAS and CSO houses, particularly on human relations, epilepsy procedures and support planning. At one CSO respite house, respite-users' profiles and support plans were not at the facility and had to be collected from head office.

Staff at two CSO houses did not understand the role of Community Visitors and the requirement to make residents' support plans and incident reports available to Community Visitors. Meetings with management of these CSOs will hopefully resolve these matters.

Residents at a number of houses are well-supported by staff to lead happy, independent and engaging lives. Staff at two houses help residents to keep in contact with each other and to meet up for barbecues and drinks, a routine they have continued despite residents of one house relocating.

At another house, staff developed a range of ways to communicate with residents who are non-verbal, and created a training video to teach new staff these communication methods.

Thanks to a grant from a local organisation, residents at a CSO house now have iPads which they enjoy using for a range of activities and communication. Staff are being trained to use the iPads to support residents' needs. At one DAS house, bikes, tricycles, helmets and vests were purchased with donations from a local organisation.

Health care

Community Visitors reported that two residents in separate houses had recurring pressure sores which were being addressed by preventative strategies after continuing advocacy from Community Visitors.

Ageing residents require higher levels of care and staff are under pressure to meet this demand. DHS is well-aware of this and have engaged in discussions with Community Visitors about it.

Health care needs are generally well-supported and residents have regular appointments with medical professionals. However, reviews of Comprehensive Health Assessment Plans are not being conducted annually in some CSO houses, as is recommended.

Facilities eligible to be visited by Community Visitors 2013–2014

Supported Residential Services

Aaron Lodge

Absalom

Acacia Gardens

Acacia Place

Achmore Lodge

Acland Grange

Adare Supported Residential Care

Airlie

Alexandra Gardens

Allbright Manor

Alma House

Arnica Lodge

Ascot House

Aveo Bentleigh

Aveo Lisson Grove

Aveo Templestowe

Aveo The George

Balmoral

Bamfield Lodge

Bayview Waters

Belair Gardens

Bella Chara

Bellden Lodge

Bentleys Aged Care

Berwick House

Bignold Park

Blue Dolphin on Bayside

Blue Willows Residential Aged Care

Brooklea Lodge

Brown Lee Home - Ballarat

Brunswick Lodge

Buninyong Lodge

Burwood Lodge

Camberwell Manor

Carrington Court

Caulfield House

Caulfield Manor

Chatsworth Terrace

Chippendale Lodge

Coorondo Home

Corandirk House

Covenant House

Crofton House

Crosbie Lodge

Crystal Manor

Darebin Lodge

Delany Manor

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

Geelong Lodge

Glenhaven Special Care Facility

Glenhuntly Terrace

Glenville Lodge

Glenwood Assisted Living

Golden Gate Lodge

Gracedale Lodge

Gracevale Lodge

Grandel

Greenhaven

Greenslopes

Hamble Court

Hambleton House

Hampton House

Harrier Manor

Hawthorn Grange

Hawthorns Victoria Gardens

Hazelwood Boronia

Heathmont Lodge

Hepburn House

Hillview Lodge

Hollydale Lodge

Home Residential Care

Homebush Hall

Iris Grange

Iris Manor

Jasmine Lodge

Kallara Residential Care

Karinya

Kiah

Kilara House

Kooralbyn Retirement Lodge

Kyneton Lodge

L'abri

Landora Care

Lilydale Lodge

Malon House

Manalin House

Mayfair Lodge

Meadowbrook
 Melton Willows
 Mentone Gardens
 Merriwa Grove
 Milford Hall
 Mont Albert Manor
 Mornington House
 Mt. Alexander
 Mulvra Aged Care
 Mulvra Place
 Nepean Gardens
 Northern Terrace
 Oakern Lodge
 Parkland Close
 Pineview Residential Care
 Princes Park Lodge
 Queens Lodge
 Queenscliff Lodge
 Raynes Park Court
 Reservoir Lodge
 Rosewood Downs
 Rosewood Gardens
 Royal Avenue
 Sandy Lodge
 Seaview House Residential Care
 Sheridan Hall - Caulfield
 Sheridan Hall Malvern
 Southcare Lodge
 St James Terrace
 Stewart Lodge
 Strabane Gardens
 Sunnyhurst Gardens
 Surfcoast Supported
 Accommodation
 Sydenham Grace

