



The South Australian Community Visitor Scheme

Principal Community Visitor

ANNUAL REPORT

Disability Services 2017-18



FOR FURTHER INFORMATION:

PRINCIPAL COMMUNITY VISITOR

South Australian

Community Visitor Scheme

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Hon. Michelle Lensink, MLC

Minister for Human Services

Level 12 South,
1 King William Street
ADELAIDE SA 5000

Dear Minister

In accordance with Regulation 6(2) of the *Disability Services (Community Visitor Scheme) Regulations 2013*, it gives me great pleasure to submit to you the Disability Services Annual Report of the Principal Community Visitor 2017-18 for presentation to Parliament.

Appendix 7 provides a summary of the Community Visitors Scheme compliance with the Department of Premier and Cabinet Circular (PCO13) on Annual Report Requirements.

This report provides an account of the work of the South Australian Community Visitor Scheme during the financial year ending 30 June 2018, in compliance with the Act and the Department of Premier and Cabinet Circular (PCO13) on Annual Reporting Requirements. However, as we learnt through last year's report, as an Independent Statutory Officer, I am not required to comply with PCO13 and believe our current report structure provides greater insight into our function, role and performance.

You will note that the report contains a total of 15 recommendations, 9 related to Disability Services, 5 to Supported Residential Facilities (SRFs) and 1 related to Day Options Programs.

I would like to highlight the more sensitive issues covered in section 2.4.1 and 2.4.2 that relates to individual and Systemic Advocacy commencing on page 13. This example 1 in individual advocacy, highlights to me just how little we do know about our staff working with vulnerable people in our services and the lengths that staff may go to if they become angry and want to retaliate by threatening harm against clients. It worries me that we still do not know who wrote this letter and if any other staff knew about it. While stating this one extraordinary action allegedly by a staff member, you will see that the vast majority of qualitative and quantitative data is very positive about the services and staff working within them.

In generating this report with my team and community visitors, it has further reinforced to me the importance of independent monitoring of the services provided to some of our most vulnerable citizens in SA and the many and varied issues that the Community Visitor Scheme has identified and followed up with service providers. Our visit enquiries also provide us with a unique exposure to the interface between disability services and many health and mainstream services both within the public system and across to the private sector. This further enables us to reflect and report to government on the experience of many South Australians with a disability who face challenges in engaging with these services from both an individual and systemic perspective.

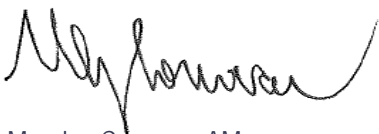
I also note that we meet many individuals with disabilities who live with the burden of expectation of their lifestyle, goals, care and potential. This is a result of their past experiences and limitations placed on them by those who supported or cared for them. This 'burden of low expectations', in most cases, reflects long standing institutional thinking rather than intentional poor practice. It is hoped that the NDIS will provide an opportunity for those people with a disability who have capacity, together with their own funds, to escape this paradigm and pursue life goals.

However, the CVS is aware of many clients who due to their intellectual disability and lack of family involvement and/or informal support, do not have the capacity nor support to argue for improvements to their lifetime support and plan. We would argue that this cohort will be reliant on visitation by people such as community visitors who have a non-blinkered perspective to identify and challenge many of the established norms and low expectations. We will argue that it will be even more important to have Community Visitors checking that individuals have reasonable NDIS plans in place that are responsive to their needs, goals and aspirations and that they are being implemented to enable individuals to reach their full potential and accelerate the raising of the bar.

Lastly, as stated at our last meeting, I need to report that there is a great deal of concern and uncertainty about the future of the Community Visitor Scheme in disability accommodation after 30 June 2019. Under the Bilateral Agreement between the Commonwealth and the SA government, it was agreed that the Commonwealth would lead an evaluation of the various Visitor Schemes for the purpose of recommending what would work best once we have the full rollout of the NDIS and have a Quality and Safeguards Commission in place.

I would argue that the need for our scheme is even more important now as we transition across to the NDIS and the Commonwealth being responsible for the delivery of these services. I believe it is crucial that independent visitors continue to monitor and report on this transition to ensure that tax payers' funding through both State and Commonwealth contributions are delivering quality services to some of our most vulnerable citizens.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Maurice Corcoran', with a stylized, cursive script.

Maurice Corcoran AM

5 October 2018

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1. Introduction

1.1 Message from the Principal Community Visitor

This report represents the work of the South Australian Community Visitor Scheme (CVS) for 2017-18 and is prepared on behalf of the great team of Community Visitors that I have the pleasure to work with, and alongside of, as well as our committed team in the office who coordinate and manage the Scheme as a whole. Although this is the Annual Report of the Principal Community Visitor (PCV), it is without doubt, the culmination of combined efforts of all our Community Visitors and staff.

As you can see from the various sections of this report, the Community Visitor Scheme, through its very committed visitors has had thousands of interactions with individuals who have been using disability services in South Australia over this past year. They have also spoken to many families and staff and from these conversations, observations and scrutiny of services, extracted valuable commentary on what is working well and what needs to be improved. The services we visit are increasing to use this feedback in a range of ways to improve quality and continuous improvement strategies.

For instance, one of the biggest Non-Government Organisations (NGO) makes sure that a sub-committee of their Board of management receives and considers all of the CVS visit reports and then discusses responses and strategies to address any issues raised in the reports. The PCV has also met with this committee on two occasions to explore how best we can ensure the monitoring and scrutiny is fearless and ensuring that this agency is fully compliant and that the people they support are being enabled to reach their full potential and have genuine choice and control.

Another NGO invited the PCV to speak at their Annual General Meeting (AGM) and to present an overall summary of our visits and inspections to their services and provide feedback on the results, trends and any issues arising. This report card gave an honest account of all visits and included the various ratings that CVs gave against key areas of our scrutiny such as:

1. communication between staff and residents;
2. responsiveness of staff to client's needs;
3. standard and quality of food and menus & level of involvement of clients and families in the selection, preparation and cooking;
4. standard of the accommodation and facilities;
5. development of individual plans and level of involvement of clients and families in shaping these plans; and
6. restrictive practices in place and required documentation.

This NGO has recently decided that they want all their disability visits to be unannounced, so although we let them know when we are doing visits to their sites, they have made a decision not to inform the staff and residents. The CVS believes this is a very positive move and one that continues to demonstrate openness and an honesty by saying come at any time and observe what we are doing without any pretences and preparation.

At a time where there is uncertainty about the future of the Community Visitor Scheme within the National Disability Insurance Scheme (NDIS) environment. It is pleasing to note that schemes like ours continue to receive recognition and support through a range of important National reviews and members of our State parliament. As example:

Senate Standing Committee on Community affairs / Violence, abuse and neglect against people with disability in institutional and residential settings

Recommendation 6

10.32 The committee recommends the Australian Government work with state and territory governments on the implementation of initiatives to improve access to justice for people with disability contained in the reports by the Law Reform Commission, Access to Justice Arrangements, with particular focus on:

- expanded Community Visitor's schemes;

Recommendation 9

10.38 The committee recommends the Australian Government work with state and territory governments on a nationally consistent approach to existing state and territory disability oversight mechanisms, to include;

- increased funding for community visitor schemes, with consideration these schemes be professionalised in all jurisdictions and with a mandatory reporting requirement for suspected violence, abuse or neglect;

Senate Community Affairs References Committee - Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices

4.67 *The Productivity Commission recommended the establishment of an Australian Aged Care Commission, with Commissioners for Care Quality and for Complaints and Reviews and to implement a national independent statutory Community Visitors Program and improvements to data collecting and sharing.*

4.68 *The ALRC June 2017 Elder abuse report recommended the development of a National Plan to combat elder abuse, and specifically in the aged care context recommended establishing a serious incident response scheme, reforms relating to the regulation of care workers, regulating restrictive practices and developing national guidelines for community visitor schemes.*

Australian Human Rights Commission - A Future Without Violence: Quality, safeguarding and oversight to prevent and address violence against people with disability in institutional settings report

The establishment of the NDIS Commission as an external authority is a crucial step to achieving the requisite independent oversight and monitoring. To supplement the NDIS Commission, the Commonwealth and state and territory governments should consider the inclusion of community visitors in the Safeguarding Framework, and take steps to ensure that independent individual and systemic advocacy organisations have adequate powers and funding.

Consistent with views expressed regarding the disability sector, both government and advocacy stakeholders across the different services sectors in all jurisdictions overwhelmingly supported independent oversight of mainstream services. In particular, community visitor programs and independent advocates were viewed as critical in order to effectively prevent and address violence against people with disability in institutional settings within the mainstream service sectors, such as justice and health.

As the Principal Community Visitor, I would also like to acknowledge and thank our State members of Parliament who on 27 September, 2017 moved a motion of acknowledgement and support for the SA Community Visitor Scheme and our monitoring role and supporting families through individual complaints that led to the independent investigation into Oakden- Older Persons Mental Health Services. This was initiated by the Hon. Kelly Vincent but members from all sides supported and spoke to the motion which we greatly appreciated.

"but without a number of voices, including that of Maurice Corcoran as our Principal Community Visitor and his team of excellent community visitor volunteers, we may never have uncovered the true and full extent of what occurred there and therefore never put forward the solutions that are now unfolding."

"his role as community visitor expands far beyond that, and every day he is working and uncovering cases of abuse, neglect and mistreatment, even cases where food standards may not be high enough in residential facilities."

"These everyday issues may not always make the papers or the media in the way that issues like Oakden unfortunately—or fortunately, depending on how you look at it—has, but they are issues that are equally as important because people with disabilities who are reliant on government support need to be able to rely on government to ensure that those supports are of the highest possible standard." The Hon. K.L. VINCENT (17:49)

"That is important to note because I think, particularly with the NDIS, there are going to be a whole range of new services that may well be provided, and I think we need to ensure that the Principal Community Visitor has access to all of those into the future. That is an area that we probably need to review as a parliament." (The Hon. J.M.A. LENSINK)

"Maurice and the many volunteers who work with him do invaluable work across our state in advocating for quality care and quality support for people with disability, and this is why our state government recently reappointed Mr Corcoran as community visitor until 2020. It is also the reason that as Minister for Disabilities together with the South Australian government we have continued to argue that as quality and safeguarding responsibility for disability services transfer to the federal jurisdiction, community visiting needs to continue." The Hon. K.A. HILDYARD (Minister for Disabilities)

"I had the opportunity to meet with him earlier this week. I think it was earlier this week. He is doing an outstanding job in his role. It is an important role and we welcome the contribution that he makes." The Hon. P. MALINAUSKAS (Minister for Health, Minister for Mental Health and Substance Abuse) (14:27):

Hansard SA Legislative Council 27 September 2017

1.2 Highlights and achievements

During the 2017-18 financial year there was a concerted effort to undertake more visits to regional settings and to visit those regional houses and day options facilities not previously visited due to resources and required travel arrangements.

Between March and June 2018 our Community Visitors conducted 65 visits in regional areas. This included 44 Disability, 12 Day Options, 8 Mental Health (3 sites) and 1 Supported Residential Facility. Of the 65 visits, 31 Disability houses and five Day Options Programs were visited for the first time. Of the 34 sites that had previously been visited, the majority had not been visited since 2016.

The total number of disability visits conducted this year was 625 representing a 7% increase over the previous reporting period.

The CVS has continued to establish and maintain strong working relationships with service managers across the disability and SRF sectors through regular correspondence and regular meetings. These meetings provide an opportunity to review the CVS visits undertaken and issues raised during the visits and give consideration to how visits can be further developed to ensure our contact with the client group is of value. The CVS can report that the responses by service providers to issues raised have improved significantly over the past 12 months.

The systems in place for tracking and monitoring of issues raised through visits have continued to improve our rates of resolution. Our consistent process of communicating issues of concern to service providers with a request for responses has rarely needed follow up or escalation in the past year. The importance of escalating issues to key responsible officers remains at our forefront and it was very helpful to confirm protocols and pathways to inform Minister Lensink and her Office soon after our first meeting on 4 June.

The PCV has also had a number of meetings with the new NDIS Quality and Safeguards Commission, including Graeme Head – the Commissioner, the Complaints Commissioner, Miranda Bruynik and many of the staff appointed in the State office. We have worked collaboratively with them to clarify protocols for referring matters to them.

We continue to increase the number of unannounced visits to facilities and do these where concerns have been raised, either through scheduled visits or by requests to visit by the Department, family, friend or others. For these visits we draw on the skills of CVs who have backgrounds and professional qualifications in investigative processes and interviewing techniques.

Identifying, tracking and resolving issue on behalf of individuals continues as a positive highlight for our team both in the office and our CVs. One hundred and eighty-four (184) reports highlighted a varying number of points of concern/issues which were all followed up with the service providers. To date seventy-seven (77%) have been resolved/completed.

1.3 Recognition of Community Visitors

The recruitment and retention of CVs remains a challenge and a regular highlight. I remain impressed by the range of high quality people from a vast array of backgrounds and ethnic diversity who volunteer to undertake this important role. While it is easy for the word 'volunteers' to cloud judgement of who CVs are, section 6.4 highlights the diversity of and quality of knowledge, education and experience they bring to the role.

They are aged between 25 and 82, come from a diverse range of cultural backgrounds, and can speak seventeen (17) languages between them. In terms of qualifications and experience, 33 have Bachelor degree in Social Work, Social Science's or related fields, 8 have completed Masters in Social Work, Law, Business Admin, Disability, 2 have PhDs and we have 3 Professors amongst our skill sets.

Importantly, the clear majority of our CVs have a lived experience of disability or mental illness. Either they themselves have an experience of mental illness or disability or they have lived with and/or cared for someone with a disability. It is this lived experience, that motivates their interest, commitment and passion to monitor and safeguard the rights of the people we are here to serve.

It is pleasing that in addition to the important visitation and reporting aspect of the role, they have opportunity themselves to gain value from the role.

"The follow up and outcomes post the report reaffirms the importance of whatever little we can do to add value to the lives of the clients."

"Very pleased to see such a quick response to what is a significant issue, and even more, given that it was driven by our CVS team". "It's great to know we are making a real, practical difference and a safer environment for the residents".

1.4 Quality Control and Safeguarding - & the role of CVS

The CVS considers that important questions remain with regard to Quality & Safeguarding mechanisms within the Disability Accommodation, SRF and Day Options sector under the NDIS most notably, pre-existing State quality review and advocacy services such as the CVS.

The need for a robust system of quality control and safeguarding is clearly identified and acknowledged - both in terms of services and programs on offer and adequate checks for providers and their staff. The *NDIS Quality and Safeguards Commission* was established in 2018 to implement the *NDIS Quality and Safeguarding Framework*. The PCV has had a range of discussions in regards to the role of the CVS and how it will interact with the Commission.

As highlighted in section 1.1 there is much support for the maintenance of independent observers such as the CVS as most recently highlighted in the Australian Human Rights Commission (AHRC) report – *A Future Without Violence: Quality Safeguarding and oversight to prevent and address violence against people with disability in institutional settings*.

The PCV therefore welcomes the Commonwealth Government's commitment to undertake a National review of Disability Visitor Programs to inform the COAG Disability Reform Council (DRC) about the role (if any) of Community Visitors in and with the NDIS at full scheme and looks forward to participation in the review.

As further highlighted in the AHRC report and of concern to the PCV, there remains uncertainty about protection and support for those people outside the NDIS who may be provided disability or mental health services by a government provider of last resort. The issue of those who live in boarding houses, gives focus in this area as in SA, they remain outside the protection offered by legislation such as the *Supported Residential Facilities Act 1992*, *Disability Services (Community Visitor Scheme) Regulations 2013* and the *Mental Health Act 2009*.

Within this uncertain environment, the CVS continues visitation and inspections. It is unclear what impact the cessation of the state's Deed of Agreement will have on CVS's capacity to undertake this role. In terms of Day Options programs, identifying the number of programs will be a challenge for the CVS, particularly when enterprises will be able to commence on a very small scale. Indeed, defining what actually constitutes a Day Options program for the purpose of the CVS visitation and inspection process, is still unclear and will need to be determined in the near future.

Addressing dual diagnosis and psychosocial support requirements is also considered a priority, particularly within the context of those not in receipt of packages.

The CVS continues to receive positive feedback from the organisations and sites that we visit, with visits being regarded as an opportunity to review service provision as well as recognising the value of the Scheme and its advocacy role for the identified client groups.

Lighthouse

The CVS already has an established credibility in South Australia, and for this, and all of the above reasons, I request that consideration be given to maintaining the CVS as part of safeguarding processes in the NDIA.

It is an important and highly valued means of providing an independent and credible opinion about the quality of care provided to extremely vulnerable people. It is also relatively inexpensive.

Minda:

The Community Visitor scheme forms a valuable component of our external audit and quality assurance loop. It provides an opportunity for independent feedback to be considered by management, often leading to actions for improvement that impact the quality of life for people we support. Reports from the Community Visitor are tabled at the Service Quality Committee to demonstrate audit results from an independent monitor and to provide the subcommittee of the board with assurances about the quality of service delivery. The important scheme also provides safeguards and an avenue for people living with a disability to seek advocacy and support in having a voice.

Orana

It is good to get feedback from the CVs even when it is negative or not quite accurate as it identifies that there are areas for improvement – in this case staff development/awareness.

Calvary

We always welcome a visit from the scheme as it provides us with an opportunity to look at how we are delivering support to the residents and consider other options. A great opportunity for us.

2. Functions of the Community Visitor Scheme

2.1 The purpose & objectives

The purpose of the Community Visitor Scheme, as described in the *Disability Services (Community Visitor Scheme) Regulations 2013*, is to further protect the rights of people with a disability who live in disability accommodation, Supported Residential Facilities (SRFs) or attend a disability day options program, through the conduction of visits and inspections and the provision of support with advocacy, and to:

- » conduct regular visits and inspections of disability accommodation, Supported Residential Facilities (SRFs) and disability Day Options programs in order to assess and report on services provided to clients, identify any gaps in service provision and report on this to improve the quality, accountability and transparency of disability services
- » recruit and train enough volunteers to ensure there is a sufficient number of Community Visitors, appointed to undertake the required visits and inspections of facilities
- » act as advocates for disability clients to promote the proper resolution of issues relating to their care, treatment or control, including issues raised by a guardian, medical agent, relative, carer, friend or any other person who is providing them support
- » refer matters of concern relating to the organisation or delivery of disability services in South Australia or the care, treatment or control of an individual to the Minister, Ministers delegate, the Senior Practitioner or any other appropriate person or body
- » ensure plans, policy and practise development is influenced by the experience of people with a disability and their relative, guardian, carer, friend or supporter.

2.2 Conducting Monthly Visits and Inspections

As previously advised, there has been a focus during this reporting period on visiting disability accommodation and day options programs located in regional cities and areas. The regional visits have included Murray Bridge, Strathalbyn, Fleurieu Peninsula, Port Pirie, Yorke Peninsula, Port Augusta, Whyalla, Port Lincoln, Riverland, the South East and Kangaroo Island.

Figure 2.2.1 provides the number of regional visits undertaken, incorporating the total number of sites in each region:

NDIS regions	Visits to each region	Sites visited in each region
Eyre Western	3	13
Limestone Coast	4	10
Murray and Mallee	4	10
Yorke and Mid North	2	10
Barossa Light and Lower North	3	9
Fleurieu and Kangaroo Island	4	13
Total	20	65

Figure 2.2.1 visits by regional areas and number of sites visited

All Day Options as well as SRFs were visited at least once during the year with each SRF now having been visited several times over the past few years.

During 2017-18, the CVS undertook 625 visits as summarised below:

- 503 visits to Disability Supported Accommodation
- 29 visits to Supported Residential Facilities (SRFs), and
- 93 visits to Day Options programs.

This represents a 7% increase over the previous 12 months.

Figure 2.2.2 provides comparative data on the number of visits conducted over the past three (3) reporting periods

Total Visits			
	2015-16 Total	2016-17 Total	2017-2018 Total
Disability	394	453	503
Supported Residential Facilities	26	41	29
Day Options Programs		89	93
Totals	420	583	625
		39% increase	7% increase

Figure 2.2.2 number of visits conducted over the past three (3) reporting periods and annual increase

Further to the monthly 'scheduled' visits as described above, the Scheme also conducts 'requested' visits. As the name suggests, these visits occur when a client, carer, guardian, relative, friend, or any person or organisation who is providing support to a client, makes a request for a visit by a Community Visitor. If a request is made to a manager of, or a person in a position of authority at, disability accommodation premises, SRFs or Day Options programs, that person must advise the CVS office of the request within 2 working days. The CVS may on occasion also undertake unannounced visits as deemed necessary.

There was a total of 51 Disability/SRF/Day Options requested visits/advocacy requests in this financial year. Examples of typical cases the CVS acted on are outlined later in the report (refer to 2.4.1).

Visitors refer to a prompt sheet (Appendix 3, 4 and 5) during their visits and inspections and this gives guidance under seven main headings as to which elements they should review/consider as part of the visit. There are specific prompt sheets for disability accommodation, SRFs and Day Options. Post visits, the CVs complete an online report that again contains a variety of predetermined questions under a range of headings that also through the reporting process give focus to the reporting of visits.

In sections 3 to 5 later in the report, provides a summary of the outcomes and themes emanating from visit reports to the three different service components of the Scheme.

Where possible, CVs will provide the site staff with informal verbal feedback about any concern that has been identified and/or any positive observations. On completion of the visit, the CVs will submit a formal written report to the Principal Community Visitor (PCV). A copy of these reports and associated feedback is provided to the sites as well as any identified issues requiring action.

Issues of concern are referred to the PCV and tracked on the *CVS Issues Register and Tracking Documents*. When required, the PCV can escalate an issue to the appropriate body for action and resolution.

The CVS continues to receive positive feedback from sites, with visits being regarded as an opportunity to review service provision as well as recognising the value of the Scheme and its advocacy role for the identified client groups.

2.3 Recruitment and Training of CVs

Our Community Visitors are the major component of the Scheme and their ongoing recruitment, training and retention are integral to maintaining the core function of conducting visits and inspections.

Two hundred and ten (210) Expressions of Interest were received during the reporting period. Of these, thirty-eight (38) applications were received. Of these thirty-eight applications Ten (10) eventually completed an intensive training and orientation process including interviews, training, screening and orientation visits with the PCV.

More details on our community visitors and their training and support is provided later in section 6.4. under Workforce.

2.4 Advocacy

2.4.1 Individual advocacy

A key element of the Community Visitors' role is to provide support and advocacy in referring matters of concern emanating from visits to the Principal Community Visitor (PCV). Requests for advocacy are in addition received directly by the CVS office from a number of sources including clients, staff, family members, guardians, the Department or other persons who may support or have contact with an individual.

Requested advocacy is often in relation to a wide range of issues outside of their direct support services, that requires engagement with a range of external organisations. Where there are a range of common themes emerging from visits that indicates a systemic impact, work is undertaken to explore how it relates to disability Standards and rights and a strategy is developed as a means to try and address the issue.

Below are some examples of effective advocacy that achieved positive outcomes for individual clients:

Example 1

CVS received contact from family regarding care being provided in Disability accommodation to a young man with complex care needs. Concerns included

- Inconsistency in carer roster and unfilled positions creating huge anxiety issues at staff change overs
- Accommodation move poorly handled including inadequate support to carers
- Hospital attendance without notification to family
- Request to family to not speak too much with carers and shift supervisors about care provision to the individual so as to not place too much pressure on them, weekly update would be provided by email
- Client taken to a topless waitress restaurant. Questionable as to whether such an outing was in his best interest and whether this led to a spike in poor behaviour.
- Introduction of a protocol to actively encourage carers to contact police when in the opinion of the carer, the client could not be placated which immediately led to a police report and attendance, which was later conceded to be an overreaction.
- Allegations of significant daily contacts by family that were eventually unreservedly acknowledged as never having occurred.
- Installed intercom system that family by accident found to have video capability which was being used by carers to monitor client – neither family nor public guardian informed of device and its use.
- NDIS assessment and plan completed without family involvement.
- Of most significance, the family found a very disturbing and threatening letter that was left in their letter-box addressed to them and allegedly from a staff member who blamed them for the site-manager being moved. The letter went on to state that *“the staff who are affected by this are angry and pissed off which puts your nephew at risk*. It went further detailing forms of harm that could be applied to the client while masked as an accident and included the following: Food...poison; medication... wrong; shampoo... what's in the bottle – acid?; how well does he swim?; going through the wind screen.. seatbelt unclipped. The letter finished with a final chilling statement – ***This little piglet is going to be abused with cruelty violence...regularly and repeatedly***

PCV immediately contacted the Department's critical incident team director expressing concern for this very vulnerable client with an intellectual disability. He also urged the Director of the service to accompany the family to the police station and report the incident and take the letter and this was done as a matter of urgency.

Unfortunately, the police decided not to investigate or even interview staff about this matter but the service provider immediately placed extra staff in the house to ensure the client was safe. As a social worker for over thirty years, this letter is one of the worst that I have seen in terms of the threats to abuse with cruelty and violence and all because of some misconception that the family had complained about a staff member. The CVS continued to support the family and client over many months and monitored the services in achieving a positive and safe outcome for the client.

The last communication from the family was via email and it simply said *"Thank you very much for visiting XXXX and I yesterday Maurice. It was lovely to meet you and greatly appreciate you keeping a monitoring eye. Things have improved since some changes have been made and I hope this progresses into the future. Should you know of something that may benefit XXXX, I would be happy to hear about it."*

However, I do need to express deep disappointment and concern that this incident was not investigated by police nor the Department's critical incident team. As far as I am aware, staff at the site were not interviewed and therefore, we still have no idea who wrote this vicious letter and they may still be working at this site or another site with vulnerable individuals.

Example 2

A visit by CVs to meet with clients who were temporarily located in accommodation on the 6th floor at Highgate while their house at Payneham where they were living, was being demolished and a new house (s) were being built. This provided the opportunity for residents to raise a number of concerns in regards to their accommodation.

