



The South Australian Community Visitor Scheme

Principal Community Visitor

ANNUAL REPORT

Disability Services 2018-19



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 2018-19 for presentation to Parliament.

This report provides an account of the work of the South Australian Community Visitor Scheme during the financial year ending 30 June 2019, in compliance with the Act and the Department of Premier and Cabinet Circular (PCO13) on Annual Reporting Requirements.

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.

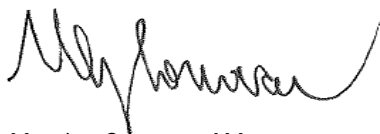
We have again met many individuals with disabilities who live with the burden of expectation of their lifestyle, goals, care and potential. This is a result of their past experiences and limitations placed on them by those who supported or cared for them. This 'burden of low expectations', in most cases, 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.

Lastly, as stated at our last meeting, I need to report that there is a great deal of concern and disappointment about the reduction in scope of the CVS where we no longer visit NGO run disability accommodation services and Supported Residential Facilities (SRFs). There was overwhelming support across the sector for the CVS to continue, especially given that all other states who had visitor schemes, found a way to enable them to continue.

I look forward to the CVS's expanded role in visiting all the clients who are under the guardianship of the Public Advocate, as this is a great opportunity for collaboration between the CVS and the Office of the Public Advocate.

Yours sincerely

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

Maurice Corcoran AM

13 September 2019

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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 2018-19 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 (CVs) and staff.

As you will see within 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, valuable commentary has been extracted on what is working well and what needs to be improved. The services we have visited were using this feedback in a range of ways to improve quality and continuous improvement strategies and many have expressed their appreciation for this independent scrutiny.

Given that my resignation takes effect on 13 September 2019, this is my final annual report as the Principal Community Visitor. It has been a great honour and privilege to serve in this position over the past 8 ½ years, since July 2011. I have stated many times over the years how much I loved this role. It has had the perfect match of roles that I enjoy, such as building and maintaining high performing, loyal teams who have a shared passion of human rights protections for vulnerable people. Being able to monitor, report, advocate and speak out on individual and systemic injustices or unfair or unreasonable treatment of people with disabilities including those with a mental illness, has indeed been an amazing role to play with a great team of exceptional Community Visitors.

We have been able to do this collectively and celebrate our achievements and changes made for the better through our many visit reports that are relayed back to services for a response and service improvements. The culmination of all our visit reports and related work is compiled into our Annual Reports to Parliament which have included the matters that have not been addressed or resolved.

It is with great concern that these interactions with individuals will significantly decrease in the future year(s) due to a reduction in scope as directed by the department (DHS) and based on advice they sought from Crown Law office. In essence, this means the CVS can no longer provide our services to individuals and families within Non-Government Organisations (NGOs) and Supported Residential Facilities (SRFs) as individuals are funded via the National Disability Insurance Scheme (NDIS). The safeguards for these clients are now through the NDIS Quality and Safeguards Commission (NDIS QSC) who have a range of quality checks such as audits, registration and complaints handling and will visit these individuals and/or facilities if concerns are raised through a combination of these checks.

Previously, one of the biggest NGOs made sure that a sub-committee of their Board of management received and considered all of the CVS visit reports and then discussed responses and strategies to address any issues raised in the reports. The PCV also met with this committee on occasion 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 scrutiny such as:

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

This NGO also decided that they wanted all their disability visits to be unannounced, so although we let them know when we were doing visits to their sites, they had made a decision not to inform the staff and residents. The CVS believes this was a very positive move and one that continued to demonstrate openness and honesty by saying 'come at any time and observe what we are doing' without any pretences and preparation.

When it became apparent that there had been no legislative amendments or Regulations drafted under the SA Disability Inclusion Act by DHS, this same NGO suggested that the CVS and their Board and Chief Executive co-design a 'Visitation Agreement' to enable the CVS to continue with visits. However, when this draft agreement was presented to DHS they responded with further advice that the NGO had no legal authority to grant 'Right of entry' to the CVS, and that this could be only given by individual residents themselves. Further, that due to these visits now being outside of CVS scope, our volunteer visitors would no longer be covered by state government insurance.

I believe it is important to place on the record that all other States that have visitor schemes in place, found either a legislative or regulatory remedy to enable their schemes to continue to visit their respective NGOs and SRFs. It's not just the SA CVS and NGOs who wanted the scheme to continue.

DHS and the Minister have stated that they do not want to rush into a policy response and that they believe there needs to be a national response that is consistent with the new arrangements under the funding and the NDIS implementation being completed.

Key to this, is the national review of visitor schemes and the associated report which highlighted that a number of visitor schemes have been in place in various States and Territories and that they operate under different legislation, have various models, and quite different reporting requirements. For instance, in Victoria they are incorporated into the Office of the Public Advocate, in Queensland they are in the Office of the Public Guardian and in NSW, they are administered within the Ageing and Disability Commission that has been established. They are also within larger visitation schemes that visit clients within mental health facilities, children in secure care and/or foster care and adults in Corrections facilities.

Therefore, it's not feasible to say this is how we will implement a new visitor model within an NDIS disability environment which is why the PCV believes these various schemes should be continued by the respective States and Territories within the context and legislation that gives them authority. Although our current model of the Community Visitor Scheme has only been in place since July 2011, many of the visitor schemes were first initiated over a hundred and fifty years ago in various forms including South Australia's, where 'appointed Visitor' records to the old asylums go back 172 years.

Comprehensive research into the first mental health asylums in South Australia by Susan Piddock, (Department of Archaeology, Flinders University, Adelaide, South Australia "The history of lunatic asylums" 2007) identified some of the earliest records and reports of 'appointed visitors' back in 1847. "A report of 1856 indicates that the first asylum had only five rooms but does not indicate their purposes (Bostock 1968: 154). It seems likely that these were primarily used by the inmates (sic) as the Visitors, who had been appointed in March 1847 to inspect the asylum, had noted the absence of accommodation for the keeper and his family (S.A. Visitors report 14/9/1847)". Another significant appointment was Mary Lee (Suffragette, Secretary and Leader of Women's Suffrage League of SA 1888-1895) who was appointed as the first female official Visitor to the Lunatic Asylums in 1896 and served in that role until 1908.

There has also been a range of important national reviews and members of our state parliament also saw the value in the continuation of the CVS. While I realise that many of the statements below were in last year's annual report, they remain relevant in this term and I believe are at odds with the changes to the scheme, such as:

Senate Standing Committee on Community affairs into 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)

"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)

Hansard SA Legislative Council 27 September 2017

1.2 Highlights and achievements

The CVS has continued to establish and maintain strong working relationships with service managers across the disability and SRF sectors through regular correspondence and 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 has continued to be strong.

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.

The PCV has also continued to meet with staff from NDIS Quality and Safeguards Commission, such as Tim Baker, Miranda Bruynik and Louise Butler. We have worked collaboratively with them to clarify protocols for referring matters to them. At the time of writing this report, a number of outstanding matters relating to NGOs and SRFs were referred to them for follow up and anticipated resolution. These matters were unable to be resolved by the CVS since the reduction in scope and therefore we can no longer provide an advocacy service for individuals and families within NGOs.

Prior to this change, the CVS continued to undertake unannounced visits to facilities where concerns had been raised, either through scheduled visits or by requests to visit by the department, family, friend or others. For these visits we drew on the skills of CVs who have backgrounds and professional qualifications in investigative processes and interviewing techniques.

Identifying, tracking and resolving issues on behalf of individuals continued as a positive highlight for our team both in the office and including our CVs. One hundred and seventy-four (174) reports highlighted a varying number of points of concern/issues which were all followed up with disability service providers and SRF proprietors. At the end of this reporting period, 160 (92%) had been resolved/completed.

During the 2018-19 financial year the total number of disability visits conducted was 580 representing a 7% decrease over the previous reporting period. This small decrease is testament to the continuing hard work of CVS staff and volunteers during times of staff shortages and changes in scope to the work of the CVS in the last two months of this period.

1.3 Recognition of Community Visitors

A highlight this year was receiving the news that our nomination for 'The Premier's Certificate of Recognition for Outstanding Volunteer Service' had been successful. The Premier's Certificate of Recognition acknowledges accomplishments, reinforces shared goals and is a sign of appreciation for volunteers across South Australia. It also assists us to highlight the great work that our volunteers do day in, day out.

Selection for the certificates is based on volunteers meeting one or more of the following criteria:

- » made significant contribution to the community and/or organisation
- » provided ongoing commitment and dedication to volunteering
- » demonstrated leadership in their volunteer role
- » promoted volunteerism within the community.

I was extremely proud to receive this Certificate on behalf of our team of dedicated Community Visitors, and as I said to our Community Visitors, the Award is for them collectively and individually. It was just unfortunate that we received this award at about the same time that our scope was reduced and having our funding for the disability CVS cut by almost \$200,000 in the State budget.

More details on our Community Visitors is provided later in section 6 - Workforce.

1.4 Quality control and safeguarding - a continuing role for the CVS

The CVS considers that important questions remain with regard to quality and safeguarding mechanisms within the NGO Disability Accommodation, SRF and Day Options sectors under the NDIS. For the time being, the CVS will continue visitation and inspections to government run disability accommodation.

The *NDIS Quality and Safeguards Commission* was established in 2018 to implement the *NDIS Quality and Safeguarding Framework*. NGOs and SRFs are subject to the NDIS Quality and Safeguards Commission (NDIS QSC) which have a range of quality checks such as audits, registration and complaints handling and will visit these individuals and/or facilities if concerns are raised through a combination of these checks.

As highlighted in section 1.1 there was great support for the maintenance of independent observers such as the CVS as 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 welcomed 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 was pleased to receive an embargoed copy of the report. Due to confidentiality conditions of the embargoed report, the PCV unfortunately cannot highlight the findings and recommendations but is hopeful that it will be released in the near future

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 (Appendix 1)* and the *Mental Health Act 2009 (Appendix 2)*.

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

The CVS continued to receive positive feedback from the organisations and sites that we visited, 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 Visitors 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.....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.

As previously mentioned, when the CVS realised that there was no intent to amend legislation or develop Regulations under the *Disability Inclusion Act 2018*, we discussed the option to prepare individual Visitation Agreements between a few NGOs and the CVS. This was very positive and an initiative we thought we should canvass with other NGOs.

We also enlisted the services of Professor Richard Bruggemann to make contact with all the other NGOs as I thought it better that these approaches or discussions would be better from an independent person and that the agencies could feel less obligated to say yes to an agreement to someone outside of the CVS. Richard's 'standing' as an 'elder statesman' and absolute legend in the disability sector for his lifetime commitment and passion for improving the lives of people with a disability is unquestionable.

After a few days I received a brief update from Richard which stated:

"Hi Maurice, I am well into my consultation with providers about the concept of Community Visitors continuing their visits through the establishment of Visitation Agreements. To date, I have spoken to over 30 organisations. The unanimous response is that they want visits to continue. They see it both as a very valuable safeguard as well as a source of information on things they can improve. Some of the comments have been:

- We hear things about our service that we didn't know about. It really gives us good information to improve what we do.*
- We get told both the good and the bad. It's always nice to hear the former but knowing what can be improved is even more important.*
- Visitors are always fair.*
- I would hate to see this programme fold up.*

Best wishes, Richard"

This was such a reassuring independent consultation that confirmed the value of what the SA CVS does, and I felt extremely proud of the service we had collectively developed and the strong working relationships built across the sector. However, within days we had to get Richard to re-contact all the CEOs of the NGOs to say we could not move forward with ongoing visits following advice we had received. This was a very emotional and sad time for all involved, especially Richard, plus the many CEOs and later the families who had loved ones in care. Many of our CVs including the PCV felt a deep sense of abandonment of the 2,200 residents in NGOs and SRFs that we can, at this stage, no longer provide a safeguarding and advocacy service to.

However, there has been considerable work being undertaken by the DHS and the Attorney-General's to enable the CVS to visit over 600 clients who are under the guardianship of our Public Advocate, Anne Gale. The Office of the Public Advocate is guardian of last resort to this cohort and many of these individuals live in SRFs and NGOs as well as government-run accommodation services.

This will be a great opportunity for the CVS to visit these very vulnerable people and to be able to report back on these individuals to the Public Advocate. Delegation powers of the Public Advocate have been drafted but there will need to be more detailed Memorandum of Understanding (MOUs) to identify the processes and protocols required and scope of this work, but we are very much looking forward to this new opportunity.

2. Functions of the Community Visitor Scheme

2.1 The purpose & objectives of the CVS

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.

As of mid-May 2019, the purpose and objectives of the CVS remain as noted above but only for Government-run disability accommodation.

As previously mentioned, it is with great concern that visitation and inspection to NGO disability accommodation, SRFs and day options programs will no longer occur due to DHS confirming that CVS Regulations under the *Disability Services Act 1993 (DSA)* no longer enable us to provide this service, as individuals in these facilities are funded via the National Disability Insurance Scheme (NDIS). They will in future be subject to the NDIS Quality and Safeguards Commission (NDIS QSC) who have a range of quality checks such as audits, registration and complaints handling and will visit these individuals and/or facilities if concerns are raised through a combination of these checks.

The DSA was a funding Act but there were also the coercive powers of unannounced visits and right of entry that were in the Provider Panel funding agreements between the State and NGOs and these are no longer in place.

The government, Attorney General's Department and DHS are exploring possible options for the CVS to visit people under guardianship of the Public Advocate. However, this is at a relatively early stage of exploring a means for the Public Advocate to delegate powers to the CVS to visit clients under guardianship. The Public Advocate is guardian for around 640 clients in a range of facilities inclusive of SRFs and both NGOs and government-run facilities.

2.2 Conducting monthly visits and inspections

The CVS continued to ensure that regional visits were undertaken to 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 number of sites visited in each region:

NDIS regions	Number of Visits to sites	Sites visited in each region
Eyre Western	10	9
Limestone Coast	12	11
Murray and Mallee	20	18
Yorke and Mid North	7	7
Barossa Light and Lower North	4	3
Fleurieu and Kangaroo Island	7	7
Total	60	55

Figure 2.2.1 visits by regional areas and number of sites visited

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

During 2018-19, the CVS undertook 580 visits as summarised below:

- 493 visits to Disability Supported Accommodation
- 31 visits to Supported Residential Facilities (SRFs), and
- 56 visits to Day Options Programs.

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

Total visits

	2016-17 Total	2017-2018 Total	2018-2019 Total
Disability	453	503	493
Supported Residential Facilities	41	29	31
Day Options Programs	89	93	56
Totals	583	625	580
	39% increase	7% increase	7% decrease

Figure 2.2.2 number of visits conducted annually over the past three (3) reporting periods

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 31 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 sheets (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 give focus to the reporting of visits.

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

Where possible at the time of the visit, 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 has continued 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

The recruitment and retention of CVs remains an ongoing challenge and a regular highlight. I remain impressed by the calibre of our CVs. Whilst there are no formal qualifications required for the role, applicants must be:

- » over 18 years of age
- » not working full-time
- » willing to undergo DHS screening, such as disability and child-related screening
- » able to access a computer and mobile phone.

and demonstrate:

- » good communication skills
- » a desire to help individuals through advocacy
- » dedication to improving services.

People with lived experience and from culturally and linguistically diverse backgrounds and Aboriginal heritage are encouraged to apply.

Suitable applicants undertake a comprehensive training program including orientation visits to facilities to gain the relevant knowledge and understanding to effectively undertake the role.

The CVs have impressive and diverse backgrounds and skills as well as passion.

It is pleasing that in addition to helping the CVS achieve their monthly visits, the CVs themselves have gained value from the role. This was articulated perfectly in the email below which was received from one of our CVs who sadly has decided not to seek reappointment, due to personal reasons:

"Today I undertook my last visit of my 3 year appointment. I want to acknowledge it has been an absolute privilege to be a part of this scheme. I have partnered with some of the most diverse, talented and committed people I have ever met and been supported by a team that goes so much more beyond professional. That is a given, however the collaboration and accessibility has made the role not just an experience but has validated the worth of the scheme and its objectives.

I hope to have contributed in some small way and have always been encouraged by seeing, sometimes very small but practical outcomes for clients and occasionally being a part of hopefully addressing much larger systemic issues.

I wish you all the very best for the future and hope there will be an outcome more appropriate in the role of CVS into the Disability NGO areas."

More details on the recruitment and training of CVs can be found in section 6 – Workforce.

2.4 Advocacy

2.4.1 Advocacy on behalf of individuals

A key element of the Community Visitors' role is to provide support and advocacy in referring matters of concern arising 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 is 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 clients:

Example 1

The DHS Feedback and Incident Review (FAIR) team had received a complaint regarding care concerns and possible neglect in an NGO group home. The FAIR team asked CVS to conduct an unannounced visit to the premises where the following concerns were observed by the PCV and another experienced Community Visitor:

- » resident concerned about how his finances were being managed
- » need for an equipment register inclusive of maintenance costs for equipment and OT assessment
- » referral for a shower chair for a resident
- » management of pressure sores for one resident
- » referral to dietitian still pending
- » issues with a sling to move a resident from his bed into his chair
- » NDIS pre-planning to be completed.

Follow-up and information was received by the PCV addressing the above issues, from the Customer Care Manager of the service provider. The PCV reviewed the information and made further suggestions for improvements to Care Plans. The FAIR team was provided with all documentation and considered appropriate actions had been undertaken by the agency to address the matters of concern. This is a good example where the CVS has been able to complement the work of another government department to produce positive results for improvements in care for residents.

Example 2

A resident at Highgate Park contacted the PCV with concerns that agency staff were being used to care for her and that she felt this was placing her at risk. The resident is totally dependent on staff for all personal care and has complex communication challenges, so having new staff who don't know her well, and cannot communicate with her, places her at risk. The PCV wrote to the Director, Accommodation Services outlining the importance of having trained staff who are aware of her physical and communication needs, providing care. The PCV received a response from the Director, Accommodation Services who indicated that there was an established process in place to ensure the resident has regular staff allocated to support her. However, due to rapid changes taking part at Highgate Park, this had been difficult to maintain. There was an assurance that the resident would be moving shortly to community accommodation, and that the resident would be involved in the selection of staff to ensure she receives the support she needs provided by staff she wants. This provided the resident with a sense of security and safety.

Example 3

Upon completion of a visit and inspection to an NGO service provider disability home, the Community Visitors' reported concerns relating to the number of medications one of the residents were taking. The Disability Coordinator discussed this concern with the PCV and wrote to the doctor at the Centre for Disability Health, including the medication list, for an opinion. The doctor responded to the PCV suggesting a review of the resident's medications should be undertaken. The Disability Coordinator wrote to the service provider informing them of this, requesting to be informed once the review had been completed. The service provider wrote back confirming that the resident had attended a GP appointment where her medications had been reviewed. The outcome was that her medication was changed and a follow-up appointment had been made with the Diabetes

Educator. The CVS was further informed that the resident's diabetes management had been much improved since this appointment.

This is not an isolated case where medications have not been reviewed for a long time, in some instances, not for many years. For some residents, having their medications reviewed has resulted in them being able to stop taking some medications altogether, while for others, medications have been decreased. In all cases, this has resulted in improved health, both physically and mentally, for those clients.

Example 4

The SRF Health Assessment Team (SRF HAT) contacted CVS expressing concern that the proprietor of an SRF is extremely defensive and reluctant to have assessments undertaken or tests performed for a resident who recently turned 65 years of age. The resident was reported as having significant cognitive impairment, no guardian, is quite wealthy and about to receive a rather large inheritance. It was further reported the resident is the 'interested party' for his elderly Mum who resides in supported accommodation nearby. He has deteriorating functioning and cognitive capacity, speaks another language as his first language and urgently needs to have an ACAT assessment (amongst other tests) to assist in planning for his future needs. Furthermore, the resident was not eligible for the NDIS last year (when 64 years of age) due to having no formal diagnosis and was not able to access aged care assistance as no ACAT assessment to date has been undertaken. Finally, it was reported to CVS that SRF management had informally taken over the management of the resident's personal and financial affairs. Apart from receiving assistance with personal care for 2hrs/week and 1hr/week to visit family (funded and arranged by the ENU), the resident does not receive any other assistance and/or undertake any other outings.

Upon receiving this information, and evidence of alleged misappropriations, the Coordinator arranged a visit to the SRF where the CVS were requested to look into this situation further. CVS also supported the SRF HAT by contacting the SA Civil Administrative Tribunal (SACAT) and requested urgency be placed on an interim order lodged for the OPA to have administration and guardianship rights. Within 24 hours of this request being lodged, an interim order was placed and within days of this occurring, it was reported the resident was moving into a suitable Residential Care Facility near his family.