The Connault
 Themar Heights
 Trentleigh Lodge
 Vermont Gardens
 Veronica Gardens
 Viewbank House
 Viewmont Terrace
 Warranvale Gardens
 Warrina Retirement Village
 Waverley Hill SRS
 Westley Garden
 Whitehaven
 Windermere Retirement Lodge
 Woodford Gables
 Wynalla House

Mental Health Providers

Alfred Health
 Austin Health
 Ballarat Health
 Barwon Health
 Bendigo Health
 Eastern Health
 Forensicare
 Goulburn Valley Health
 La Trobe Valley Health
 Mercy Health and Aged Care Inc
 Monash Health
 Northern Health
 North East and Border
 Mental Health
 NorthWestern Mental Health
 Peninsula Health
 Ramsay Health Services

Royal Children's Hospital
 South West Health Care
 St Vincent's Mental Health
 Stawell Regional Health Services
 West Wimmera Health Services
 Western Health

Disability Services Providers

ABLE Australia
 Accomodation Care Solutions
 AGAPI Care
 Alkira Centre - Box Hill Inc.
 Amicus
 Annecto Inc.
 Araluen Centre
 Ashcare Incorporated
 Asteria Inc
 Australian Community Support Organisation Inc.
 Australian Home Care Services
 Autism Plus Transitional Accommodation
 Bayley House
 Care Beyond Measure
 Carinya Society
 Central Access Ltd
 Colac – Otway Disability Accommodation Inc.
 Community Connections (Victoria) Limited
 Community Living and Respite Services Inc.
 ConnectGV
 Cooinda-Terang Inc.
 Department of Human Services

Epworth Foundation	Monkami Centre Inc.
EW Tipping Foundation Inc.	Multiple Sclerosis Limited
Family Plus Inc.	Murdoch Community Services Inc.
Focus	Murray Human Services Inc.
Gateways Support Services	Nadrasca
Gellibrand Residential Services Inc.	Nepean Centre for Physically Handicapped Inc.
Golden City Support Services Inc.	Northern Support Services for People with Disabilities
Golden Valley Centre	Noweyung Limited
Haven	Oakleigh Centre For Intellectually Disabled Citizens Inc.
Healthscope Limited	ONCALL Personnel & Training
Independence Australia	Ozchild
Ivanhoe Diamond Valley Community Centre Inc.	Plenty Valley Community Services Inc.
Jesuit Social Services Limited	Providing All Living Supports (PALS)
Jewish Care (Victoria) Inc.	SCOPE Victoria Ltd
Karingal Inc.	Southern Way Direct Care Services Inc.
Kirinari Community Services Inc.	St John of God Services Victoria
Knoxbrooke Inc.	Statewide Autistic Services Inc.
Kyeema Support Services Inc.	STAY - Residential Services Association Inc.
Life Without Barriers	Sunraysia Residential Services Inc.
Lifestyle Solutions	The Salvation Army (Victoria) Property – Trust Western
Maccro, Mansfield Adult Autistic Services Limited	Uniting Care Harrison Community Services
Mallee Family Care Inc.	Victoria Deaf Society
Marillac Ltd	Villa Maria Society
McCallum Disability Services Inc.	Vista
McKillop Family Services	Wallara Australia Ltd
Melba Support Services Inc.	Wesley Mission Victoria
Melbacc	Wimmera Uniting Care
Melbourne City Mission Inc.	Woodbine Inc.
Melbourne Health	Yooralla
Merriwa Industries	
MIND	
Mirridong Services Inc.	
MOIRA Inc.	

Community Visitors

2013-2014

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.