They informed the CVs that they were not allowed out onto the balcony which deprived them of easy access to the outdoors and to fresh air, given that their rooms are often warm and stuffy. They also had restrictions on the type and amount of electrical appliances which could be used in the kitchen and bedrooms. They were also informed that bedroom doors should not be closed because it effected the air-conditioner and this was impacting on their general living conditions and their feeling of safety.

The clients reported that occasionally people that they did not know walked into areas where they were living on the 6th floor and one of the women had her iPad stolen which had many of her family photos on it that cannot be replaced. In addition, the lack of security and loss of property resulted in them feeling anxious, insecure and worried about the loss of other valued personal property.

PCV met on site with clients and a senior department director responsible for infrastructure to work through the presenting issues. In addition to the progression of these issues the forum provided opportunity for a range of other issues to be raised of which many have been resolved. These clients now have access to the balcony and many of the issues raised have since been resolved.

The one major issue that was continuing to frustrate these clients was the length of time it is taking to demolish their house and build their new house and requested that the PCV write a formal complaint to the SA Housing Authority which was done. However, these clients have been in this temporary accommodation for almost 18 months and the new build is yet to commence which is very frustrating for all.

Example 3

In November 2017, the CVS office received phone call from the proprietor of an SRF expressing concerns about the finances of a resident that were being managed by a family member. This resident was receiving cancer treatment that requires regular medication, but the last three rounds of medication have not been paid for by the family member. While the Pharmacist has to date, been willing to carry the amount, further non-payment has potential to compromise service and therefore treatment. Further to this, a recent eye check has incurred additional cost and revealed potential requirement for additional services.

On further exploration by the CVS, it became evident that three months earlier (August 2017), the Department had received an anonymous letter with bank statements as evidence that raised concerns that this individual's finances were potentially being misappropriated on a very regular basis. There were a series of deductions in hotels and clubs across Adelaide and the CVS immediately contacted the Department, raising concerns that this resident remained vulnerable to further misuse. It also questioned why no protection had been initiated through SACAT, and there had been no reports to SAPOL to investigate what is potentially fraudulent behaviour.

The gravity of the issue was reinforced, as was the concern that although there had been internal communication in relation to the matter, 15 weeks had now elapsed and the person's financial situation was placing their health and quality of life at risk. While recognising the sensitivity of the issue relative to the impact it may have on their relationship with their family, it would appear the urgency of the issue and the recommendations of Health & Community Complaints Commission (report to SAPOL) had been lost.

This issue was raised by the PCV during his regular meeting with the Minister. This led to an escalation of the issue and a more rapid response to progressing the issue to final resolution. The CVS continued to support and contribute to the SACAT process of achieving long-term protection of the resident's finances and therefore capacity to pay for required health services then and into the future.

2.4.2 Systematic advocacy

During this reporting period, the CVS has continued to lobby for systemic change that would deliver improved outcomes for service consumers. Three key areas all of which have been long standing are:

Medication

The CVS has continued to advocate for the retention of state funded specialist psychiatric services for people with disabilities including continuation of the 'chemical restraints project' during transition to the NDIS. The PCV notes the significant work of the project team in completing a review of all current Disability Services clients who were identified to be on a range of psychotropic medications to ensure they are not being used inappropriately for restraint, are required for a current diagnosis and ultimately, to hopefully reduce the use of such medication.

Given the findings and resultant outcomes of this extensive project, it could be assumed that there are similar number of clients being supported by the NGO sector who would benefit from such a medication review. While in part, it would be understandable for the state government to expect this type of service to be available to individuals under the NDIS, it is difficult to imagine that without leadership, coordination and access to the learnings from the project, that a similar outcome could be achieved. In addition, given that the NDIS will deliver a purchasing model into a small market place with a more dispersed approach, it is anticipated that it would be difficult for the current skilled staff to establish a sustainable business model in such an environment.

An open market under the NDIS will give opportunity for the emergence of new support service models. More at risk for the State is a dispersed or lost specialist skill set that would otherwise educate and guide individuals or provide support to the service sector. The CVS has been monitoring the Centre for Disability Health, a specialised health unit that included psychiatric services, psychological services and GP services for those with both intellectual and psychiatric support needs. The service was moved back to SA Health and a number of key staff have now left the service, including Dr Maria Tomasic, the psychiatrist who was a recognised expert in this field and who has been arguing for greater resources and training in this field. It appears that there is now only one specialist GP who works part time and very conscious of demand and need that is not able to be met now and into the future.

SA Health has initiated an independent review of the Centre for Disability Health by ZED Management Consulting (ZED) and the CVS call upon the Department to release the findings of this report and recommendations.

Forensic Disability Services

This is a long-standing issue first raised in the 2011-12 PCV annual report. It is covered further in section 3.3.3.

Given that the NDIS will primarily be a funding organisation and the Quality and safety Commissioner responsible for the quality of service provided to individuals supported by NDIS registered organisations, it is not clear as to who will take responsibility from the Department of Human Services perspective to ensure the special needs of this client group are given the required attention and their integration into the community is skilfully managed.

The PCV has continued to argue for an open and transparent process to 'implement the recommendations of the 2015 independent review of Forensic services in SA'. The PCV has written to the Minister for Mental Health and Wellbeing about this and has had it as an agenda item for his meetings with both Minister and the Chief Executive of NALHN. In doing so, the PCV has highlighted the potential for the NGO sector to deliver a new community-based service model for the specific needs of those with a Dual Disability.

This model is also supported by the NDIS and could potentially transition up to 12 clients out of James Nash House into the community. A number of NGOs have had years of experience in managing clients with complex needs and challenging behaviour in community settings with the added benefit of freeing up much needed forensic beds.

Comorbidity

Comorbidity has been a long-standing issue advocated on by the CVS.

A significant time has elapsed since the Social Development committee's "Inquiry into Comorbidity"¹ was released. At

¹ Inquiry Into Comorbidity, thirty eight report of the Social Development Committee
<https://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=5&CId=302>

the time, both the Minister for Disabilities and the Minister for Mental Health and Substance Abuse² presented the NDIS as the potential solution to many of the recommendations.

A key recommendation of the report was that *"It is imperative that they experience an integrated treatment and service system that has a 'no wrong door' approach. A system where they receive timely and appropriate screening, and assessment, and are assisted with all of their treatment and service requirements"*. Given that the NDIS is focussed on empowering individuals with choice and control rather than establishing system solutions (focus on market driven solutions), it is unlikely that the key health and human services departments will be developing integrated pathway solutions. It will therefore be important that this client group have the required support to navigate the pre-existing systems.

It is difficult to assess at this time, as to the quantity and quality of complex care coordination that will be available to individuals under the NDIS. The Mental Health Coalition has been flagging concerns that the NDIS funding model does not give consideration to the ongoing mentoring and support required for such clients under the NDIS. They are also concerned that funding will not be sufficient to attract, retain or train people with specialist skills in this area.

The Productivity Commission Study report highlights mental health services as a particular concern, especially where the Commonwealth, States and Territories are withdrawing their funding for a number of mental health support programs and using this funding to offset part of their contribution to the NDIS. It further highlights that there needs to be support for people with mental health illnesses outside of the scheme — a responsibility that remains (largely) with State and Territory Governments. It identifies that at this stage, it is unclear what supports will be available for people with a mental illness who do not meet the NDIS eligibility criteria and that this should be clarified as a matter of urgency.

Early indications are that some solo private practitioners will not find it financially viable to operate under the funding model as well as meet the reporting requirements. The PCV is however pleased to note that funding for the Exceptional Needs Unit (ENU), Centre for Disability Health and the Chemical Restraints project has been committed by the State government for the next 12 months.

The establishment of the Psycho-Social Taskforce, chaired by the Chief Psychiatrist should also be acknowledged, as it brings together a range of key stakeholders who have identifying the gaps in the transition over to the NDIS and highlighting the potential risks to service users. It includes representation from DHS and Sa Health, the NGO sector, the NDIA and lived experience members, all who have made valuable contributions.

2.5 Referring matters of concern

A key component of the role of the CVS is to refer matters of concern raised in visit reports to the appropriate organisation for resolution. Dependent on the nature and scope of the issue, these referrals can be to management of the service provider, the Minister's delegate or to the Minister.

A protocol for the referral of matters of concern to the Minister for Disabilities has been developed. The purpose of this protocol was to set out an agreed process for managing issues of concern raised with a CV and the requirement to, where necessary, refer matters of concern to the Minister for Disabilities, in line with the *Disability Services (Community Visitor Scheme) Regulations 2013*.

The CVS has also established MOAs with other agencies, including the Office of the Public Advocate (OPA) and the Health and Community Services Complaints Commission (HSCCC). The CVS has also referred a number of issues to the Critical Incident Team with DHS and consulted with the Director of the unit and obtained advice on how best to address issues raised.

Any significant issues of concern or reoccurring themes indicating a possible systemic issue that are raised within visit reports, are transferred onto the *Issues Register* and referred to the CVS Advisory Committee meeting for discussion. The Advisory Committee provides advice to the PCV about potential actions and develops shared, cross agency strategies and responses where there are common issues.

Of the reports prepared by CVs this reporting period, 184 highlighted a varying number of points of concern/issues raised at visits. The numbers varied from 1- 4 points of concern per report. At the time of writing this report, 142 of the issues raised in the reports had been resolved or completed and 42 (23%) remain ongoing or are outstanding. The respective Coordinators continue to monitor the outstanding issues and follow-up with the respective services.

² Social development Committee – Inquiry into Comorbidity Submission from the south Australian Government 8 February 2016
<https://www.parliament.sa.gov.au/Committees/Pages/Committees.aspx?CTId=5&CId=302>

2.6 Influence plans, policy and practice development

A significant and important role the CVS plays is its contribution to planning, policy, strategy, reviews and investigations at both a commonwealth and state level. The PCV has been invited to attend committees and discussion panels and been asked to contribute to an array of reviews, investigations, reports and discussion papers. Examples include:

- » Australian Human Rights Commission - A Future Without Violence: Quality, safeguarding and oversight to prevent and address violence against people with disability in institutional settings report
- » Senate Community Affairs References Committee - Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised

In addition, the CVS has an important role to play to ensure policy and clinical practise development is influenced by the experience of people with disability and their relative, guardian, carer, friend or supporter. The CVS therefore takes targeted opportunities through representation on committees and through input/comment on planning, policy and clinical practice documentation as listed below:

- » The PCV is the SA representative on the Independent Advisory Council of the National Disability Insurance Agency
- » NDIS Stakeholder Forum - Key Influencers and Industry Group
- » Regular meetings with other Statutory officers such as the Public Advocate, Chief Psychiatrist, Mental Health Commissioner and Health and Community Services Complaints Commissioner
- » Human Rights and Equal Opportunity Commission consultation
- » ICAC investigation into Oakden
- » Attorney-General's Department assessment of whether existing inspectorate/oversight bodies in South Australia are Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)
- » National Public Advocate/ Guardian meeting
- » Commonwealth Ombudsman – OPCAT consultation
- » Disability Inclusion Bill
- » SA Health Oakden Oversight committee
- » SA Mental Health Act Review Implementation
- » Statutory Authorities Group and Rights Protection Agencies meeting
- » SA Ambulance Services – Community Advisory Committee
- » Stakeholder Focus Group on Supported Decision-Making
- » Teleconference meetings with Community Visitor Scheme managers across Australia.
- » Rooming Housing Roundtable - Minister Zoe Bettison
- » SA Intellectual disability and Mental Health network meeting
- » NDIS Quality and Safeguard Commission Transfer and Establishment meeting
- » DSS and SA Regulatory Bodies Information sharing workshop

3. Disability Accommodation outcomes and themes

3.1 Visits and data

At commencement of the 2017-18 reporting year the CVS introduced a new report format (appendix 6) to be completed by Community Visitors (CVs) after every visit.

The new report gives focus to five (5) main categories:

- » Communication – resident and staff interaction/respectful communication
- » Environment – suitability of facilities and their maintenance
- » Quality of client services and access
- » Safety and Rights – least restrictive practices, and
- » Treatment and Care planning

The report also provides opportunity for any issue of concern or request for advocacy to be presented to the Principal Community Visitor for follow up.

In the first three areas of the report, the CVs are requested to provide a rating out of five for the service against a range of questions related to that section.

Following is a presentation of the rating and a snap shot of comments made:

3.2 Key Report Findings

3.2.1 Communication - resident and staff interaction/respectful communication

The following two (2) charts present data on CV ratings of services in respect to communication between staff and clients and staff responsiveness to client needs.



In addition to rating CVs were invited to provide comment

There were 170 **positive comments** noted in reports related to communication and staff responsiveness to clients. Some extract examples are as follows:

3 of the clients had limited verbal abilities, but seemed to communicate their needs and understanding of our visit well, and the relationships seemed warm, facilitative and understanding. The 4th resident was very verbal, welcomed us, showed us around. Staff seemed warm and understanding with her, while also setting limits to some of her exuberance

Active and constant interactions were observed, as residents prepared to leave for Day Options for the day. The atmosphere was relaxed and comfortable.

It is immediately apparent there is a high degree of interaction and connection between the staff and clients. Most of the clients have been together in this unit for many years and the staff is regular and so have an obvious bonding

which is great to see

All staff evidenced untiring willingness to engage with clients. Clients, having various mental, emotional and physical issues, were reported to sometimes be contentious and anti-social.

While the number of **issues** highlighted in visit reports were low, some examples of issues include:

Residents were complaining about a few things around the house etc. The residents moved in 2 months ago, a few teething problems that staff need to fix.

We were contacted by parents of a young man who shared a house in the South with another man who has a head injury and at times becomes angry and very aggressive, so much so, that the staff have to call the police and lock themselves in their office. . The family reported to CVS that there have been many occasions when their son, XXX has had to wait for some considerable time for food or hygiene issues due to XXX's behaviour. In one instance, he was in a soiled bed for 4 ½ hours.

The family wrote to the PCV after he had conducted a number of unannounced visits saying the following:

I guess you can imagine how upsetting it is to see someone you love at risk of injury and physical abuse and suffer and you feel powerless. We are extremely grateful you not only took the time to visit James but for the first time someone has given us some hope that James may have a brighter future.

In summary, CVS rated their observations of the communication and interaction between staff and clients as being high with only 3.72% not receiving a satisfactory rating. This is extremely pleasing, given that it is without doubt a key indicator underpinning quality care and support provision. The challenge remains on how to ensure visit observations best reflect normal life in the house. While there are significant advantages of preannounced visits the orchestrated nature, especially where service managers make a point of attending, create a more artificial environment.

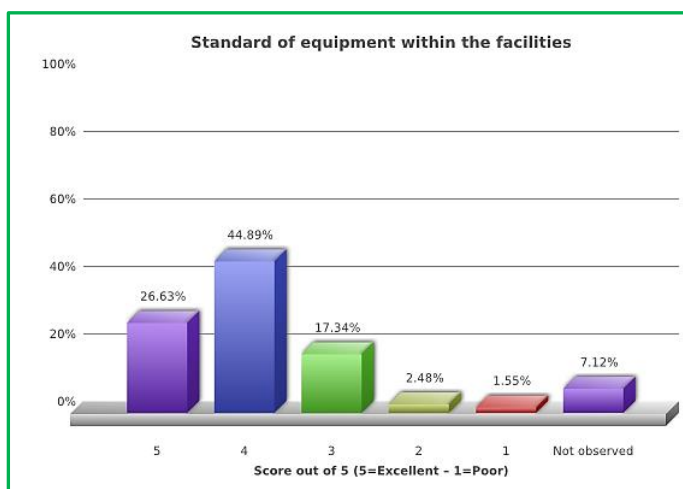
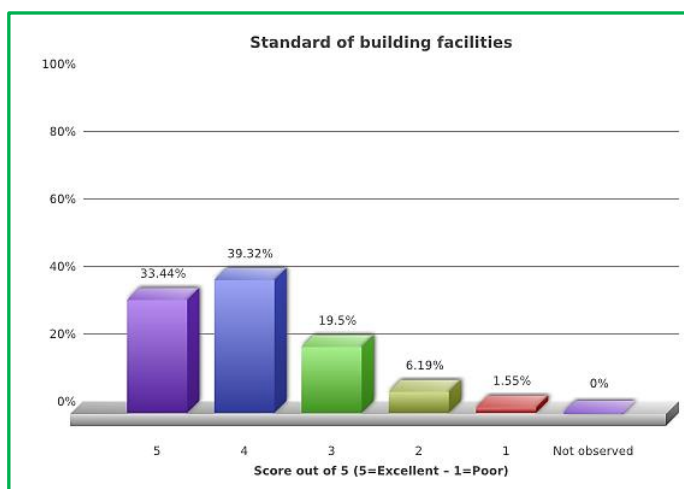
If the CVS has any concerns about how the service is operating and 'feeling', e.g., if there is a sense of pretention or underlying concerns, we tend to follow up with an unannounced visit.

Recommendations

1. The CVS to continue to monitor interactions between staff and residents and report on whether these observations are either positive, sensitive and respectful or to the contrary.
2. CVS to look at strategies to reduce service providers preference for a more orchestrated visit so more natural house interactions can be observed.

3.2.2 Environment – suitability of facilities and their maintenance

A key component of any visit and inspection is to assess the appropriateness, accessibility and standard of the house and facilities, including whether they are well maintained. This includes assessing building, equipment, grounds, emergency procedures and privacy for clients. Previous annual reports identified the direct correlation between client and staff satisfaction and the standard of accommodation.



As per the above charts, the stock of houses that provide accommodation for those with a disability were rated on average as being very good and meet the needs of the client group. However, there are examples of houses that remain unsuitable or require significant investment to upgrade. It appears that in many of these situations there is found

to be an impasse due to transitional arrangements between Housing SA and Access to place or where there are delays in transfer to a new house with assessment there is no value in further maintenance of the current run down building

Visit reports contained 183 **positive comments** in relation to the standard of accommodation as exemplified below:

All housing units are quite new (5 or 6 years), in excellent condition, commodious and well equipped. Passages and work areas are wide to allow wheel chair movement. Outside areas are large, paved, landscaped and pleasant.

Both residences were surprisingly large once they were accessed. The 2 home units were mirror images of each other with both having 2 separate bedrooms 1 with an on-suite and another separate bathroom, 1 office in each unit and a large lounge area in each, with a separate kitchen, and dining area. The units were very neat, clean, tidy and very well maintained.

Each client had the privacy needed and the building was observed to be neat and well maintained. The houses are clustered but felt very homely and personal suitable to individual client and their choices. The houses have gardens and fence surrounding them. Each house has 2 bedrooms. and open spaces.

There were 44 **issues** of concern raised that required follow up by the CVS, examples as follows:

Housing Trust building & leased to XXXX. 2 Air conditioners, BUT are over rear door jams, and do not cool bedrooms adequately. Major structural cracks in walls and bathroom, and ceiling cornices are almost falling down. They look dangerous and are creating major safety issues for clients.

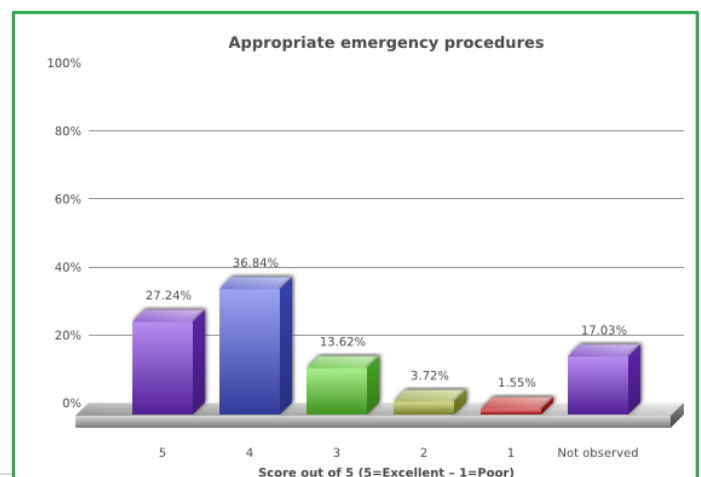
This house is aged, not in good condition and too small for 4 residents + staff, including 1 staff on passive nights. At the last CVS visit, 2 years ago (Jan 2016) XXXX staff indicated that active steps were being taken to find a bigger and better alternative and were 'hopeful' a move would be arranged. This has not happened. All residents wish to continue to share together in an area that is convenient for their work and other activities. Although HSA has done some repairs, resident B showed us many bad interior and exterior cracks in walls, floor/wall junctions and ceilings. There is no 5th bedroom so the staff's overnight is spent on a bed in the living/dining area (not private) and also making that area very unattractive and seriously limiting its use by residents. There is only one bathroom which includes the only toilet. The house interior is dark and there is not enough storage space. The issue of a move needs CVS follow-up.

There remains the problems of the uneven floors throughout, the narrow doorways providing access challenges for wheelchair users and the useless bathtub taking up precious space in the only client bathroom. SA Housing has declined to undertake this work despite the uneven floors and narrow doorways pose safety issues.

The premises are not fit for purpose both in terms of functionality and ambience. Fortunately the group will move within months to a new, purpose built home in an adjacent suburb.

The building is quite unsuitable for the purpose as a home for people with a disability, particularly those who are ambulant disabled. XXXX is wheelchair bound and has difficulty getting through many of the spaces; some are quite inaccessible. The spaces and configuration of the building are not up to the current Australian Standard Disability Standards.

The buildings themselves although purpose built for people with mobility needs, looked "shabby". What is shabby.....well the walls in passage ways and lounge rooms had all suffered wheel chair damage over time with large gouges, paint damage and wheel chair marks. There was a curtain rail in the lounge room of unit 1 hanging over the courtyard door that looked like it was just hanging on. Maintenance is managed by XXXX and it would be pleasant to see that the wear and tear caused by heavy wheel chair use over a length of time could be repaired.



Another key accommodation related aspect assessed during visits was emergency equipment and procedures. This again was assessed as being at a relatively high standard drawing many (74) **positive comments** in visit reports:

As the 5 clients were in wheelchairs and were mostly non verbal, staff explained that there are mock fire drills that are conducted with all permanent and agency staff to keep them up to date as how to evacuate the high needs clients if required. There was a fire extinguisher, a fire blanket in the kitchen and an evacuation plan on the wall.

Emergency egress information is available in all of the principal rooms, including the bedrooms we inspected. A fire alarm system is provided.

There was a number of houses assessed as needing attention in relation to appropriate emergency procedures which were referred to their management:

Evacuation drills are not performed. No evidence of personal emergency and evacuation plans. Access to the fire extinguisher was obstructed. No evidence that first-aid box, smoke detectors and fire-equipment are regularly maintained and tested.

No exit signs installed. Smoke alarms were not noticed by CV's

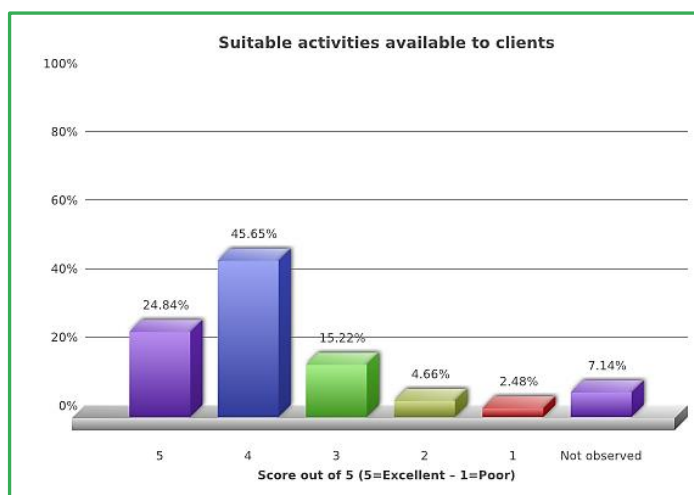
Emergency procedures were discussed and agreed that they need to be practiced every 6 months. There were no emergency instructions for residents to see. We discussed that XXXX and XXXX would be able to leave if there were an emergency but XXXX will need assistance. This is something that may need more attention.

Recommendations

- CVs continue to thoroughly inspect all areas of the facilities they visit and report on any environmental concerns or inadequacies, especially where this has an impact on the provision of client centred care.

3.2.3 Quality of client services

Components considered within the category include: *Transport, quality and choice of food, entertainment, family or carer involvement, and access to personal documentation, information regarding rights and advocacy, and access to holidays.*



For a range of people with disabilities their access to appropriate and valued entertainment is important. Report data in relation to this aspect of service delivery indicates that in general this is at a high or appropriate standard. Report comments include:

Art and craft, Daily activity, Entertainment e.g. television, games, books, DVD, Family friendly spaces, Life skills e.g. cooking/food preparation, budgeting

CVs noted that a variety of entertainment are available to the residents including art and craft, printed books, Television and outside sitting area. Both residents enjoy family time

Excellent choice of activities, from active sport based activities such as playground equipment, with adequate sail/sun protection, to a fortnightly disco, watching the footy, listening to music, watching TV, to quieter, less active pursuits such as jigsaws, toys, dolls and the like. Clients participate in the gardening activities. A full range of age

appropriate activities are offered.