Example 5

Upon completion of a visit and inspection to a SRF, the Community Visitors identified a resident who had been released on bail and was awaiting resolution to a number of offences he was charged with in December 2017. The resident, although living in Australia for many years is an Iraqi national who has limited English skills, is socially isolated and living with schizophrenia. Before being released on bail he was held at James Nash House for assessment and is currently under the guardianship of the Public Trustee. There was a need to assess his current level of care and welfare.

Follow up occurred by the PCV who wrote to all key staff involved in the resident's care and support to ensure that he was given opportunity to link back to his culture and people. Through doing this it was found that he was having his medication reviewed in the hope of reducing/eliminating the tremors and side-effects of drooling which may be effecting his motivation to interact with others. His community mental health workers also confirmed that they had met with him on at least 3 occasions and had used the interpreting services to ensure a reasonable level of communication was possible. They further confirmed that they were going to encourage him to make connections with the Iraqi community in Adelaide which they did and this led to a connection with his direct family who had been trying to locate him for years.

2.4.2 Systemic 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:

Support for disability clients whilst in hospital

It has been reported to the CVS by service providers and by family members of disability clients, that there have been instances of inadequate support for disability clients whilst in hospital. Service providers are not always able to supply support staff to accompany disability clients to hospital and provide bedside care. The CVS has been liaising with Local Health Networks to work towards a consistent approach to this issue.

CALHN developed the "Carers policy for disability SA patients" effective from July 2016, which "...is to clearly outline appropriate processes to ensure that optimum care is provided to Disability SA patients through collaboration between Carers, CALHN Registered Nurses, patients and all other relevant stakeholders". The policy provides a clear process for negotiating the funding of carers with DSA, whilst disability clients remain a patient of the hospital.

The PCV wrote to the CEO's of SALHN, NALHN and CHSALHN asking whether similar policies existed in their Local Health Networks, and if not, to consider developing a similar policy:

- » SALHN confirmed their Nursing Information System Team are reviewing the policy developed by CALHN and will begin the development of a policy for SALHN.
- » NALHN acknowledged the development of a specific Carer's policy would be relevant and undertook to provide a copy when endorsed through their policy governance processes.
- » CHSALHN advised they do not have a direct policy such as the CALHN procedure but they are represented on the SA Health Partnering with Consumers and the Community Advisory Group which has developed the SA Health Partnering with Carers Strategic Action Plan 2017-2020 to recognise and empower better carer engagement in health care decisions. Country Health SA reported they are working with SA Health to develop a consistent approach with carers to be applied across all acute facilities. CHSALHN gave an ongoing commitment to ensure that any person with a disability admitted to a country hospital is provided with the necessary and appropriate support, including making clear the roles between health providers and the patient's carer(s) during any hospital admission.

Previously, Disability SA had negotiated with carers and agreed to cover the costs of them staying at health facilities, however the NDIS does not have a policy for this eventuality. Unless there is clear policy direction from the NDIS, the care of people with disability during hospital stays could be less than optimum.

Continuation of specialist services

The CVS has continued to liaise with relevant government departments on the importance of retaining specialist services such as the Centre for Disability Health, the DHS Exceptional Needs Unit, and ASSIST Therapy Services.

The Centre for Disability Health underwent a review in July 2018 recommending that it remain. In a press release, Minister Wade said a locum psychiatrist is now in place, after the former specialist retired in September 2018. Minister Wade also wants the unit to offer services to clients beyond the north-eastern suburbs. Minister Wade said "My understanding is that the centre will actually expand over time. These psychiatric services are being recruited now to evolve into the new models of care."

The NDIS continues to impact on services previously run by Disability SA. ASSIST Therapy Services transferred to Minda ASSIST in November 2018 and in February 2019, the Exceptional Needs Unit changed reporting lines from Disability Community Services to the DHS division of Community Services.

The CVS understands that the DHS commissioned the Public Sector Innovation Lab to consider how future services will be provided for people with exceptional needs in the new National Disability Insurance Scheme (NDIS) environment, ensuring no client is left behind. The Lab found a need for complex clients, who are not eligible for the NDIS, to continue to be supported in the short to medium term. It also recommended a new service model be created, focussing on system management, risk mitigation and control, sector capability and capacity building.

At the time of writing this report, the CVS was informed by a number of sources that the impact of losing 'case-management' for many clients with complex needs is resulting in poor coordination between the multiple services who are involved and people are becoming 'stuck'. This comes at an enormous cost to the individuals themselves but also to the state in a number of instances where they spent several months in hospitals.

We have also lost the position of Senior Practitioner, that Professor Richard Bruggemann held and did an outstanding job with very limited resources and somehow managed to do this on a part-time basis. As many of you would know, Richard is an absolute legend in the disability sector and is recognised nationally as a leader in the intellectual disability field and is passionate about the rights and choices of people with disabilities and the need to remove all restrictive practices that impair individuals reaching their full potential. Richard has been so willing to share his knowledge and educate others about the Rights and freedoms of people with a disability, he has facilitated training modules for all our new CVs and he literally empowers them to go out and monitor,

enquire and report on any form of restrictive practice.

It was most disappointing to lose this position but especially Richard who was so committed to the role especially when we consider that other states have kept there Senior Practitioners.

As the PCV, I must express serious concerns that the State seems to be withdrawing from many specialized services on an assumption that this is all lumped into the NDIS and now the Commonwealth's responsibility. I would argue that the NDIS is just about a personal support package that enables individuals to reach their full potential but the State has a responsibility to ensure a whole of government, whole of life response to make sure people have access and inclusion to all mainstream services. Under the United Nations Convention on the Rights of Persons with Disabilities (UNCPRWD) and Australia's National Disability Strategy 2010-2020 (NDS), the State Government has clear requirements to take positive steps to ensure compliance.

South Australia signed up to the NDS in May 2011 under the auspices of the Council of Australian Governments (COAG) and to a shared vision for **an inclusive Australian society that enables people with disability to fulfil their potential as equal citizens.**

The Strategy covers six policy areas:

- ***Inclusive and accessible communities***—the physical environment including public transport; parks, buildings and housing; digital information and communications technologies; civic life including social, sporting, recreational and cultural life.
- ***Rights protection, justice and legislation***—statutory protections such as anti-discrimination measures, complaints mechanisms, advocacy, the electoral and justice systems.
- ***Economic security***—jobs, business opportunities, financial independence, adequate income support for those not able to work, and housing.
- ***Personal and community support***—inclusion and participation in the community, person-centred care and support provided by specialist disability services and mainstream services; informal care and support.
- ***Learning and skills***—early childhood education and care, schools, further education, vocational education; transitions from education to employment; life-long learning.
- ***Health and wellbeing***—health services, health promotion and the interaction between health and disability systems; wellbeing and enjoyment of life.

While it is acknowledged that the state government has been developing the *Disability Inclusion Act 2018* and consulting on this, I am aware that DHS has made a significant reduction in staff who are focussed on disability policy and the implementation, monitoring and reporting against these policy areas.

Accommodation and support for clients with complex and challenging behaviours

The CVS visited disability clients with complex behaviours contained in what can best be described as fortress style accommodation, in one instance the PCV asked the Senior Practitioner to accompany him to a visit as a means to obtain advice on the balance between duty of care, dignity of risk and restrictive practices. In one of these visits where there was just one client with two staff, we observed that all the windows were boarded up with the exception of one heavy duty Perspex window, virtually no furniture and a mattress on the floor in his bedroom. We also found that at the time, the majority of staff did not have specific training relating to a behaviour support plan nor de-escalation training. They were instructed by management to lock themselves into the office if the client's behaviour became too threatening to them.

There are questions to be answered as to whether this style of accommodation delivers meaningful support and care, and provides value for money. Community Visitor reports to the PCV have indicated that at times, complex needs clients requiring respite, have come into a home which has been very disruptive to other residents.

Under the NDIA, Specialist Disability Accommodation (SDA) is eligible for payment to clients with 'extreme' functional impairment or very high support needs. There are four (4) main design categories for SDA – improved access; fully accessible; high physical support, and robust. Robust SDA must include retreat areas for clients and staff, and the materials used must be impact resistant and reduce the need for repairs and maintenance.

The NDIS itself predicts that only 6% of participants will qualify for SDA.¹

To assist in the management of behaviours of concern, the NDIS funds specialist behaviour support from registered behaviour support providers. Specialist behaviour support providers undertake functional behaviour assessments, and develop a behaviour support plan for the participant.

It is hoped that these initiatives from the NDIA and NDIS, result in improved quality of life for those clients with complex behaviours and their carers. The CVS will look forward with keen interest to seeing the development of a best model of care for this client group.

The challenge for all involved in providing services to people with disability, is to consistently reflect on how continued NDIS reforms shape service delivery models, and how this impacts on those that matter most – people with disability, their families and carers.

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, DHS, the Minister's delegate or to the Minister. Referral of any future matters of concern brought to the attention of CVS, relating to NGO and SRF services has been referred to the NDIS Quality and Safeguards Commission.

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 (HCSCC). The CVS has also referred a number of issues to the Feedback and Incident Review (FAIR) team within DHS and consulted with the team to obtain 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, 174 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, 160 of the issues raised in the reports had been resolved or completed. Fourteen (14) systemic or emerging issues have since been handed over to the NDIS Quality and Safeguards Commission.

These are:

- » the amount of increase in rent by landlords since NDIS packages have been available to clients
- » clarity needed about when service providers should report restrictive practices to the Commission ie should the impact of the restrictive practice on other residents form part of the reporting process?
- » service providers using rooms in houses for their own office and for their own storage eg taking up space in the resident(s) garage and their contribution to utilities accounts
- » inadequate provision of equipment
- » instances where 3 or 4 residents sharing of bedrooms which results in privacy issues
- » the installation and use of security cameras in SRFs
- » the provision of meals ('line-up'/'batches' style of serving and timing)
- » potential of coercion when some SRF proprietors are too involved
- » support coordination and plan management in NDIS plans
- » the unintended consequence in expansion of SRFs
- » withdrawal of council programs and reduction of external services into SRFs
- » early discharge from hospital and the lack of support at home

¹ "The top 10 things to know about SDA". (2018) Victorian Advocacy League for Individuals with Disability

- » restrictive practices being utilised on Day Options client(s)
- » travel time to and from Day Options Programs.

2.6 Influence plans, policy and practice development

A significant and important role the CVS performs is its contribution to planning, policy, strategy, reviews and investigations at both a commonwealth and state level. In addition, the CVS has an important role to play to ensure policy and clinical practice development is influenced by the experience of people with disability and their relative, guardian, carer, friend or supporter.

The PCV has been invited to attend committees and discussion panels and has been asked to contribute to an array of reviews, investigations, reports and discussion papers. Examples include:

- » Disability Inclusion Bill
- » ICAC Recommendations Implementation Working group
- » Inclusive Play Workgroup
- » Intensive Monitoring and Inpatient Rehabilitation Governance Steering Committee
- » Meetings with CE DHS, ED Disability and Reform Services, ED Accommodation Services, Director Accommodation Services
- » Minda Human Rights Committee and Social Justice Committee
- » National Review of Community Visitor Schemes – Westwood Spice
- » NDIS Quality and Safeguard Commission meetings
- » NDIS Stakeholder Forum - Key Influencers and Industry Group
- » Reducing the use of chemical restraint within Disability Services
- » Regular meetings with other Statutory officers such as the Public Advocate, Chief Psychiatrist, Mental Health Commissioner and Health and Community Services Complaints Commissioner
- » Review of Mental Health Governance
- » Review of SA Community Visitor Scheme – Julian Gardner
- » Royal Commission into Aged Care Quality and Safety
- » SA representative on the Independent Advisory Committee of the National Disability Insurance Agency
- » SA Ambulance Services – Community Advisory Committee
- » SA NDIS Psychosocial Disability Transition Taskforce
- » Senate inquiry interim report – “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.”
- » Statutory Authorities Group and Rights Protection Agencies meeting
- » Workshop for Royal Commission into Violence, Abuse, Neglect and Exploitation of people with Disabilities

3. Disability accommodation outcomes and themes

3.1 Visits and data

Community Visitors continue to complete reports and send to the PCV after each visit.

Reports provide a focus on five (5) main categories:

- » communication – resident and staff interaction/respectful communication
- » environment – suitability of facilities, grounds 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 ratings and a summary 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 374 **positive comments** noted in reports relating to **communication** and **staff responsiveness** to clients. Some extract examples are as follows:

A relaxed, informal and respectful pattern of communication was observed throughout our visit.

The close rapport between the staff present at our visit and the three clients is an exceptional example of a positive and supportive environment.

There is a group of staff who have known some of these clients for many years and all efforts are made to ensure that the support team, even temps, are familiar faces. Relations seems positive, professional and caring.

Resident is very capable of communicating his needs. As a result, the staff are very forthcoming in responding to his requirements. Resident is provided with active supervision during the day and passive night time supervision. YourKids provides transportation to and from his grandmother's where he spends his weekends.

All clients have a call pendant that alerts staff that they are needed. When tested, two staff promptly arrived at the house ready to respond.

Although the clients are non-verbal, the staff are able to understand the clients' needs (ie going to the toilet). Four of the clients have vision and hearing impaired, extra attention is given by the staff.

While the number of **issues** highlighted in visit reports were low at 21, some examples of issues include:

Some residents have communication difficulties. Resident uses an iPad to type but it is difficult for her to control and time-consuming. PCV suggested eye-gaze device, laptop and NDIS funding for OT assessment mentioned in last report. PCV encouraged resident to try eye-gaze device by giving examples of where it had worked well.

There are monthly meetings with clients and staff. Every month the progress of previous decisions are evaluated. However, the previous Decision Facilitator who did a good job is not coming any more. An alternative arrangement would be good.

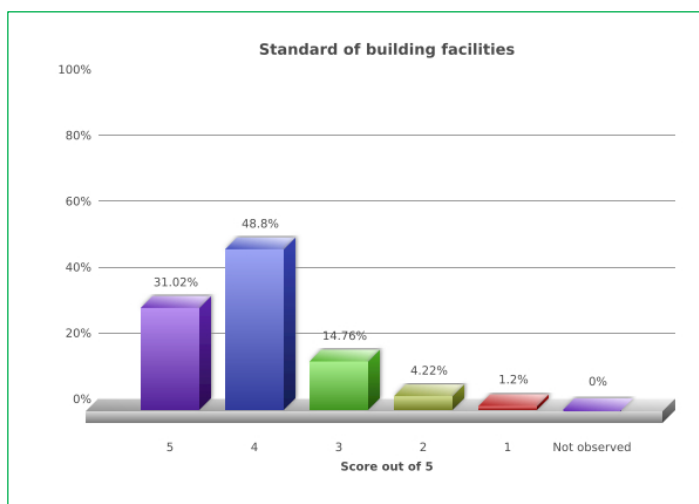
Staff get frustrated when things take too long to get fixed for the residents - the lifters/rails took 8 months (manual lifters were used). OT is needed to look at client's wheelchair as she looks uncomfortable - OT can take a long time to visit.

Two residents do not work and are at home a lot. The staffing ratio makes it hard for individual activities except if the other client is out at day options. Similar limitations seem to apply at weekends; all engage or none can enjoy activities. Given the relatively complex issues that one resident is living with, it was not clear to CVs that she in particular had enough support and stimulation to live the best life she can with this staffing ratio.

In summary, CVs rated their observations of the communication and interaction between staff and clients as being high with only 3% not receiving a satisfactory rating. This is extremely pleasing, given that it is without doubt a key indicator underpinning quality care and support provision.

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. The standard of accommodation impacts on the satisfaction of residents and staff.



The housing stock that provides accommodation for those with a disability were rated on average as being very good and meeting the needs of the client group.

Visit reports contained 108 **positive comments** in relation to the **standard of accommodation** as exemplified below:

Beautiful house - brand new, very clean, more personalised this time. Purpose built housing.

Both homes are very well decorated and personalised with photographic images of residents and their families decorating the walls.

Both houses had lovely big back yards with privacy gates, they were quite old houses but suitable for both clients.

Clean, brightly decorated dwelling with seemingly suitable railings, ramps and support equipment provided for the Client. No adverse comments were made to us during the time of our visit.

However, there are examples of houses that remain unsuitable or require significant investment to upgrade. It appears that in many of these situations, there are delays due to unclear responsibilities between the landlord,

the service provider and the resident. This has been further impacted by NDIS when trying to ascertain what should be paid for by the landlord, and what should be included in the resident's plan eg if a ramp is needed for the resident to access outside, who is responsible for this?

There were 33 **issues** of concern raised that required follow up by the CVS, examples as follows:

While the building facilities do accommodate the needs of these individuals, Highgate is a large institutional-type building that is more like a hospital. There have been some improvements as a result of our advocacy, but it has been a very long stay and the new house build has not even commenced which is so frustrating for residents who were initially told it would take 12 months. And who could blame them!

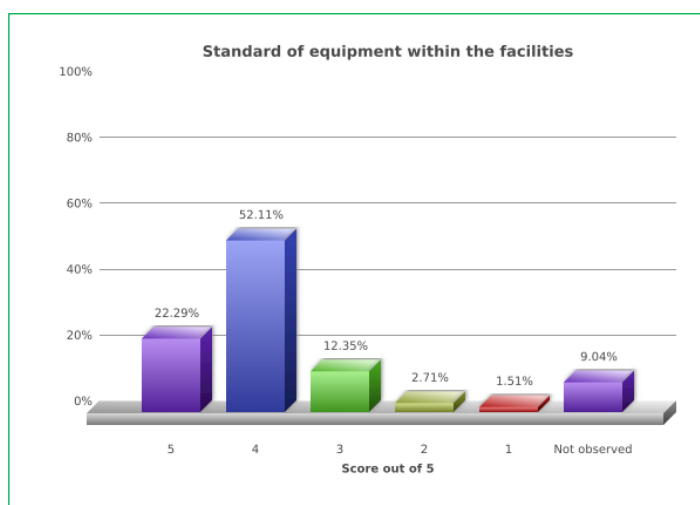
According to the staff, no action has been taken for the unsafe balcony on upstairs yet as they do not know the landlord's opinion on this and they are going to contact CVS office to follow up this problem.

Broken rail in bathroom has been repaired as have the doors which were damaged by a client, and some of the cracks in the walls. One room has just been repainted ready for a new resident. When asked about the wall which still is deeply cracked, staff said that the builder who inspected it said that it is not structural, and so will not need repair.

Home has been refurbished to meet client's needs, but there are some areas where the client's wheelchair cannot access, or access is difficult.

Inside needs updating - bad flooring and walls needs to be repainted - very old home but large rooms. Doorways are narrow for wheelchairs, resulting in many gouges.

Most properties are in need of upgrades of some type but the landlord, the Salvation Army, is slow to respond to requests. Of major concern is an area to the rear of the common area which has an uneven surface and poses a trips risk. Indeed, one resident recently did trip there and broke his knee. This matter has been included in past CV reports and requires urgent attention. Also some work that commenced about six weeks ago to repair fencing and gates at the front of the premises has stalled and needs to be completed for security reasons.



The **standard of equipment** within the houses is of equal importance as the structural soundness of the property. The ease of which residents can access heating, cooling, kitchen and bathroom facilities is vital to their sense of independence and wellbeing.

Visit reports contained 124 **positive comments** in relation to the standard of equipment as exemplified below:

Where applicable, multi rail lifters are in the individual rooms, also have electric beds etc. Resident is able to achieve some standing mobility in transfer so her room is equipped with a handrail to assist. Excellent

Laundry and Kitchen provision.

Very well equipped laundry and bathrooms. Hot water service is set at a safe temperature to avoid residents scalding themselves, and monitored on a regular basis. The heater is serviced regularly by the landlord.

Two residents have received new electric wheelchairs through Assist. One is still being adjusted but is due to arrive in the coming days. Lifters were observed in the bedrooms and at least two clients had their own reclining chairs.

The various equipment, white goods and appliances in use within the kitchen, laundry and other areas of the house and yard appeared to be in good working order. No broken equipment sighted.