Susan Aarons	Marion Blythman (RC)	Jo Cohen
Marta Acton	Margaret Bodenham	Terry Collison
Ian Adair	Roger Boey	Sandra Cooper (RC)
Beverly Adams	Dominic Boland	Christine Cooze
Deanne Ades	Sally Bolton	Doug Cox
Ian Alexander	John Bowen	Bryan Crebbin
Priya Alexander	Kathleen Bragge (RC)	Patricia Cross (RC)
David Allen	Jenny Broughton	Graeme Crutchfield
Jo Allen	Geoff Brown	Stephen Culhane (RC)
Arthur Apostolopoulos	Jeanise Brown (RC)	Robert Cull
Shirley Armitage	Marc Brubacher	Robyn Cunningham (RC)
Mary Armstrong	Ian Buckles (RC)	Lucille Cutting
Lyn Arnold	Ronald Butler (RC)	Shruti Dahal
Karina Au	Rick Byrne	Peter Dalglish
Taddaeus Bako (RC)	Teigen Bywater	Doreen Dalrymple
Joyce Ball	Jacqui Campbell	William Daly
Anne Bambrook	Kevin Campbell	Linda Dare
John Bamkin	Paul Campobasso	Margaret Davidson
Sandra Bamkin	Eve Caplan	Wendy Davies
Rajashree Banerjea	Christine Carder Rice	Aaron Davies
Christine Barbuto	Ken Castanelli	Pat Davison
Ennio Bardella	Joan Castledine	Susan Dedes-Bonneau
Andrew Baugh	Julie Cesal	Sonia Di Iorio
Nyamka Bayanmunkh	Chris Chapman	Graham Dickinson
Jane Beard	Melissa Chapman	Christine Dimer
Suzanne Beaton (RC)	Patricia Cheary	Sue Dixon
Vicki Bechaz	John Chesterman	Diane Doherty
Anne-Marie Becket	Siok Chew	Diana Donohue
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Judith Bink	Bruce Coate	Majella Dryden

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Ian Dunn	Eddie Graham	Amanda Hurley
John Dunn	Avril Green	Carolyn Hutchens (RC)
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Rosalie Edge	Kay Gregory	Chris Ingram (RC)
Tony Ellis	Alison Gribble	Dallas Isaacs
Marilyn Faiman	Alan Grigson	Beverley Jacob
Eveline Fallshaw (RC)	Susanne Grosser	Robert Jeffree
Fred Falvo	Judi Groves	Angus Jessel
Mark Feigan	Alan Gruner	Lyn Johnson
Ruth Felbel	Donna Gulizia	Raymond Johnson
Miguel Feliciano	Mark Gunn	Catherine Jones
David Ferguson (RC)	Wendy Guy	Taffy Jones
Trudy Firth	Michael Hadley (RC)	Catherine Joyce
Max Fletcher	Ghassan Haidar	Lynda Judkins
Maureen Fontana (RC)	Rachel Hansford	Donald Juniper
Debbie Fowler	Alexander Hardy	Peter Kadar
Pauline Franc	Susan Harraway (RC)	Soula Katsaros
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Janis Fregon	Rowena Hart	Brian Kiley
Joseph Fung	Amanda Harvey	Joan Kincade
Dale Furey	Cliff Hawkins	Katrina Kincade-Sharkey
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Suzette Gallagher	Coral Heazlewood	Karen La
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James Glenn (RC)	Robyn Hickey	Debra Lee
Una Gold	Colin Hinckson	Briar Leece
Karyn Golumbeck	Karen Hitchen	Beverley Libbis
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Kathleen Loxton (RC)	Neil Michael	Wendy Patchett (RC)
Graeme Luke	Jan Middleditch	James Paterson (RC)
Jennifer Lush	Sandra Miles	Loes Pearson, JP
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Keith MacKenzie	Frank Miragliotta	Peter Penry-Williams
Vicki Mahony	Irene Morgan	Jennifer Perry (RC)
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Kaye Manners	David Morris	Lyn Phelan
Heather Marmur	Jennifer Morris	Aldo Pitre (RC)
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Debra McCann	Paul Newman	Sowmya Rao
James McCarthy	Craig Ng	Judy Rattray
Stan McCredden	Donna Ng	Helen Rawicki
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Celia McKenzie	Judi Nicholson	Keren Reeve
Deborah McLachlan (RC)	Edwina Nutt	Brian Reeves
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Heather McLeish	John O'Connor	Sue Rewell (RC)
Claire McLinden	Kim O'Donoghue	Joy Reyment
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Brenda McMinn (RC)	Joanne Page	Dawn Richardson (RC)
Louise McPhee (RC)	Izabella Pankowska	Norman Richardson
Hilary McVey	Christian Papadopoulos	Dany Roberts
Janet Meiklejohn	Faye Pargetter	David Roche