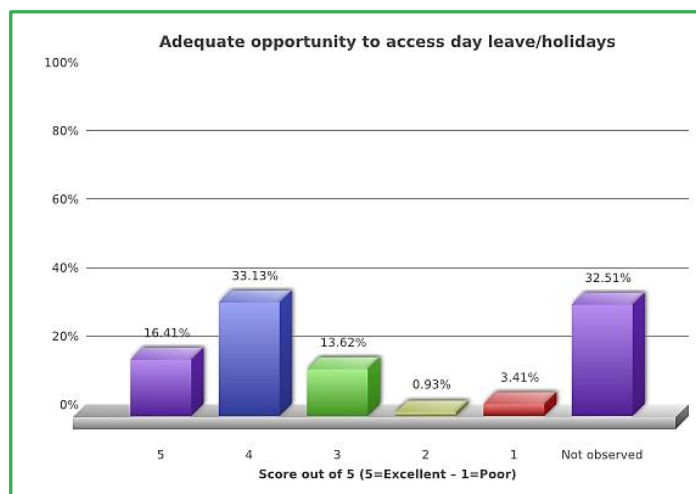
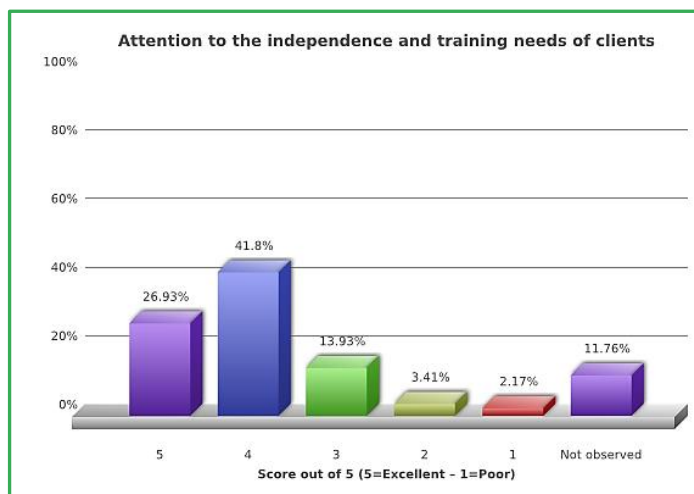
Some settings remained challenged in this area especially in settings where achieving the balance between safety and quality of life is difficult to achieve (explored further in 3.3.1)

Clients would benefit from a specific-design entertainment room as a relaxing, sensory room, low impact, where they could move freely and safely (according to the needs of clients with low mobility and high levels of care. XXXX informed us that this is the wish of staff.

A suitably challenging range of activities tailored to XXXX's creative interests is required in order to meet XXXX's intellectual needs

A key component of the role of the CVS as an external, independent visitors is to enquire into and challenge established norms that appear to inhibit the potential growth or opportunities for individuals. Experience and research has shown that in some situations, staff can establish routines and have low expectations towards the people they are supporting. Unfortunately for some individuals, a lifetime of support from the only people they have contact with, has resulted in them accepting lower expectations. So the Status quo is maintained, nothing changes and all the routines within the house are the same.

It is therefore most positive that the response to questions around attention to the independence and training of individuals and access to holidays receives a strong rating as demonstrated in the following graphs.



Positive comments noted include:

An active support program exists to involve the clients in day-to-day tasks of the units. A visual weekly schedule board was observed in the unit

Clients are provided with additional carers/support workers to arrange additional activities with the client. For example, during our visit, an external support worker XXXX was in the house to assist XXXX in arranging cooking classes and a forth-coming fishing trip

Support workers we spoke to appeared to be very dedicated in progressing XXXX's development to its full potential, especially in the areas of communication and mobility. They had observed marked improvement in behaviour since XXXX's move into the residence at XXXX St, as she developed more independence and there were fewer episodes of biting and screaming which she would do when frustrated or angry.

Since that last report, 2 previous clients are now living independently. XXXX makes an effort to take their old friends currently at the residence to visit clients now living independently. On a regular basis Developmental educators are visiting the facility to run programs like cooking lessons, and show staff how to teach clients cooking, and general household duties.

Strategies are currently being employed to increase XXXX's independence. These include: accommodating him in an independent unit attached to the house; leaving him at home alone on some days to manage his own day; allotting him his own chores around the house (eg, washing cars, tidying backyard); catching the bus home to Port Pirie; undertaking an employment course with a view to employment in the open market.

Conversely, reports highlighted for some service providers where more imaginative and contemporary approaches to the support of individuals could be applied to enhance their life experience:

I noticed a childlike treatment. One client is allowed one hour a day on his computer gaming and if he is a good boy he earns more time.

There did not appear to be a focus on the training needs of the clients but mostly to keep them amused in some activity.

Two parents indicated that they would like to see more support for their daughters to upskill. One was mainly in the area of the preparation of freshly prepared healthy meals and the other in terms of support for motivation for cleaning her own bedroom and unit.

It is unclear what level of independence A could or would like to achieve. Perhaps more focus on encouraging him to express himself rather than remain passive would provide a better picture. The interactions we observed did attempt this but did not provide the time for him to consider and respond.

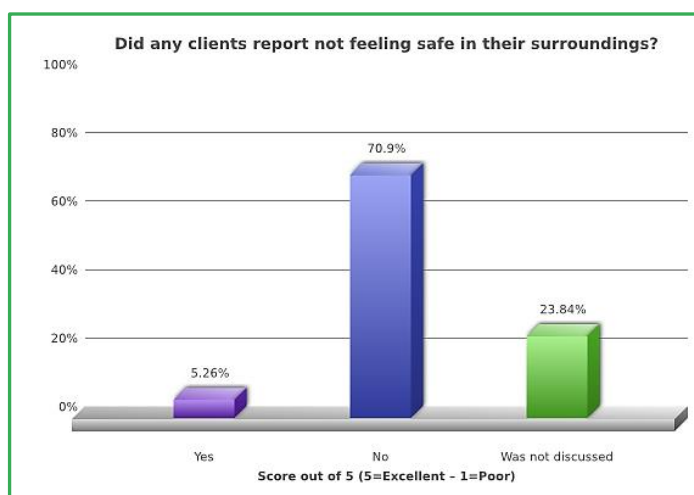
There did not seem to be much encouragement or support, especially for XXXX to get out and about

3.2.4 Safety and Rights - least restrictive practices

The issue of personal safety (for both residents and staff) remains a key area of interest and is regularly a point of discussion at the CVS Advisory Committee meetings.

The CVS continues to monitor personal safety at all visits drawing attention to situations and environments, which could potentially expose individuals to risk. This year the CVS undertook a two-month focus on consumer safety that is highlighted later in the report.

The following chart of responses to the question of whether any clients report not feeling safe indicates that there is a strong sense of comfort within the accommodation sector that individuals feel safe. Clearly this is a difficult question to explore in some houses reflecting the high rate of not discussed.



Some of the concerns expressed to CVs as contained in the visit report include:

Although G made no complaint, the Staff said that they felt unsafe at times as the park area that abuts the facility is often frequented by unruly children and older people who from time to time harass the staff and clients and damage the surrounding fencing and attempt to steal loose items and equipment. All windows and the rear door are fitted with security screens. Staff have reported this issue to their management and have been told that alternative premises would be considered.

B spoke to one of the CVs towards the end of the visit concerning a situation at her workplace in XXXX. B mentioned it was noisy and the tables shook. She also said that somebody named XXXX stood over her and she did not like it. B is aware that she can speak out and say "stop", and talk to XXXX (her supervisor?). As the environment at work is making B feel uncomfortable, she would benefit from CVS support to address the issue.

Staff advised CV's that in their opinion M is on too much anti-anxiety medication and is on the next team meeting agenda on finding ways to reduce his anxiety and to also train staff on how to deal with his loud noises.

As highlighted in the following extracts, the issue of accommodating those with more challenging behaviours into environments without adversely impacting on the other house residents, remains a challenge

4 clients expressly said they had, or were said to evidence feelings of threat because of the behaviour of client A;

one of these 4 is so frightened by the last event that she is presently staying off site.

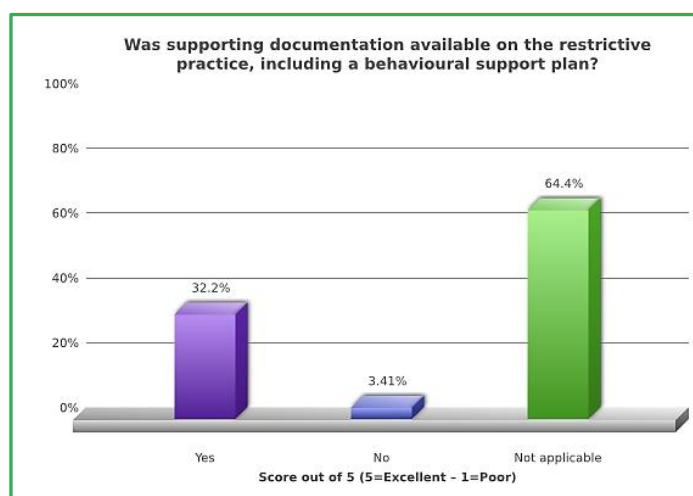
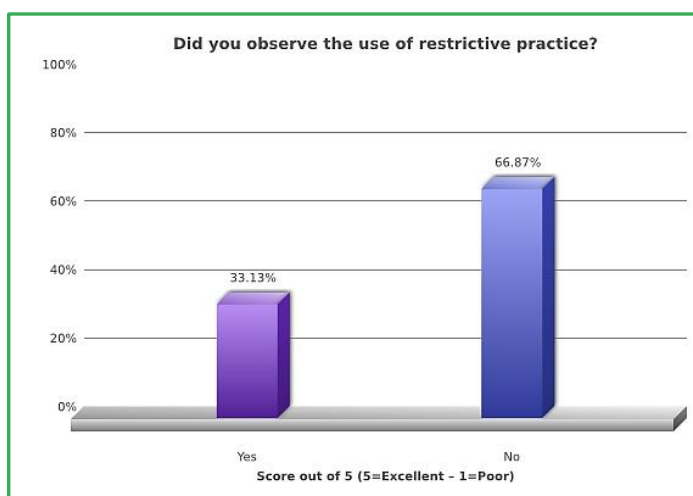
Client M is apparently intimidated by client A who displays violent and aggressive behaviours. Staff try to manage as best they can and A is on PRN medication. There is also an issue of A stealing from the house, next door and from the shops.

Clients are generally not verbal, however they are able to indicate preferences to staff. We were told that the women sharing Unit 2 with XXXX become distressed with the volume and longevity of noise she can create by screaming. (CVS were able to hear XXXX when we were in the adjacent Unit.) Clients need to be moved away from XXX because of the disturbance of her ongoing screaming. Because of her behaviour, XXXX is taken in the Van on her own. In addition to the noise hazard, is stressful for staff working with XXXX who demands constant attention.

XXXX was asked specifically about how safe he felt and what he would do in an emergency. He brought up his relationship with his neighbour in Unit 1, XXXX, who has an explosive temper problem, and outlined how he withdraws to his bedroom and notifies a carer if he feels threatened.

In theory, under the NDIS, clients will have ultimate control over where they live, the CVS does not anticipate that where there is conflict between individuals in a house, one or two moving out to alternate accommodation will not be so easy. Evidence is that most people expect that the person responsible for the adverse situation should move out (this may at times be a point of dispute). The landlord and service provider will be a different person/agency which may add another level of complication to the negotiation and decision but it shouldn't. Alternate housing options will always be difficult to find for a person with behavioural issues however, the CVS has become aware of a number of sites where 'other residents' are experiencing higher stress levels and a reduced quality of life due to having to share their house with a fellow client with extremely challenging and loud behaviours.

Another key element of visits is the monitoring of restrictive practices. This includes medication specifically prescribed to manage challenging behaviour(s).



There was evidence from visit reports that in most cases where there was observation of restrictive practice, there was in place supporting documentation and positive evidence where staff were working hard to manage behavioural challenges without the application of restrictive practice. Most common forms of restrictive practice were access to fridge/food and straps to maintain position in chairs. Examples as extracted from reports:

All the clients are using restrictive practice, which is the medication that prescribed by the doctor. Supporting documentation has provided and staff confirms that they are using Positive Support and ABC chart (Antecedent-Behavior-Consequence (ABC)) for preventing self-harm and behaviour issues of the clients.

An enclosed bed is available as 2 regular clients need/prefer it for their safety. Both these situations are thoroughly documented and we examined the documentation. Jodie described the extensive work being done currently at CARA to clarify and minimise restrictive practices, to train staff and to maintain a robust process of authorisation and documentation. This includes the appointment of a Restrictive Practice Compliance Officer, the establishment of an organisation-wide RP Register and input from the Senior Practitioner.

As J is non-verbal it was not possible for the CVs to inquire about safety. However, the house manager and her

support workers appeared to be taking all precautions to make J's surroundings safe. In fact, as a result of J's tendency to self-harm aggressively, practices that may be deemed restrictive (such as wrapping Joel in a quilt when his self-harming behaviour escalates, had to be put in place. The restrictive practices are recorded and approved by J's care and support stakeholders.

Some restrictive practices were in place. 1 client wore gloves to stop persistent chewing of hands, 1 client had his ankles strapped as he constantly banged his legs into his wheelchairs, and they had become extremely sensitive. Some PRN was used sparingly for challenging behaviours, and the front door was always locked. There was detailed authorization for all of these restrictive practices.

The restrictive practices included a locked fridge & pantry to prevent over-consumption of food. Notably, healthy snacks are provided throughout the day.

The restrictive practices were well documented. Mostly relating to the locking of kitchen to prevent clients from injuring self and others or eating inappropriate food (eg raw meat)

These clients moved directly here from Strathmont 18 months ago. Their challenging behaviours are quoted to justify the locked external and kitchen doors. A fridge is always available to them with water and snacks if they wish and staff seemed enthusiastic about accompanying them outside into the yard as clients enjoyed being in the fresh air.

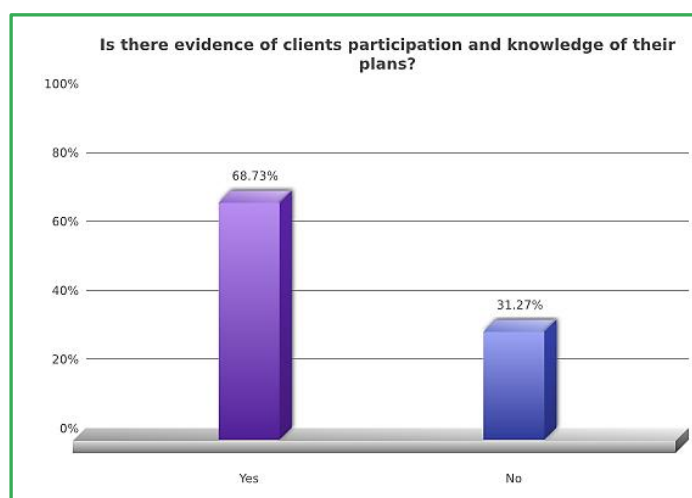
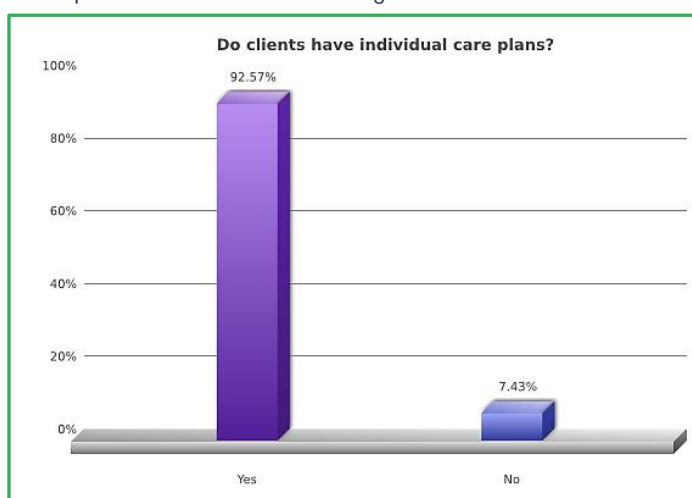
During our visit one client, B, was 'resting' but we were told that as he was having a 'bad day' he had been medicated before we arrived. Client M's PC Plan included an item to have a psychiatrist review her medication regime because family thought she was being over-medicated, having noticed her drowsy state during their visits. Our visit would have been a disruption to normal routines and may have caused disappointment if the 2 active clients thought they we were there to take them on a trip. We noticed that both were quite agitated during our time with them.

Recommendations

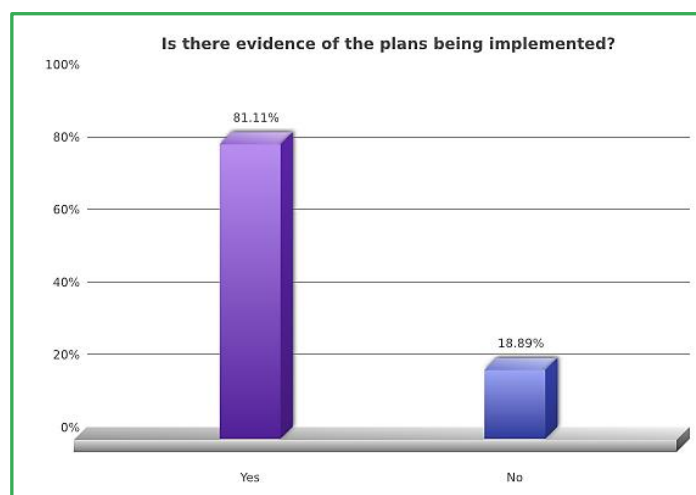
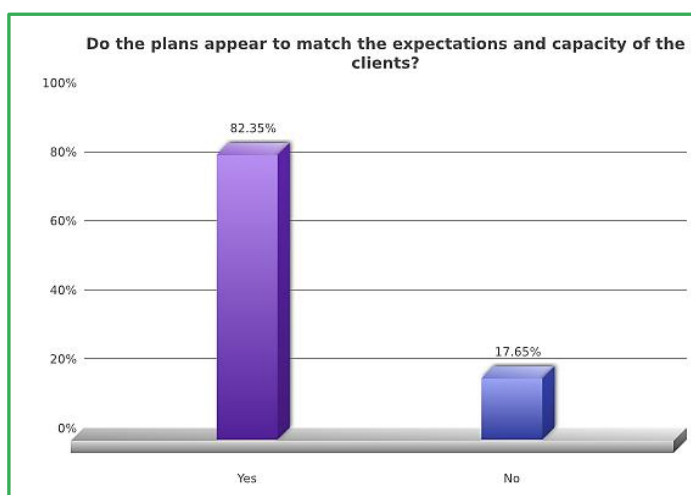
4. That the CVS continues to monitor personal safety of both residents and staff.
5. That the CVS looks into undertaking a focus on medication reviews including PRN.
6. The CVs continue to check on the use of restrictive practices and report undocumented or unusual practices to the PCV who will report to the Senior Practitioner at the SA office Quality and Safeguards Commission.

3.2.5 Treatment and care plans

Reviewing as to whether residents have in place a life style centred or similar individual care plan (ICP) remains a priority for CVS visits. This was of particular importance during this reporting period which aligned with transfer to the NDIS. Reviewing of these plans formed part of the pre planning and therefore a precursor to the achievement of optimal NDIS plans and associated funding.



The development of plans that match an individual's expectation or their capacity and then whether they are fully implemented remains the most vexed issue. Without this alignment and without implementation there will be minimal opportunity for individuals to maximise their capacity, achieve their goals or lead as fulfilling a life as is possible.



From the above charts, indications are that this is successfully occurring in 80% of situations. There was lots of commentary about implementation of new plan formats/systems by a range of organisations. These changes were being supported by key quality staff and the training for house staff. It therefore appears that preparing for and the implementation of the NDIS has driven significant improvement in this area. Extracts from visit reports that highlight this positive outcome include:

It was raised as an issue of concern by CVs at the last V&I that care plans/support plans were outdated. This issue had been addressed and the support plans and person centred plans were now current, and detailed. However, staff explained there was still more work to do for the support plans in transitioning to the NDIS which they believe they were well prepared for.

All plans and documentation are primarily stored electronically. With the resident's consent we examined one set of documentation. It appeared to be thorough and carefully maintained. In time, further prompted by NDIS, 'goals' etc will no doubt become (even) more ambitious.

XXXX seem to be implementing a program of reviewing ICP in the context of the NDIS roll out and with their own program of PATH, an objective based (and visually supported) means of demonstrating movement and achievement of a goal-focussed program. Each client has their PATH program visually demonstrated in his or her own room and many could show how these have been met. The comment was made that there must be 3 goals set for the NDIS program so a review is underway to formalise these.

It remains disappointing that a positive outcome is not being achieved for 18% of the population. Examples from reports where this is not being achieved are as follows:

After talking with XXXX, we pickup that he needs a review on his expectations and activities plan, CVs mentioned this to the care workers. He expressed that he would like to do some swimming and perhaps he would like the idea of another person to move into the facility to gain more interaction within the house.

A major concern raised was the lack of a structured objective and outcome based plan for the client. The support worker was unable to locate any documentation supporting this and while the daily activity / support is provided, there seems to be no overarching plan to achieve specific outcomes. The care is obvious, however why the activities are being undertaken beyond occupying the day seems vague and brings into question, if new or relief staff are employed, how would they know how to implement activity etc beyond 'babysitting'?

A visual weekly wall chart is created for the Client detailing activities for the day, appears the client updated magnetic images for the tasks etc.(had not been updated for the day)

XXXX has a very comprehensive Risk Assessment & Management Plan (essentially for the safety of staff) and a Behaviour Support Plan, but not a Care Plan documenting steps agreed with A or his supporters to progress his self-reliance and desires for a more fulfilling and independent life. Staff know the steps they plan to take and can discuss progress (or lack of it) but do not have the benefit of an agreed plan that he can work with staff to achieve.

No current Person Centred Plans were available for perusal by CVs (nor copies of old). The staff told CVs that the reason why there is no update care plan is associated with the uncertainty funding provided by NDIS.

Recommendations

7. That CVs continue to monitor and report on lifestyle/person centred plans and NDIS plans being in place, the involvement of residents and where appropriate families and guardians in their compilation.
8. That CVs enquire into the implementation of plans and seek evidence that the plans are being implemented and regularly reviewed and monitor the level of encouragement and support by staff to assist residents in developing independent living skills.
9. That Community Visitors continue to monitor and report on activities and structured programs that residents are involved in and that they are consistent with the preferences and capability of residents.

3.3 Issues and Challenges impacting Disability Services

3.3.1 Accommodation and support for those with complex care needs

The CVS has identified 12 houses they have visited which can best be described as fortified places of containment. These houses are often run by NGO organisations and contain residents with a mix of diagnosis and challenging behaviours. Resources are mainly centred around supervision and safety for resident, staff and the broader community.

Diversification from a restrictive daily pattern within the house appears very challenging for those organisations. The State does not appear to have in place specialist centres for those with more challenging behaviours as can be found in other states or internationally. These specialist services would typically be found to have purpose built facilities (hardened), specialist skilled staff and access to activities that provide a safe diversion from a locked house. Most importantly, location needs to be considered as a lot of the restrictions are based on protecting the individual from access to roads and protecting neighbours.

CVS has highlighted this as an issue with DHS and in a number of forums and will look to work with key stakeholders to produce a long-term strategic solution.

While the CVS respects the challenges faced by these organisations and the work they undertake to make outcomes as positive for individuals in a difficult situation, it is clear that a broader strategic approach is required. It is difficult to predict who may undertake this work in an NDIS environment. While there is funding for specialist housing and funding for complex care support, if a broader approach is not adopted then considerable money will be spent providing a very basic service.

3.3.2 Correct mix of clients

As highlighted in previous annual reports and again in section 3.2.4, the issue of accommodating those with more challenging behaviours into environments without adversely affecting the other house residents remains a challenge.

While in theory, choice and control will provide opportunity for individuals to elect to move when not feeling comfortable or safe, this will not be such an easy process for many reasons:

- » Moving house is never easy especially compounded in these situations with a change in whom you will share with and who will be providing you support. It is anticipated there will be requirement to meet with members of prospective houses to assess if you would want to share with them and for them to be accepting of you. This itself will require significant coordination and create further anxiety for all concerned.
- » Due to house shortages, finding alternate housing options will be difficult.
- » For those with behavioural issues, support will be required to achieve a positive outcome and a balance of fairness so as not to create another challenging situation for other vulnerable clients.

The division of property owner and service provider will add further complication to the negotiation and decision especially where behaviour may include some property damage. There is a high risk that those with complex needs and challenging behaviours will become isolated in stand-alone houses or become colocated with similar clients creating more fortified accommodation, with moderated individual plans.

3.3.3 Access - transport and service availability

The importance of residents being able to readily access transport to attend activities and obtain diversion from their house especially on weekends is significant.

Many of the residences visited, had an appropriate vehicle allocated to the house while other residences did not and either shared a vehicle with another house nearby or had access to taxi vouchers/other means of transport. Many service providers expressed their concern regarding the funding of vehicles when the NDIS comes into effect. The recent independent evaluation of the funding model found that "Current travel allowances do not adequately cover the costs of provider travel and participant transport in regional areas and isolated communities".

Early indications are that funding for transport contained in NDIS individual packages is primarily allocated for access to daily activity programs leaving little or none for individual access to medical appointments, shopping etc. It is predicted that in the future under the NDIS, there will no longer be a car available at most houses. The pooling of resources and the complexity of leasing vehicles will prohibit attaining what is currently valued by some houses. Creative solutions to

the provision of transport will need to be considered. Recently presented NDIS Plan Utilisation Rates, are a concern and it is anticipated that limited access to transport will be a contributing factor. CVS will continue to monitor and highlight where transport is an inhibiting factor to people fulfilling their individual plans

3.3.4 Clients with disabilities such as intellectual disability, brain injury or autism in acute mental health units

The issue of clients with dual-diagnosis of intellectual disability and/or acquired brain injury with mental illness remains a significant agenda item for the CVS.

As reported in previous PCV Annual Reports, research has been undertaken on this issue with State government reports prepared such as the *Gaps in Secure Services Brief* (SA Health, February 2012) and *Forensic Disability: The Tip of Another Iceberg* (Exceptional Needs Unit, September 2011). The reports recognised that both correctional and forensic services are ill equipped to adequately cater for the specific support and developmental needs of those with both a mental health and intellectual disability or brain injury or autism.

CVS Findings

There remains an unfortunate mix of clients with intellectual disability and those with a mental illness who must cohabit because of their security status, despite having quite different support needs and management requirements. Skill levels for staff for both groups vary and the mixing of these clients leads to incidents and a failure to cater for differing needs.