There were 19 **issues** of concern raised that required follow up by the CVS, examples as follows:

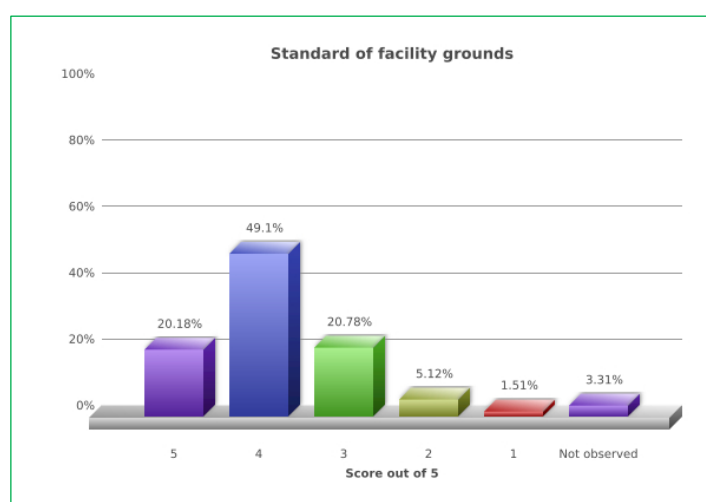
Until the last few months these units have apparently been very bare, lacking any catering equipment (e.g. no jugs, toasters, microwaves, ovens, plates, glasses or cutlery) and all meals have been prepared by staff in unit 2. Now everyone has fridge, jug, microwave and toaster and can prepare their own breakfast; will soon prepare lunches on weekdays etc and when individual stoves are supplied will be encouraged to make all meals, with support as necessary. In addition, residents recreational equipment (iPads, keyboards etc) was kept locked up centrally, to be requested and used at weekends. This has now changed and clothes, personal equipment etc is under residents' individual control. So the equipment situation is evolving.

CVs met one resident in the lounge. CVs didn't see the other units or other areas in the unit. PCV suggested environmental control equipment to help resident control her appliances in the unit. PCV informed residents about the importance of listing of equipment, its age and maintenance in the NDIS plan, e.g. how long has the equipment been used? Anything needed to be repaired?

The dwelling was assessed as unclean and untidy at the time of our visit. The floors and walls were in a poor state. The washing machine was filthy inside the tub rim area and there was pungent smell in the toilet and bathroom areas.

Unfortunately on this visit, the heating and air-conditioning in number 3 was not working and had been reported back in March. A heating globe in number 3 in the bathroom needs to be replaced and this was also reported some time ago. There are a number of other maintenance issues which have been reported, but are still waiting to be fixed.

Having a good **standard of the facility grounds** enables residents to participate in everyday activities such as gardening and helping to hang out washing, as well as being a pleasant area to socialise and enjoy the outdoors.



The standard of facility grounds was overall rated highly with 185 **positive comments** included by CVs in their reports:

Very usable: wide covered areas; paved patios; some lawn; room for plants/pots/raised beds/seed beds; good furniture: very inviting. 3 Lomond also had a range of coloured tactile installations much enjoyed by resident.

This property has a large outside area which has been re-designed and worked on by staff and residents to provide a relaxing garden area, a trampoline area, shed and a hot tub. It's nicely landscaped and

incorporates plants, garden beds and some furniture donated to the residents by family members.

There is a large rear lawn covered with a canopy where clients can play basketball, jump on the trampoline or ride the tricycle. The paved outdoor dining area is attractive and one client chooses to eat there routinely. It also has a barbecue for cooking for family events.

The rear gardens between the two units are only partly partitioned/fenced, to enable the ready access of residents and carers throughout the rear garden. At Christmas, both of the houses come together for a combined party, with the parents and families involved also.

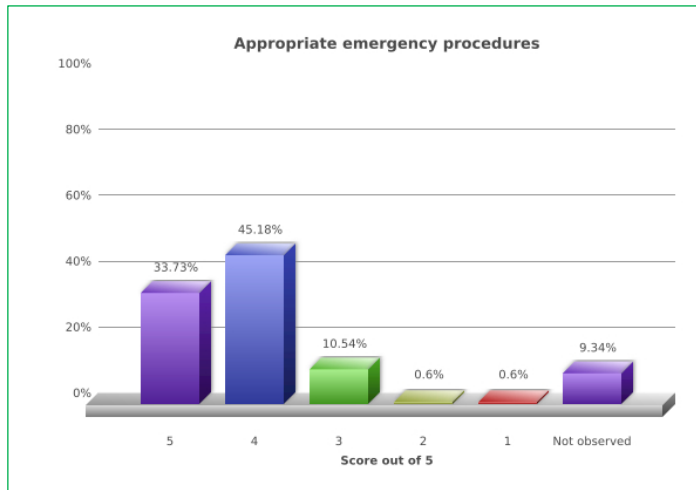
The CVS followed up 27 **issues of concern** regarding the standard of the grounds:

This house is situated on a corner, and has a very large garden which bears more resemblance to a desert. Staff cars must be parked within the grounds, for safety reasons. There is no carport, no covered recreation area for the residents, no outdoor furniture, no garden shed to house garden equipment, nothing to provide an enjoyable outside environment. The grounds are very much in need of a substantial makeover to provide a better environment for both the residents and the staff.

The paths between some of the units are very steep and would be difficult for clients needing wheelchair access. Much of the outside area at the back of the units is untidy. To increase visual ambience some gardening would definitely improve the outlook from the clients back windows.

Tatty. We were told the usual gardener is unwell and has not been able to keep to his schedule. Outdoor furniture was very worn and looked grubby. The lawn was uncut; weeds in the patio concrete and driveway gravel; very little apparent development of the garden. The front yard is mostly used for parking.

Staff noted that the property owner is sometimes slow in responding to repairs requested. For example, a depression in the outside walkway presents a tripping hazard and has not been attended to.



Another key accommodation aspect assessed during visits was **emergency equipment and procedures**. This again was assessed as being at a relatively high standard drawing 192 **positive comments** in visit reports:

We were told the alarms are tested by both the staff and Chubb so as to ensure regular testing is undertaken several times each year. Quality safety checks are undertaken every 3 months. The evacuation drill is practiced every six months with the participation of the residents. The CVs were

advised that the residents are now so accustomed to the evacuation procedure that they respond immediately when the car keys are held up high by the support worker. The residence is also fitted with emergency lights which are illuminated if the electrical supply is compromised.

They do evacuation procedures and have a fire blanket, extinguisher and there is evacuation information in the office. Everyone has a personal Fire Plan which contains information about how each client would respond and has responded to fire drills.

Alarms in place, clients are non-verbal but are trained to follow prompts from staff in case of emergency.

An emergency evacuation plan was in both houses. Houses were spacious and felt to have good, clear emergency route if needed. There wasn't clutter and doors were not obstructed. Unit 42 was observed to have smoke alarms.

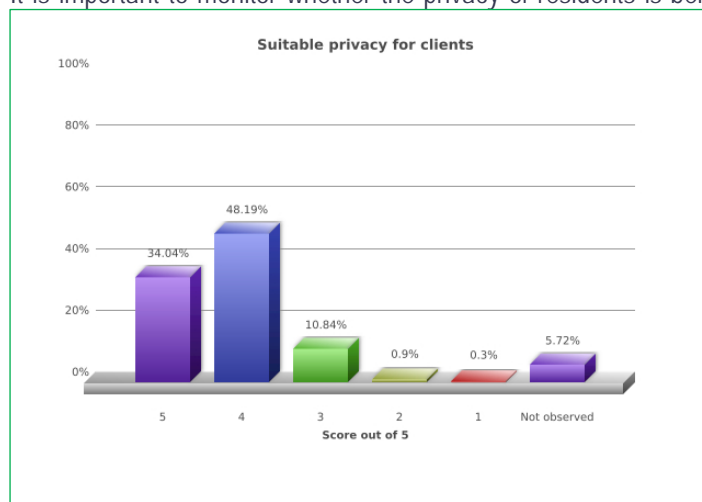
There were 11 houses assessed as **needing attention** in relation to appropriate emergency procedures which were referred to management:

There are fire extinguishers however the fixing for one has been broken and it now rests on the floor in the corner, this was a concern. There is a hand-drawn evacuation plan in the kitchen. Emergency procedures did not appear to be in place or well practised after speaking to the staff.

We were concerned to note there is no displayed emergency evacuation plan, no fire extinguishers, no fire blanket in the kitchen. There is a working smoke detector. We asked resident what he would do if there were a fire, and were relieved when he answered immediately "get outside".

Evacuation drill not clearly articulated by the support workers. The CVs were told that (the organisation) demonstrates how to use extinguishers. However, the support workers could not elaborate on when, how often and whether training records were kept. Only 1 small extinguisher was visible. This was located in the kitchen. An evacuation plan was not visible or made available to the CVs. No exit signs. The support workers advised that the evacuation procedure was not practiced with or without the participation of the residents.

It is important to monitor whether the privacy of residents is being respected and they have a 'space' in which they can retreat or spend time on their own.



Community Visitors reported 222 **positive comments** in relation to **suitable privacy for clients**:

Whilst clients were unable to verbally communicate, they seemed settled. Doors were well used for each client (for example when neurophysio was present). Each client was dressed appropriately.

Each client has their own bedroom. Staff seem to know when to move clients into shared areas such as the combined kitchen/lounge room or garden and when to provide quiet or resting time.

The house has individual bedrooms with adjacent private rooms for entertainment. The female client has her own unit at the back end of the house. One vacant room is kept locked as there is capacity to accommodate another client.

Rooms are highly personalised and because of the client's individual situations there is a limited degree of socialisation. However feedback from staff suggest the home works well.

Eight **issues of concern** were reported and followed up:

Each client has their own bedroom and ensuite bathroom. However, one resident is known to go inside the other clients' bedrooms at times and bang her head on the plasterboard. Padding has been erected to prevent injury and further damage to walls.

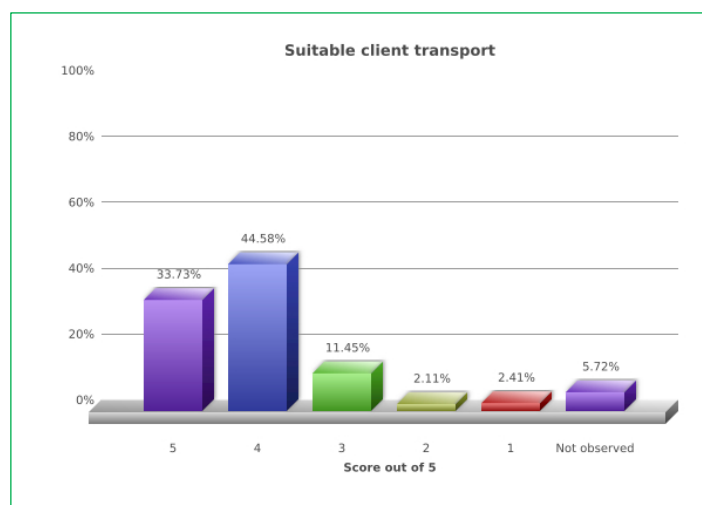
The rooms are cluttered and staff go in and out of one resident's living room constantly.

Two women are sharing one bedroom. Clients moving into a larger home early in 2019.

There aren't many comfortable areas for residents to have time to themselves. The only lounge room is empty except for two couches. The rooms of two clients are empty and do not allow for a pleasant area to retreat if desired.

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.



There were 188 **positive comments** relating to **transport** for residents:

Two cars and a van sharing between 8 houses. If these vehicles are not available there is a pool of vehicles (e.g. for longer use: outings etc) but staff need to book these. We were told that, to date, there has been no problem in accessing vehicles as needed/wanted.

A bus is available and staff are able to take the residents for drives and to suitable parks which he loves. He is particularly fond of going for drives as it seems to calm him and is the highlight of his day.

All clients we spoke to were happy with their ability to get out to the shops, pictures, visit families etc, so we assumed transport is not an issue.

House has transport but the independent client will take taxi, public transport including train, bus if needed.

Twenty **issues of concern** were followed up by the CVS:

Concerns raised about bus transport for wheelchairs by one client.

It is mentioned that 3 cars are shared between 8 units. It makes it difficult for the clients to plan weekend outings, etc. Although this site has an activity site called My Path (weekdays) for the residents to spend the day, having more suitable transport would be helpful.

There is no dedicated vehicle for the house. Vehicles have to be booked from a pool, which is uncertain, stifles spontaneity and can restrict options available to clients, especially at weekends or for medical etc appointments. We were told that the process of booking vehicles changes frequently and absorbs increasing amounts of carers' time, reducing the time available for direct support.

Staff indicated that they have only two cars sharing between ten houses. They need more vehicles.

Interestingly, many of the comments relating to issues regarding transport, mentioned the impact of the NDIS and the worry that vehicles available to residents at the present time, will no longer be available:

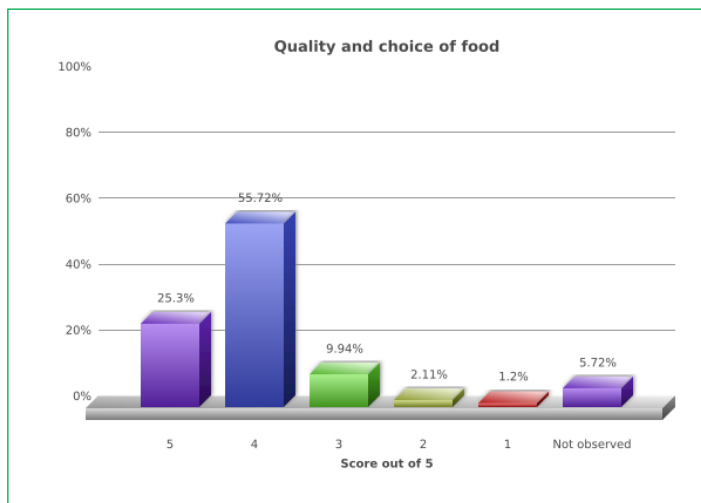
Suitable at present but much concern about what will happen with full implementation of NDIS where transport not funded and transfer to NGO.

The residence has two vans to utilise. With the NDIS being implemented for this house soon, the transport funding could be in jeopardy.

Currently the unit has their own van. However this is an issue to be resolved as all clients now have NDIS plans in place and it is not clear whether funds can be pooled and whether this will cover the existing provision. Similarly the change to vouchers for transport etc will quickly deplete funding.

There is currently a vehicle which can fit everyone. It's not clear how NDIS will affect this.

The provision of **healthy and nutritious food** offers residents with an opportunity to be involved in meal planning, grocery shopping and the preparation of meals, increasing their life-skills and knowledge about healthy foods.



There were 239 **positive comments**:

Weekly menu is worked out with both residents input, their likes and dislikes taken into consideration. The weekly meal planner is written up and pinned up in the kitchen/dining area.

Weekly menu developed in consultation with residents and shopping trip conducted accordingly. Residents give some assistance in cooking meals.

This is changing to facilitate much more participation by residents in choice, purchase and preparation and to include more fresh fruit and veggies. Purchasing via

Coles Online has been stopped, a nutritionist has overhauled the menu and residents are being encouraged to join in shopping and will be encouraged to join in cooking. There are also regular Friday baking sessions led by staff and residents.

They have a set weekly menu planned out. On weekends they may vary things and have takeaway for at least one of the meals. Staff say that the meals served were based on client choice but still nevertheless healthy and substantial. One client requires a pureed diet.

Some of the 16 **issues of concern** reflect disparities in resident choices of unhealthy foods, and the staff encouraging the choice of more healthy options:

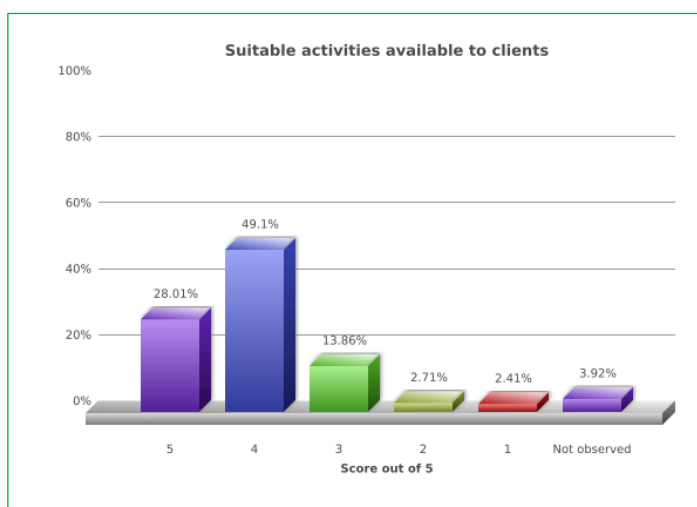
At least one of the 2 residents has input into menu choice. This can be problematic, as she has Diabetes and some of her choices are not necessarily healthy ones.

Has some fresh food and vegetables. Client enjoys Milo. There is milk, and a meal plan. The CVs have some concerns about the nutritional quality of the meals.

One resident has a lot of energy drinks, caffeine and junk food that is attributing to his weight gain and maybe his behaviour. It got to the point where he had a blood pressure monitor on. Staff are concerned but find it difficult to stop him having so much.

There was very little food. A few vegetables, a few pieces of fruit, some milk and yogurt. No menus or meal plans. CVs were surprised at the lack of food and lack of meal plans. The mother of one resident cooks and sends food to the house which is stored in the freezer and dated. The lack of fresh food is concerning. Although staff mention that shopping takes place on Wednesday there was no shopping list within the house that could be seen.

Suitable activities should be planned in conjunction with the resident taking into account their interests and abilities.



Two hundred and fifty-three (253) **positive comments** were reported:

Wide variety of activities available. 2 clients work at Orana. Others go out with staff to shops, lunch. At home there are a variety of activities available eg assisting with cooking and groceries. Each resident has a weekly schedule of activities.

Varied activities are available including picnics, meals, shopping, swimming. Activities in house including puzzles, drawing, TV, magazines. Recently 2 residents attended the Aladdin concert. Annual visit to the Royal Adelaide Show.

The clients all have daily activities, some with day options and others with outings with staff depending on their preferences. They help with cooking and often go on walks or have BBQs at the house for example.

Most clients require low-level support and choose their own activities with friends and family. There is opportunity to go out as group and use the van to undertake various activities based on preferences and budget.

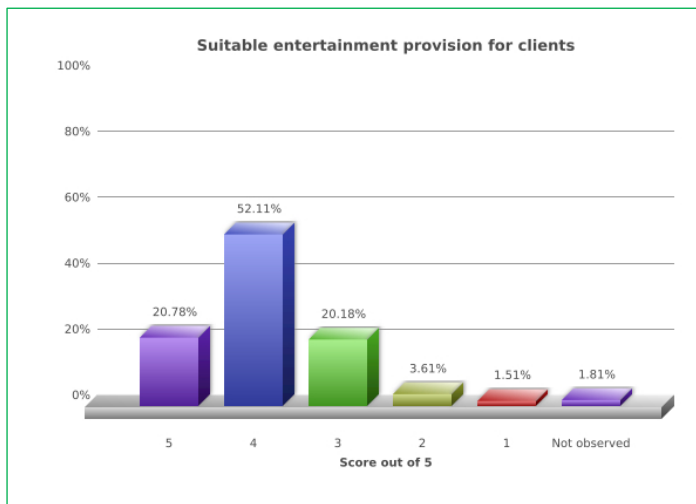
Fourteen (14) **issues of concern** required follow-up:

One client goes to Day Options every Tuesday. Not many activities for the clients, however, the clients always help to cook and do the shopping. The clients also enjoy to go near the airport to watch the airplanes.

There didn't appear to be any activities available although some clients had social support as part of their care plans, staff said that a lot of effort went into offering activities but motivation is an ongoing issue.

Impacted by NDIS reduced funding, staff seeking to work out other solutions.

Resident has stopped ten pin bowling and stated that he has not been fishing for a long time which he used to do. By his own admission, he has put on weight & could do with some active choices.



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.

One hundred and five (105) reported positive comments include:

Various digital equipment, including televisions, DVD player, and CD player are available.

TV, DVD, radio and books are found in lounge. Some clients have their own TV and DVD in their rooms. One resident has 3 pet birds. Another has a tablet as well.

There are TVs and music in the shared areas and in residents' rooms. Some rooms and the yards also reflect individual interests.

A sensory room has been set up with cushions, TV, coloured lights, DVDs and music for the residents' enjoyment. It's a pleasant space for some quiet time alone if they so desire. They also have a pet fish.

There are some challenges in this area especially in settings where achieving the balance between safety and quality of life is difficult to achieve. Five (5) issues of concern were reported:

There did not appear to be a great deal in the way of entertainment for the clients, particularly in number 2 house. Staff cited the high needs of the clients limiting the range of activities they can participate in. They were watching TV when CVs visited. In number 4 house the men were cooking and had the TV on.

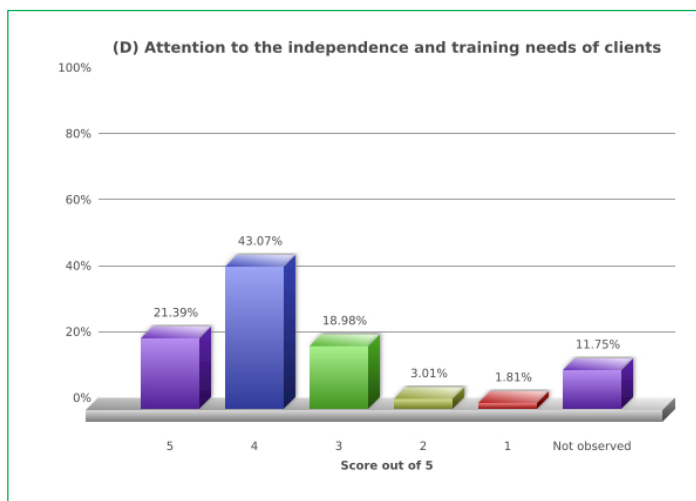
The range of entertainment should be reviewed to alleviate boredom.