Vivienne Roche	Emma Steele	Colin Wales
Stephanie Rock	Erlinda Sterlus	Brian Wallace
Jo Rodger	Margaret Stevenson	Lynn Wallace-Clancy
Mick Rosier	Evan Stewart	Sebastian Waluk
Ainsley Rozario	Graham Stickland	Elizabeth Warren
Linda Rubinstein	Loraine Stone	Betty Waters
John Russell	Bernadette Sullivan	Anita Watt
Michael Rye	Victor Sullivan	Taryn Webb
Jeanette Santowiak	Robert Swiger	Joy Webster
Liane Schuhen	Leon Taft	Marion Wellwood (RC)
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Raymond Scrace	Tanjila Tayeb	Jan Wiebe
Brenda Seavers	Margot Thimm	Dianne Wilde
Debra Sevastianov	Kathryn Thomas	David Williams
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Yvonne Sherlock	Julia Tivendale	Ted Woollan
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Tanya Smith	Helen Vallance	
Moira Somerville	Luke Van Den Dikkenberg	
June Soutar	Tina Veliscek	
Michele Sproule	Bethany Veysey	
Meredith Stafford	Alexa Viani	
Glenn Staunton	Christine Volk	
Ray Steadman (RC)	Connie Vukotic	

Acronyms

AAU	Adult Acute Unit	NUM	Nurse Unit Manager
ABI	Acquired Brain Injury	NWMHS	North West Mental Health Service
ACSO	Australian Community Support Organisation	PACER	Police Ambulance Crisis and Emergency Response
BSP	Behaviour Support Plan	PARC	Prevention and Recovery Care
CAG	Consumer Advisory Group	PCP	Person-Centred Plan
CALD	Culturally and Linguistically Diverse	PDRSS	Psychiatric Disability Rehabilitation Support Services
CAT	Crisis Assessment and Treatment	PRS	Plenty Residential Services
CCU	Community Care Unit	SAVI	Supporting Accommodation for Vulnerable Victorians Initiative
CDDHV	Centre for Development Disability Health Victoria	SECU	Secure Extended Care Unit
CHAPS	Comprehensive Health Assessment Plans	SOCIT	Sexual Offences and Child Abuse Investigation Team
CRP	Community Recovery Program	SRS	Supported Residential Services
CSO	Community Service Organisation	STO	Supervised Treatment Order
DAS	Disability Accommodation Service	VCAT	Victorian Civil and Administrative Tribunal
DFATS	Disability and Forensic Assessment and Treatment Service	VDDS	Victorian Dual Disability Service
DH	Department of Health	VEOHRC	Victorian Equal Opportunity and Human Rights Commission
DHS	Department of Human Services	VIHMS	Victorian Incident Health Management System
DSR	Disability Support Register	VSA	Victims Support Agency
ECT	Electroconvulsive Therapy	VSDP	Victorian State Disability Plan
ED	Emergency Department	Y-PARC	Youth Prevention and Recovery Care
GP	General Practitioner		
HCA	Housing Choices Australia		
HDU	High Dependency Unit		
IGUANA	Interagency Guideline for Addressing Violence, Neglect and Abuse		
IHBOS	Intensive Home-based Outreach		
ISP	Individual Support Package		
LGA	Local Government Area		
OPA	Office of the Public Advocate		
OPP	Office of Professional Practice		
MHRB	Mental Health Review Board		
NAMHS	Northern Area Mental Health Service		
NDIS	National Disability Insurance Scheme		
NPU	Northern Psychiatric Unit		



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