The situation of clients with an intellectual disability being housed in a mental health unit is inadequate for them and unfair on staff. A number of these clients are not receiving medication or treatment interventions - but there is no other suitable safe and secure accommodation for them.

Discussion

An external and independent review of forensic mental health services was conducted in July 2015. The report was released to the public on 7 July 2017. SA Health has adopted most of the recommendations which was detailed in an Response report and there is work happening with specific clients who are transitioning out of secure care with the support of NGOs.

The NDIS will primarily be a funding organisation and the Quality and safety Commissioner responsible for the quality of service provided to individuals supported by NDIS registered organisations. However, it is not clear as to who will take responsibility from the Department of Human Services perspective to ensure the special needs of this client group are given the required attention and their integration into the community is skilfully managed.

As previously mentioned, the PCV has advocated for the 'implementation of the recommendations of the 2015 review of Forensic services in SA' and has had it as an agenda item for his meetings with the Minister and Chief Executive of NALHN. In doing so, the PCV continues to advocate strongly for those with a disability to transition out into a new service model in the community with skilled and experienced NGOs.

4. Supported Residential Facilities outcomes and themes

The Supported Residential Facilities (SRF) sector has undergone significant change during this reporting period. In this report these changes will be considered within what has been the overarching context of the sector as it relates to 2017-2018.

Supported Residential Facilities (SRFs) are accommodation services licensed under the *Supported Residential Facilities Act 1992* (the Act) to provide low level care services in a group setting, for people living with a disability or mental health issues. They are defined in the Act as “premises at which for monetary or other consideration (but whether or not for profit), residential accommodation is provided or offered together with personal care services (other than for members of the immediate family of the proprietor of the facility).”

A ‘pension only’ SRF is defined as such because most residents are in receipt of a pension or other government allowance and rent assistance and pay the majority of their income to the facility for their ongoing care.

At the end of this reporting period, there were 21 ‘pension only’ SRFs in South Australia, the majority of which are privately owned commercial enterprises. Of these, all but two are located within metropolitan Adelaide and represent the facilities visited and inspected by the CVS (see figure 4.1 –SRFs by location and NDIS region).

As of July 2017, the SRF sector provided accommodation and low level support services to approximately 790 individuals. Closures of two SRFs during this time – Amber Lodge and Mandeville Lodge – reflected a reduction in sector capacity of 72 licenced ‘pension only’ beds. Historically, SRFs in South Australia have varied considerably in size from 12 beds to the largest being 68 beds.

However, it is important to note that changes made to the sector accommodation model during this reporting period - in response to the NDIS during this reporting period - makes exact determination of resident numbers very difficult. This will be further explored in section 4.4.

Local government is responsible for the auditing and licensing requirements of SRFs, under the Act. However, the Eastern Health Authority undertakes these responsibilities on behalf of most local councils located in the eastern region of Adelaide. Section 4.4 of this report explores how the NDIS is likely to impact local government.

Under current legislation, SRFs must provide a Prospectus clearly identifying such things as the services provided; terms and conditions; type of accommodation and facilities; staffing levels; meals; medication management; and rights and responsibilities of both the facility and the residents.

Of significant importance to the SRF sector, is the SRF Intake and Support Service (SRF&SS), located in the Exceptional Needs Unit (ENU) of DHS (previously DCSI). The SRF&SS undertakes non-clinical assessment for individuals seeking SRF accommodation or for existing SRF residents who may require additional supports. The SRF Entry Point Assessment (SEP) considers a person’s needs and risks in the context of low level care, congregate accommodation.

A person assessed as eligible will be approved for the government’s Board & care Subsidy. These payments are made to an SRF proprietor on behalf of the eligible person to offset some of the cost of providing care. While this assessment process is actively encouraged, it is not a pre-requisite for entry to an SRF.

Further, if an SRF wishes to claim the Board and care Subsidy, they can only charge a maximum of 79% of a person’s Centrelink entitlement. The Board and care Subsidy is only payable to those who access the SEP. The SRF&SS team also undertake assessments of residents who may require additional psychosocial and or health support to enhance a person’s tenancy, reduce social isolation and links to mainstream community services and activities. Support Services are provided through a ‘package’ delivered by a non-government organisation (NGO) and department of Health & Aging.³

The aforementioned description of the role played by the SRF I&SS is provided with awareness that this will change with the NDIS transition. We know for example that the Board & Care Subsidy is only being continued until the end of 2018 and that the ongoing role of the SRF I&SS is as yet unclear. This has specific relevance when being considered in the context of those individuals currently living in SRFs but not on an NDIS package and those potentially seeking to enter

³ Information provided by the SRF I&SS Exceptional Needs Unit DHS

an SRF.

Residents of SRFs are recognised as a particularly vulnerable and disadvantaged population group, reflecting a range of complex needs. The majority present with a primary diagnosis of disability or mental illness, with a significant number having a dual diagnosis. Complex co-morbidities are a major issue in SRFs with health conditions associated with premature ageing clearly and consistently identified.

Historically, there has been reasonable stability within the sector, incorporating a degree of mobility at any given time as residents move between SRFs and in and out of the sector. Under certain circumstances this has required that a person is reassessed through the SEP. This is likely to change with the NDIS transition. The closure of a further two SRFs in the past twelve months has also affected sector stability. This is discussed further in section 4.3.4.

Through-out 2017-2018, the SRF Association has been proactive in presenting its concerns regarding the sector to the relevant bodies and in developing alternative accommodation models. CVS and other stakeholders have continued to advocate for the specific needs of the SRF residents within this changing landscape. The SRF Association is represented on the CVS Advisory Committee.

The CVS continued its participation in the sector through attendance at Regional SRF Network meetings. In August 2017 the CVS hosted a '*CVS and Local Government Forum*', providing an opportunity to explore the respective roles of each within the SRF sector and consider networking opportunities to enhance service provision to SRF residents. As an outcome, the CVS was invited to the EHO SRF Special Interest Group meetings.

The commencement of CVS visitation to Community Mental Health settings during this reporting period has enhanced the recognition of CVS as a resource available to service providers. This has been well referenced with regard SRF residents and the high proportion of whom experience mental health issues.

SUPPORTED RESIDENTIAL FACILITY (SRF)	LOCATION	REGION (NDIS)
Aldridge Court	109-111 Young Street PARKSIDE SA 5063	Eastern
Clifford House Rest Home	4 Farrant Street/179 Prospect Road PROSPECT SA 5082	Eastern
Kingswood Hostel	26 Cambridge Terrace KINGSWOOD SA 5061	Eastern
Magill Lodge	524 Magill Rd MAGILL SA 5072	Eastern
Ocean Grove at Myrtlebank	494 Fullarton Road MYRTLEBANK SA 5064	Eastern
Prospect Residential Care Services	6 Dean Street PROSPECT SA 5082	Eastern
Rose Terrace Hostel	102 Rose Terrace WAYVILLE SA 5034	Eastern
Brooklyn Supportive Care	377 Henley Beach Road BROOKLYN PARK SA 5032	Western
Hindmarsh Lodge	15-19 Holden Street HINDMARSH SA 5007	Western
The Oaks at Rosewater	7 Lincoln Street ROSEWATER SA 5013	Western
Semaphore Hostel	160-164 Military Road SEMAPHORE SA 5019	Western
Sunnydale Rest Home	247 Military Road SEMAPHORE SA 5019	Western
Walkerville lodge	6 James Street CHELTENHAM SA 5014	Western
Alexam Place Rest Home	24 Hazel Road SALISBURY SA 5016	Northern
Brighton Ocean Grove	39 Beach Road BRIGHTON SA 5048	Southern
The Oaks on Sussex	37-39 Sussex Street GLENELG SA 5045	Southern
Glenelg Supportive Care	26 Byron Street GLENELG SA 5045	Southern
The Oaks on Byron	16 Byron Street GLENELG SA 5045	Southern
Gawler Supportive Care	8 Bishop Street GAWLER EAST SA 5118	Barossa Light & Lower North
Lambert Lodge	87 Gray Street MOUNT GAMBIER SA 5290	Limestone
Southern Fleurieu Silver Circle	55 Victoria Street VICTOR HARBOUR SA 5211	Fleurieu & KI

Figure 4.1 –SRFs by location and NDIS region

4.1 Visits and data

During the 2017-18 reporting period, the CVS was funded to provide visitation and inspections to 23 'pension only' SRFs located across the state.

Visits to SRFs are undertaken by two Community Visitors (CVs). The Coordinator provides the CVs with a copy of the previous visit's report that gives context and highlights any areas that would benefit from follow-up.

The majority of visits undertaken by the CVS are scheduled visits, with provision of advance notice to the organisations. However, requested visits and unannounced visits are undertaken as required and in line with scheduling opportunities.

CVs are asked to report to the manager or identified staff person on arrival and sign the Visitors Book as per the *Supported Residential Facilities Regulations, 2009*.

The size of SRFs and the residents' demographic can entail the involvement of and visits by multiple service providers. The CVs are encouraged to remain mindful that they are entering peoples' homes and that residents may view it as intrusive. However, our experience has been that residents appreciate the opportunity to engage with the CVs, particularly as they have become more familiar with the Scheme and what it offers. Staff similarly have indicated that they recognise the value of the Scheme and its advocacy role for this client group.

On completion of the visit, the CVs are encouraged to raise any issues of concern or positive observations with the manager. A report is then prepared and submitted through the online reporting tool to the SRF and Day Options Coordinator for review. Issues of concern are raised with the Principal Community Visitor (PCV).

Issues raised in reports are logged onto an issues tracking document which is monitored by the Coordinator.

A record of significant, sector wide or cross sector issues is maintained and tabled at Advisory Committee meetings for consideration and recommended action.

A copy of the report is forwarded to the SRF manager, with general feedback and recommendations to address any issues that have been identified during the visit.

During 2017-2018 the CVS conducted 29 visits to SRFs with several being visited twice in the 12 month period. Wherever possible, frequency of visitation to SRFs was maintained due to the changes rapidly occurring in the sector.

A total of 17 issues and requests for advocacy were received in relation to SRFs during this reporting period. Of these 13 have been completed while 4 remaining open (Refer Figure 4.1.1).

The majority of these issues are raised through the visit and inspection reporting process. However, issues of concern can also be raised by family or friends as well as government and non-government organisations.

2017 - 2018	Issues raised	Issues completed / no action required	Issues outstanding
	17	13	4

Figure 4.1.1 Details number of issues raised and resolved during 2017 – 2018.

4.2 Key report findings

As with the Disability visits and inspection reports, the SRF visit report gives focus to the five (5) main domains of communication, environment, quality of client services and access, safety and rights and treatment and care planning.

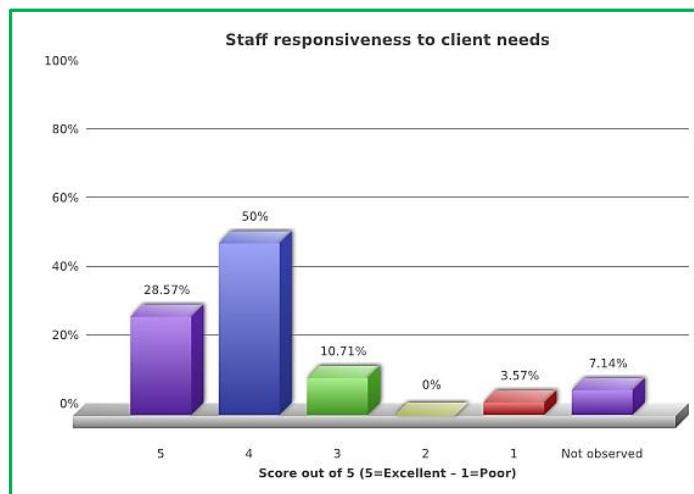
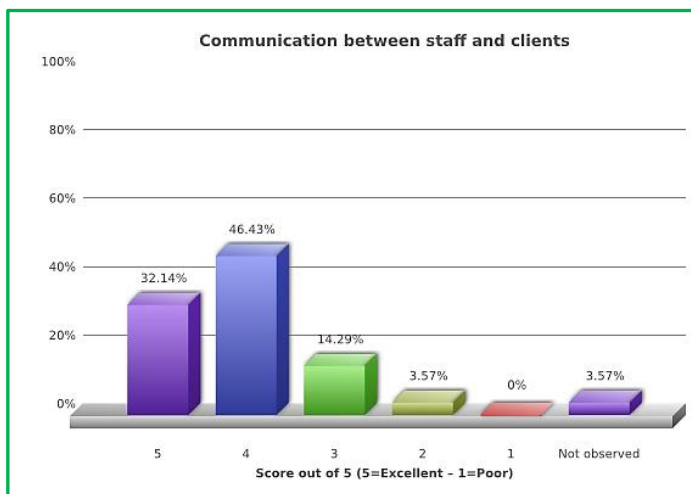
The report also provides opportunity for any issue of concern or request for advocacy to be presented to the Principal Community Visitor for follow up.

The first three areas of the report requires the CVs to provide a rating out of five for the service against a range of questions related to that section.

4.2.1 Communication

Components considered within this category include: Communication between staff and clients; Staff responsiveness to client needs; and Site/staff relationship with external services and providers

The CVS recognises that the attitude and engagement of SRF staff has a significant impact on how the facility operates and the overall atmosphere. This is something that CVs are particularly mindful of when visiting and comments received throughout this reporting period were generally positive.



Positive Comments: of the 18 comments made, 13 were positive comments with examples as follows:

CVs witnessed good communication between the manager, XXXX and the residents and there was encouragement by him, for them to speak openly about their experience in SRFs.

It was lovely to see the staff really attentive to the clients and knew them all personally. It felt like a big family and caring environment. Clients are aware that staff are open and available to talk to at all times and if there are any serious issues.

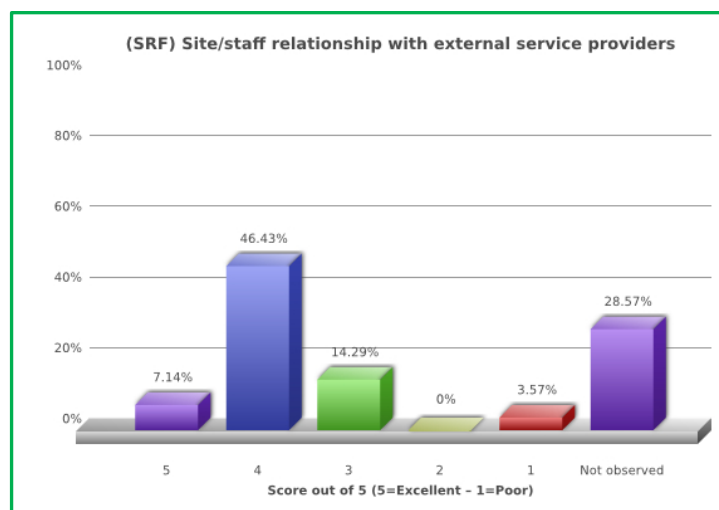
Staff were clearly respectful and attentive to residents, several of whom interrupted our conversations when on tour to show their affection for staff who accepted the interruption as their priority.

Issues; 3 of the comments raised issues:

Clients did not seem to have a natural connection with management, and only reacted when prompted. However, they seemed confident to approach staff with queries or requests, for example while we were in the office one client asked to use a phone and was assisted with courtesy.

Communication that was witnessed during the time of the visit was to direct residents. At one point the manager just opened a residents bedroom door without knocking and then proceeded to tell her to turn the TV down. In the lounge room where there were 5 women sitting there but there was no interaction witnessed at all

While it is difficult to measure the relationship between an SRF and external service providers, reports provided comments on residents accessing allied health appointments and involvement of non-government agencies for example. Consistent with the last reporting period, some managers again identified timely access to Community Mental Health Services as being problematic.



Comments include:

Local pharmacist and GP are very helpful in caring for residents' health. Volunteers come from Life Links and Anglicare, and advocates from the Office of the Public Advocate and the Public Trustee.

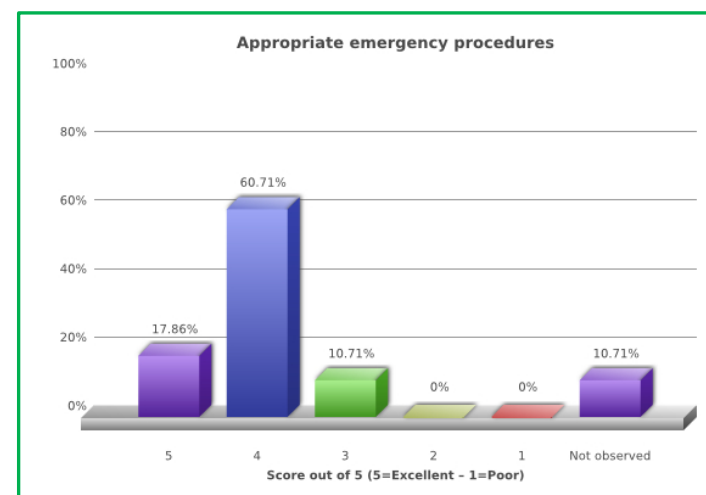
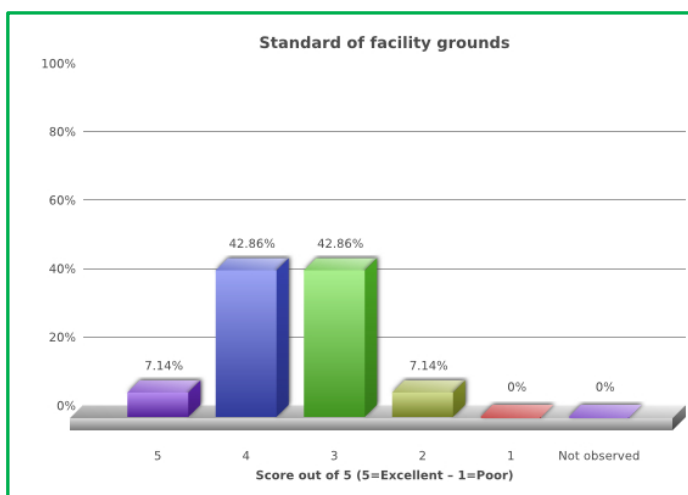
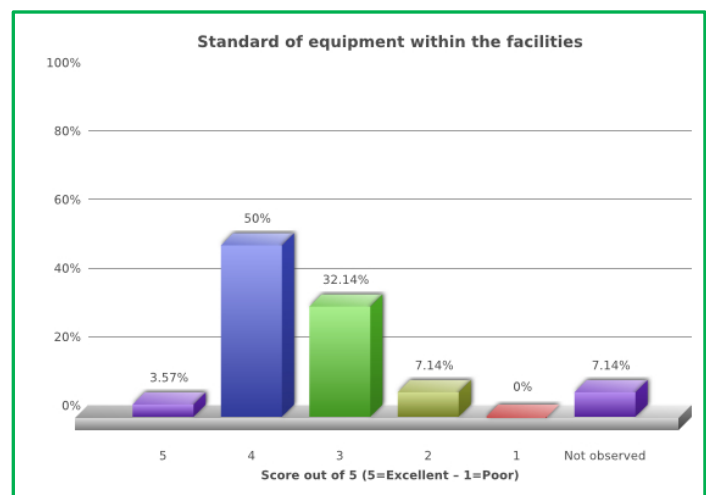
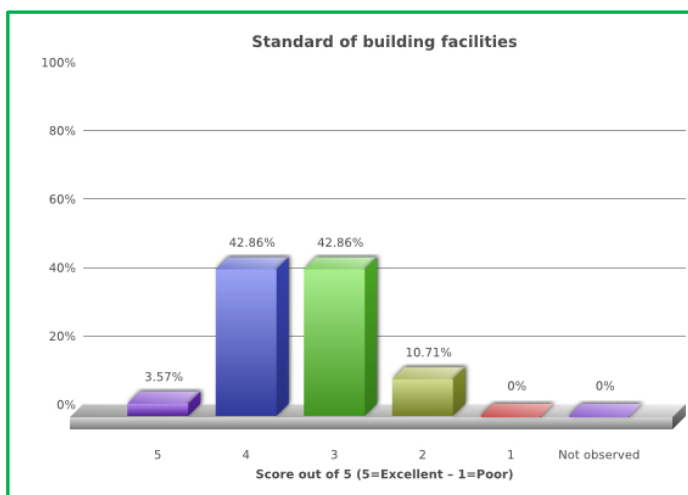
A number of service providers attend the Hindmarsh Lodge including a medical practitioner on a fortnightly basis.

Provision of mental health nursing services by outside agencies has to date been extremely poor and quite counterproductive. The provision of an outside mental health nurse has been so unreliable, so bad that the organisation has opted to not have such a service, rather than put up with a mediocre service and upset and inconvenience to the residents.

4.2.2 Environment – suitability of facilities and their maintenance

This category considers: *Standard of building facilities; Standard of equipment within facility; Standard of facility grounds; Appropriate emergency procedures; and Suitable privacy for clients.*

The following graphs provide CV ratings against these elements:



Many of the SRFs are located in large, older style houses or sites that were previously used as aged care facilities or private hospital. Reports have at times commented on interiors being aged and 'tired' with some yards not being well cared for. Due to the nature of some of the buildings, there has also been reference, for example, to the number of bathrooms for the number of residents. Correspondingly, the existence of close to commercial size kitchens has also been noted.

Reports have also acknowledged the continued upgrading that is occurring at some sites and that physical limitations can be somewhat mitigated when the site is clean and tidy and homely. However, there are still some settings that are not providing a level of accommodation that is considered optimum. One issue mentioned on multiple occasions, referencing one or two specific sites, has been the neglected state of communal furniture. Chairs and lounges are tattered and odorous. Suggestion has been made to management that furniture be purchased that can be readily cleaned and freshened given the number of residents using it. Unfortunately, follow up CVS visits indicate this has not been acted on.

Much improvement has been achieved in terms of building safety and amenity since XXXX took over the business. Access has been enhanced, bathrooms upgraded and there is further work planned.

As mentioned, improvements to the rear common room has been made recently and XXXX showed CVs where residents rooms at the rear are being upgraded. It is a lovely old building

Large old structure with two floors and verandas; residents have shared bedrooms except for four, and these are filled with personal objects giving a homely atmosphere. Bathrooms and lounge areas were clean and tidy, as was the rather small kitchen

Much of the furniture has been replaced including beds, seating and storage facilities. A coffee nook is planned for an underutilised area in one of the houses.

The facility is quite dated and there was a low-level back ground odour in the building. The areas of the facility we inspected did look clean and tidy. However, the Hall way near the dining room does contain a line of chairs which could potentially be an obstruction

Furnishings in particular are in need of urgent replacement

The grounds are well maintained with pleasant outdoor areas spaced through the complex, punctuated by well mown, neat and edged lawns.

Lovely private smoking area for the clients as well as nice outdoor settings with personal art work around. Garden is lovely.

Back garden was unkempt and a courtyard area where residents gathered to smoke was bare earth with 2 fruit trees. Staff advised that attempts had been made to establish a lawn, but this had proven unsuccessful.

Emergency procedures have been identified as in place, although one SRF noted that the new fire alarm system is so sensitive and being regularly activated, that it has cost the proprietor considerable money to engage the MFS on multiple call outs. Another manager commented to CVs that fire drills are practiced regularly with residents and residents were able to tell the CVs where the evacuation meeting place was located.

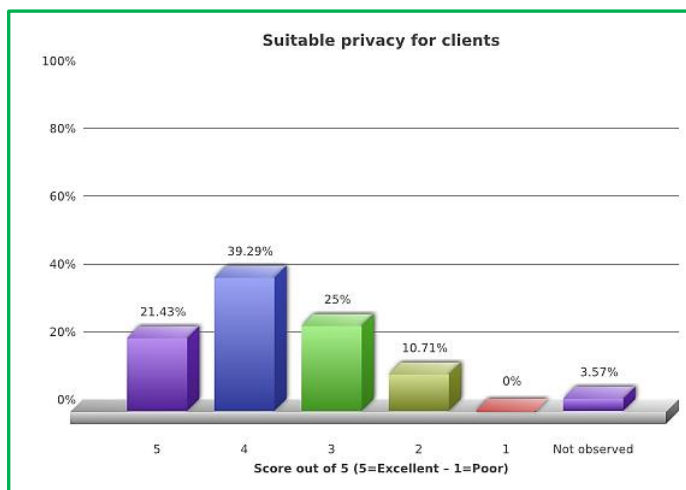
Each resident has a fire evacuation procedure on the wall of the room.

Exit signs, fire extinguishers and fire blankets in dining room. Smoke alarms and a sprinkler system is installed and tested regularly.

Since last visit, electrical equipment tested & tagged & glass window next to 'Men's Lounge' door marked to prevent show it is glass. Fire safety training planned. Wardens appointed. Extinguishers tested in Nov 2017. Fire evacuation exercises are conducted fortnightly, which is not surprising given the configuration of rooms and number of residents. Council at the owners other SRF asked for drills monthly which prompted an increase in frequency here. Full evacuation takes 20 - 30 minutes as it is a long building and some residents do not yet take it seriously, needing to be gotten out of bed etc, but improvement is coming with the frequent drills.

Two residents indicated they could not remember the last fire drill. They stated they use to have them on a regular basis but believed it had been ages since the last one.

The CVS recognises that in some instances, an SRF licensee does not own the actual premises, which can influence responsiveness or otherwise to identified maintenance issues. Further, and in alignment with other sector stakeholders, the CVS would assert that the ambiguity contained within the *Supported Residential Facilities Act 1992*, can make enforcement of identified requirements difficult for regulatory and licencing authorities.



Achieving privacy for residents is always a challenge in large congregate settings. This is further reflected in the fact that the majority of residents share their bedroom with at least one other person, sometimes two. In a small number of instances, residents have their own room, some with ensuite. It is clear that many SRF proprietors have endeavoured to address this by establishing inside and outside spaces that can be utilised for private meetings or just some quiet time. Some SRFs have provided separate male and female bathrooms.