It should be noted that, because of the residents' specific physical and mental status, the difference between entertainment activities and 'suitable' activities is blurred.

Not much - just sitting around watching TV or lying on their beds.

A key component of the role of the CVS as an external, independent visitor, 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 good rating as demonstrated in the following graphs.



From 166 positive comments include:

This service was strongly focussed on facilitating client independence and improvement.

The staff members pay attention to the clients' activities each day and respect the fact that the clients are very independent.

The CVs were advised that residents are encouraged to participate in household chores and out-of-house activities according to their individual capacity and aptitude.

The activities the clients were involved in seemed to match up to their levels of independence and training needs. For example, one resident is about to learn how to use a tablet, while another is learning to count. Another client attends cooking classes.

There were 20 **issues of concern** to be addressed:

This seems to be a challenging area with complex needs of clients.

The resident can go out, but there is a staff deficiency to support his independence. He goes swimming once a week. He gets agitated quite frequently, possibly due to insufficient opportunities.

Long term planning for this resident is scant.

Clients help with cooking and cleaning, however there seems to be no encouragement for working towards goals or improving skills. We were told that staff know the clients goals and that they have goals written however there was little evidence of this.

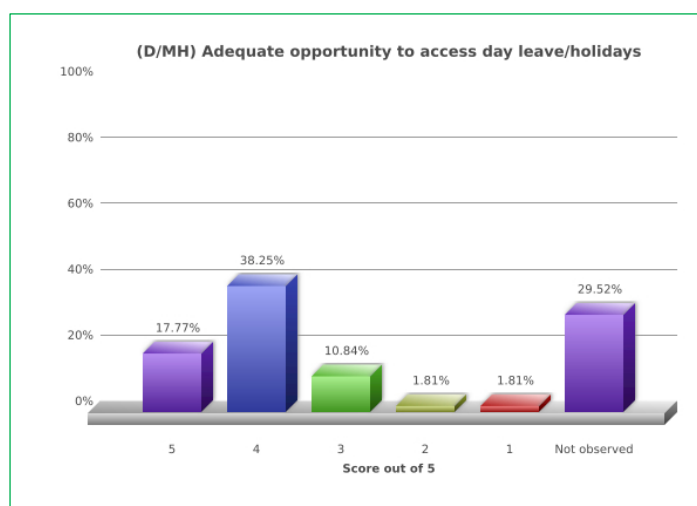
There were 136 **positive comments** regarding holidays:

We were advised that residents have opportunities to go home with family, or on holiday.

Resident had recently holidayed at Wallaroo and attends Crows games.

These are negotiated with each client as an aspect of their goals and aspirations.

Staff say that there are no problems in providing this type of leave. Resident has flown to Queensland to visit his Guardian and travelled interstate for Tri-State games attendance. Another regularly visits his mother in the northern suburbs.



Fifteen **issues of concern** were noted, some especially mentioned the NDIS:

Staff expressed concern that the current way Minda supports staff to travel with clients may not work as well under the NDIS funding model.

Although they have been on holidays in the past, clients are waiting to hear about NDIS before they can think about this. They have had NDIS meetings and waiting on plans to come back.

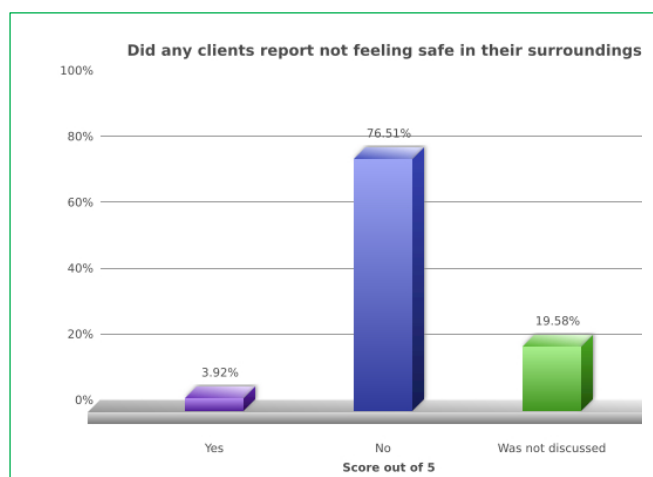
Clients have not been on holidays recently. Even day trips are difficult due to lack of transport.

Have to self-fund and none of the clients have enough money to fund going on holidays.

3.2.4 Safety and Rights

The issue of personal safety (for both residents and staff) remains a key area of interest and the CVS continues to monitor personal safety at all visits drawing attention to situations and environments, which could potentially expose individuals to risk.

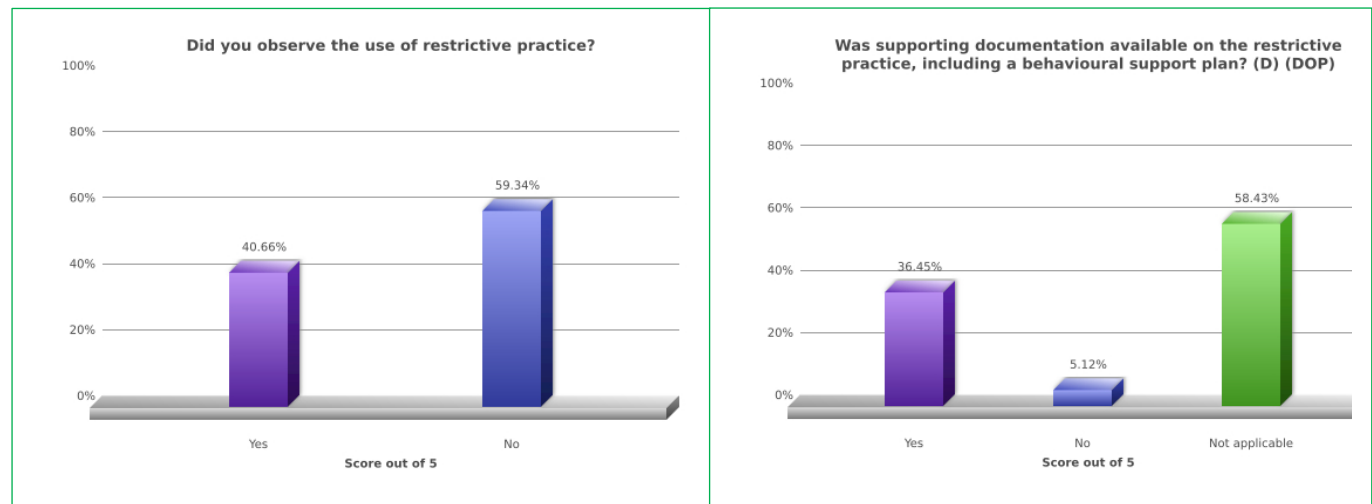
The following chart of responses to the question of whether any clients report not feeling safe indicates that there is a strong sense of comfort within the accommodation sector that individuals feel safe. At times, this can be a difficult question to explore in some houses reflecting the high rate of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



Under the NDIS, clients have ultimate control over where they live. However where there is conflict between residents, the expectation is that the person responsible for the adverse situation should move out (this may at times be a point of dispute). Under NDIS, the landlord and service provider will be different agencies which may add another level of complication to the

negotiation and decision. 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 were 105 **positive comments** 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:

We were told that since April a large number of pre-existing RPs had been stopped and all staff were undertaking ongoing RP training, to get to grips with the subtleties of the issues.

The restrictive practice is for protection and safe practice. This has been confirmed by the staff and has been documented.

The front door remains locked as resident may wander. however he can always access the back yard which is spacious and attractive.

Restrictive practice documentation was dated 2017 initially, but signed off as a review in October 2018. The restrictions related to locks on food cupboards and fridge to prevent gorge feeding and locked doors and gate to prevent wandering. Both residents have no traffic awareness.

Forty-two **issues of concern** were noted:

Resident informed the CVs in the presence of the support worker, that she was relocating to Magill for 'psychological reasons' and because she felt unsafe in her current surroundings. However, neither resident nor staff member elaborated further when they were invited to do so by the CVs.

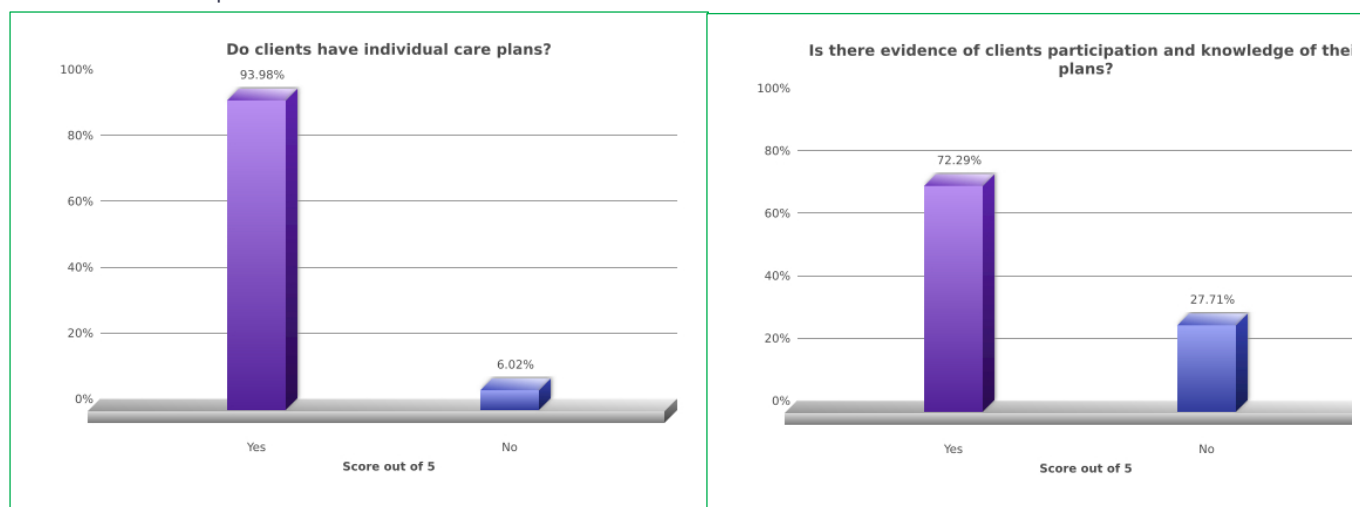
Staff say the client feels safe & secure with the cot around his bed to keep him in at night time. The Restrictive Practice approval is due to be reviewed in April, 2018. It wasn't clear whether this was done as documentation was not available.

CV's quizzed staff about their knowledge of behavioural support plans for the residents. It was not clear whether or not a plan existed and if it did the staff members asked were not clear how to implement it. Clients indicated no knowledge of an outcome or objective based plan in place and were dismissive of the idea.

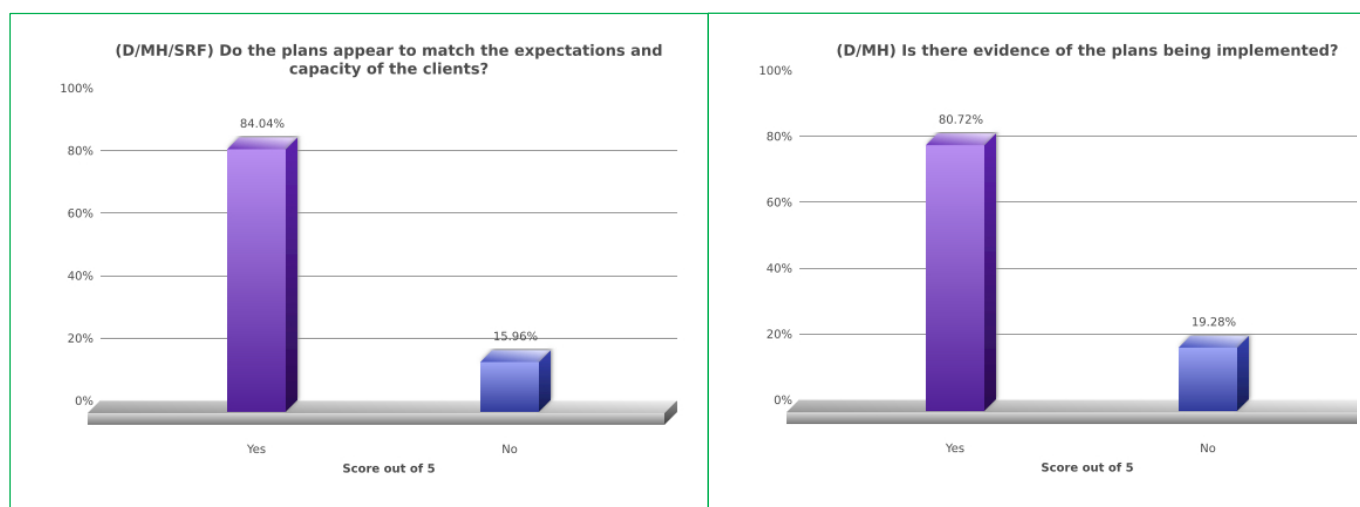
All the safety or restrictive practices are under review and awaiting for an OT to draw documents as required. Due to NDIS there are some delays in the process.

3.2.5 Treatment and care plans – Person Centred 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 is still of particular importance as more clients transfer to the NDIS. In many cases the review of these plans formed part of the NDIS pre-planning and therefore a precursor to the achievement of optimal NDIS plans and associated funding. Forty-six percent (46%) of plans were reviewed annually, and 34% are reviewed as required.



The development of plans that match an individual's expectation or their capacity and then whether they are fully implemented must be aligned to ensure there are opportunities for individuals to maximise their capacity, achieve their goals and lead as fulfilling a life as is possible.



From the above charts, indications are that this is successfully occurring in over 80% of situations. It appears that preparing for, and the implementation of the NDIS, has driven significant improvement in this area. Seventy-five (75) **positive comments** included:

Staff indicated that the care plans are recently updated. It also includes progress notes, personal goals as well as positive behaviour support plan.

NDIS plans have not been implemented as yet. However, Minda's documentation is well organised and complete. Regarding client finances, every fortnight the night staff check account balances and bookkeeping. Minda also ensures internal and external audits are also completed.

It is anticipated that more casual staff will be involved in the future to implement goal-directed personal care plans with the introduction of the NDIS.

Individual care plans are developed in conjunction with clients and family members if possible and available for families on request.

It is disappointing that for approximately 19% of residents, evidence is lacking as to whether their plans are being implemented. Examples from reports where this is not being achieved are as follows:

Not all sections of the files are updated regularly, e.g. personal profiles. CVs were told that financial records are updated daily.

Only saw 1 page plan for 1 client which was done in 2014 - needs update.

Previous visits have identified the lack of personal care plans. Staff were unaware of the status of these plans as the previous service provider appears to have removed most of the paper work.

Some of the individual care plans need to be updated. Although the staff mentioned that it is reviewed annually, the evidence was not sufficient.

3.3 Issues and challenges impacting disability services

3.3.1 Changes to scope of work of the Community Visitor Scheme

In May 2019, the Department of Human Services advised the PCV that due to significant changes with the full transition to the NDIS, the role of the CVS was changing. The department advised the PCV that the CVS was not to continue with visits to people with disability living in non-government organisation homes. However, the CVS could continue to visit people with disability residing in government supported homes.

The reason cited for the change was that the CVS Regulations under the *Disability Services Act 1993 (DSA)* no longer enabled the CVS to visit NGO disability accommodation, Day Option Programs and SRF's due to the state no longer funding these services, as individuals receive their funding via the NDIS. In other states, where the Community Visitors are operating there have been legislative or regulatory changes to enable their respective schemes to continue. In Victoria, amendments have been made to the Residential Tenancies Act to ensure CVs can continue visiting NGOs and SRFs and report back to the Public Advocate. In NSW, the Disability Visitor Scheme will report under the new Disability and Ageing Commissioner. Finally, in Qld CVs will continue to operate under the Guardian.

These jurisdictions are all continuing their Visiting schemes and will be referring issues of concern to the NDIS QSC where appropriate.

There was extreme disappointment regarding this change not only from CVS staff and volunteers, but from CE's of NGO's who welcomed the CVS visits, and used the reports they received about the visits as a quality improvement measure for their service. One Director of a service provider commented that they considered *"the closing of the Community Visitor Scheme is several steps backwards"*. Another CE said *"never has there been a more critical time for the type of advocacy you provide than during this transformation. We have supported people to go through the other advocacy groups but the waiting times are significantly impacting people's ability to enjoy the choice and control we want for them. We hope that CVS will continue to build upon this foundation in some form or another into the future as we value its work immensely"*.

Clients, residents and others who support the work of the CVS were also dismayed at this change as it raised questions as to who would be advocating on behalf of vulnerable residents, especially those with no family support.

However, as previously mentioned, there has been considerable work being undertaken by the DHS and the Attorney-General's to enable the CVS to visit over 600 clients who are under the guardianship of our Public Advocate, Anne Gale.

This will be a great opportunity for the CVS to visit these very vulnerable people and to be able to report back on these individuals to the Public Advocate. Delegation Powers of the Public Advocate have been drafted but there will need to be a more detailed Memorandum of Understanding (MOU) to identify the processes and protocols required and scope of this work and we are very much looking forward to this new opportunity.

CVS staff met with the NDIS Quality and Safeguarding Commission to discuss some outstanding issues of concern from recent visits to NGOs and SRFs. It is now up to that agency to determine next steps.

3.3.2 Use/misuse of medications including PRN, and the frequency of medication reviews

A number of visit reports raised issues of concern regarding appropriate medication usage and the review of medications. In some instances, Community Visitors were able to obtain a copy of the resident's medication list (with their permission) which was passed on to the CVS office. For one particular resident, there were seventeen (17) medications listed as of May 2018. It is not possible to tell how long the resident had been on some of the medications from the listing alone. Liaising with the doctor from the Centre for Disability Health, it was apparent that a review of medications was warranted. The Disability Coordinator spoke with the service provider to ask that this review take place. The outcome of the review was that the medications were changed for this particular resident in January 2019.

The CVS planned to undertake a focus on the use of medications, including PRN and the frequency of medication reviews throughout visits during the 2019-2020 year. However, due to the changes to the scope of work of the CVS, this important strategy will need to be reviewed. This has been raised with the state office of the NDIS Q&SC and with the peak body for NGOs, National Disability Services, in the hope that this important work can be progressed.

3.3.3 Suitable accommodation - shortages in the community

The CVS has been made aware that there are a number of people with disability that are 'stuck' in hospitals waiting for NDIS plans and the allocation of appropriate accommodation. This puts pressure on beds in hospitals which lead to bed shortages across the health system. While hospitals may have policies that no patient will be discharged into homelessness, we are aware that people with a disability and/or mental illness have been discharged to caravan parks and cabins. In broader terms, there is a shortage of suitable housing for people with disability across the community.

The 'Every Australian Counts'² campaign reports that if no action is taken, there will be up to 122,000 NDIS participants without appropriate disability housing. Affordability is another issue with the CVS being made aware by concerned relatives, that since the introduction of the NDIS, some landlords have increased rents markedly. A study from the Centre for Research Excellence in Disability and Health³, using the Household, Income and Labour Dynamics in Australia survey, found that 11.2% of Australians with disability were living in unaffordable housing compared to 7.6% of people without disability.

Without advocacy from independent agencies such as the CVS, it is difficult to determine how this issue will be addressed. While families can advocate on behalf of their relatives, it is only with numbers and momentum that the issue of accommodation shortages will be able to be kept on agendas of government and non-government agencies respectively.

3.3.4 Access to 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. Many service providers expressed their concern regarding the funding of vehicles since the NDIS came into effect. There is a view that current transport allowances do not adequately cover the costs of provider travel and participant transport especially in regional areas and isolated communities.

² "Every Australian Counts" campaign, Housing Stories. (2017). John Della Bosca, Campaign Director.

³ Zoe Aitken, Emma Baker, Hannah Badland, Kate Mason, Rebecca Bentley, Andrew Beer & Anne Marie Kavanagh (2019) "Precariously placed: housing affordability, quality and satisfaction of Australians with disabilities." *Disability & Society*, 34:1, 121-142, DOI: [10.1080/09687599.2018.1521333](https://doi.org/10.1080/09687599.2018.1521333)

An article from the Disability Services Consulting's Resource Hub dated 29 July 2019⁴, reported that transport in the NDIS is the number one cause of all NDIS related breakdowns. Transport funding has been tried and tested in Australian courts and tribunals more than any other single issue in the NDIS. A central aim of the NDIS is to improve the social and economic participation of people with disability. However, this is difficult to achieve if they cannot use public transport and do not have enough funding for alternative transport such as taxis.

Indications are that funding for transport contained in NDIS individual packages is primarily allocated for access to daily activity programs leaving little or no funding for individual access to other appointments such as medical, shopping etc. CVS visit reports, indicate 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 many houses. Creative solutions to the provision of transport will need to be considered. While the CVS would continue to monitor this issue, it remains to be seen whether the future scope of the CVS will allow it to highlight where transport is an inhibiting factor to people realising their social and economic participation.

When all the initial work was done by the Productivity Commission on the proposal for the NDIS⁵, it did not include transport nor other mainstream services such as education, however it appears to have crept in.

The mobility allowance was a Commonwealth concession that recognised the added costs to people were due to their disability, they were unable to access mainstream public transport. Likewise, the SA Transport Subsidy Scheme (SATSS) and the vouchers provided were a 'reasonable accommodation' under the *Disability Discrimination Act 1992* in recognition that where people were reliant on access taxis, there were significant extra costs associated with taxi travel.

So there are many individuals who previously received mobility allowance (\$97.90 per fortnight or \$2,522 per year), and SATSS of 80 vouchers every six months which has a potential value of \$4,800 per year and combined has a value of \$7,322. Under the NDIS, the highest level for transport is \$3,456 and this is for people who are looking for work or studying for 15 hours per week or more. So this represents a significant overall reduction for many people.

What most people fail to recognise is that all forms of public transport are subsidised by government, every train, tram and bus trip are subsidised. The amount that each person pays for a ticket on a train or bus is topped up by government funding.

Disability recommendations

1. CVS be provided with a future mandate to continue to inspect disability facilities, both government and NGOs, and report on any concerns or inadequacies, especially where this has an impact on the provision of client centred care.
2. That the CVS looks into undertaking a focus on medication reviews including PRN.
3. The CVS continue to check on the use of restrictive practices and report undocumented or unusual practices to the PCV who will refer to the appropriate agencies.
4. That the CVS develop a revised MOU with the Office of the Public Advocate (OPA) to enable the CVS to visit all individuals who are under the guardianship of PA.

⁴ "Is the Agency ignoring legal rulings on transport?". (2019) Disability Services Consulting.

⁵ Productivity Commission 2011, Disability Care and Support, Report no. 54, Canberra.

4. Supported Residential Facilities outcomes and themes

The Supported Residential Facilities (SRFs) sector has continued to undergo significant change during this reporting period. In this section these changes will be reflected within what has been the overarching context of the sector as it relates to 2018-19.

Supported Residential Facilities (SRFs) are accommodation services licensed under the *Supported Residential Facilities Act 1992*⁶ (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 23 ‘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 2018, the SRF sector provided accommodation and low level support services to approximately 773 individuals. The opening of two SRFs during this time – Gawler Supportive Care (South Campus) and Woodville West Lodge – reflected an increase in sector capacity of 124 licenced ‘pension only’ beds, totalling approximately 897 individuals. Historically, SRFs in South Australia have varied considerably in size from 12 beds to the largest being 104 beds.

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 4.3.2 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, was the SRF Intake and Support Service (SRF I&SS), now a part of the Exceptional Needs Unit (ENU) of the Department of Human Services (DHS). Non-clinical assessments for NDIS ineligible individuals seeking SRF accommodation or for existing SRF residents who may require additional supports is undertaken by this unit. The SRF I&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.

The SRF Entry Point Assessment (SEP), has ceased. DHS is no longer the gatekeeper for people entering the SRF sector. The SEP was only relevant to eligibility for the Board and Care subsidy. SRF Proprietors could accept whoever they chose to but would only receive the subsidy with a SEP approval. Given that the National Disability Insurance Agency (NDIA) is now the first contact point for people with significant functional impairment/disability, and the Board and Care subsidy no longer applies for new entrants, SEP is no longer required.

A person previously assessed as eligible for the government’s Board & Care Subsidy will continue to be in receipt of this subsidy until 31 December 2019. 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 was 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.

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

⁶ Supported Residential Facilities Act 1992. South Australian Legislation.

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. The closure of a further two SRFs in the past twelve months has also affected sector stability. This is discussed further in section 4.3.1.

Throughout 2018-19, the SRF Association has continued in being proactive in presenting its concerns regarding the sector to the relevant bodies and in developing alternative accommodation models. CVS (up to mid May 2019) 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.

Due to staff changes within the CVS and direction received from the department (DHS), based on advice they sought from Crown Law, that we can no longer provide advocacy support, the CVS was unable to participate in the sector through attendance at Regional SRF Network meetings, as had previously been the case.

The ongoing CVS visitation to Community Mental Health settings during this reporting period has continued to enhance the recognition of CVS as a resource available to service providers. This has been well referenced with regard to 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	4-8 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
Woodville West Lodge	15 Rosemary Street WOODVILLE WEST SA 5011	Western
Alexam Place Rest Home	24 Hazel Road SALISBURY SA 5016	Northern
Ocean Grove Supportive Care	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 (North Campus)	6/8 East Terrace GAWLER EAST SA 5118	Barossa Light & Lower North
Gawler Supportive Care (South Campus)	1 Main North Road EVANSTON SA 5116	Barossa Light & Lower North
Lambert Living	87 Gray Street MOUNT GAMBIER SA 5290	Limestone
Southern Fleurieu Silver Circle	55 Victoria Street VICTOR HARBOR SA 5211	Fleurieu & KI

Figure 4.1 SRFs by location and NDIS region

4.1 Visits and data

During the 2018-19 reporting period, the CVS was funded to provide visitation and inspections to 23 'pension only' SRFs located across the state. Such visits occurred until mid-May 2019 when direction was received from the department (DHS) that we can no longer provide this service.

As previously mentioned, the DHS confirmed that our Regulations under the *Disability Services Act 1993 (DSA)* no longer enables the CVS to visit SRFs and/or Disability NGOs as individuals in these facilities are funded via the NDIS. They will now be subject to the NDIS Quality and Safeguards Commission (NDIS QSC) who have a range of quality checks such as audits, registration and complaints handling and will visit these individuals and/or facilities if concerns are raised through a combination of these checks.

The DSA was a funding Act but there were also the coercive powers of unannounced visits and right of entry that were in the Provider Panel funding agreements between the State and NGOs and these are no longer in place.

The government, Attorney Generals and DHS are exploring possible options of the CVS being able to visit those under guardianship of the Public Advocate. However, this is at a relatively early stage of exploring a means for the Public Advocate to delegate powers to the CVS to visit clients under guardianship. The Public Advocate is guardian for around 640 clients in a range of facilities inclusive of SRFs and both Non-Government Organisations (NGOs) and Government-run.

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

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

CVs were 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 were encouraged to remain mindful that they were entering peoples' homes and that residents may view it as intrusive. However, our experience has been that residents appreciated the opportunity to engage with the CVs, particularly as they had become more familiar with the Scheme and what it offers. Staff similarly indicated that they recognise the value of the Scheme and its advocacy role for this client group.

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

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

A record of significant, sector wide or cross sector issues was maintained on an 'Issues Register' and tabled at Advisory Committee meetings for consideration and recommended action.

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

During 2018-19 the CVS conducted 31 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 24 issues and requests for advocacy were received in relation to SRFs during this reporting period. Of these, 20 have been completed while 4 remain open (Refer figure 4.1.1). The issues that remain open have been referred to the NDIS Q&SC in anticipation of resolution.

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

2018 - 2019	Issues raised 24	Issues completed / no action required 20	Issues outstanding 4
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Figure 4.1.1 Details number of issues raised and resolved during 2018 – 2019.

4.2 Key report findings

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

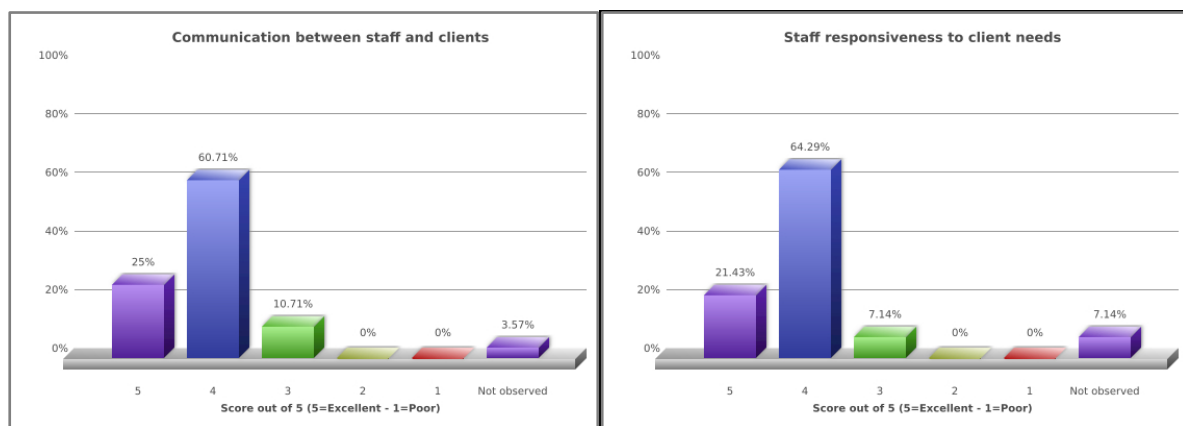
The reports provide opportunity for any issues of concern or request for advocacy to be presented to the Principal Community Visitor for follow up.

The first three areas of the report required the CVs to provide a rating out of five for the service against a range of questions related to each 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 55 comments made, 40 were positive comments with examples as follows:

CVs observed a good level of staff/residents interactions and communication. Residents appeared to be engaged in house chores and helped staff to keep the residence clean and tidy.

Warm and easy going; there is a great sense of familiarity between staff and clients as the majority of both have been at this facility for a long time. The facility is 37 years old.

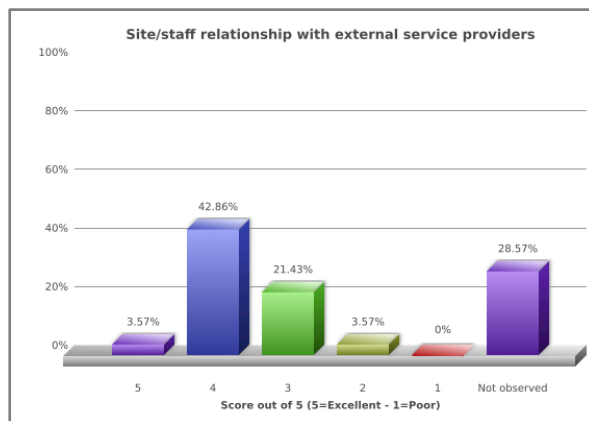
The Manager knows her residents very well and there is a friendly, healthy but no-nonsense clarity between her and all residents. She and they are all clear on rights and responsibilities and she does not tolerate bad behaviour that could affect the other residents. A good balance.

Issues: 8 of the comments raised issues:

We were shown around by a part-time staff member, who was a little invasive of residents' private spaces, and somewhat inappropriate in his language - 'they can get a bit difficult' and 'they do need a lot of supervision' etc. - not individualised and respectful enough.

Given there were not many staff on duty, this seemed to be an issue as there were residents waiting to see someone in the office, which was locked and unattended while the staff member was "on the floor".

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 previous reporting periods, some managers again identified timely access to community mental health services as being problematic.



Comments included:

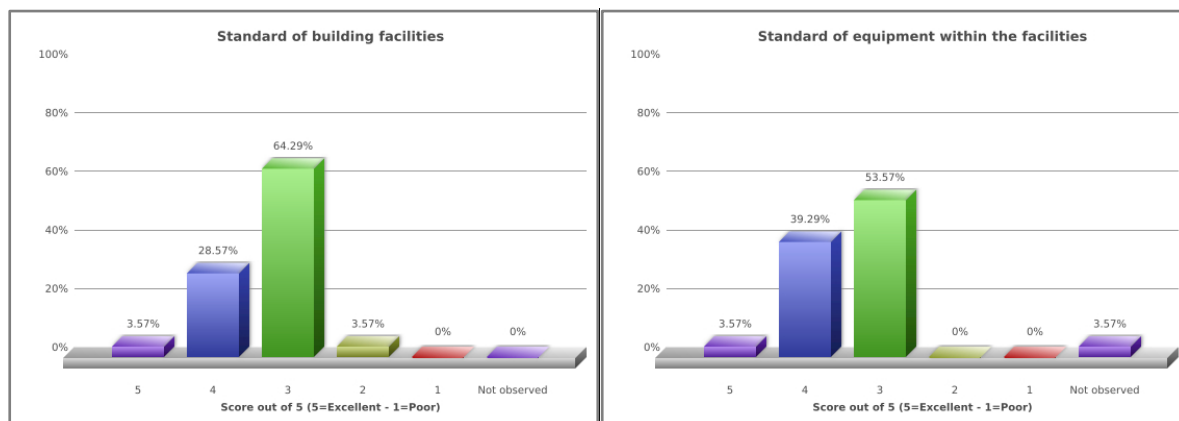
A range of external providers are involved in supporting SRF clients on site: Uniting Communities; Anglicare; Uniting SA plus a range of providers including a hairdresser, podiatrist, GP (onsite visits about to begin), dietitian and RDNS UC (support depends on the amount of NDIS funding provided to individual clients).

Staff reported challenges supporting clients to access Community Mental Health Services and when issues are brought to the attention of Housing SA, it can take a long time for any action to be taken. The SRF has good working relationships and connections with Lifelinks through the Council, GPs and with Anglicare for clients who have Anglicare funded packages.

4.2.2 Environment – suitability of facilities and their maintenance

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

The following charts 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 hospitals and SRF proprietors quite often lease the facilities. Reports have at times commented on interiors being aged and 'tired' with some yards not being well cared for.

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 a number of occasions, has been the lack of accessible bathroom facilities. Suggestions have been made to management and Landlords to look into the provision of at least one that is accessible given the number of residents that use strollers and who would benefit from easier access.

Positive Comments: of the 105 comments made, 85 were positive comments with examples as follows:

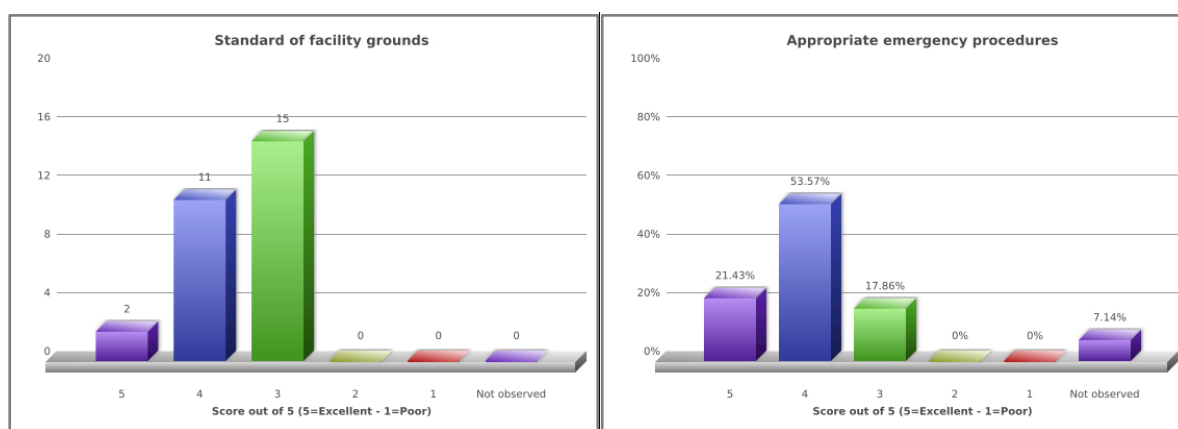
Although the building was very old, there is evidence that the current proprietors are doing their best for the residents and had re-furnished the whole facility including each bedroom. The heating is limited because of the age of the building so bedrooms viewed had small heating appliances. The building was originally a hospital built in 1929. The bathrooms were all clean and well-maintained but it would be good to have at least one that is wheelchair accessible.

Care is taken of the premises but the interior is showing its age and looks dowdy in some areas of the old house section. Rooms we were shown looked comfortable and equipment (air-con, electricity) is all in order. The buildings are quite extensive and spacious and residents' individual rooms are quite functional.

Although the facility is a few years old, it is fit for purpose with each room having an ensuite and balcony.

Major improvements are being made, including the installation of security cameras, a fresh coat of paint, new furniture and increased common space.

The proprietors have now completed extensive renovations and they and the residents are very pleased and proud of these.



The SRF has extensive gardens on 3 sides. The present company has taken much trouble in restoring them to a very attractive state, looking good from the road and providing a very pleasant environment for residents, some of whom have their own areas to cultivate or develop. Synergies with another company facility are exploited so younger clients come from that facility to maintain the gardens, socialise/BBQ with the residents and generally enliven the environment. There are chooks in a well-kept chicken run and there is plenty of shade so the gardens can be enjoyed throughout most of the year.

Evacuation drills are undertaken with the full participation of the residents. The manager reflected that two residents have personal emergency and evacuation plans. Fire equipment (including sprinklers) are checked every 3 months.

Fire practices are held; the residents within this facility were recently announced the 'best' of all xxxx sites in their practice evacuation!!



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 an 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.

Apart from most residents sharing rooms, privacy is OK. All residents can have a lock on their door if they so choose. At this facility, only two rooms have taken up that option.

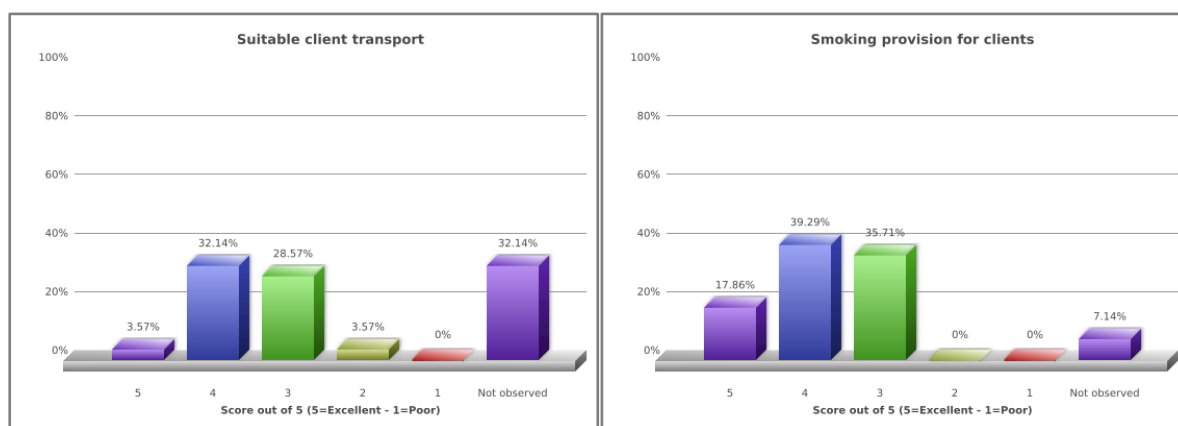
Most residents except for two have their own rooms. There are ensuite bathrooms shared by pairs of rooms.

Most of the residents can retreat to their single occupancy rooms if they wish to do so. There are currently three rooms shared by two residents each. Asking if they may want a single room, the manager assured us that these residents are comfortable in the current arrangement.

There are many areas for residents to have private time. Bedrooms are shared by two, in a good setting that offer privacy. In the near future, bedrooms will be divided to create single bedrooms to provide residents with more privacy.

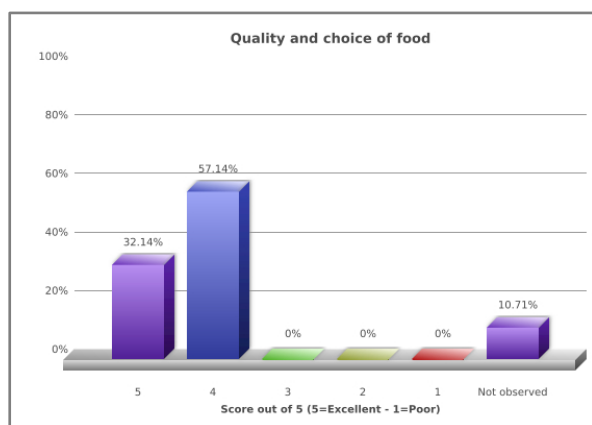
4.2.3 Quality of client services and access

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.