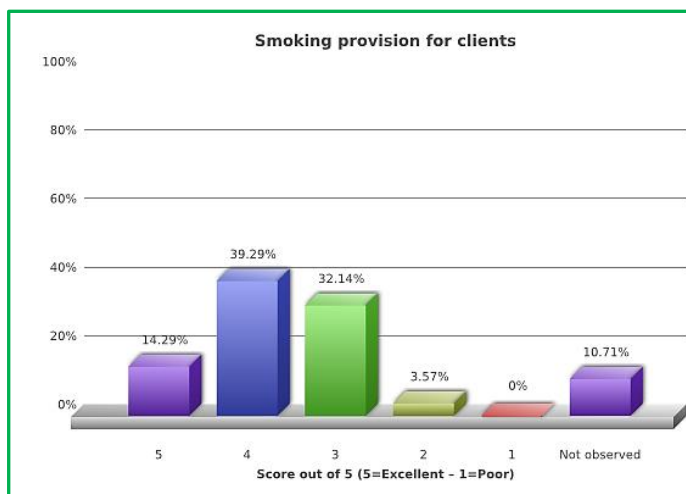
All clients have their own room set up and can be locked. If clients feel they want privacy there are many areas they can go to, besides their own rooms. Women are supported with their personal care and use mainly female staff

Area available for private consultations with medical providers, family etc if own room is not suitable (some are cramped as set up for resident's daily living, TV, heater/cooler, etc

Bedrooms are shared. There are dividers which gives them a certain degree of privacy

4.2.3 Quality of Client Services and Access

Suitable client transport; Smoking provision for clients; Quality & choice of food; Suitable activities available to clients; Suitable entertainment provision for clients; Client access to personal documentation; Access to information regarding rights, complaints and advocacy; and Access to allied health services were considered in this category.



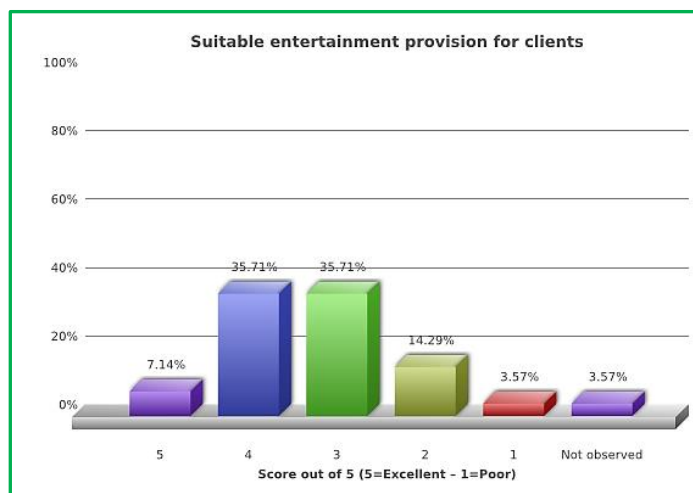
The majority of residents are independent and utilise public transport. However, support is sometimes required to attend medical appointments or the like. Taxis may be utilised and for those with support packages in place, assistance may be available through the support agency. It is more challenging for residents without a package or who have no family involvement.

The vast majority of SRF residents smoke. While smoking is not allowed inside the SRFs, there is plentiful external provision. At some of the sites, it is more of a challenge to ensure that those residents who do not smoke also have equitable access to smoke free outside areas.

Following on from the previous reporting period, the quality and choice of food has generally been reported positively through CVS reports (refer to above chart). Given the majority of SRFs do not involve the residents in food purchase or preparation, choice with regard menu options for example and provision for specific dietary needs takes on additional significance. Further, as some SRFs serve dinner early, flexibility regarding supper would also enhance a sense of choice and take into account the requirements of certain health conditions such as diabetes.

There have however been some issues noted regarding food. Some residents have indicated that the menu plan does not always coincide with what is served and a number of reports noted that no menu was displayed.

The early commencement of evening meals has also been identified as a potential concern as has small meal sizes in one instance.



CVs have reported that the main entertainment options are TV, board games and books with some SRFs having computers and WiFi connection for residents' use. In most instances, SRFs do not arrange for regular on-site activities to be provided. More often, residents are linked into activities and opportunities for community connection through external organisations such as various non-government organisations (NGOs) and the local government Regional SRF Programs.

However, at the end of 2018, specifically funded local government SRF programs will cease. While some councils are endeavouring to maintain a level of SRF involvement in their general community programs, this will certainly negatively impact social opportunities available to SRF residents.

CVS reports also regularly describe residents sitting around with no obvious engagement. The CVS recognises that while this may well reflect an individual's choice it can also be representative of a general disengagement, sense of loneliness or indeed the impact of a particular diagnosis or medication. Unfortunately, there has been occasion when management response has been dismissive to CVS questions about particular residents' interests and what efforts have been made to find possible avenues of engagement.

SRF residents usually have good access to allied health services. Often these visits happen on site – such as the SRF Health and Treatment (SRF HAT) team, podiatrists and Mental Health. However, as stated previously, transport to appointments can be a challenge.

A number of reports noted information displayed about individual rights and advocacy. CVs were told that residents can access their personal information and as per the SRF legislation, SRFs are required to provide residents with a service plan detailing provision of accommodation, services and supports. There were instances of residents reporting that they would be happy to discuss concerns with the proprietors.

However, CVS is aware of informal statements where residents claimed that proprietors responded with 'well if you don't like it you know you can just leave' creating fear and uncertainty for the resident. This needs to be monitored, particularly with regard residents not on an NDIS package, the demise of the government's Board and Care subsidy and those residents aged over 65.

The CVS is cognisant of the fact that a significant proportion of SRF residents do not have regular ongoing family contact. It is therefore pleasing to see the involvement of family specifically mentioned on occasion.

4.2.4 Safety and Rights

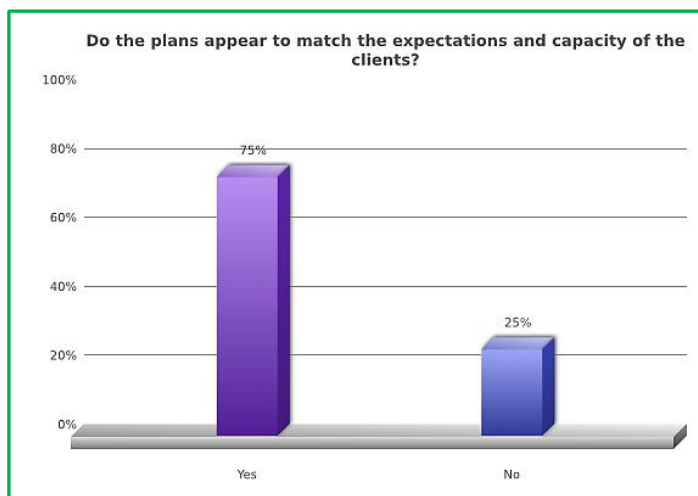
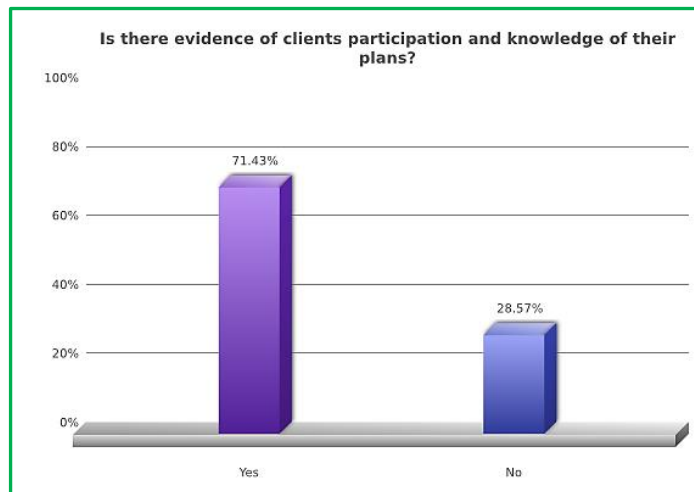
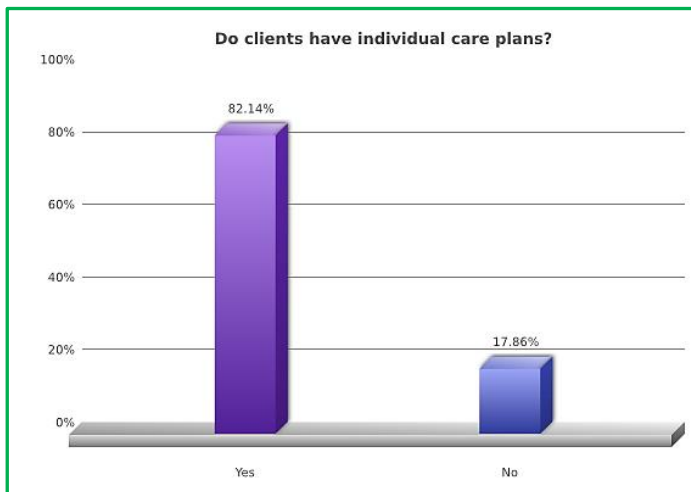
Comprising this category are the components: *Did any clients report not feeling unsafe in their surroundings? Did you observe the use of restrictive practice? If yes did you enquire as to why restrictive practice was utilised?; Was a Visitors Book clearly displayed?; and Do residents have access to freely available drinking water?*

There were no specific reports of residents feeling unsafe. However, the CVs did suggest that the layout and size of one or two of the facilities, did in their view potentially pose a security risk due to reduced visibility of certain sections. At another site, security cameras had been installed in all of the common areas. This raises the fine balance of security versus privacy when managing residences for large numbers of people. It was interesting that in this instance when CVs asked residents how they felt about the cameras they stated it made them feel safer.

No instances of restrictive practice were reported. Visitors books were clearly displayed and fresh drinking water freely available.

4.2.5 Treatment and Care Planning

A key component of client service delivery is the development and implementation of care plans. Most significantly is client engagement in the process and the setting of goals and achievement commensurate with the expectations and capacity of the client.



The majority of clients were assessed as having a care plan in place, there was evidence of their participation in its development and that they appeared to match the expectations and capacity of the client

Their plans were reviewed annually or as needed.

4.3 Issues and Challenges Impacting SRFs

The 2017-2018 reporting period has reflected considerable change for the SRF sector. Completion of the NDIS transition has been extended past July 2018 and there remain some areas of uncertainty with regard SRF residents.

The CVS has addressed the recommendations contained within last year's report and has continued to advocate and promote identified issues through appropriate channels.

4.3.1 NDIS and My Aged Care and a changing accommodation model

During this reporting period, the SRF Association (SRFA) consulted extensively with relevant agencies, including NDIA and with DCSI (now DHS). All but two SRFs have become registered NDIS providers.

SRFs did not meet the initial NDIA accommodation criteria of non-congregate settings. The NDIA had also stipulated that organisations could not provide accommodation and care services. However, the SRF legislation states (and the Funding Deed of Agreement) that SRFs do provide both and the NDIA has accepted the current SRF model. Some SRFs have also incorporated additional accommodation options, for example a motel complex and a 'satellite' of units. (The Deed of Agreement will of course cease at the end of December 2018 with the cessation of the Board and Care Subsidy).

Some level of concern has continued to be expressed regarding the involvement of SRF managers in individual planning meetings. There are claims that this does not support full choice for the individual and that independent exploration of housing options should be specifically part of every planning meeting.

Leading into this reporting period, there were strong concerns regarding the NDIS eligibility of SRF residents and their ability to access the assessment process. Department figures state that 90% of the approximate 50% of SRF residents who have been assessed, have been deemed eligible for the NDIS.

However, concern still remains for those resisting assessment or with psychosocial disability and those assessed as ineligible, including residents over 65. The Board and Care subsidy ceases at the end of 2018 and there is a risk that individuals could either be forced to leave SRFs or have their payments raised from the current level of 79%. It is also highly unlikely that individuals over 65 – or others without NDIS packages - would have access to SRFs as the 79% of their pension less B&C subsidy would not compare with costs available for someone with an NDIS package.

Individuals over 65 who are not already in receipt of any disability support are required to access My Aged Care, reported by service providers to be a difficult process. Those over 65 and in receipt of disability supports will continue to access through the Continuity of Support program.

The SRF Intake and Support Service (SRF I&SS) Exceptional Needs Unit, monitors the progress of SRF residents within the NDIA process. Time limited programs such as the Continuity of Support, the In Kind Unit and Complex Services Unit, have been established in an effort to ensure that those individuals over 65 or not eligible for NDIS – or those receiving services from a Disability SA office that has been devolved – have access to appropriate support. This includes psychosocial disability, of particular relevance in the SRF sector where comorbidities/ dual diagnosis are frequently evidenced.

4.3.2 Role of Local Government

The CVS hosted a CVS and Local government SRF Forum in August 2017. This forum considered the roles performed by local government and the CVS within the SRF sector and pathways of communication that could be of assistance when dealing with sector issues.

The CVS has strengthened its relationship with local government, through contact with the Environmental Health Officers (EHOs). Opportunity to attend meetings of the Environmental Health SRF Special Interest Group has been particularly appreciated.

Local government has historically undertaken the licensing and regulatory role within the SRF sector as prescribed in the SRF legislation. However, the change of business model has implications for local government and legislation. This requires clarity, as the current lack of places, potentially puts individuals at risk, particularly through this transition period. For example, a 'satellite' of units as previously mentioned, established as an extension of an existing SRF has not been included in CVS visitation and inspections nor, to the CVS's knowledge, has it been visited by regulatory authorities.

As reported in the Special Report Disability Services 2016 – 2017, the regional local government SRF social programs ceased at the end of June 2018. This is likely to have, particularly in the initial transition period, significant impact on SRF residents.

4.3.3 Review of relevant legislation including the Supported Residential facilities Act 1992 (the Act)

The need for review of the Act - and associated legislation - has been recommended in the previous two Disability CVS Annual Reports. This has been supported by the *Co-morbidity Inquiry of 2016*, undertaken by the Social Development Committee of the South Australian Parliament, in which Recommendation 28 states: *'It is recommended that the Supported Residential Facilities Act 1992 be amended to include adequate provisions for co-morbidity to ensure appropriate accommodation and support is provide'*.⁴

The government's response was to support this recommendation in principle. However, it further added: 'As with the Disability Services Act, 1993, a review of the Supported Residential Facilities Act 1992, is planned to coincide with full implementation of the NDIS in South Australia'.

The CVS noted in last year's Disability Annual Report, that legislative review needs to incorporate both current legislation and the development of new legislation, encompassing both SRFs and boarding houses within consideration of the accommodation requirements of vulnerable population groups.

Further, the Shelter SA report, 'End of the Road' released in 2017, identifies the limitations of the *Residential Tenancies Act 1995* : *'This legislation....is outdated and does not reflect the requirements of the current resident population, particularly those living with high and complex accommodation, health and/or mental health needs'*.⁵

However, what impact will the NDIS have on relevant legislation? What roles will the respective layers of government play?

4.3.4 Boarding (Rooming) Houses

As noted earlier in this report, SRF residents are widely recognised as a particularly vulnerable cohort, the majority presenting with a primary mental health or disability diagnosis. However, dual diagnosis and complex morbidities are frequently evidenced, including health conditions reflective of premature ageing. A significant number of SRF residents do not have a key support worker or active engagement with family.

The CVS acknowledges the similarity between residents living in SRFs and individuals living in boarding houses, with the difference being that SRFs are registered and licensed under legislation to provide low level support and accommodation. While boarding houses are included in the Residential Tenancies Act (1995), Shelter SA notes that *'This legislation that predominantly regulates the sector is outdated and does not reflect the requirements of the current resident population, particularly those living with high and complex accommodation, health and/or mental health needs. There is no consistent or uniform registration process for rooming houses'*.⁶

Further SRF closures will potentially displace people - who already meet the definition of tertiary homelessness - into this sector. The risk of homelessness is real, particularly for those individuals not eligible for NDIS (or who have not been supported to access) and those over 65. This is highlighted when viewed in the context that both of these accommodation models are of commercial enterprises. The boarding house sector places individuals at increased risk of social isolation and reduced capacity to access community and support services.

The lack of a formal boarding house register and the difficulties associated with clearly identifying boarding houses (particularly smaller establishments) makes it very difficult for those local councils that do have by laws related to boarding houses to enact them.

The CVS participated in the Round Table discussion convened by then Minister Bettison, on 3 July 2017 to discuss concerns and recommendations raised in the Shelter SA report. The CVS recognises the importance of participation in cross sector opportunities with regard addressing the accommodation needs of vulnerable groups.

Recommendations related to SRFs

10. That there be a review of the Supported Residential Facilities Act 1992 that also look into Rooming/Boarding Houses in the context of the NDIS.
11. That CVS continue to assess the standard of SRF buildings and facilities and provisions for residents

⁴ Co-morbidity Inquiry of 2016 undertaken by the Social Development Committee of the South Australian Parliament

⁵ Shelter SA 'The End of the Road – Rooming Housing in South Australia'

⁶ Ibid

12. That the CVS continues to monitor individual NDIS plans and to ascertain whether they genuinely reflect the individual goals and aspirations of the individuals and provide genuine choice and control
13. The CVS continues to monitor the menus and food choices within SRFs
14. The CVS monitors the activities and supports to SRF residents to enable greater community participation.

5. Day Options Programs outcomes and themes

The Day Options component of the Scheme is now well established and has ensured a more comprehensive service provision to the disability sector. Community Visitors (CVs) appreciate the opportunity to gain further insight into the disability sector and the interconnections that can be made through visitations to two components of the Scheme.

Overall, the response continues to be positive, with providers identifying the CVS visits as a valuable resource for both the individual clients and the providers themselves.

The CVS currently has 23 organisations on its data system, providing Day Options programs across 66 sites. Some organisations manage activities across multiple sites while others are smaller operations with one or two programs.

The programs vary widely with respect to number of clients, clients' support requirements, programs on offer and the sites themselves. Of the programs visited by the CVS, 50 are located in the metropolitan area while 16 are regionally based. Day Options programs offer both onsite and community-based activities.

The CVS is aware that the NDIS has potential to significantly impact Day Options programs given the provision of individual packages as opposed to the historical block funding. The style and delivery of programs are where the most obvious changes are likely to be observed. However, the actual definition of what constitutes a Day Options program will also no doubt evolve, potentially becoming quite different to the model that operates today.

It is therefore impossible for the CVS to accurately predict both how this sector will be configured and what impact that may have on the role of the CVS within the NDIS transition process and beyond (see section 5.3 Issues and Challenges Impacting Day Options programs).

5.1 Visits and Data

In keeping with the visit and inspection protocols established by the Scheme, visits to Day Options programs are undertaken by two Community Visitors (CVs). The Coordinator provides them with a copy of the report from the previous visit, which gives context and highlights any areas that may benefit from follow-up. A 'Day Options Prompt Sheet' is also provided (see Appendix 5) highlighting key areas for consideration during the visit.

On completion of the visit, the CVs raise any issues of concern or positive observations with the staff. A report is then prepared and submitted through the online reporting tool to the SRF and Day Options Coordinator for review. Issues of concern are raised with the Principal Community Visitor (PCV). Organisations are provided with a copy of the report and asked to respond to any identified issues.

Issues raised in reports are logged onto an issues tracking document which is monitored by the Coordinator. An *Issues Register* is maintained for significant, recurring, sector wide or cross sector issues and taken to the CVS Advisory Committee for consideration and recommended action.

The majority of visits undertaken by the CVS are scheduled visits, with provision of advance notice to the organisations. However, requested visits and unannounced visits are undertaken as required and in line with scheduling opportunities.

During 2017 -18, the CVS conducted 93 visits to Day Options programs. Various considerations impact scheduling and frequency of visits including additional considerations for regional visits, allowance for school holidays, visitation requirements of other components of the Scheme and Community Visitor availability.

During this reporting period a total number of 33 issues and requests for advocacy were received in relation to Day Options programs. Of these 27 have been completed while 6 remain open (Refer Figure 5.1.1).

The majority of these issues are raised through the visit and inspection reporting process. However, issues of concern are also raised by family or friends, carers and support staff, as well as government and non-government organisations.

2017 - 2018	Issues raised	Issues resolved, no further action	Issues outstanding
	33	27	6

Figure 5.1.1 Details number of issues raised and resolved during 2017 – 2018.

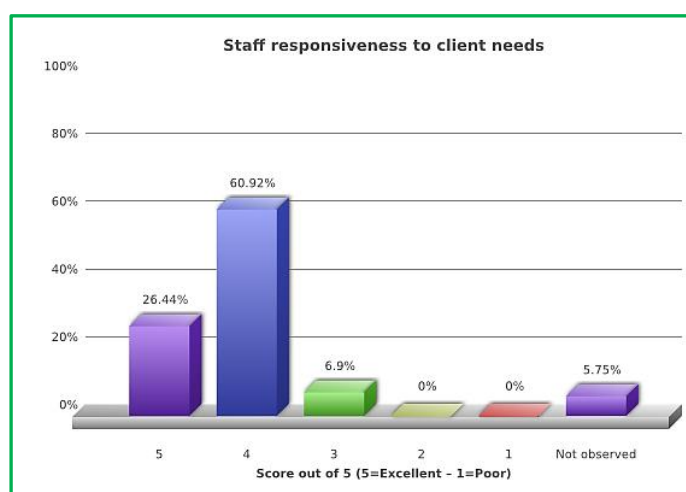
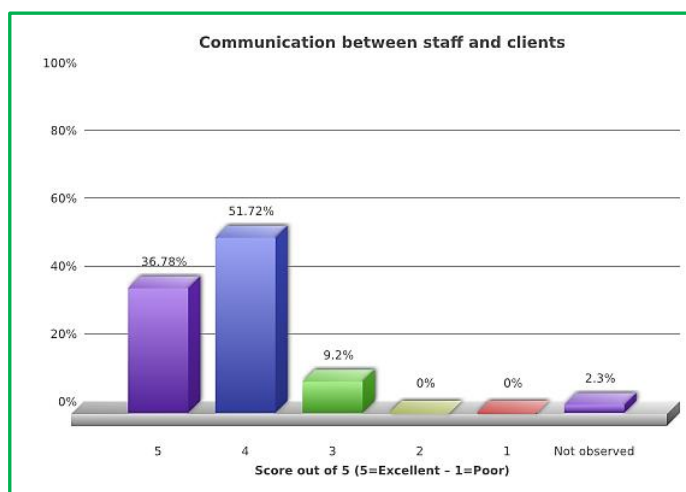
5.2 Key report findings

The Visit and Inspection Report is divided into key categories (see Appendix 6) with each containing a number of components for consideration. The report incorporates provision for Community Visitors to utilise a rating system for these components and to make additional comments. The following section details CV assessment of services under those categories.

5.2.1 Communication

Communication between staff and clients; Staff responsiveness to client needs; and Communication between site staff and disability accommodation are the key components considered within this category.

As per the following charts, the vast majority of reports have noted positive and respectful communication between staff and clients and staff responsiveness to clients' needs. Low staff turnover was mentioned on a number of occasions as a positive contributing factor, enabling an understanding of individual clients to be established over time and a sense of trust and safety to be generated for the clients.



All staff attentive to participants showing care and participating in activities. XXXX has opted to refer to clients as 'participants' to better reflect the staff-participant relationship, being one of working together to achieve their agreed goals

CVs observed positive interaction between staff and clients. Staff were supporting clients by prompting and reinforcing manners and good social interaction towards them, to us as visitors and towards each other. The staff: client ratio is appropriately high and it was good to see gender balance with staffing too

Most clients are non-verbal, so staff are attentive to client indications of needing attention. The staff were great with clients and used sign language to communicate

The reports have also demonstrated the value of communication and relationship building with the local community. This has been particularly evident in regional communities, but also in some of the outer metropolitan areas. Projects have been able to be developed, providing further opportunities for client participation and contribution. Additionally, in some instances the 'informal communication network' evident in regional locations has also been able to identify issues of concern and raise them with the CVS. .

Some organisations have also created different program structures over different days to better meet the varied needs and interests of clients. Further, some larger organisations with multiple sites have a different focus at different sites

Clear and consistent communication between Day Options programs and disability accommodation providers and family is essential in supporting seamless and appropriate service provision for clients. Various communication methods are used, including email and phone contact, focus groups and family social gatherings. The importance of the individual clients' Communication book is discussed in section 5.2.4 and to date has played an integral role in ensuring quality control is maintained for clients.

5.2.2 Environment – suitability of facilities and their maintenance

This category considers *Standard of building facilities and grounds; Size suitability and layout of facility for purpose; Appropriate emergency procedures; and Provision of equipment within the facility.*

Many of the Day Options sites are not 'built for purpose' but rather are regular houses that have been modified to accommodate program requirements. The most frequently mentioned shortcomings relate to the internal layout of the building which can impact accessibility (particularly for wheelchair users) and also potentially reduce the range of available activities; a lack of adequate and appropriate outdoor areas; and buildings that are in a 'tired' or rundown condition.

However, evidenced in the majority of reports, modifications – both internal and external - have enhanced opportunities for clients. Examples have been provided that describe complete rebuilds, repurposing of existing facilities and development and beautifying of gardens and patio areas.