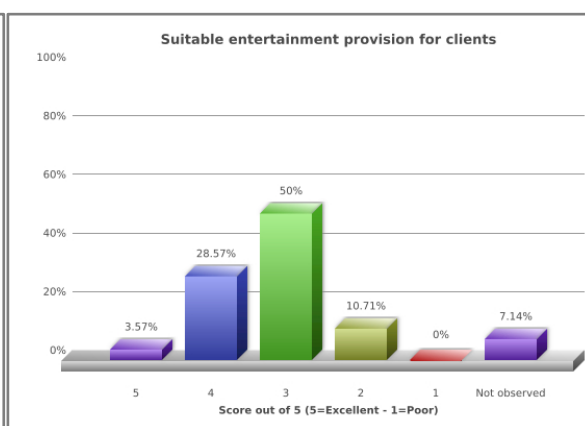
The majority of residents are independent and utilise public transport. However, support is sometimes required to attend medical appointments or the like. Taxis may be utilised and for those with NDIS packages, transport funding may be available through the NDIS. It is more challenging for residents without NDIS funding or who have no external supports.

The vast majority of SRF residents smoke. While smoking is not permitted inside the SRFs, there is ample external provision as the right to smoke is recognised as important to residents. 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 previous reporting periods, the quality and choice of food has generally been reported positively through CVS reports (refer to above chart). A number of SRFs have engaged dieticians to review menu plans and consult with residents and chefs. It has been noted that menus are beginning to transition from older-style meals to lighter, healthier, fresher food. It is anticipated that dietician's participation will greatly assist this process and will help provide more interesting and nourishing meals that also continue to cater for dietary needs.

The early commencement of evening meals in some SRFs has continued to be identified as a concern as has the 'line-up' / 'batches' style of serving, where 5 to 6 residents at a time exit out of the dining room as equivalent numbers enter. Staff reported it assisted with the provision of meals and medications at the same time.



CVs have continued to report that the main entertainment options are TV, board games and books with some SRFs having computers and Wi-Fi connection for residents' use. In most instances, SRFs do not arrange for regular on-site activities to be provided.

Often, residents were 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. Unfortunately, these local government volunteer SRF programs also ceased. Many of these volunteers had been visiting the same clients for several years and had strong bonds and provided external scrutiny and support. This will certainly impact social opportunities available to SRF residents.

A number of reports noted positively to residents accessing their personal documentation and being encouraged to be involved with their financial affairs if able. In one case it was noted that residents help SRF staff prepare their personal care plan when they join the house, but these tend to cover health and medical needs and diagnoses, with less attention to goals.

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 and were aware that if a concern was out of the staff's capacity, a third party would be involved.

SRF residents usually have good access to allied health services such as GPs and podiatrists with visits often happening on site. From CV reports, it appeared staff were observant and noticed health issues arising for residents and took steps to help address them, via the GP in the first instance.

4.2.4 Safety and Rights

This category comprised the components: *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? Was a Visitors Book clearly displayed? Do residents have access to freely available drinking water?*

There was one specific report of a resident feeling unsafe due to their concern of another resident's violent outbursts. CVs suggested that the resident speak with one of the managers to determine what could be done and the Coordinator raised this concern with the proprietor.

The use of security cameras in common areas within some SRFs was also brought to CVS attention when some residents spoke of their discomfort. Again, the Coordinator and PCV raised this concern with the proprietor.

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

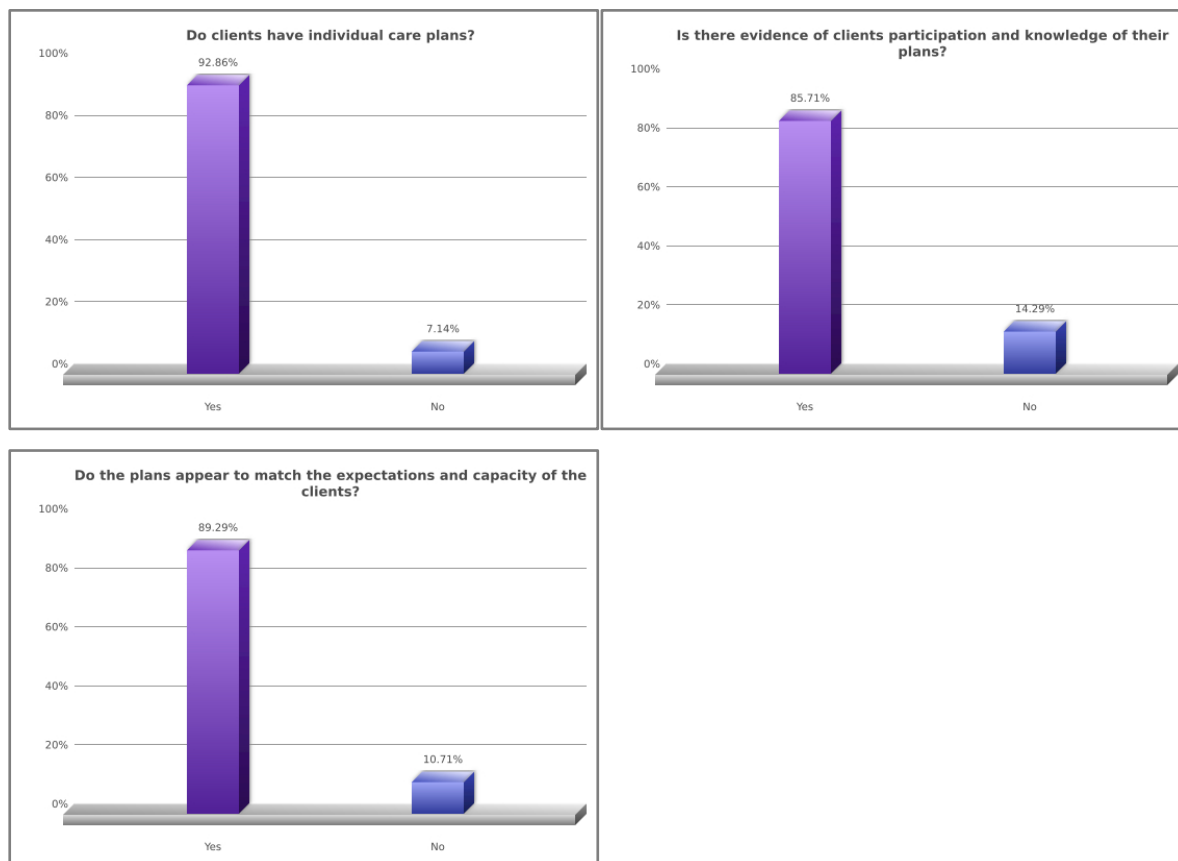
4.2.5 Treatment and Care Planning

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.

As seen in the charts below, the majority of residents were assessed as having a care plan in place, there was evidence of their participation in its development and that the plans appeared to match the expectations and capacity of the resident.

A significant increase in this category was noted from that of previous reporting periods. This is assumed due to the number of residents assessed as eligible for the NDIS and planning meetings that took place accordingly.

In many cases, plans were reviewed as required or annually.



4.3 Issues and challenges impacting SRFs

The 2018-19 reporting period has reflected considerable change for the SRF sector. Completion of the NDIS transition has occurred and a higher number of residents under 65 years of age were assessed and deemed eligible than previously thought.

The CVS addressed the recommendations contained within last year's report and continued to advocate and promote identified issues through appropriate channels up until mid-May 2019. As mentioned previously, due to direction received from DHS, the CVS can no longer provide individual and systemic advocacy support for residents, and is unable to undertake regular and requested visits to SRFs.

4.3.1 NDIS, My Aged Care and a changing accommodation model

During this reporting period, the SRF Association (SRFA) continued to consult extensively with relevant agencies, including the NDIA and DHS.

Whilst it was initially stipulated that organisations could not provide both accommodation and care support services, current SRF legislation states that SRFs do provide both and the NDIA appears to have 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 is due to cease at the end of December 2019 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 and with the signing of Service Level Agreements (SLAs). 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. Concerns have also been raised about the potential for coercion of existing residents to remain in their current SRF if all accommodation options are not considered in the planning process.

Previously 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 SRF residents who have been assessed, have been deemed eligible for the NDIS. This figure includes those with psychosocial disability, previously a disability not assessed.

However, concern still remains for those assessed as ineligible, including residents over 65. The Board and Care subsidy ceases at the end of 2019 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 the Board and Care 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 package are required to access My Aged Care, and both individuals and service providers raised concerns about how difficult this process is. Those over 65 and in receipt of disability supports will continue to access the Continuity of Support program.

The Exceptional Needs Unit (ENU) has been monitoring 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, were established in an effort to ensure that those individuals over 65 or not eligible for NDIS have access to appropriate support. For the time being, these programs are still available and operate within the ENU.

Concern has been expressed regarding time delays in accessing in-kind support. Particularly worthwhile of noting the delay in accessing in-kind support coordination and plan management which has resulted in many individuals being informed they can purchase these services out in the marketplace. However, this continued to cause significant delays in utilising NDIS plans with individuals and families reporting difficulties trying to navigate the system and finding providers who could deliver this support.

4.3.2 Role of Local Government

The CVS relationship with local government, through contact with the Environmental Health Officers (EHOs) and attendance at information sharing meetings of the Environmental Health SRF Special Interest Group had previously been a strength. Unfortunately, since mid-May with the directive and almost \$200,000 cut from our budget, we can no longer provide advocacy service to the SRF sector, and our involvement with Local Government has reduced.

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

The impact of the National Disability Insurance Scheme (NDIS) and the role of the Quality and Safeguarding Commission will have a significant impact on residents living in SRFs. As such the Department of Human Services (DHS) are currently undertaking a review of the impact of the NDIS on the SRF sector. This will include consideration of the *SRF Act 1992* and *SRF Regulations 2009*.

Under Section 9 of the *SRF Act 1992*, local governments are required to undertake “administration and enforcement” including by “licencing supported residential facilities that are situated within the area of the Council”.

Anecdotal information suggests that there is a local government view that the role of licensing SRFs would be more appropriately undertaken by a state government agency, which would have the advantage of standardised licensing and training regimes. South Australia is currently the only state whereby councils have this role in supported accommodation.

4.3.4 NDIS Quality and Safeguards Commission and the hand-over of ongoing concerns

As mentioned throughout this report, due to direction received from the DHS that the CVS can no longer provide individual and systemic advocacy support for residents, there are a number of ongoing concerns that require addressing. A summary is provided below.

4.3.4.1 Inadequate provision of equipment

A family member contacted CVS and expressed concern that her son was sleeping on a urine-soiled mattress on the floor of his bedroom. She further expressed that her son is a NDIS participant, but his funding is inadequate.

4.3.4.2 Inadequate privacy (sharing of bedrooms)

Community Visitors reported at a number of SRFs, the inadequacy of single rooms where many SRFs require residents to share bedrooms. It is not unusual for two or three residents having to share a bedroom and there are SRFs who have up to four people in one bedroom in some instances. This is clearly at odds with the intent of the NDIS who at very early consultations specified that they would not fund services that had more than five residents (each with their own bedroom). Some SRFs have upwards of eighty or more residents and have two, three, or four to a bedroom.

4.3.4.3 Use of security cameras

Observations were made by Community Visitors of the use of security cameras in common areas within some SRFs. When speaking with residents, some reported their discomfort, others said they were not worried about them.

4.3.4.4 Meal provision

Community Visitors reported at some SRFs, the provision of meals occur in a ‘line-up’/‘batches’ style where the evening meal provision occurred as early as 4:15 - 4:30pm. Staff reported it assisted with staffing and provision of medications at the same time when there was only one staff member rostered on for approximately 40 residents.

4.3.4.5 Potential of coercion

On a few occasions, reports to the CVS that some SRF managers were too involved (in some cases were the ONLY representative and encouraged it to be this way) at NDIS individual planning meetings. Further concern was expressed that SRF managers were signing Service Level Agreements and no independent, external supports were available or encouraged to assist residents.

4.3.4.6 Support coordination and plan management in NDIS plans

The concern that support coordination and plan management was not being actively encouraged in NDIS plans was reported to CVS and observed by Community Visitors on a number of occasions. It was further reported when support coordination and plan management was provided, the time delay in provision of support was untenable.

4.3.4.7 Unintended consequence in expansion of SRFs due to accommodation shortages

Initially, many proprietors assumed that only a small proportion of SRF residents would be successful in getting an NDIS plan however, the CVS has been advised by DHS that 90% of eligible SRF residents now have an NDIS package and for the first time have significant funding to pursue goals. Due to this success, the CVS is aware that some SRFs have invested in other large accommodation facilities, for example a motel complex and a 'satellite' of units providing up to 104 beds. Another provider of a large SRF purchased a facility that previously accommodated over forty aged care residents in the Western suburbs and is quickly filling the beds.

There remains a desperate accommodation shortage, especially for many individuals who are bordering on homelessness and we hear regularly from Social Workers in hospitals and mental health units who are struggling to find accommodation to discharge patients to. Anecdotally, we hear of people being discharged to 'Rooming Houses', caravan parks and short-term hotel accommodation. The staff from Hutt Street Centre Homelessness program reported to the Principal Community Visitor (PCV), that they had people arrive at Hutt Street in a taxi after being discharged from a hospital and/or a mental health unit which they then had to try and find emergency accommodation.

4.3.4.8 Withdrawal of council programs and reduction of external services

The withdrawal of Council voluntary programs will likely impact a number of residents resulting in them becoming further socially isolated. It has been further reported some SRFs are discouraging the use of external service providers as they would rather keep personal support, etc. 'in house'. This is another unintended consequence of the NDIS where the SRF Proprietor is the landlord, service provider for meals, medication and provider of personal support and therefore a reduction in external providers entering the premises is deemed necessary.

4.3.4.9 Early discharge from hospital and lack of home support

Reports of early discharge from hospital and the lack of support being afforded within the SRF has resulted in a death of a resident on at least one occasion in the past and placed many others in extreme risk. A proprietor contacted the PCV after one of their long-term residents had become unwell, was rushed to hospital and had surgery. They had visited this person in hospital during his recovery and within days of the surgery, they received a call from the hospital saying they wanted to discharge the patient back to the SRF.

The owner/manager explained to the hospital that their model of accommodation was insufficient to provide the level of support this person obviously needed. The hospital indicated that they would refer to RDNS to provide regular nursing support upon discharge. However, the owner explained that due to the complex and challenging needs of this individual, he will not comply with this arrangement and will tell them to "bugger off".

According to the owner, this was exactly what happened and within days after discharge, the resident was found dead in his room. The CVS reported this case to the Coroner's office.

Other SRFs have reported some hospital discharges have happened late at night, over the weekend and in the early hours of morning.

Summary of issues – where to from here?

Given that the CVS can no longer follow up on these issues, we have since met with the NDIS Quality and Safeguards Commission (NDIS QSC) and provided a comprehensive handover of these concerns. It is anticipated the NDIS QSC will address these concerns through their range of quality checks such as audits, registration and complaints handling and will visit these individuals and/or facilities through a combination of these checks.

Recommendations related to SRFs

1. That the review of the Supported Residential Facilities Act 1992 be completed post-haste and that Rooming/Boarding Houses also be looked into in the context of the NDIS.
2. That mechanisms be put in place to enable independent visitation of SRFs to assess and monitor the five main domains addressed earlier in this section (communication; environment; quality of client services and access; safety and rights and treatment and care planning).

5. Day Options Programs outcomes and themes

As with the SRF component of the Scheme, the Day Options component was well established and ensured there was a more comprehensive service provision to the disability sector. Visitation to Day Options programs (DOPs) occurred until mid-May 2019, when direction was received from the department (DHS) that we can no longer provide this service. Prior to this, Community Visitors (CVs) appreciated the opportunity to gain further insight into the disability sector and the interconnections that were made through visitations to two components of the Scheme.

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

The CVS had 23 providers on its data system, providing Day Options Programs across 70 sites. Some providers 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, 53 were located in the metropolitan area while 17 were regionally based. Day Options Programs offer both onsite and community-based activities.

With the transition of NDIS and provision of individual packages as opposed to the historical block funding, change in the style and delivery of programs was observed. The increase in participants attending programs was also noted.

5.1 Visits and data

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

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

Issues raised in reports were logged onto an issues tracking document which was monitored by the Coordinator. An *Issues Register* was 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 were scheduled visits, with provision of advance notice to the organisations. However, requested visits and unannounced visits were undertaken as required and in line with scheduling opportunities.

During 2018-19, the CVS conducted 56 visits to Day Options Programs. Various considerations impacted 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 18 issues and requests for advocacy were received in relation to Day Options Programs. Of these 12 have been completed while 6 remain open (Refer figure 5.1.1). The issues that remain open have been referred on to the NDIS Q&SC.

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

2018 – 2019	Issues raised	Issues resolved, no further action	Issues outstanding
	18	12	6

Figure 5.1.1 Details number of issues raised and resolved during 2018 – 2019.

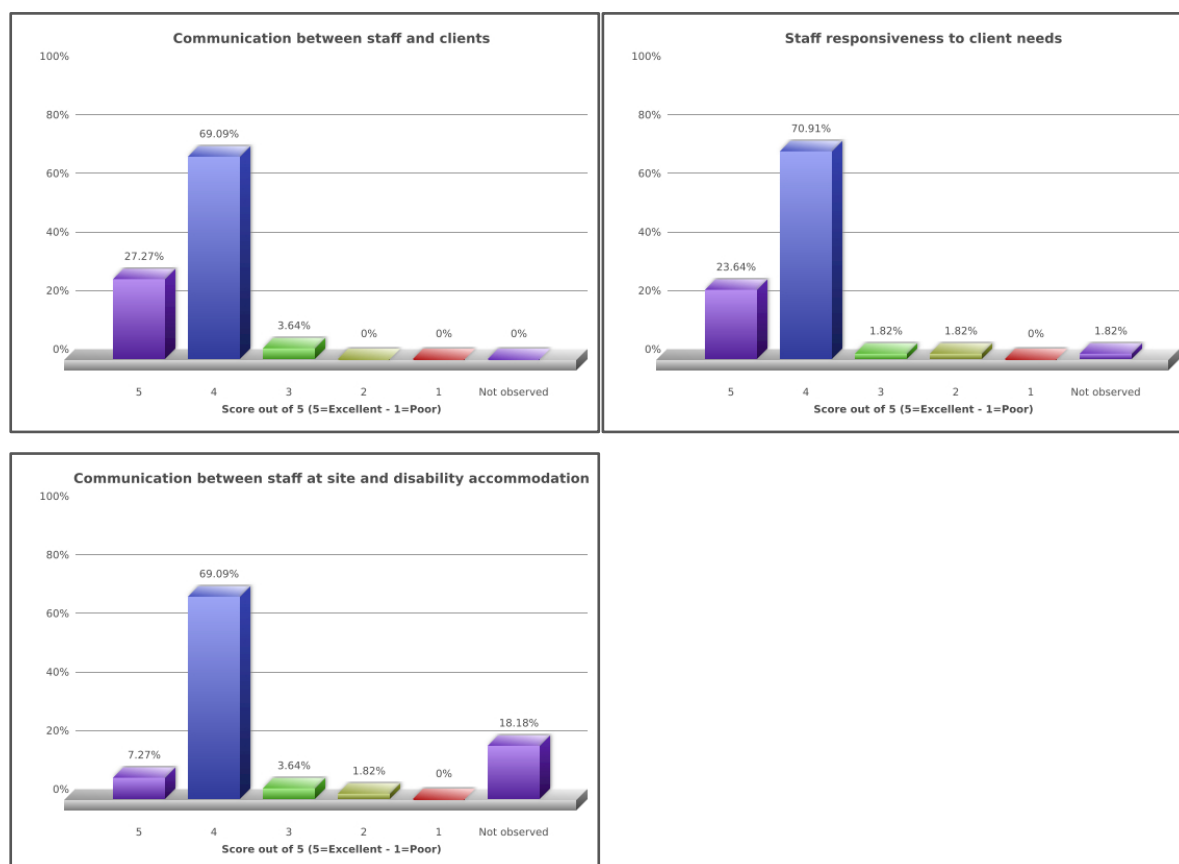
5.2 Key report findings

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 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.



Very engaged and personalised interactions between all staff and clients, it was clear that they know each other well and have developed bonds.

This program is developing their facility based on the clients' needs, such as developing the learning centre so that the clients can maintain their literacy, numeracy and computer skills; adequate sensory room; and gym centre which includes foot massage and other suitable physical activities for each client.

The program uses the electronic Seesaw App to provide parents and carers at disability accommodation with daily updates on clients' activities and behaviour. It has been successfully trialled for schools where teachers and students can share progress in classrooms with parents. The ability to share several, immediate brief updates and notes as well as photos was seen as an advantage over a written diary.