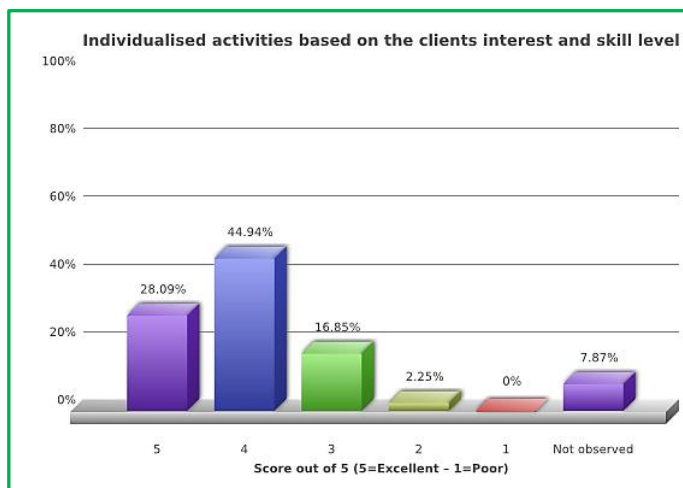
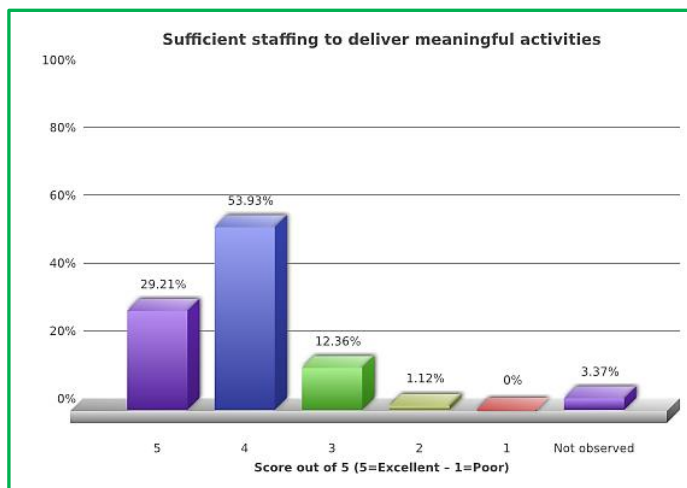
Some of the Day Options programs operate from halls and larger shed like structures. This can provide greater challenges with regard creation of separate program spaces as well as the maintenance of appropriate internal temperature control. Additionally, when these sites are shared with other organisations, it requires the packing and unpacking of resources for each session and can limit the opportunity to personalise the space. Alternatively, such spaces can afford the opportunity for completely different activities compared to smaller and more traditional settings and provide additional resources that may not be available otherwise.

It was often noted in reports, that while a certain standard of facility is recognised as necessary, any identified shortcomings are minimised if the feeling and qualities generated within the program are positive, affirming and inclusive.

Reports indicate that in the main, organisations have appropriate emergency policies, procedures and equipment in place. Community Visitors have on occasion recommended consideration be given to the development of Personal Emergency Evacuation Plans (PEEPS) and the inclusion of clients in safety drills, when appropriate.

5.2.3 Quality of Client Services and Access

Components considered within the category include: *Suitable client transport and appropriate time spent travelling to and from site; Individualised activities based on the clients' interest and skill level; Sufficient equipment, staffing and facilities to meet the personal hygiene needs of clients; and Sufficient staffing to deliver care needs and meaningful activities.*



Most reports have commented positively on the range of activities available and the efforts taken to provide programs that are responsive and premised on clients' interests and skill levels. In particular, the range of community-based activities highlighted in reports, reflect this approach. Organisations also welcome the involvement of family in activity and program planning.

Activities are based on client's interest and based on strength approach. As previously reported these follow the 'My Path' model focussing each day on a key program, as example the day we visited was Garden and Environment. Some clients attend all week, others as they chose for the selected program. Discussion with a client suggested a high level of satisfaction and enjoyment of the facility.

All clients have a Care and Support Plan, which outlines goals for that client. On a regular basis, a meeting is held to discuss activities for the following week, and these goals are taken into consideration at that time. A Month's schedule of activities is displayed on the wall inside the entrance

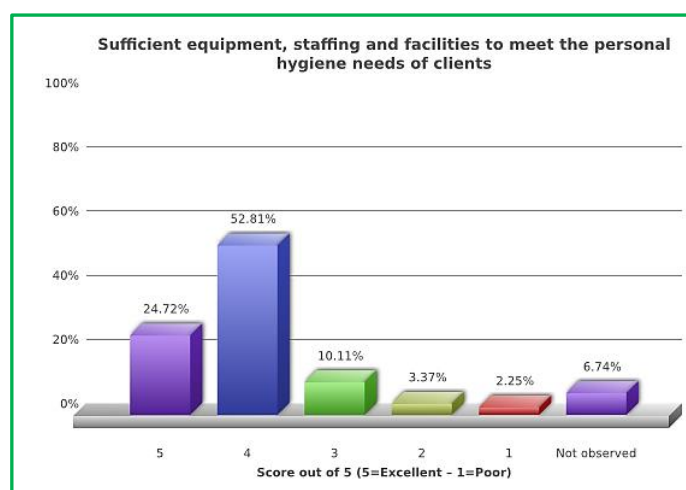
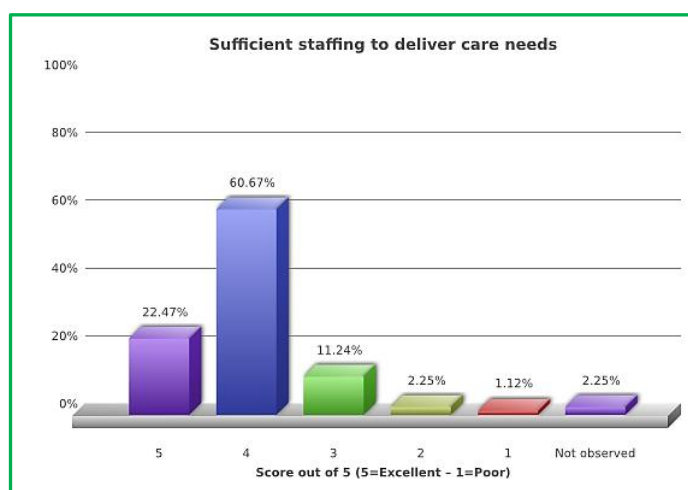
It was lovely to see how each client is treated as an individual and how staff aim at creating independence. Each client has individual goals that are either co-created with by staff and/or family. They have created an activity sheet that has various activities including exercise, haircuts, swimming, fringe shows, shopping etc. Cody was taking some of the residents to go food shopping so they are very included in daily activities. Clients have a choice of 3 activities.

The majority of organisations have established specific spaces, particularly 'quiet rooms' and 'sensory rooms' where clients are able to enjoy some time out from a busy environment.

Some larger organisations have multiple sites and provide specific resources at a particular site that can then be accessed by clients from other sites as part of 'inter group' socialising opportunities.

Reports have also revealed some very innovative and entrepreneurial initiatives, providing clients with enhanced opportunity for community engagement and contribution and supporting independence and skill development. However, examples were also noted where regardless of the genuine care of staff, it appeared that clients just sat and were 'done for' rather than engaged as much as possible. One example was a group of high need non-verbal clients who were all sitting inside rather than being taken outside to enjoy the sunshine. Other examples have questioned whether staff could utilise - and receive training for - a greater range of communication aids to strengthen communication with nonverbal clients in particular.

The support requirements of clients attending Day Options programs vary widely from very independent to 1:1 support. It is therefore essential that programs are sufficiently resourced to deliver both the care needs and varied and meaningful activities.



Virtually without exception, CVS reports have noted the quality of care being provided by staff and that the majority of settings are ensuring adequate staffing levels. However, on occasion Community Visitors have raised concerns about adequate staff ratios, particularly in situations where the majority of clients have high level support needs. They have observed that this can place staff under undue pressure and pose potential safety risks for both clients and staff.

Provision of personal hygiene support remains a specific focus of the CVS visits and reports indicate that programs are being conducted with access to appropriate facilities and staff resources. Where this has not been the case, the CVS makes immediate contact with the organisation. Examples of concerns raised include inadequate privacy, frequency and routine of personal care provision and access to appropriate facilities. Time spent travelling to and from the program has also been raised as an issue with regard personal care.

Currently, two participants need three staff to meet their personal caring need because of their physical and medical needs. Often it's a challenge to meet that need.

Approximately 25 of the participants attending at the time of the visit required feeding assistance. Up to 30 can require assistance with toileting. Generally, there can be up to three participants a day that require one-on-one care. The general ratio is 2 carers for 5 participants.

It is critical that both Day Options programs and disability accommodation maintain awareness of any instances of clients being left soiled and unattended. The capacity for CVS to 'cross check' such issues raised in disability accommodation reports also offers a greater level of client protection.

The majority of organisations provide transport to and from the Day Options programs and community activities. Usually this is in the form of a mini bus and some programs also utilise access cabs depending on the needs of the clients. The time spent travelling to and from Day Options programs has been raised at times as a concern particularly where it involves multiple transport exchanges and impacts personal care requirements. Larger organisations have been able to address this by providing multiple buses simultaneously, thus reducing the individual transport time. However, this poses more of a challenge for smaller organisations.

Can be up to two hours travel but CVs advised that clients see travel in the bus as an activity they enjoy, looking at and talking about the things they pass along the way

The Van/Bus starts at 8.30 in the morning, collecting clients, arriving at the facility about 10.30am. Departure is 2.45pm, to return clients home. The Van is empty by 4.30 pm.

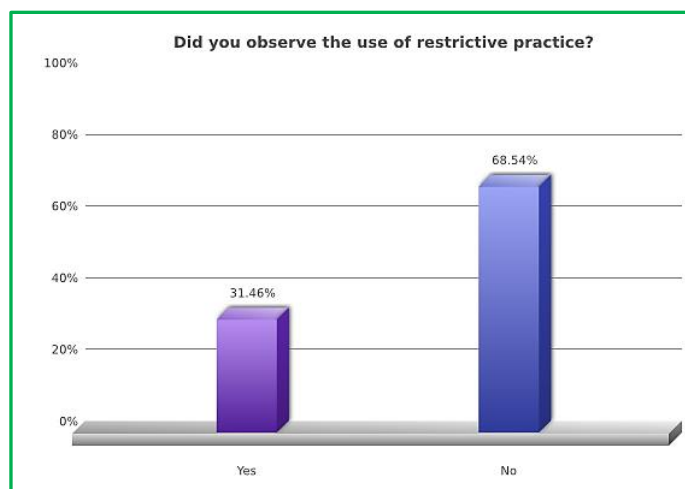
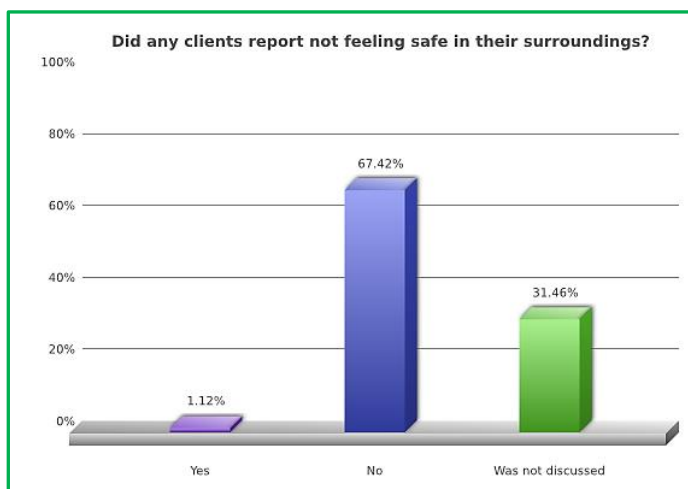
There is a greater acceptance of travel time in regional areas as a general lifestyle consideration as well as being premised on a more limited range of accessible opportunities

The issue of transport is discussed further in 5.3.2.

5.2.4 Safety and Rights

This category focuses on: *Clients feeling safe in their surroundings; The use of restrictive practices and if so presence of supporting documentation including a Behavioural Support Plan (BSP); and Does each client have a Communication book.*

It has been evident throughout the visits that very genuine efforts are being made to apply the least restrictive practice in any situation. Issues raised were identified as being 'therapeutic or safety practices' and reports indicated that supporting documentation was in place.



Certainly the work of Professor Richard Bruggemann has championed this focus and some organisations have specifically engaged with him in development of their related policies and procedures.

Requirements for the establishment of Behaviour Support Plans are underpinned by *The Restrictive Practices Reference Guide for the South Australian Disability Services Sector* launched by Professor Bruggemann in 2017.

The CVS recognises the importance of this document in providing clear and concise direction in the reduction of the use of restrictive practices.

Community Visitors noted the presence of Behavioural Support Plans (BSP) in and in some cases the involvement of behavioural therapists to assist with particular clients. However, other programs were not able to provide well developed individual plans and this is seen as an area of improvement for some organisations. It was evident from reports that family are involved in the development of personal plans.

Clients' sense of safety is well evidenced from reports with the Community Visitors frequently commenting on the positive atmosphere and level of engaged communication between staff and clients. Organisations endeavour to provide

a range of spaces that accommodate individual needs and personalities. Safety procedures and incident reporting protocols are in place. Discussions with staff indicate a strong level of responsiveness in dealing quickly with any issues that might become apparent, thus generating a sense of safety for clients.

Good communication between Day Options programs, disability accommodation and family is critical. The use of individual Communication books greatly assists this process and CVS reports indicate they are utilised very consistently. When this is not the case, organisations express a high level of frustration. Some Day Options programs have described instances of disability accommodation or family not using the book to notify them of issues that may directly impact care of that client.

5.3 Issues and Challenges Impacting Day Options programs

The CVS recognises that there are a number of issues and challenges affecting Day Options programs. This section identifies those issues that have been seen as most significant during this reporting period. The CVS understands that different issues are likely to emerge with the consolidation of the NDIS. The NDIS is recognised as being the most significant influence on the Day Options sector. The challenges identified below are therefore considered within the context and inherent influence of the NDIS.

5.3.1 The Day Options model

Exactly how Day Options will evolve is unclear. However, what is clear is that the NDIS will certainly impact the Day Options model as we know it today.

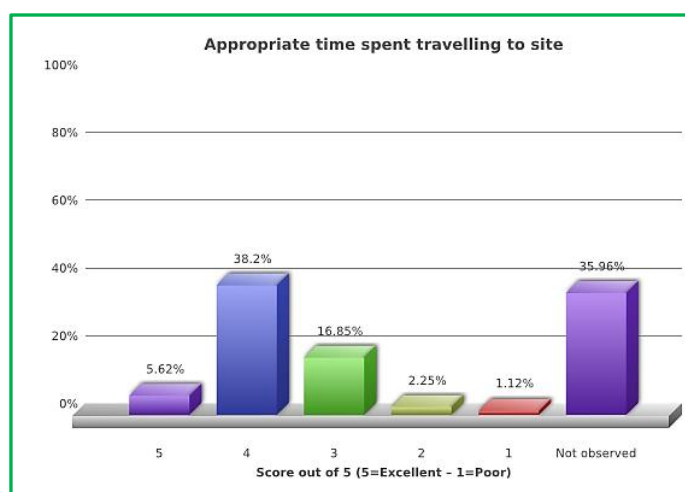
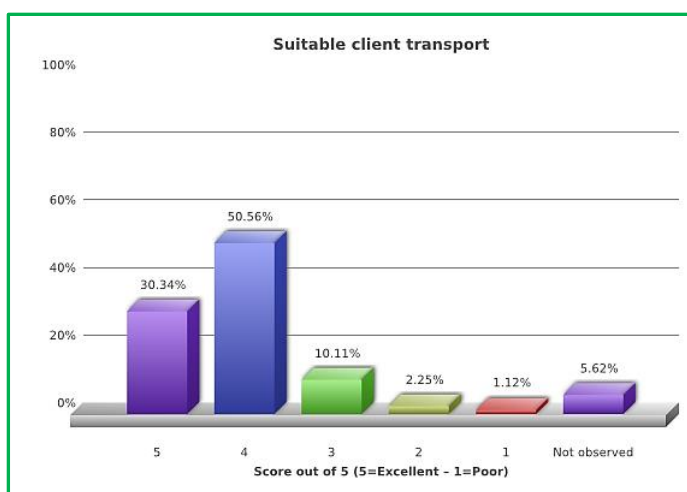
It is impossible to predict how many new providers will enter this space and how many current providers will exit. Indeed, the definition of what constitutes a Day Options program is at this stage unknown and will no doubt evolve. Rather than the current model of a group of individuals being transported to and from a site for group activities, programs are likely to be a mix of group activities and opportunities provided at home and available in the community. Individuals will be able to create their specific 'social program' incorporating all manner of different options, reflecting a more accurate life rhythm of socialising and recreating.

Organisations will need to be responsive and flexible and some will potentially develop a niche focus rather than attempting to cover a broader range of different options.

The challenge for current programs is not knowing how many participants they might have and the inherent budget challenges this presents, particularly with regard appropriate levels of resourcing. Larger organisations are better positioned to absorb such challenges, smaller organisations less so.

A major consideration for the CVS will be determining what constitutes a Day Options program for the purpose of CVS visitation – and therefore what role will the CVS have in relation to the NDIS Quality and Safeguarding Framework.

5.3.2 Transport



Transport is frequently highlighted as an issue for both providers and clients, increasingly so as the NDIS transition progresses. This is again an area where the size of an organisation can modify the degree of impact.

Currently, most organisations have access to buses that are used for client transport to and from the program and to community activities. The CVS is also aware that on occasion organisations collaborate and share transport resources.

Under the NDIS, clients incorporate travel costs into their plan. However, there has been criticism that adequate transport provision is not being allocated equitably and in line with core supports. There have been claims that some individuals are receiving less than they were under previous South Australian Transport Subsidy Schemes (SATSS) where a number of individuals were also able to obtain the Journey to Work vouchers on top of SATSS and these were specifically for people who were unable to transfer from wheelchairs and these vouchers covered 75% of the journey up to the value of \$30.

The potential value of SATSS vouchers of which those in the scheme get 80 every 6 months, could be as much value as \$4800 per year. However, if individuals are travelling to and from paid employment, inclusive of Supported Employment they may also be eligible to receive the Journey to work vouchers for each day they attend work. If they are attending a location to volunteer, they are eligible to receive 2 vouchers per week.

According to the DHS website, the SATSS program will run until mid-2019 for all current members, whether or not they have transitioned to the NDIS. After this date, the State has transferred these funds as part of State's contribution to the NDIS.

Once individuals join the NDIS and have an approved plan, participants lose the Commonwealth Mobility Allowance that is \$95 per fortnight or \$2,470 that was provided to those unable to use public transport.

Transport funding under the NDIS

A participant is generally able to access NDIS funding for transport assistance if they cannot use public transport because of their disability. There are three levels of transport assistance (two of which reflect the Commonwealth Mobility Allowance):

- **Level 1-** Up to **\$1,606** per year for participants who are not working, studying or attending day programs but are seeking community access
- **Level 2-** Up to **\$2,472** per year for participants who are currently working or studying part-time (up to 15 hours a week) or participating in day programs or other social, recreational or leisure activities.
- **Level 3-** Up to **\$3,456** per year for participants who are currently working, looking for work or studying for 15 hours a week or more.

For many individuals, these levels will be significantly less than what they were receiving via SATSS, which has the potential to limit an individual's community access to their identified social opportunities and therefore become isolated.

Implications for organisations have also been identified, with some choosing to divest their vehicles due to the uncertainty of individuals' level of funding. Where individuals have transport assistance within their NDIS plans and even if they are willing to combine these with others in their share-house, this will still be insufficient to lease and maintain a vehicle. Organisations have expressed concern that funding allocations will not adequately cover the transport costs currently being incurred and will have to sell the vehicles attached to the house or at the very least share between two houses.

5.3.3 NDIS packages

Adequacy and accuracy of individual packages has been raised as a potential point of concern. Some providers have described instances where an individual's support requirements are not adequately reflected in their plan, potentially compromising both the individual and organisation. Organisations are required to have appropriate levels of staffing resources to meet the support requirements of clients in attendance. However, if for example, the level of personal care needs or behavioural issues are not accurately identified, the organisation is faced with either having insufficient staff rostered on or to some extent absorbing the shortfall of increased staff costs to meet the unidentified needs.

The CVS is also aware of instances in which organisations have described funding shortfalls, which they are covering in order to meet duty of care requirements. An example is clients being transported to a Day Options program at 8.45am instead of 9.00am when the program opens and being picked up by the accommodation organisation at 3.15pm (or possibly later). This reflects a potential 2.5 hours per week of care which the program is not funded for – potentially significant when extrapolated across multiple clients over a full year.

The CVS acknowledges a further challenge evident in the NDIS transition, which is having sufficient providers available for provision of services identified in individual plans. It has been highlighted that an underspend in a plan – due to a lack of provider options – could result in a reduced package the following year.

5.3.4 Personal care support

People attending Day Option programs have a variety of support requirements, particularly with regard personal care. Some clients have high-level support needs, for which an organisation will need to ensure provision of both the necessary physical resources as well as sufficient staffing allocation and clear protocols as to how any accidents are dealt with.

While the vast majority of organisations demonstrate compliance in this area, the CVS considers it important to retain a focus on this area, particularly throughout the NDIS transition.

The PCV also believes that all services need to ask the question as to whether clients are having to fit into a Day Options model verses individual's having genuine choice and control as to what activities people want to be involved in and how that is delivered or experienced. Support agencies providing accommodation and support to people with a disability do need to ask whether the people they are supporting would genuinely want to get up early all throughout the year in order to catch a bus to a Day Program where they have less support available to them. Or, would they prefer to have a more flexible approach and partake in activities from their home like most other people and have the benefits of their home environment and equipment for eating, drinking and toileting.

By way of example, I recently visited a house and sat down with the two support staff who have worked with their four clients for several years or longer. These clients are now getting into their 50's, they are non-verbal and fully dependent on support staff for drinks and vitamised food and need lifters from their wheelchairs for toileting and changing and one of these is also blind. They regularly come home from their Day Program dehydrated and/or wrongly positioned back in their chairs or overdue for changes of their continence pads. The staff feel guilty getting these people up at 6:30am or 7:00 throughout the winter months or in extreme temperatures in order to catch transport to a Day Program where they have very little capacity to get involved in activities and have less personal support.

One of these residents now stays at home two days a week and it's obvious to the staff that he love these days where they can sleep in and have a leisurely long bath. When I questioned staff about what would be the other client's real choice about doing a home-based flexible activity model, they were extremely confident that all bar one resident would choose to stay at home.

I therefore recommended to the service that they should consult with the families and the individuals as far as is possible in an effort to ensure that genuine choices are honoured and believe this should be undertaken with all participants. It is no longer about individuals fitting into service models.

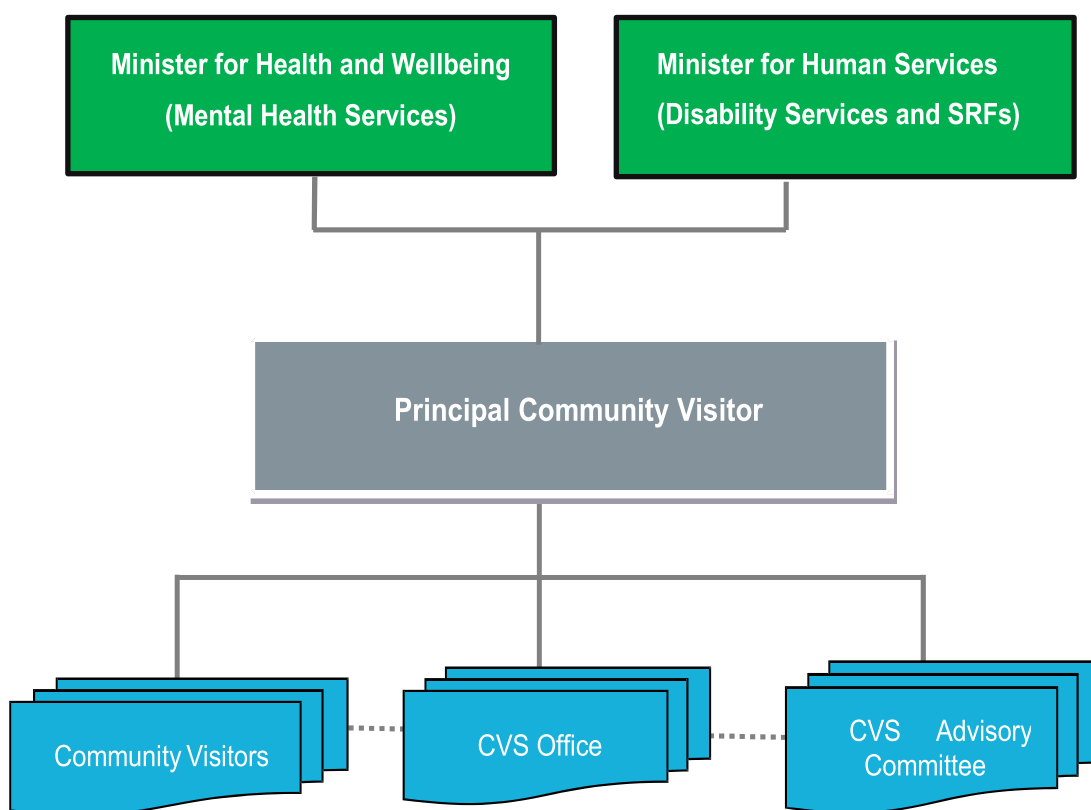
6. Workforce

6.1 Governance of the Community Visitor Scheme

The Principal Community Visitor (PCV) and Community Visitors are independent statutory appointments by the Governor of South Australia. The PCV reports to the Minister for Health and Wellbeing (Minister for Mental Health Services) on matters related to the Scheme's functions under the *Mental Health Act, 2009*; the Minister for Human Services (Minister for Disability Services) on matters related to the Scheme's functions under the *Disability Services (Community Visitor Scheme) Regulations, 2013* and on matters relating to Supported Residential Facilities.

The independence of the CVS is integral to the program, enabling patients/residents, carers and family members to speak with individuals who are not associated with the provision of support and services.

An Advisory Committee provides strategic advice and support to the PCV, monitors and evaluates the CVS, and contributes to strategic networks and relationships.



The Community Visitor Scheme is auspiced by the Department for Human Services (DHS) for administrative purposes only.