In summary, reports also demonstrated the value of NDIS funding. A number of clients spoke of having more choice to move from one program to another now that more funding to achieve their goals has become available.

The facility is undergoing a major program change due to NDIS requirements of clients. The programs will be based around a 'term' approach which fits with many client families with current school arrangements. Basically

selection options will be offered from which clients can select up to 3 programs. The programs are usually structured around morning or afternoon activities both onsite and offsite community based interaction. The programs attempt to cater for the varying abilities of clients and client focus is evident in the provision, connection and development of independence offered within this framework.

As noted above, some service providers have undertaken quite a program change to better meet the varied needs and interests of clients. Further, some larger organisations with multiple sites have a different focus at different sites.

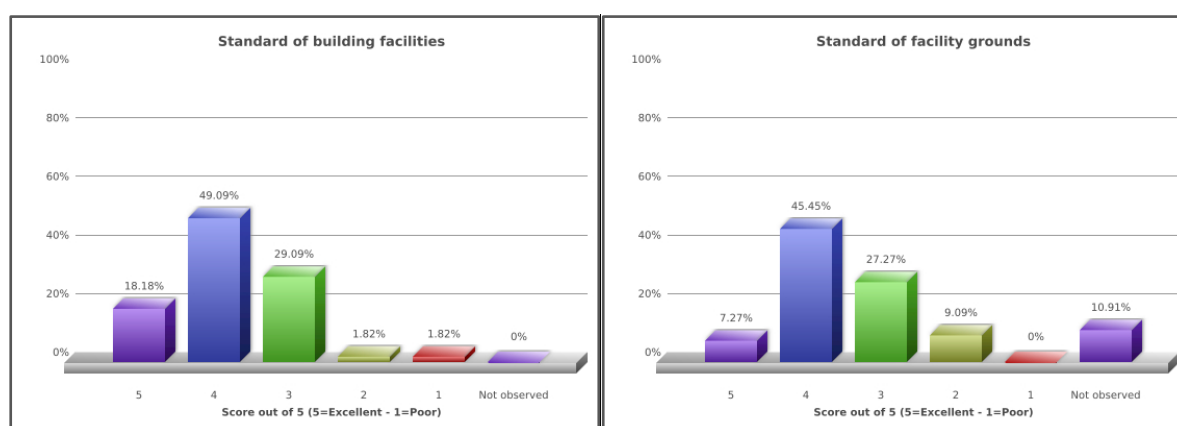
Clear and consistent communication between Day Options Programs and disability accommodation providers and family is essential in supporting seamless and appropriate service provision for clients. Various communication methods are used, including email and phone contact, focus groups and family social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

5.2.2 Environment – suitability of facilities and their maintenance

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

Reflected in the ratings provided below, 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, noted in many reports, modifications – both internal and external - have enhanced opportunities for clients. Examples were provided that described complete rebuilds, repurposing of existing facilities and development and beautifying of gardens and patio areas.



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

Reports indicated 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 (PEEP) and the inclusion of clients in safety drills, when appropriate.

5.2.3 Quality of client services and access

Components considered within the category included: *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.*

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 or sharing disability accommodation vehicles if not required at the accommodation site during the day, thus reducing the individual transport time. However, this poses more of a challenge for smaller organisations.

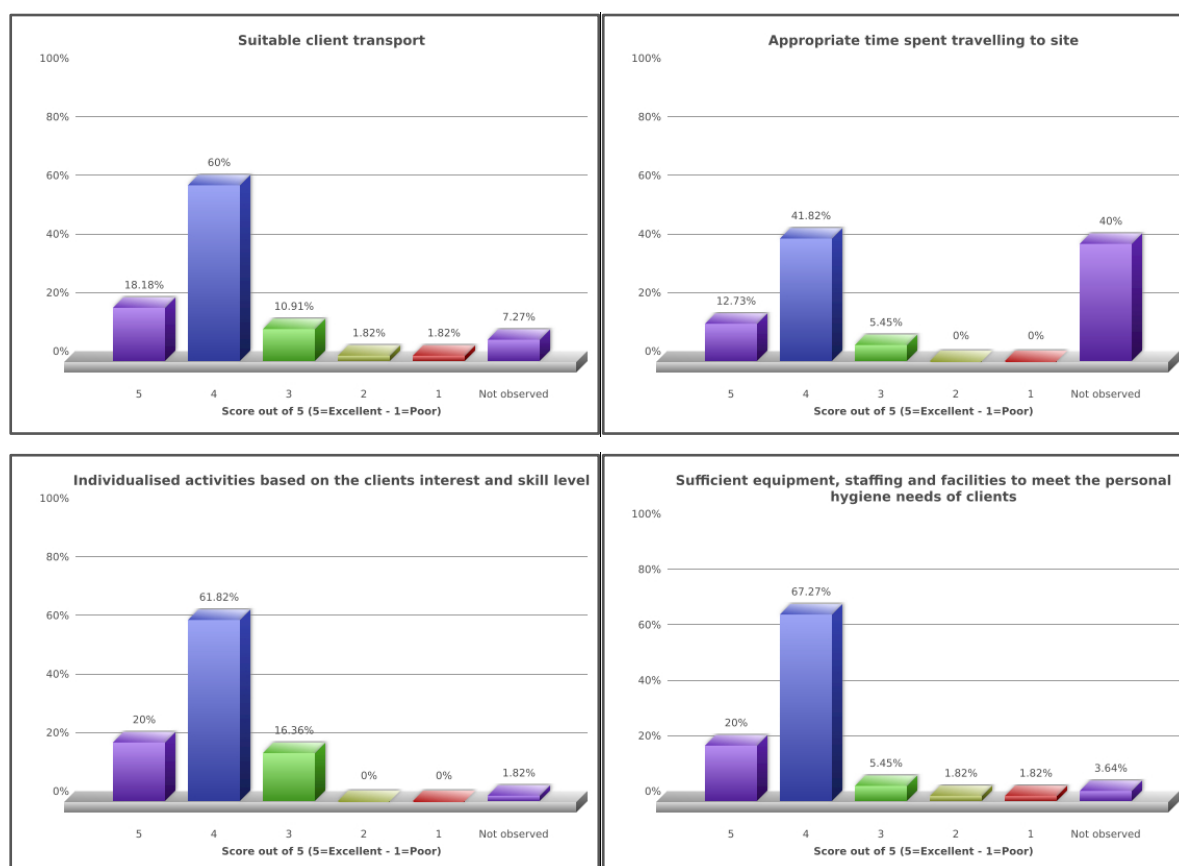
All the clients live close to the facility and the average travelling time is ½ hour.

Although some clients travel from 45kms away, it is really only a 45-minute drive which is not seen as unusual in the country.

With the transition to NDIS now complete, the impact of inadequate transport funding is being felt as the development of programs being more community based is increasing.

The facility has 2 vans for outings but transport to and from the program is not supported by NDIS in all instances so mostly, parents do it. The program lost 3 clients when this was not convenient for some parents.

The issue of transport is discussed further in 5.3.2.



As evidenced above, most reports 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, reflected this approach. Organisations also welcome the involvement of family in activity and program planning.

A staff member was kind enough to provide a hard copy of their proposed Program for Oct - Dec. The range covers community board games, Art, Bowling, Swimming, Cooking, Cooking for independence, Craft, Computing, Dance, Drumming, Outdoor Gardening, Gym Healthy Lifestyles, Job Skills, Music, Budgeting and Job Skills. The program is adaptive and very much client focused. While we were there a group was undertaking a 'budgeting' workshop which as a project will cost out and provide for a Xmas show.

Not only is there a great variety in group activities at the facility and in the community but the integration of activities with local business is commendable. There is local gym, pool, pub/hotel and CWA access either through long standing relationships and/or business owners approaching Bedford's to partner with them. There is even opportunity to participate in Meals on Wheels preparation and delivery activities. Participants have also been invited to visit residents in a local aged care facility.

The clients were working on individualised projects, eg a model aeroplane or a pot plant holder. (Worker) is a skilled support worker, and closely supervises the clients to build and practice skills safely at an appropriate level. The group has also made bird houses and a possum house that they intend to sell, with all profits to go back into the day options program.



Painting of Uluru by Darren Morris (Compass DOP participant)



'A Vase of Roses' painted by Adrian Bonney (Compass DOP participant)

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.

Whilst examples provided above revealed some very innovative and entrepreneurial initiatives, some examples were also noted where regardless of the genuine care of staff, it appeared that clients just sat rather than being engaged as much as possible.

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 inadequate 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 remained a specific focus of the CVS visits and reports indicated that the majority of programs were being conducted with access to appropriate facilities and staff resources. Where this has not been the case, the CVS made immediate contact with the organisation. Examples of concerns raised include inadequate privacy, frequency and routine of personal care provision and access to appropriate facilities.

One room for the use of 16 clients, which also contains one of the two toilets. Concern about the lack of personal care facilities, the location of the bathroom and kitchen. It was reported that if a client has a bowel action in the bathroom it can be smelt in the kitchen. There are also concerns about the maintenance of the

bathroom. The toilet seat cannot be lifted making it more work to clean. A second bathroom for another group of 9 clients again is a concern regarding the lack of facilities.

The building has only one toilet and bathroom. Sometimes there will be more than 10 clients.

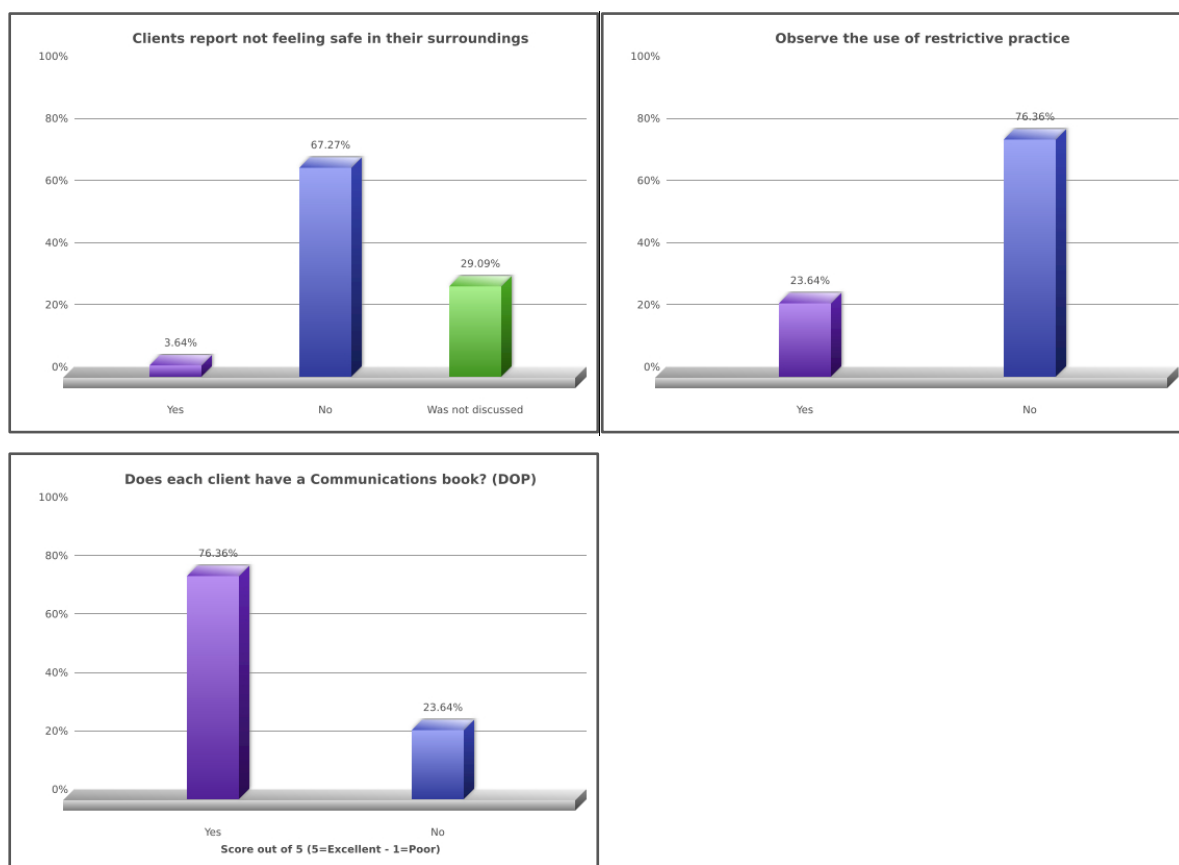
It is critical that both Day Options programs and disability accommodation maintain awareness of any instances of clients being left soiled and unattended. The capacity for CVS to 'cross check' such issues raised in disability accommodation reports also offered a greater level of client protection.

5.2.4 Safety and rights

This category focussed 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 was again 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.

Where concerns regarding restrictive practices were reported, they were dealt with immediately and with the utmost of importance. One such situation involved the Office of the Chief Psychiatrist being requested to undertake an investigation as multiple restrictive practices were enforced on a client during transportation from a program to hospital.



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 an increase in the presence of Behavioural Support Plans (BSP) and in some cases the involvement of behavioural therapists to assist with particular clients. It was evident from reports that in many cases, family are involved in the development of personal plans.

Clients' sense of safety was 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 indicated 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 indicated they are utilised very consistently. When this is not the case, organisations express a high level of frustration.

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 transition to NDIS now complete.

5.3.1 The Day Options model

Exactly how Day Options will evolve is still unclear. However, what is clear is that the NDIS will certainly impact the Day Options model as we have known it in the past.

Since the direction received from the department (DHS) in mid-May 2019, that CVS can no longer provide visitation and inspections and advocacy support to Day Options Programs run by NGOs, it is difficult to comment on how many new providers will enter this space, how many current providers will exit and what will represent a Day Options program in the future. What is hoped is that 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.

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 will continue to support and the inherent budget challenges this presents, particularly with regard to appropriate levels of resourcing. Larger organisations are better positioned to absorb such challenges, smaller organisations less so.

5.3.2 Transport

Transport is frequently highlighted as an issue for both providers and clients, increasingly so as the NDIS transition is now complete. 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 occasions, organisations collaborate and share transport resources.

Under the NDIS, clients incorporate travel costs into their plan. However, there has been ongoing 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. At the time of preparing this report, updated information was not available on the website. Therefore, it is unknown whether 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 funding

Adequacy and accuracy of individual funding has again been raised as a 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.

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 Options Programs have a variety of support requirements, particularly with regard to 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 'incontinence incidents' are dealt with.

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

The CVS also believes that all services need to continue 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 need to continue 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.

CVS cannot stress enough the importance of support agencies consulting with the individuals and their families 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 having to fit into Day Options service models because there are no staff at their home to provide the support they need. There needs to be genuine choice and control about where, how and who with, these individuals want to engage in activities.

5.3.5 NDIS Quality and Safeguards Commission and the hand-over of ongoing concerns

As with the SRF component of the Scheme, due to direction received from the department (DHS) that the CVS can no longer provide individual and systemic advocacy support for clients, there are two ongoing concerns that require addressing. A summary is provided below.

5.3.5.1 Restrictive Practices

Staff at a Day Options program contacted CVS expressing their concern with a client who received multiple restrictive practices (4-point shackling, netting and chemical restraint) during transportation and admission at a hospital. Whilst this concern was immediately raised with Dr John Brayley (Chief Psychiatrist), requesting his office investigate this incident, CVS have since met with the NDIS Quality and Safeguards Commission (NDIS QSC) and provided a comprehensive handover of this concern.

5.3.5.2 Travel time to and from Day Options programs

Community Visitors have reported of clients travelling excessive distances and/or being confined to a vehicle(s) for a large length of time.

It is anticipated the NDIS QSC will address these concerns through their range of quality checks such as audits, registration and complaints handling and will visit these individuals and/or programs through a combination of these checks.

Summary of issues – where to from here?

As with the SRF component of the Scheme, that the CVS can no longer follow up on these issues, we have since met with the NDIS Quality and Safeguards Commission (NDIS QSC) and provided a comprehensive handover of these concerns. It is anticipated the NDIS QSC will address these concerns through their range of quality checks such as audits, registration and complaints handling and will visit these individuals and/or facilities through a combination of these checks.

Recommendations related to Day Options Programs

1. That independent monitoring be put in place to ensure ongoing assessment of the five main domains addressed earlier in this section (communication; environment; quality of client services and access and safety and rights).
2. That there continues to be independent scrutiny of DOP participant's choice and control over the model that enables them to reach their full potential through individual activities and experiences they want.

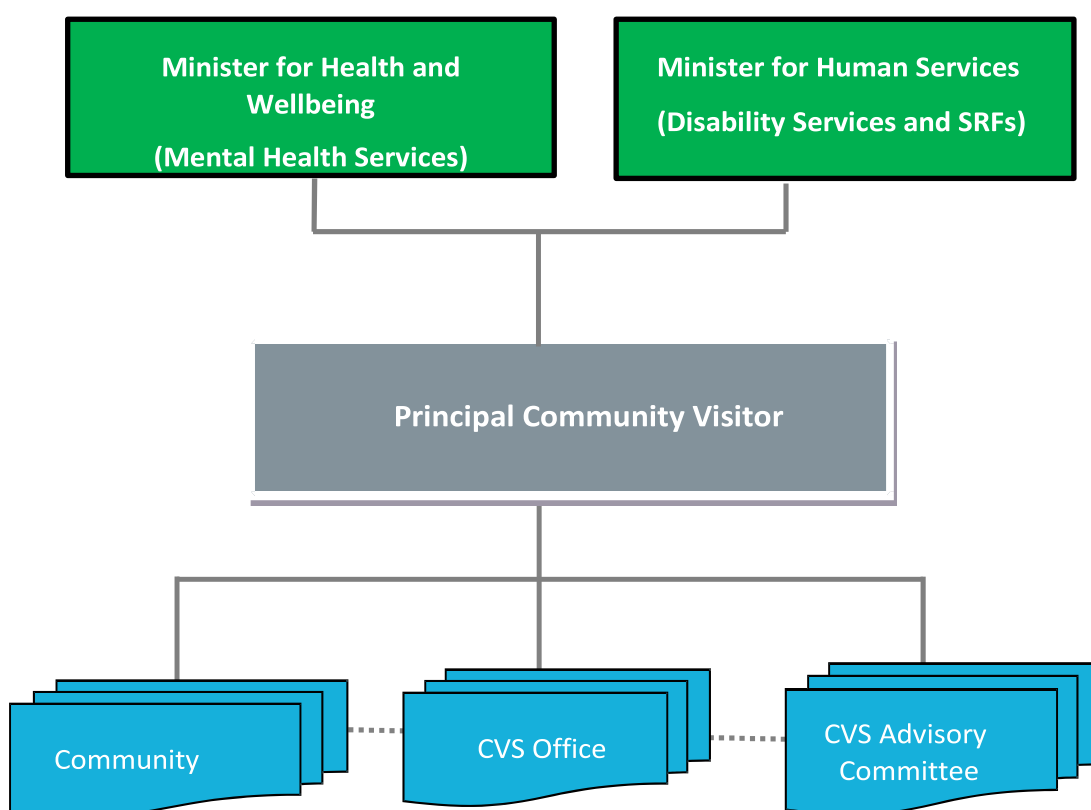
6. Workforce

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 the key issues arising from the work of 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 2018-19 reporting period:

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

6.3 Advisory Committee

The members of the Advisory Committee during 2018-2019 were:

Ms Anne Burgess	Chairperson
Mr Maurice Corcoran AM	Principal Community Visitor
Dr Niki Vincent	Equal Opportunity Commissioner
Ms Anne Gale	Public Advocate
Dr Grant Davies	Health and Community Services Complaints Commissioner
Mr John Hermann	<i>proxy for</i> Health and Community Services Complaints Commissioner

Mental Health Representatives:

Dr John Brayley	Chief Psychiatrist and Director Mental Health Policy
Ms Lisa Huber	<i>proxy for</i> Chief Psychiatrist and Director Mental Health Policy
Mr Chris Burns	Mental Health Commissioner
Ms Carol Turnbull	Private Mental Health Services Representative
Mr David Saunders	<i>proxy for</i> Private Mental Health Services Representative
Ms Ellie Hodges	Consumer Representative
Ms Charmaine Gallagher	Carer Representative
Mr Tony Rankine	Community Visitor Representative (Mental Health)
Mr Kim Steinle	<i>proxy for</i> Community Visitor Representative (Mental Health)

Disability Representatives:

Dr David Caudrey	Disability Advocate
Ms Zofia Nowak	Director, NDIS Implementation
Professor Richard Bruggemann	Former Senior Practitioner
Ms Sandra Wallis / Ms Lorraine Marshall	Government Disability Accommodation Representative
Mr Peter Hoppo	Non-Government Disability Accommodation Representative
Ms Kris Maroney	Supported Residential Facilities Sector Representative

Ms Jayne Lehmann

Mr Jim Evans

Ms Judy Harvey

Disability Carer Representative

Community Visitor Representative (Disability)

proxy for Community Visitor Representative (Disability)

6.4 Community Visitors

The Community Visitors (CVs) have impressive backgrounds, skills and passion which have helped to deliver the Scheme's key outcomes of monthly visits and inspections and associated reports at a very high level.