6.2 Staff of the Community Visitor Scheme

Following is a list of paid staff members who worked either full or part time in the Community Visitor Scheme Office during the 2017-18 reporting period:

Principal Community Visitor	Mr Maurice Corcoran AM
CVS Manager	Mr John Alderdice
Mental Health CVS Coordinator	Ms Kate Thomas
Disability Services CVS Coordinator	Ms Michelle Egel
SRF and Day Options CVS Coordinator	Ms Karen Messent
Recruitment and Training Officer	Ms Leanne Rana
Project Support Officer	Ms Rondelle Oster
Administration Officer	Mr Micah Mango

6.3 Advisory Committee

The members of the Advisory Committee during 2016-2017 were:

Ms Anne Burgess	Chairperson
Mr Maurice Corcoran AM	Principal Community Visitor
Ms Niki Vincent	Equal Opportunity Commissioner
Ms Anne Gale	Public Advocate
Mr Steve Tully/Mr Grant Davies	Health and Community Services Complaints Commissioner

Mental Health Representatives:

Dr Aaron Groves/Dr Brian McKenny	Chief Psychiatrist and Director Mental Health Policy
Chris Burns	Mental Health Commissioner
Ms Carol Turnbull	Private Mental Health Services Representative
Mr Ben Sunstrom	Manager, Legislation and Policy – Office of Chief Psychiatrist
Mr Jason Cutler	Consumer Representative
Ms Julia Mc Millian	Carer Representative
Tony Rankine	Community Visitor Representative

Disability Representatives:

Mr David Caudrey	Executive Director, Disability SA
Ms Zofia Nowak	Director, NDIS Implementation
Mr Richard Bruggemann	Senior Practitioner, Disability SA
Ms Sandra Wallis	Government Disability Accommodation Representative
Ms Narelle Jeffery/Ms Janine Lenigas	Non-Government Disability Accommodation Representative
Ms Kris Maroney	Supported Residential Facilities Sector Representative
Ms Jayne Lehmann	Disability Carer Representative
Mr Jim Harvey	Disability Community Visitor Representative

6.4 Community Visitors

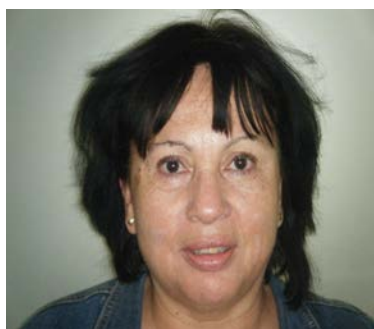
The Community Visitors (CVs) have impressive backgrounds, skills and passion that have helped to deliver the Scheme's key outcomes of monthly visits and inspections and associated reports at a very high level. They are aged between 25 and 82, come from a diverse range of cultural backgrounds, and can speak seventeen (17) languages between them.

They have achieved the following qualifications:

Level of qualification	Number of Community Visitors
PhD	2
Masters - Social Work, Law, Business Admin, Disability	8
Bachelor Hons	4
Bachelor - Social Work, Social Sciences, Psychology, Arts, Architecture, Civil Engineering, Economics, Law	33
RN	1
Grad Dip – OH&S, Education, Technology	5
Grad Cert – Disability, Tertiary Teaching	3
Assoc Dip - Social Work	1
Advanced Dip	1
Diploma - Social Sciences, Education, Counselling, EN, Marketing	18
Advanced Cert - Accounting	1
Cert 4 – Mental Health, Tourism, Training & Assessment, Drug & Alcohol	18
Cert 3 – Small Business Management, Disability, Training & Assessment	3
Cert 2 – Community Services, Auslan, Business, Retail	8
Cert 1 – Assessment & Workplace Training, Hospitality, Counselling	6
Mental Health First Aid	3
Senior First Aid	2
Other eg Child Safe Environments, OH&S, Mediation, Peer Work, Communications, Financial Planning	41

As an integral and valued component of the Scheme, it is with great pleasure that we showcase two of our Community Visitors that have been volunteering with us for many years:

Ingrid Davies – appointed 2/2/2012



I completed studies in politics and economics at University of Chile, completed nursing studies at Caritas Chile Nursing school and worked in Emergency Department of hospital in Chile until coming to Australia in 1986. After working many years in the 'blue collar' sector e.g GMH as vehicle test driver, I then volunteered with the Community Visitor Scheme. My role as a Community Visitor has been very valuable to me in gaining knowledge and experiences to add to my strong humanitarian values and my lived experience caring for adult sons with a mental illness. I enjoy being able to connect with people who often have so much to overcome and endure in their lives. enjoy being able to connect with people who often have so much to overcome and endure in their lives.



Ann Rymill has been a Community Visitor for over 5 years, having started with the CVS in March 2013. Ann had many years as a Social Worker where she was part of the Exceptional Needs Unit with interest and expertise in systems and services for forensic clients with a dual disability and has completed research and significant reports in this field. Ann's career has also included substantial time with the Intellectually Disabled Services Council (IDSC) and Monash University. Ann's work with the CVS has predominantly been in the disability sector and she has been a great mentor to others, served on the CVS Advisory Committee and assisted in our training of new CVs through sharing her experiences and knowledge in our training workshops. Ann is committed to human rights and has strong support for advocacy and social justice.

Community Visitors are an integral and valued component of the Scheme and following is a list of all the Visitors who have contributed during the 2017-18 reporting period:

Adele Querzoli	Judy Harvey
Angela Duigan	Julie Margaret
Angela Glenn	Kim Steinle
Angela Koutsidis	Lee Ridge
Ankur Patel	Lindy Thai
Ann Rymill	Marianne Dahl
Anne Burgess	Mark Rogers
Annette Glover	Maurice Corcoran
Brian Day	Michele Slatter
Bryn Williams	Nike Babalola
Cecil Camilleri	Ron Oliver
Chan Panditharatne	Sally Goode
Elle Churches	Sara Elfalal
Erika Davey	Sharon Hughes
Garry McDonald	Shipra Sareen
Helen Winefield	Sophie Dai
Ingrid Davies	Sue Whittington
Jacy Arthur	Sultana Razia
Jenni Kendal	Tony Rankine
Jim Evans	Von Cheng
John Leahy	Wendy Norman
John Lykogiannis	Yinzi He
John Sheehan	Maurice Corcoran AM (Principal Community Visitor)

6.4.1 Community Visitor Recruitment

The CVS is a member of Volunteering SA-NT Incorporated, a non-profit organisation and peak body dedicated to promoting and supporting volunteers and volunteering in South Australia and the Northern Territory.

Recruitment advertising for Community Visitors (CVs) is primarily facilitated through the Volunteering SA-NT website. However, the CVS has also used other career sites such as Seek Volunteer and Go Volunteer. Volunteering SA-NT has provided training to allow for agencies to manage their own online volunteer ads. This has resulted in a better process for managing changes in recruitment procedures.

People interested in applying to become a Community Visitor must be over 18 years of age and be willing to undertake both disability and child-related screening checks with DHS. Before applying, interested people are encouraged to go to the [Community Visitor Scheme](#) website, which outlines the attributes and level of commitment required to undertake the role.

Two hundred and ten (210) Expressions of Interest were received during the reporting period. Of these, thirty-eight (38) applications were received. Thirty (30) Expressions of Interest were followed up because of their potential as Community Visitors, and two (2) responses were received. One respondent was working fulltime and therefore unable to commit to CVS, and the other was found to be unsuitable.

Individuals submit an application form with a current curriculum vitae and three referees. If shortlisted, the applicant is invited to undertake the following activities for further assessment:

- » attend an interview
- » participate in a two day workshop (see Section 6.4.2)
- » undergo DHS screening checks and referee checks, and
- » undertake a minimum of two orientation visits with the PCV.

Sixteen (16) applicants proceeded to training after undergoing a successful interview.

If successful, the applicant is nominated for appointment and required to sign a *Conditions of Appointment* and a *Code of Conduct*.

A cabinet submission is prepared recommending the appointment of the applicant to the role of Community Visitor and endorsed by His Excellency, the Governor of South Australia.

Ten (10) applicants were appointed and (6) did not proceed to appointment after training or orientation due to not attending training, withdrawing, or being unsuccessful after training.

Once appointed, Community Visitors are provided with a photo identification security badge.

6.4.2 Initial and Ongoing Support and Training for Community Visitors

Initial Training and Orientation

Potential CVs are invited to participate in a two-day training program aimed at providing them with the skills and knowledge required to fulfil the legislative functions of the role. The training program is split into 11 modules and assumes no prior knowledge of mental health or disability services. The content is delivered over two consecutive days with values, exercises, role plays and various guest presenters. The modules covered are:

- » **Module One:** Introduction, Overview and History of the Community Visitor Scheme
- » **Module Two:** Role, Functions and Scope of the Community Visitor Scheme
- » **Module Three:** CVS Visits and Inspections
- » **Module Four:** Practical Matters for Community Visitors
- » **Module Five:** Lived Experience
- » **Module Six:** Mental Health
- » **Module Seven:** Communication Strategies
- » **Module Eight:** Disability
- » **Module Nine:** Dual Disability and Gender Safety
- » **Module Ten:** Cultural Competencies, and
- » **Module Eleven:** Values Testing for Disability and Mental Health.

Sessions were held in August 2017 and February and May 2018. Sixteen participants (16) attended training sessions.

On completion of the program, an assessment of the two days is undertaken through an attendee satisfaction survey. Each questionnaire is completed anonymously to ensure all attendees can be open and honest about their comments.

The questions are designed to solicit information from the attendees as to whether they found the information clear, the style of presentation suited their needs, the presenters were knowledgeable, resource notes sufficient, there was opportunity for participation interaction and if they felt confident in meeting the learning objectives of that module.

An online tool, "Limesurvey" was used as the survey tool. Participant use of the tool was high and it provided a clear means of being able to collect and analyse participant feedback.

One hundred percent (100%) of respondents either strongly agreed or agreed to the following 2 questions for 10 Modules:

- The information was clear
- The resource notes were sufficient

Ninety-one percent (91%) of respondents either strongly agreed or agreed to the following 4 questions for 10 Modules:

- The style of the presentation suited my needs
- The presenters knowledge was sufficient
- Participant interaction was adequate
- I feel confident in meeting the learning objectives of this module

Module 10 is presented as information and readings only, and is therefore not assessed in the feedback process.

In addition to rating each module, the attendees are encouraged to provide some written feedback. Following are comments from this reporting periods three series of workshops:

- Overall, this training is well delivered. The 11 modules are extremely important. Inviting the people who are related to Mental Health and Disability sector were the best part of this training. I have met wonderful people during my 2-days training. My knowledge has been challenged and improved at the same time. The content of training is very thorough and helpful
- The training program was put together very well, very informative and helpful. Thank you!
- I think this training was really useful. It might be unconventional at times but really fun and helpful. The speakers' honesty and openness also helps us to better understand the topics discussed. THANK YOU to everyone for putting the training together
- Well paced and very informative. I learned a lot
- I thoroughly enjoyed the two days training and felt I gained a lot of new information. I also enjoyed the participation with the other members of the group and felt that their diverse backgrounds and thoughtful comments very valuable
- I found the training to be interesting and informative and beneficial to my needs
- Really appreciate for the training and knowledge sharing. Thank you, CVS team

Overall, training session participants "strongly agreed", or "agreed" that the training sessions met their needs and objectives. The CVS team is confident that prospective visitors are receiving the necessary information to prepare them for the role.

A minimum of two observation visits are undertaken with the PCV for further assessment. This provides the trainee Community Visitor with an opportunity to see the practical application of key areas covered in the training program. A total of twenty-eight (28) observation visits were completed with the PCV.

During the training and orientation process, the PCV assesses the applicant's suitability and individual capacity to fulfil all of the functions of a CV, as described in section 51(1) of the *Mental Health Act, 2009*. Orientation feedback meetings were held with 8 prospective CVs.

From the number of participants (16) attending the 2 day training, five (31%) have not progressed through to appointment, providing support that the current recruitment process and training program is thorough and robust in matching appropriate applicants to the role.

Ongoing Training and Support

Professional development needs are assessed and workshops are developed to ensure that CVs have the necessary skills and knowledge to effectively complete visits and inspections. "Personal safety of clients in Care" training was provided to twenty (20) CVs in April 2017. This included five (5) regional CVs.

Community Visitors have access to ongoing training and professional development opportunities through the SA Mental Health Training Centre (Department of Health and Ageing) and other external agencies such as Volunteering SA&NT, Northern and Southern Volunteering, and local councils.

CVs were offered 7 external training opportunities:

- Responding to Anger - Southern Volunteering
- Open State festival
- Public Speaking and Presentations - Southern Volunteering
- Learning about Autism <http://www.torrens.edu.au/mooc-the-voices-of-autism> The CV that completed this training would "highly recommend it" to others
- Accidental Counsellor - Southern Volunteering
- Volunteering Conference
- Elder Abuse Awareness - Southern Volunteering

In addition, five (5) CVs participated in the National Volunteer Week parade



John, Jacy, Marianne, Sharon and Tony enjoy the sunshine in the grounds of Government House during the National Volunteer Week parade May 2017

Annual development reviews are conducted with the PCV to provide a formal avenue for feedback and development discussions. Thirty-five (35) yearly reviews were conducted throughout the year with CVs participating in performance and development discussions with the PCV. Community Visitors are encouraged to pursue development opportunities and discuss other interests with the PCV.

Underperforming CVs are invited to meet with the PCV and the Recruitment and Training Officer to discuss any concerns and to work through strategies to assist them to improve their performance.

There are presently 42 active CVs, with six (6) being reappointed for a second term of 1 year. Nine (9) CVs have resigned due to gaining work and/or health conditions.

A 'Reflective Practice' session is offered to CVs for the hour before the 'Get togethers'. This enables CVs to share their experiences encountered during visits and any challenges faced. They can share what works for them and provide peer support to one another.

CVs have had the opportunity to meet 5 times during the year to informally discuss their experiences during visits and provide group feedback for service improvement. Some of the ideas discussed have been:

- August 2017 – COMPAS program, Jen Jacobs guest speaker
- October 2017 – Suicide Prevention Plan
- December 2017 – Ideas and planning for 2018
- April 2018 – online Mental Health course
- June 2018 – ICAC findings

There were 60 attendances by CVs across the 5 'get togethers'. Notes from the August, October, December, April and June meetings have been included in monthly newsletters, which are an important way of passing on relevant information to regional CVs.

These forums have encouraged a cohesive team approach, provided opportunity for shared learning among peers and been highly valued by the CVs.

The CVS Newsletter is distributed to the Community Visitors on a bi-monthly basis providing general updates and information regarding strategic direction and issues arising.

The Recruitment and Training Officer uses of 'Sharepoint' as another communication strategy for keeping in touch with CVs. Newsletters, policies and key forms are kept on Sharepoint for ease of access and use by CVs.

Community Visitors can also access the SA Government Employee Assistance Program.

6.4.3 Recruitment strategies external to CVS

Attendance at relevant networking, policy and strategic meetings have occurred with the Recruitment and Training Officer attending three Central Volunteer Managers, five Public Service Volunteer Policy, and 2 Volunteering Strategy for South Australia meetings. In addition, the R&T Officer met with 6 interviewers from Volunteering SA-NT to encourage them to look for prospective CVs.

Liaison with the Mitcham chapter of Probus occurred in August 2017 with approximately 70 people in attendance. In addition, training dates are posted on Facebook and CVs are encouraged to talk about their role within their networks to encourage others to take an interest in the Scheme.

7. Conclusion

The past twelve months reporting period has again proved to be a very successful for the scheme with the continued increase in number of visits conducted and a further expansion of the services it provides with the commencement of visits to mental health community settings.

As you can see from the various sections of this report, the Community Visitor Scheme, through its very committed visitors has had thousands of interactions with individuals who have been using the disability services in South Australia over this past year. They have also spoken to many families and staff and from these conversations, observations and scrutiny of services, extracted valuable commentary on what's working well and what needs to be improved. The services we visit are increasing to use this feedback in a range of ways to improve quality and continuous improvement strategies.

The CVS has noted that the introduction of the NDIS is providing positive outcomes for many individuals. However, general feedback is that the implementation period has as expected, created some tension and confusion. As example, there was initially much concern about the future for SRF residents and the future sustainability of SRF organisations. This was further heightened by the closure of two SRFs and discussions that others were considering closure. The positive has been that most SRF residents have to date been assessed as eligible for the NDIS and their funding packages are providing confidence to owners of long-term viability.

Another key learning from the SRF process is that pre planning prior to the initial access assessment and NDIS planning meeting, does bring more positive outcomes for individuals.

The CVS now has a well-developed, robust process of tracking and following up on all issue raised in reports and continues to deliver many positive outcomes for individuals and their families. There continues to be an urgent and positive response by the Disability services sector when issues are raised.

There have been significant lessons learnt from our involvement in Oakden Services investigation and the ICAC Enquiry. This includes but not limited to, that we now ensure there is agendas and notes of all meetings with Ministers, Senior Departmental staff and other Statutory officers. The process of submitting this information and documentation also facilitated vast improvements in our document storage and records management.

The CVS is committed to improving its quality and practice following the recommendations of the ICAC report and welcomes the forthcoming review of the CVS as previously outlined. It also looks forward to the national review of Community Visitor Schemes where I am confident that we can demonstrate that our visits and reports and follow up with services genuinely adds value and is separate to the role that the Quality and Safeguards commission has.

I also believe that the instigation of monthly meetings between the key statutory officers i.e. the Public Advocate, Anne Gale, the Mental Commissioner, Chris Burns, the Health and Community Services Complaints Commissioner Dr Grant Davies, the Chief Psychiatrist, John Brayley and myself has been a great initiative to enable better collaboration and address any duplication of efforts.

Lastly, I would like to acknowledge the CVS Advisory Committee and its diverse members across the mental health and disability portfolios where there has been robust discussion, debate and strategies developed to help us address the many issues that arise from our collective work. Our great facilitator and chair, Anne Burgess always enables this forum to explore better ways to collaborate with both committee members and other external stakeholders as a means to extend our influence and ultimately, service improvements for the people we are here to serve.

7.1 Future steps of the South Australia Community Visitor Scheme

As part of its broader planning the CVS team established the following 10 priority actions for 2018. Progress against these issues and their strategies are presented at each advisory committee meeting.

	Issue	Strategy
1	Roll out of the CVS visitation program to Community Mental Health Services <ul style="list-style-type: none"> The Mental Health (Review) Amendment Act 2016 requires the CVS to visit community MH facilities every 2 months 	<ul style="list-style-type: none"> Meet with MHS community teams to present CVS role and explore how best to deliver this service to their clients Draft the visitation model and present to CVs Draft new report format in line with the different setting
2	Accommodation Shortages in the Community <ul style="list-style-type: none"> SRF closures has reduced accommodation options in the community MHS are experiencing great difficulty in discharging patients due to lack of community accommodation options As highlighted in the Shelter SA report 'The End of the Road' 	<ul style="list-style-type: none"> Continue to present issue to Ministers and relevant government department senior staff Continue to be engaged in the outcomes of the 'Round Table' in response to the Shelter SA report 'The End of the Road'
3	Forensic Services <ul style="list-style-type: none"> The independent review report into forensic care and the response to the report recommendations by SA Health have been completed. CVS has submitted its response to SA Health document CVS needs to closely monitor implementation of the actions agreed to by Health 	<ul style="list-style-type: none"> Ensure regular meetings are held with the Directors of NALHN and that Forensic Services is a standing agenda item Continue through above forum to monitor progress of the SA Health agreed actions in response to the recommendations of the report Offer to participate in or support any of the sub projects that are commenced Monitor progress through visits from both a strategic and consumer perspective Escalate issues as required either to management or the Minister if there is frustration with a lack of progress
4	Focus on Personal Safety of Clients in Care <ul style="list-style-type: none"> Issue highlighted in several years of CVS annual reports CVS continues to lobby DCSI and Health for related policy 	<ul style="list-style-type: none"> Undertake a focus on this topic during visits in May and June Draft review prompt sheet, train CVs, communicate to organisations and conduct focus Produce a report on the outcomes of the focus Present report to Advisory Committee, senior management within DHS and Health and service providers
5	Regular meetings with LHNs <ul style="list-style-type: none"> Meetings with the MH Executive Directors of the LHNs have become inconsistent. These are important to ensure issues are transferred to a responsible officer It is also important to improve their responsiveness to issues raised 	<ul style="list-style-type: none"> Establish meeting schedule for the year Establish agenda with standing strategic items relevant to their area plus the agenda of issues raised in recent visits
6	Policy on Support for Disability Clients whilst in Hospital <ul style="list-style-type: none"> It was revealed that there was in place (now lapsed) an MOU to enable Disability SA to be 	<ul style="list-style-type: none"> Establish current policy position for each LHN Lobby for new or amended policy if not in place or inconsistent with other LHNs.

	<p>funded by hospitals to support their clients while an inpatient. It was also reported that this had been extended to some of the NGO organisations such as MINDA</p> <ul style="list-style-type: none"> CVS has been advocating for all the LHNs to establish a policy that is in alignment with the MOU but that would also be available to all disability service providers The SRF Dental Program has funded transport and where necessary care worker support for residents who do not have a current NGO package. 	<ul style="list-style-type: none"> Communicate to the broader sector
7	<p>Medication Management</p> <ul style="list-style-type: none"> CVS strongly supported the Chemical Restraints project given the estimated 300 clients that were on psychotropic or polypharmacy (concurrent use of multiple medications) without review. CVS will continue to monitor and support progression of this project 	<ul style="list-style-type: none"> Continue to receive update from the project sponsor and manager Lobby for the allocation of additional resources if required Seek clarity on how this will be continued under the NDIS
8	<p>Specialist Services:</p> <ul style="list-style-type: none"> CVS has highlighted the importance of ensuring continued access to mainstream health services, in particular state funded psychiatry services for clients with Intellectual Disability given rates of mental illness are significantly higher in this population The CVS continues to liaise with both relevant departments the importance of retaining the Centre for Disability Health (CDH), Exceptional Needs Unit (ENU), ASSIST Therapy Services(ATS), SRF Health Access Team, and the SRF Dental Program that they be sufficiently resourced to ensure they remain sustainable. 	<ul style="list-style-type: none"> Continue to monitor the retention and resourcing of these specialist services Seek clarity on how they will be maintained under an NDIS environment
9	<p>Accommodation & Support for Clients with Complex and Challenging Behaviours</p> <ul style="list-style-type: none"> Several disability clients with complex behaviours are being contained in what can best be described as fortress accommodation with very expensive support packages It is questionable as to whether this delivers meaningful support/care or provides value for money 	<ul style="list-style-type: none"> Research the range and types of services that best cater for this client group Seek clarity on how this client group will be supported under the NDIS both in service and accommodation Inquire as to whether the NDIA is researching the best models of care and how best to fund services to this client group Present to both State and commonwealth governments if there are any perceived/potential gaps in funding and services or they are assessed as lacking quality and value for money
10	<p>CVS Quality Development</p> <ul style="list-style-type: none"> Continue to increase number of Community Visitors Increase number of Disability visits and ensure priority houses are visited 	<ul style="list-style-type: none"> Continue to focus on the recruitment of additional CVS Continue to look at CV retention and utilisation strategies Further develop CVS data base so that houses identified as needing follow up visit or whose residents are assessed as more vulnerable can be identified and given priority during visit scheduling

7.1.1 Reviews of the CVS

The Commonwealth Government has committed to undertake a National review of Disability Visitor Programs to inform the COAG Disability Reform Council (DRC) about the role (if any) of Community Visitors in and with the NDIS at full scheme. In doing so there are two key questions that the review will address:

1. In light of the Framework, and the functions of the Commission in particular, can Community Visitors, as independent bodies, play a role in terms of safeguarding vulnerable NDIS participants? If yes, what role can they play?
2. If they can play a role, what are the appropriate functions and powers needed for Community Visitors to operate within the NDIS and how should Community Visitors best interface with the Commission?

The SA CVS welcomes this review and looks forward to its participation.

The South Australian Independent Commissioner Against Corruption (ICAC) in its report on investigations into Older Persons Mental Health Services at Oakden made the following recommendation relevant to the CVS:

Recommendation Seven: The Minister for Mental Health and Substance Abuse (the Minister) cause a review to be conducted of the community visitor scheme (CVS) to determine whether the CVS should be amended to:

- require community visitors be trained in mental health care;
- require community visitors to possess certain qualifications in mental health care; and
- provide that some of the community visitors' current functions be discharged by persons with specialist qualifications in mental health.

The SA CVS again welcomes this review and looks forward to its participation. Time frames for this review are similarly anticipated to be conducted in the last third of 2018.

7.2 Recommendations

Throughout sections 3 to 5 of this report a range of significant issues that have emerged have been discussed and attempts to arrive at a set of recommendations as a means of continuous improvement reached. These are recommendations from the Principal Community Visitor alone and do not necessarily represent views of the CVS Advisory Committee or the collective views of Community Visitors.

1. The CVS to continue to monitor interactions between staff and residents and report on whether these observations are either positive, sensitive and respectful or to the contrary.
2. CVS to look at strategies to reduce service providers preference for a more orchestrated visit so more natural house interactions can be observed.
3. CVs continue to thoroughly inspect all areas of the facilities they visit and report on any environmental concerns or inadequacies, especially where this has an impact on the provision of client centred care.
4. That the CVS continues to monitor personal safety of both residents and staff.
5. That the CVS looks into undertaking a focus on medication reviews including PRN.
6. The CVs continue to check on the use of restrictive practices and report undocumented or unusual practices to the PCV who will report to the Senior Practitioner at the SA office Quality and Safeguards Commission.
7. That CVs continue to monitor and report on lifestyle/person centred plans and NDIS plans being in place, the involvement of residents and where appropriate families and guardians in their compilation.
8. That CVs enquire into the implementation of plans and seek evidence that the plans are being implemented and regularly reviewed and monitor the level of encouragement and support by staff to assist residents in developing independent living skills.
9. That Community Visitors continue to monitor and report on activities and structured programs that residents are involved in and that they are consistent with the preferences and capability of residents.

Supported residential Facilities (SRFs)

10. That there be a review of the Supported Residential Facilities Act 1992 that also look into Rooming/Boarding Houses in the context of the NDIS.
11. That CVS continue to assess the standard of SRF buildings and facilities and provisions for residents
12. That the CVS continues to monitor individual NDIS plans and to ascertain whether they genuinely reflect the individual goals and aspirations of the individuals and provide genuine choice and control
13. The CVS continues to monitor the menus and food choices within SRFs
14. The CVS monitors the activities and supports to SRF residents to enable greater community participation.

Day Options

15. That accommodation services should consult with the individuals in their facilities and their families in an effort to determine that genuine choice of Day Options and activities are being honoured or that a more flexible activities program out of their home be a preferred option.

8. Acronyms

Acronym	Definition
ABF	Activity Based Funding
AGD	Attorney General's Department
AMHS	Area Mental Health Services
APY	Anangu Pitjantjatjara Yankunytjatjara
ATSIMHSPAG	Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Advisory Group
CALD	Culturally and Linguistically Diverse
CALHN	Central Adelaide Local Health Network
CBIS	Community Based Information System
CCTV	Closed Circuit Television
CEO	Chief Executive Officer
CLCA	Criminal Law Consolidation Act
COAG	Council of Australian Governments
CTO	Community Treatment Order
CV(s)	Community Visitor(s)
CVS	Community Visitor Scheme
DASSA	Drug & Alcohol Services South Australia
DCS	Department of Correctional Services
DCSI	Department for Communities and Social Inclusion
ECH	Elderly Home Care
ED(s)	Emergency Department(s)
FFT	Fitness for Trial
FO	Forensic Orders
HCSCC	Health and Community Services Complaints Commissioner
ICAC	Independent Commissioner Against Corruption
ICCs	Intermediate Care Centres
ICT	Information and Communication Technology
IHPA	Independent Hospital Pricing Authority
IT	Information Technology
ITO(s)	Involuntary Treatment Order(s)
JNH	James Nash House – Forensic Facility
KOB(C)	Kenneth O'Brien Centre
KPI	Key Performance Indicator
MHS	Mental Health Service
NALHN	Northern Adelaide Local Health Network
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NGO	Non-Government Organisation

Acronym

Definition (cont)

NHMRC	National Health and Medical Research Council
NHPA	National Health Performance Authority
NMHC	National Mental Health Commission
NRT	Nicotine Replacement Therapy
NSW	New South Wales
OACIS	Open Architecture Clinical Information System
OCF	Office of the Chief Psychiatrist
OPA	Office of Public Advocate
OT	Occupational Therapy
OHW&S	Occupational Health, Welfare and Safety
PCV	Principal Community Visitor
PECU	Psychiatric Extended Care Unit
PICU	Psychiatric Intensive Care Unit
QLD	Queensland
RSL	Returned and Service League
S269 Clients	Section 269 of the Mental Health Act, 2009
SA	South Australia
SA&NT	South Australia and Northern Territory
SASP	South Australian Strategic Plan
SICC	Southern Intermediate Care Centre
SRF	Supported Residential Facility
SSU(s)	Short Stay Unit(s)
TAFE	Technical and Further Education
TSI	Torres Strait Islander
UNCRPWD	United Nations Convention on the Rights of Persons with Disabilities
VMIAC	Victorian Mental Illness Awareness Council Australia
VSA&NT	Volunteering South Australia and Northern Territory

9. Appendices

Appendix 1: Disability Services (Community Visitor Scheme) Regulations, 2013

These Regulations are to be read in conjunction with Subsection 50 – 54 of the *Mental Health Act, 2009*.

Under the *Disability Services Act, 1993*

1—Short title

These regulations may be cited as the *Disability Services (Community Visitor Scheme) Regulations 2013*.

2—Commencement

These regulations come into operation on the day on which they are made.

3—Interpretation

In these regulations, unless the contrary intention appears—

Act means the *Disability Services Act, 1993*;

Community Visitor has the same meaning as in the *Mental Health Act, 2009*;

Disability Accommodation Premises means any premises at which a disability services provider is providing accommodation services to persons with disabilities;

Principal Community Visitor has the same meaning as in the *Mental Health Act, 2009*;

Resident means a person with a disability who resides at disability accommodation premises.

4—Functions of Community Visitors

(1) Community Visitors have the following functions under these regulations:

- (a) to visit disability accommodation premises to inquire into the following matters:
 - (i) the appropriateness and standard of the premises for the accommodation of residents;
 - (ii) the adequacy of opportunities for inclusion and participation by residents in the community;
 - (iii) whether the accommodation services are being provided in accordance with the principles and objectives specified in Schedules 1 and 2 of the Act;
 - (iv) whether residents are provided with adequate information to enable them to make informed decisions about their accommodation, care and activities;
 - (v) any case of abuse or neglect, or suspected abuse or neglect, of a resident;
 - (vi) the use of restrictive interventions and compulsory treatment;
 - (vii) any failure to comply with the provisions of the Act or a performance agreement entered into between a disability services provider and the Minister;
 - (viii) any complaint made to a Community Visitor by a resident, guardian, medical agent, relative, carer or friend of a resident, or any other person providing support to a resident;
- (b) to refer matters of concern relating to the organisation or delivery of disability services in South Australia to the Minister;
- (c) to act as advocates for residents to promote the proper resolution of issues relating to the care, treatment or control of residents, including issues raised by a guardian, medical agent, relative, carer or friend of a resident or any person who is providing support to a resident.

- (2)A Community Visitor may, for the purposes of carrying out the functions of a Community Visitor, enter disability accommodation premises at any reasonable time and, while on the premises, may—
- (a) meet with a resident; and
 - (b) with the permission of the manager of the premises—inspect the premises or any equipment or other thing on the premises; and
 - (c) request any person to produce documents or records; and
 - (d) examine documents or records produced and request to take extracts from, or make copies of, any of them.

5—Requests to See Community Visitors

- (1) A resident or a guardian, medical agent, relative, carer or friend of a resident or any person who is providing support to a resident may make a request to see a Community Visitor.
- (2) If a request is made under sub regulation (1) to a manager of, or a person in a position of authority at, disability accommodation premises that person must advise a Community Visitor of the request within two days after receipt of the request.

6—Reports by Community Visitors

- (1) After a visit to disability accommodation premises, the Community Visitors must (unless one of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.
- (2) The Principal Community Visitor must, on or before 30 September in every year, forward a report to the Minister on the work of the Community Visitors under these regulations during the financial year ending on the preceding 30 June.
- (3) The Principal Community Visitor may, at any time, prepare a special report to the Minister on any matter arising out of the performance of the Community Visitor's functions.
- (4) The Minister must, within six sitting days after receiving a report under this regulation, have copies of the report laid before both Houses of Parliament.

Appendix 2: Mental Health Act, 2009 Division 2 — Community Visitor Scheme

51—Community Visitor's Functions

- (1) Community Visitors have the following functions:
 - (a) to conduct visits to and inspections of treatment centres as required or authorised under this Division;
 - (ab) to conduct visits to and inspections of authorised community mental health facilities as required or authorised under this Division;
 - (b) to refer matters of concern relating to the organisation or delivery of mental health services in South Australia or the care, treatment or control of patients to the Minister, the Chief Psychiatrist or any other appropriate person or body;
 - (c) to act as advocates for patients to promote the proper resolution of issues relating to the care, treatment or control of patients, including issues raised by a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act;
 - (d) any other functions assigned to Community Visitors by this Act or any other Act.
- (2) The Principal Community Visitor has the following additional functions:
 - (a) to oversee and coordinate the performance of the Community Visitor's functions;
 - (b) to advise and assist other Community Visitors in the performance of their functions, including the reference of matters of concern to the Minister, the Chief Psychiatrist or any other appropriate person or body;
 - (c) to report to the Minister, as directed by the Minister, about the performance of the Community Visitor's functions;
 - (d) any other functions assigned to the Principal Community Visitor by this Act or any other Act.

51A—Delegation by Principal Community Visitor

- (1) The Principal Community Visitor may delegate a power or function of the Principal Community Visitor under this Act to another community visitor.
- (2) A delegation under this section—
 - (a) may be absolute or conditional; and
 - (b) does not derogate from the power of the Principal Community Visitor to act in a matter; and
 - (c) is revocable at will by the Principal Community Visitor.

52—Visits to and Inspection of Treatment Centres

- (1) Each treatment centre must be visited and inspected once a month by two or more Community Visitors.
- (2) two or more Community Visitors may visit a treatment centre at any time.
- (3) On a visit to a treatment centre under subsection (1), the Community Visitors must—
 - (a) so far as practicable, inspect all parts of the centre used for or relevant to the care, treatment or control of patients; and
 - (b) so far as practicable, make any necessary inquiries about the care, treatment and control of each patient detained or being treated in the centre; and
 - (c) take any other action required under the Regulations.
- (4) After any visit to a treatment centre, the Community Visitors must (unless one of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.
- (5) A visit may be made with or without previous notice and at any time of the day or night, and be of such length, as the Community Visitors think appropriate.

- (6) A visit may be made at the request of a patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act.
- (7) A Community Visitor will, for the purposes of this Division—
 - (a) have the authority to conduct inspections of the premises and operations of any hospital that is an incorporated hospital under the *Health Care Act, 2008*; and
 - (b) be taken to be an inspector under Part 10 of the *Health Care Act, 2008*.

52A—Visits to and inspection of authorised community mental health facilities

- (1) **An authorised community mental health facility—**
 - (a) must be visited and inspected at least once in every 2 month period by 2 or more community visitors; and
 - (b) may be visited at any time by 2 or more community visitors.
- (2) However, the Principal Community Visitor may visit an authorised community mental health facility alone at any time.
- (3) On a visit to an authorised community mental health facility, a community visitor must—
 - (a) so far as practicable, inspect all parts of the facility used for or relevant to the care, treatment or control of patients; and
 - (b) take any other action required under the regulations.
- (4) After any visit to an authorised community mental health facility, the community visitors must (unless 1 of them is the Principal Community Visitor) report to the Principal Community Visitor about the visit in accordance with the requirements of the Principal Community Visitor.
- (5) A visit may be made with or without previous notice and at any time of the day or night, and be of such length, as the community visitors think appropriate.
- (6) A visit may be made at the request of a patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act.

53—Requests to See Community Visitors

- (1) A patient or a guardian, medical agent, relative, carer or friend of a patient or any person who is providing support to a patient under this Act may make a request to see a Community Visitor.
- (2) If such a request is made to the director of a treatment centre in which the patient is being detained or treated, the director must advise a Community Visitor of the request within two days after receipt of the request.

54—Reports by Principal Community Visitor

- (1) The Principal Community Visitor must, on or before 30 September in every year, forward a report to the Minister on the work of the Community Visitors during the financial year ending on the preceding 30 June.
- (2) The Minister must, within six sitting days after receiving a report under subsection (1), have copies of the report laid before both Houses of Parliament.
- (3) The Principal Community Visitor may, at any time, prepare a special report to the Minister on any matter arising out of the performance of the Community Visitor's functions.
- (4) Subject to subsection (5), the Minister must, within two weeks after receiving a special report, have copies of the report laid before both Houses of Parliament.
- (5) If the Minister cannot comply with subsection (4) because Parliament is not sitting, the Minister must deliver copies of the report to the President and the Speaker and the President and the Speaker must then—
 - (a) immediately cause the report to be published; and
 - (b) lay the report before their respective Houses at the earliest opportunity.
- (6) A report will, when published under subsection (5)(a), be taken for the purposes of any other Act or law to be a report of the Parliament published under the authority of the Legislative Council and the House of Assembly.

Appendix 3: Visit and Inspection Prompt (Disability)

The Community Visitor Scheme coordinates Community Visitors (CVs) to visit disability accommodation premises to inspect premises and consult with residents, staff and relevant others to ensure that people with disabilities are receiving appropriate accommodation.

The Visit and Inspection Prompt is designed to guide CVs through the visit and inspection process. The areas highlighted within this prompt are consistent with the 'Disability Services Standards'. The prompt should not be used as a 'step-by-step checklist' as this may hinder the CVs observations but should be read in conjunction of the 'Community Visitor Scheme Visit and Inspection Protocol'.

Prompts to Observe and note at Visits and Inspections of Disability Premises

Customer Service	Assess the welcome to the facility and introductions to residents and staff. Personal and respectful interactions between staff and residents/CVs. Adequate and accurate information provision about resident's rights and entitlements.
Environment	How does the place feel e.g. warmth, private and personalised spaces for clients? Are resident's rooms and amenities reasonable e.g. sufficient space, clean, temperature controlled, with well-maintained equipment and furnishings? Are residents happy with their food and is there a menu plan that residents have been consulted on and reflects their preferences and dietary requirements? Sufficient provision for space for residents to spend time in, participate in a range of activities as well as conduct confidential conversations with Visitors. Are resident's personal care and hygiene needs being met? Is the facility designed in a manner that is accessible, allows easy movement throughout including access to bathrooms, kitchen, cooking and cupboards?
Rights	Do clients feel they (and their carer, family member or other supporter) are being involved in decisions about the accommodation services? Do clients feel safe and is there consideration towards gender safety? Are clients provided with access to advocacy and legal representation?
Access to Information	Is there sufficient information provided to residents and do they have access to appropriate assistance to be able to understand the information about services offered, the CVS and other agencies that could support or advocate for them? Do residents whose first language is other than English or who are unable to read, have sufficient access to alternative formats or supports including interpreters? Are residents or CVs provided with access to medication records, behaviour and support plans when appropriate?
Activity/Entertainment Provisions	Are the independence and training needs of residents being met? Are residents being assisted to obtain and maintain suitable employment? Is there provision for entertainment for residents e.g. television, exercise equipment, board and electronic games? Are activities provided at the facility e.g. music therapy, art and craft, cooking and walking groups? Have the residents been asked what outside activities they enjoy and are they provided with sufficient opportunities to take part in such activities?
Treatment and Care	Do residents feel engaged in their personal support plans, treatment and care? Do residents feel they are being treated in the least restrictive manner? Are there any restrictive practices e.g. people locked in their rooms, people restrained in wheelchairs, tied up, doors locked, lack of access to parts of the building, locked refrigerators, inappropriate control by staff? If there are any restrictions, is there documentation that demonstrates the appropriate processes have been followed i.e. that there had been an investigation of less-restrictive alternatives, the development of a behaviour support plan with appropriate consents. There is a review date and considerations as to whether other people were also affected by the practices (e.g. a locked door for a person with a plan will also affect all other residents). Is there a personal support plan for each resident and if so, how frequently are they reviewed?
Grievances	Do residents feel they are safe to make a complaint if need be and free from any reprisals or threats to be evicted? Is the complaint treated confidentially and efficiently and is the complaints resolution process open and transparent?

Appendix 4: Visit and Inspection Prompt (Supported Residential Facility)

The Community Visitor Scheme coordinates Community Visitors (CVs) to visit Supported Residential Facilities (SRFs) to inspect premises and consult with residents, staff and relevant others to ensure that the residents are receiving appropriate accommodation and services.

The Visit and Inspection Prompt is designed to guide CVs through the visit and inspection process. The areas highlighted within this prompt are consistent with the *'Supported Residential Facilities Regulations, 2009'*. The prompt should not be used as a 'step-by-step checklist' as this may hinder the CVs observations but should be read in conjunction of the 'Community Visitor Scheme Visit and Inspection Protocol'.

Prompts to observe and note at Visits and Inspections of Supported Residential Facilities

Customer Service	<p>Assess the welcome provided to the facility and introductions to residents and staff</p> <p>Ensure a Visitors' Book is displayed and CVs are to sign in – and out on completion of the visit</p> <p>Are there personal and respectful interactions between staff and residents/CVs?</p> <p>Was prior notification of the visit provided to residents?</p>
Environment	<p>What is the general atmosphere of the SRF?</p> <p>How many residents live at the SRF?</p> <p>Consider residents' rooms – are they single or shared; secure; private; clean with adequate space; a comfortable temperature with well-maintained equipment & furnishings?</p> <p>Are the grounds well maintained and usable?</p> <p>Are residents consulted about the menu plan? Is it nutritious and does it reflect their preferences and dietary requirements? Do the residents have free access to water?</p> <p>Is there provision of space for residents to spend time in and participate in a range of activities as well as conduct confidential conversations with CVs or other service providers?</p> <p>Is there appropriate heating and cooling options within the SRF?</p> <p>Is there provision of sufficient bathrooms that are clean and private & laundry and drying facilities?</p>
Rights	<p>Is there provision of accurate information regarding resident's rights and entitlements and appropriate services?</p> <p>Are residents (and when appropriate, support person) involved in decisions about their care and accommodation?</p> <p>Have residents received a copy of the SRF Prospectus and their Contract and Service Plan?</p> <p>Do residents feel safe and is the SRF mindful of gender safety?</p>
Access to Information	<p>Is information provided to residents about available services and how to access them? Are residents aware of the CVS and other agencies that could support or advocate for them?</p> <p>Are alternative supports made available for residents whose first language is not English, and for those residents with low literacy skills?</p> <p>Are residents or CVs provided with access to medication records and service plans when appropriate?</p>
Activity/Entertainment Provisions	<p>Is there entertainment provided for residents e.g. television, exercise equipment, board and electronic games?</p> <p>Are residents supported and encouraged to access and participate in activities that enhance independence and community engagement?</p> <p>Are activities provided at the SRF e.g. music therapy, art and craft, cooking and walking groups - either by the SRF or an external organisation?</p>
Treatment and Care	<p>Do residents feel engaged in development of their service plan? How often are they reviewed?</p> <p>Do residents feel they are being treated respectfully and in the least restrictive manner?</p> <p>Are there any restrictive practices e.g. people locked in their rooms, doors locked, lack of access to parts of the building, locked refrigerators, inappropriate control by staff?</p> <p>If there are any restrictions, is there documentation that demonstrates the appropriate processes have been followed and that there is a review date and considerations as to whether other people were also affected by the practices. (e.g. a locked door for a person)</p>
Grievances	<p>Do residents feel they are safe to make a complaint and free from any reprisals or threats of eviction?</p> <p>Is the complaint treated confidentially and efficiently and is the complaints resolution process open and transparent?</p>

Appendix 5: Visit and Inspection Prompt (Day Options Programs)

The Community Visitor Scheme coordinates Community Visitors (CVs) to visit Day Options (DOPs) to inspect premises and consult with clients, staff and relevant others to ensure that individuals attending are receiving appropriate services.

The Visit and Inspection Prompt is designed to guide CVs through the visit and inspection process. The areas highlighted within this prompt are consistent with the 'Disability Services Standards'. The prompt should not be used as a 'step-by-step checklist' as this may hinder the CVs observations but should be read in conjunction with the 'Community Visitor Scheme Visit and Inspection Protocol'.

Prompts to Observe and note at Visits and Inspections of Disability Day Options Programs

Customer Service	<p>Assess the welcome to the facility and introductions to clients and staff.</p> <p>Are there personal and respectful interactions between staff and clients / CVs?</p> <p>Was prior notification of the visit provided to clients?</p>
Day Options Program Profile	<p>Do you have a theme or focus at your Day Options Program and if so what is it?</p> <p>What would you identify as the key challenges faced by your Day Options Program?</p> <p>What do you consider to be the opportunities and strengths provided by this Day Options Program?</p> <p>How many days a week does this program operate?</p> <p>How many clients attend? Does this vary on different days?</p> <p>Does your program have different themes on different days?</p> <p>What is the age range of your clients? Does this vary on different days? – i.e. some programs focus on particular age groups on particular days.</p> <p>Do you provide both on-site and off-site activities?</p> <p>Does your program have vacancies – or is there a waiting list?</p> <p>What is the cost per client to attend this Day Options program? Do all your clients receive funding to attend your program or are some self-funded?</p> <p>What is the staff ratio?</p> <p>How are clients transported to and from Day Options – and to other Day Options sites?</p>
Environment	<p>Comment on the general environment of the site.</p> <p>Is the size of the site suitable for its purpose? Can clients with wheelchairs or walkers move around easily and readily access all facilities?</p> <p>Is there appropriate heating and cooling?</p> <p>Are there any resources for activities e.g. board and electronic games, television, DVDs, 8 ball etc.?</p> <p>Is it clean and well maintained? Consider all inside areas as well as outside areas.</p> <p>Do all clients bring their own food and drinks or does the program provide this? Alternatively, do clients assist with meal preparation?</p>
Personal Support	<p>Of the clients attending, how many require full or partial assistance with toileting and changing? How many would require two (2) staff for personal assistance?</p> <p>Of the clients attending, how many would require full or partial assistance with drinks and food?</p> <p>What is your protocol for managing a client that becomes unwell during the day or wets and soils themselves?</p> <p>How is medication dispensing managed?</p>
Treatment and Care	<p>Do you have restrictive practices in place? If so, is there paperwork that outlines the need for identified restrictions? Are there any behaviour support plans in place?</p> <p>Do you have an incident reporting tool?</p> <p>Do you have a process in place to communicate back to family or house support staff about issues that arise?</p> <p>Is the program developed in consultation with clients and their families?</p>
Grievances	<p>Do you have a complaints process/procedure? Is the complaint treated confidentially and efficiently and is the complaints resolution process open and transparent?</p> <p>Are clients and their families provided with information about agencies that provide support and advocacy services?</p>

Appendix 6: Visit and Inspection Report (blank form)

- (D) = Disability CVS
 (MH) = Mental Health CVS
 (S) = Scheduled Visit
 (R) = Requested Visit
 (SRF) = Supported Residential Facility
 (DOP) = Day Options Programs

REPORT TYPE	
Select report type	
ABOUT THE SITE	
Service Provider	
Address	
ABOUT THE VISIT	
Date of Visit	
Time of Visit	
Details of any Senior Staff spoken to during the visit (Name and Position):	
ABOUT THE VISITOR(S)	
Community Visitor (writer)	
Community Visitor (contributor)	
Community Visitor (other) - Details of any other community visitors present during the visit	
REQUEST DETAILS	
(R) Client Name	
(R) Requester's Name (if different to the above):	
(R) Requester's Contact Details	
(R) Requester's Relationship to Client	
REQUESTED VISIT	
(R) Has the client contacted any other agency regarding their issues?	
(R) Other Agency Contacted	
(R) What were the presenting issue(s)?	
(R) What are the client's desired outcomes?	

ENVIRONMENT AND SERVICES	
Communication (5=Excellent – 1=Poor, Not Observed)	
Communication between staff and client	
Staff responsiveness to client needs	
(SRF) Site/staff relationship with external service providers	
(DOP) Communication between staff at site and disability accommodation	
Quality of Site (5=Excellent – 1=Poor, Not Observed)	
Standard of building facilities	
Standard of equipment within the facilities	
(DOP) Size, suitability and layout of facility for purpose	
Standard of facility grounds	
Appropriate emergency procedures	
Suitable privacy for clients	
(DOP) Provision of equipment within the facilities	
Quality of Services (5=Excellent – 1=Poor, Not Observed)	
Suitable client transport	
Smoking provision for clients	
Quality and choice of food	
Suitable activities available to clients	
Suitable entertainment provision for clients	
Access to Allied Health Services	
(DOP) Individualised activities based on the clients interest and skill level	
(DOP) Sufficient equipment, staffing and facilities to meet the personal hygiene needs of clients	
(DOP) Sufficient staffing to deliver care needs	
(DOP) Sufficient staffing to deliver meaningful activities	
(DOP) Appropriate time spent travelling to site	
Rights and Responsibilities (5=Excellent – 1=Poor, Not Observed)	
Client access to personal documentation	
Access to information regarding rights, complaints and advocacy	

Appropriate family/carer/representative involvement	
(D/MH) Adequate opportunity to access day leave/holidays	
(D) Attention to the independence and training needs of clients	
(D) Opportunity for clients to obtain and maintain suitable employment	
(SRF) Opportunity for clients to access external/community based activities	
(SRF) Attention to the independence needs of clients	
Rights	
Did any clients report not feeling safe in their surroundings?	
Did you observe the use of restrictive practice?	
If yes, did you enquire as to why restrictive practice was utilised?	
(D) (DOP) Was supporting documentation available on the restrictive practice, including a behavioural support plan?	
(SRF) Was a Visitor's Book clearly displayed?	
(SRF) Do residents have access to freely available drinking water?	
(DOP) Does each client have a Communications book?	
Additional comments regarding the rights of clients	
Individual Care Plans	
Do clients have individual care plans?	
How frequently are the plans reviewed?	
Is there evidence of clients participation and knowledge of their plans?	
(D/MH) Is there evidence of family/guardian involvement in development of the plans?	
(D/MH) Is there evidence of the plans being implemented?	
(D/MH/SRF) Do the plans appear to match the expectations and capacity of the clients?	
Additional comments regarding Individual Care Plans	
FINAL COMMENTS	
Please provide any additional comments regarding this visit	
Please outline any issues for CVS office attention	
Please provide a short overview of the visit that can be sent to the site	
Please confirm that both Community Visitors have agreed to the content of this report	

Appendix 7: Compliance with Premier and Cabinet Circular (PC013) on Annual Report Requirements

The following table provide CVS compliance with the Department of Premier and Cabinet Circular (PC013) on Annual Report Requirements.

PC013 Statutory Reporting Requirement	
Employment opportunity programs	Response included in the Department of Human Services Annual Report 2017-18
Agency performance management and development systems	Response included in the Department of Human Services Annual Report 2017-18
Work health, safety and return to work programs of the agency and their effectiveness	Response included in the Department of Human Services Annual Report 2017-18
Work health and safety and return to work performance	Response included in the Department of Human Services Annual Report 2017-18
Fraud detected in the agency	Number of instances - 0
Strategies implemented to control and prevent fraud	Budget and Finances of the CVS is managed by DHS. Requirement to comply with all departmental, Treasury and audit frameworks.
Whistleblowers' disclosure	Response included in the Department of Human Services Annual Report 2017-18
Executive employment in the agency	Response included in the Department of Human Services Annual Report 2017-18
Summary of complaints by subject (table)	Response included in the Department of Human Services Annual Report 2017-18
Complaint outcomes (table)	Response included in the Department of Human Services Annual Report 2017-18