Community Visitors are an integral and valued component of the Scheme and it is with great pleasure that we introduce two of our long-serving Community Visitors:

Lindy Thai – appointed 3/10/2013



I studied a Bachelor of Social Science (Human Services) at The University of South Australia.

The knowledge and skills developed in my studies, as well as insights from my work as a support worker, guide my practice in my role as a CV.

One of the most rewarding aspects of being a CV is seeing improvements in service provision at the sites visited, knowing that the reports written following the visits have contributed to bringing about positive change.

It is also a privilege to work alongside my fellow CV colleagues who I have learnt a lot from as well as formed friendships with.

Marianne Dahl – appointed 28/01/2014

Having studied Social Work back in the 80s, I undertook a variety of roles, mainly related to community development. This highlighted the serious inequalities faced by many groups within our society and the lack of understanding of many policy makers of the resulting impacts on people's daily lives. I have always had an acute sense of social justice and fairness. I also think that many community responses to marginalised groups are not always kind or fair.

Involvement with CVS has given me an opportunity to contribute to a client centred evidence based process which can influence positive change. This is such a privilege but is sometimes tough. Working with other like-minded people in the pursuit of systemic improvement makes CVS work not only satisfying but very enjoyable.

My small contribution will be my legacy.



It is also a pleasure to share some examples of the feedback provided from other CVs during the year.

"I am very proud to be a part of the CV scheme that supports both staff and clients in the disability and mental health sectors. Its presence is a sure sign of a healthy community." [Community Visitor]

"The CVS staff are such a professional, helpful, warm and friendly group and headed up by a Principal who is a model of these attributes." [Community Visitor]

"I continue to regard the CVS as the benchmark in "How to look after and retain volunteers" – you could put it into a manual and offer it to other government departments." [Community Visitor]

Although it is always sad to see CVs leave the Scheme, it is also wonderful to see the opportunities which have opened up to them, demonstrated by three recent examples which are shared below.

"I would like to state that being given the opportunity to work as a volunteer in the role of Community Visitor with CVS has given me a true sense of pride and an invaluable experience. It created a stepping stone for much learning, experience, confidence and further employment."

Having the opportunity to meet and chat with and advocate for the vulnerable in our community has enriched my life in so many ways. As a person with lived experience myself it gave me a sense of worth and empowerment."

I loved the time and role and it really did give me such value and helped me in so many ways. I am grateful this service exists and thank the team and Maurice for the huge opportunity and honour of having worked in such a quality team and role."

[Resigning Community Visitor]

"I really can't speak highly enough the honour I feel for the opportunity to have been a Community Visitor with the Community Visitor Scheme."

I have sincerely enjoyed being part of the team, the friendships formed, the wonderful people I had the opportunity to meet from all walks of life, and the educational opportunities gained through the course of the work. Even today, first-hand knowledge acquired through the role assisted me as I was speaking with two carers from different families who currently have loved ones in the xxx Centre, one of whom was quite disappointed and thoroughly drained as she felt her daughters needs were not being met and the pressure for her to be discharged home when she is clearly still acutely unwell, requiring constant supervision."

I feel to a certain extent, once a Community Visitor, always a Community Visitor!"

[Resigning Community Visitor]

"I have enjoyed the contact I have had with you all and it truly was a privilege to be able to work towards the goals of the CVS with the team. It is pleasing to hear that the CVS role is valued highly by staff and management of facilities visited – and other related agencies serving clients of these facilities."

[Resigning Community Visitor]

Below is a list of all the Community Visitors who have contributed during the 2018-19 reporting period:

Adele Querzoli	John Leahy
Andrea Richardson	John Sheehan
Andrew Crowther	Judy Harvey
Angela Glenn	Kim Steinle
Angela Koutsidis	Lia Bibbo
Anna Segreto	Lindy Thai
Ayu Pamungkas	Maree Hollard
Brian Day	Marianne Dahl
Bryn Williams	Michele Slatter
Cathy Walsh	Nike Babalola
Cecil Camilleri	Nirvana Hurworth
Chan Panditharatne	Ron Oliver
David Meldrum	Sally Goode
Elle Churches	Sara Elfalal
Erika Davey	Sharon Hughes
Garry McDonald	Shipra Sareen
Gitta Siekmann	Sue Whittington
Helen Winefield	Sultana Razia
Ingrid Davies	Tony Rankine
Jacy Arthur	Von Cheng
Jane Meegan	Yingchao Han
Jenni Kendal	Yinzi He
Jim Evans	Maurice Corcoran (Principal Community Visitor)
Joanna Zhuang	

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 sixty-eight (268) Expressions of Interest were received during the reporting period, this represents a 27% increase on the previous year. Of these, sixty-six (66) applications were received (a 73% increase).

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 4.4.2)
- » undergo DHS screening checks and referee checks, and
- » undertake a minimum of two orientation visits with the PCV.

Twenty-five (25) applicants proceeded to training after undergoing a successful interview (an increase of 56.25%).

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

Recommendations for appointment to the role of Community Visitor require Cabinet approval and endorsement by His Excellency, the Governor of South Australia. All appointments are then published in the Government Gazette.

Eleven (11) applicants were appointed. Seven (7) did not proceed to appointment after training or orientation due to withdrawing (for a number of reasons, including securing full-time employment or personal / health reasons), or being unsuccessful after training / orientation. A further seven (7) are undertaking Orientation visits at the time of writing, with a view to being appointed if assessed as being suitable.

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

As reported in last year's Annual Report, the ICAC Commissioner, the Honourable Bruce Lander undertook an enquiry into Oakden which followed a report by the then Chief Psychiatrist. The Commissioner's report, 'Oakden: A Shameful Chapter in South Australia's History' contained a recommendation that a review of Community Visitors training and qualifications be carried out. As mentioned earlier in this report, an independent review has been undertaken by Julian Gardner AM who was the inaugural Public Advocate in Victoria and established their Community Visitor Scheme. This review has been completed but as a result of the uncertainty about the outcome of the review, the Minister for Health and Wellbeing requested that appointments be for a one year term (rather than three years) until further notice.

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, Function 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, Gender Safety, Restrictive Practices & Disability and its impact
- » **Module Ten:** Cultural Competencies, and
- » **Module Eleven:** Values Testing for Disability and Mental Health

Sessions were held in August and November 2018 and February and May 2019. Twenty-five (25) participants attended training sessions, which is an increase of 56.25% on the previous year. In addition, two new staff members also attended the training as part of their induction.

On completion of the program, attendees are asked to complete a 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.

Participant use of the online survey 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 six (6) statements for six (6) of the ten assessed Modules:

- » the information was clear
- » the style of presentation suited my needs
- » the presenter's knowledge was sufficient
- » the resource notes were sufficient
- » participant interaction was adequate
- » I feel confident in meeting the learning objectives of this module.

The results for the remaining four (4) modules were that 95% of respondents strongly agreed or agreed. The remaining 5% selected "neither agrees nor disagrees".

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

Following are comments from the four training workshops held during this reporting period:

- » **Module One:** Introduction, Overview and History of the Community Visitor Scheme
 - I felt I gained a good understanding of the background, purpose and basic structure of the Community Visitor Scheme.
 - A good overview of the scheme.
 - Scenarios provide good examples when dealing with complex issues.

- » **Module Two:** Role, Function and Scope of the Community Visitor Scheme
 - Information provided in the manual backs up the presentation and will be a very useful resource for the future.
 - In this module, I gained a good understanding of the role of a Community Visitor, limitations of the role and responsibilities as a Statutory Officer.

- » **Module Three:** CVS Visits and Inspections
 - While the presentation and the manual provide a considerable amount of information it also made me realise that there is much more still to be learned through participation in the visits with the PCV and other CVs.
 - The experienced Community Visitors that presented this module gave a great overview of the facilities and services that Community Visitors inspect and the scope and purpose of visits and inspections. I also gained a good understanding of the reporting requirements and how to deal with issues of concern.
 - Current Visitor presentation was interesting and engaging.

- » **Module Four:** Practical Matters for Community Visitors
 - In this module I gained a good understanding of Community Visitor's reporting relationship with the Principal Community Visitor, reimbursement entitlements, support mechanism and volunteer rights.
 - Information was well covered and provided reassurance that any support that was required would be provided.

- » **Module Five:** Lived Experience
 - Good to hear from someone who has lived experience.
 - I gained an understanding of some of the experiences of individuals using mental health facilities and living in disability homes and their families, including stigmatisation, grief, the strengths based partnership model of care and consumer rights.
 - Good to challenge perceptions.

- » **Module Six:** Mental Health
 - A good overview of relevant sections of the Act.
 - Gained a basic understanding of mental disorders, the Mental Health Act and individual and consumer rights.

- » **Module Seven:** Communication Strategies
 - An important topic with many different facets which was well covered. The manual will provide a useful resource.
 - I gained a good understanding of the variety of communication needs of service users and strategies for effective communication.
 - Many ideas and pointers of appropriate communication with the examples that were discussed.

- » **Module Eight: Disability**
 - Presentation was excellent and clearly demonstrated some of the values and attitudes we don't always realise that we have. Again it was good to be able to meet and discuss some of these issues with a person who has lived experience.
 - In this module I gained a clear understanding of disability and associated myths and stereotypes, as well as the history of disability and disability legislation.
 - A good interactive session I won't forget quickly!

- » **Module Nine: Dual Disability, Gender Safety, Restrictive Practices & Disability and its impact**
 - The presenter was extremely knowledgeable about the topic which was excellent.
 - In this module I gained a good understanding of the impact of disability on individuals and families, gender safety and restrictive practices.
 - Good to hear about what a restrictive practice is.

- » **Module Eleven: Values Testing for Disability and Mental Health.**
 - The questionnaire was very useful and did challenge your values. It was good to discuss with other participants and re-evaluate your own ideas.
 - Again, I have learned new things and ways to practice my future CV role and tasks.

In addition to rating each module, the attendees are encouraged to provide some written feedback. Following are comments from this the four workshops held during this reporting period:

- » *Well-structured and managed training which covered very relevant topics.*
- » *I thoroughly enjoyed the training and left feeling confident to begin working as a Community Visitor. I am eager to apply all that I learnt in the training and am looking forward to learning more along the way.*
- » *A lot of information was presented in a clear and engaging manner. This made the volume of information much easier to process whereas at other courses one may have tuned out after some time.*
- » *Was lovely to hear first-hand experience for both those with lived experience and those who are current visitors. Everyone was very nice and easy to approach. It was lovely meeting all the people in the office too.*
- » *The folder presentation and resources included are brilliant. Although so much information was presented over the 2 days it was easy to follow. Discussing real life scenarios and thought provoking discussions are personally my favourite way of learning so I really appreciated those discussions. It was a pleasant learning environment.*
- » *I strongly agree that the course was delivered by well-informed speakers to a very high standard, and I'm certain that every participant will come away more confident and effective in the scope of the CV role.*
- » *All up very comprehensive training thanks.*
- » *I learnt an incredible amount over the course of the two days! Maurice, Margie, Marianne, Bryn, Nick, Trevor and Richard were fantastic speakers and very knowledgeable about anything CVS, as well as bringing their personal experiences to the group which was very insightful. Leanne, Kate, Micah and Nicole were very helpful in explaining how the system works and offering tips and advice to us. Rondelle did an amazing job of making sure the two days ran smoothly and I really appreciated all the work that went into the training days. Even the food and drinks were excellent. A big thank you to everyone involved. The rest of the trainees were lovely people too!*
- » *My feedback re the training is entirely positive. I would like to thank and commend you and the CVS team for the thoroughness with which you addressed all of the modules. To Leanne, John, Micah, Nicole & Kate - thank you for the invaluable input; I appreciate the effort Maurice made in popping by to introduce himself. To the guest presenters - Margie, Trevor, Michelle, Sharon and Richard - for the challenges, inspiration and wealth of insight - I feel the foundation has been well laid in providing we novice 'Community Visitors' a useful perspective/toolkit to commence our roles. Thank you Rondelle for your adept management of our training.*

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 thirty-eight (38) orientation visits were completed with the PCV (an increase of 35% on the previous year).

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.

From the twenty-five (25) participants attending the 2 day training, seven (28%) have not progressed through to appointment, providing confirmation 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.

Community Visitors have access to ongoing training and professional development and were offered a number of external training opportunities, including:

- » Intellectual disability – e-learning
- » The Voices of Autism – Torrens University
- » Manual Handling
- » Disability Awareness Training – online course
- » LGBTIQ - Sexual Diversity - Southern Volunteering
- » TheMHS (The Mental Health Services Learning Network) Conference – Adelaide
- » Self-care for Mental Health professionals - webinar by Mental Health Professionals Network (MHPN)
- » NDIS Quality & Safeguarding for Operational Managers
- » Mental Health Advocacy and Leadership Training - Health Consumers Alliance
- » Behaviour Support, Compliance & Public Advocacy under the NDIS
- » Mental Health First Aid
- » Provide First Aid
- » NDIS Defensible Documentation

Appointed Community Visitors are also invited to attend the ‘Introduction to the Mental Health Act and basic Communication Strategies in Mental Health’ and / or ‘Restrictive Practices’ sessions of the training, as a refresher.

The CVS sponsored six (6) CVs to attend the TheMHS Learning Network 2018 Annual Conference which was held in Adelaide. The Mental Health Services Learning Network is an international learning network for improving mental health services in Australia and New Zealand. TheMHS Learning Network events bring together people from across Australia and New Zealand to stimulate debates that challenge the boundaries of present knowledge and ideas about mental health care and mental health systems.

Four (4) CVs participated in the National Volunteer Week parade, along with the Principal Community Visitor and staff from the CVS Office.



Annual development reviews are conducted with the PCV to provide a formal avenue for feedback and development discussions. Twenty-six (26) 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 43 active CVs, with 16 being reappointed for a second term of 1 year. A further sixteen CVs have resigned due to gaining work and/or health conditions (a 77% increase on the previous year).

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. A wide array of guest speakers have also been welcomed this year:

- » August 2018 – Hon. Michelle Lensink MLC, Minister for Human Services, guest speaker
- » October 2018 – Hon. Stephen Wade MLC, Minister for Health and Wellbeing, guest speaker
- » December 2018 – Caroline, who lives in supported disability accommodation and has previously had a visit from the CVS, came along to share her experiences of the visit with the group
- » April 2019 – Commissioner Chris Burns, South Australian Mental Health Commissioner, guest speaker
- » June 2019 – representatives from The NDIS Quality and Safeguards Commission

There were 72 attendances by CVs across the 5 'get togethers'. Notes from the August, October, December, April and June meetings have been included in bi-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 with positive feedback being received, such as:

This was my first get together and I found it very useful getting to know other CV's and hearing their views.

Great job yesterday, thank you and to all others involved! As always, the day went smoothly; most professional.

I thought that there was some great information & discussion; really got a lot out of it.

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.

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.

In early 2019, a 'Members Only' section was added to the CVS website which is another communication strategy for keeping in touch with CVs. Newsletters, policies and key documents are regularly uploaded to the site 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 and one Public Service Volunteer Policy meeting, in addition to an information session regarding the new Free Volunteer Screening Checks.

In addition, 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 very successful for the scheme with many refinements and improvements following the independent review of the CVS. However, it is deeply disappointing to have our scope of visits reduced that now prevents us visiting NGO disability providers of accommodation and Day Options Programs and SRFs.

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's working well and what needs to be improved. The services we visit are increasingly using 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 and there is significant inconsistency in individual care plans. As an 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 individuals and SRF owners.

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 has a well-developed, robust process of tracking and following up on all issues 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 the Oakden Services investigation and the ICAC enquiry. This includes but is not limited to, that we now ensure there are 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 the independent review of the CVS was very open and transparent as previously outlined. The PCV also looked forward to the release of the report on the national review of Community Visitor Schemes having the benefit of reading an embargoed copy of this report. The PCV believes that it is in the public interest that all stakeholders with an interest in safeguarding get to read and discuss this important report.

Given that my resignation takes effect on 13 September 2019, this is my final annual report as the Principal Community Visitor. It has been a great honour and privilege to serve in this position over the past 8 ½ years since July 2011. I have stated many times over the years how much I love this role. It has had the perfect match of roles that I enjoy, such as building and maintaining high performing, loyal teams who have a shared passion of human rights protections for vulnerable people. Being able to monitor, report, advocate and speak out on individual and systemic injustices or unfair or unreasonable treatment of people with disabilities including those with a mental illness, has indeed been an amazing role to play with a great team of exceptional Community Visitors.

We have been able to do this collectively and celebrate our achievements and changes made for the better through our many visit reports that are relayed back to services for a response and service improvements. The culmination of all our visit reports and related work is compiled into our Annual Reports to Parliament which have included the matters that have not been addressed or resolved.

To paraphrase Sir Ronald Wilson, the first President of the Australian Human Rights Commission, I can think of no greater role in life than advocating on behalf of those unable to speak for themselves, and we have done this as a team.

At this time last year, the CVS was just coming to terms with the recommendations made by the Independent Commissioner Against Corruption (ICAC) in his report on the Oakden Older Person's Mental Health Service, and some of the key questions the Commissioner had of the CVS, especially in relation to rates of unannounced visits and the training and qualifications of CVs. These were important questions to ask and the independent review of the CVS was also very important as a means to respond to these questions and provide objective advice back to the Minister about the scheme and its overall performance.

I would like to acknowledge the very open and transparent process that has been undertaken to address, consider and respond to the recommendations made by the ICAC. The Office of the Chief Psychiatrist (OCP) that has led this work, has been exceptionally open and genuinely consulted the CVS throughout this process and has been respectful of the independent statutory role and function. Likewise, Julian Gardner AM (the inaugural Public Advocate of Victoria who established their Visitor Scheme), who was the independent consultant tasked with conducting the review of elements of the CVS, was very clear and open with the CVS on the review process and consultation opportunities. He kept us informed throughout the review and shared copies of his draft report and key findings. Mr Gardner has had many years of experience in the human rights field and has an outstanding way with words that captured complex key findings in simple language.

This resulted in the CVS trusting and valuing this opportunity to have independent scrutiny of what we do as a Scheme and actually expanding the independent review into our processes for the recording, referring and monitoring of issues identified by our visits and/or complaints that individuals and their families have disclosed to us about services. As a result of this and our own continuous improvement strategies, I can genuinely and confidently state that we now have a far better internal system that is efficient and effective for being accountable and responsive to our safeguarding role and our functions and powers described under the *Mental Health Act 2009, Part 8, Division 2 – Community Visitor Scheme*.

The review was a positive outcome from the ICAC Recommendation 7 and the process of the review allowed the CVS to look closely at all aspects of the scheme including recruitment and training of CVs, visit processes and issues tracking and follow up. The independent reviewer found that "the process for resolving issues applied by the CVS is methodical, timely, has appropriate steps for the escalation of serious or urgent matters and ensures that the appropriate persons do provide a response". I am confident that the final review report will showcase the strengths of the SA CVS and I look forward to the release of the report in the near future.

Reduction of scope of the CVS in the disability and SRF sectors

In terms of the significant reduction of scope of the CVS in the disability and SRF visits, I believe it is important to place on the record that all other states that have visitor schemes in place, found either a legislative or regulatory remedy to enable their schemes to continue to visit their respective NGOs and SRFs. It's not just the SA CVS and our NGOs who wanted the scheme to continue. The SRF Association, the National Disability Services (the peak body for NGOs) and the NDIS Quality and Safeguards Commission all expressed views about the importance of the CVS continuing, especially during this early stage of the NDIS implementation.

South Australian tax payers are contributing over \$740M per year to the NDIS and I would have thought that the cost of the Disability CVS being approximately 0.1% of this amount would be a worthwhile investment to have independent visits, inspections and checks on how well individual NDIS plans are being utilized, whether there are any systemic issues emerging, and ultimately, are we getting value from our investment. I wrote to Minister Lensink on 21 June 2019 to question the will and intent of government and DHS in maintaining the CVS and raised questions about the integrity of the advice and the context in which advice was sought.

While I understand the basis of this legal advice, other people I have discussed this advice with have questioned whether there was a concerted effort to find a legal remedy to enable the scheme to continue in these areas. When I had the opportunity to discuss the advice with Crown Law, they confirmed that the basis of the advice sought did not include making enquiries into what other states had done in terms of legislative or regulatory changes, nor having the benefit of reading the Westwood Spice report on the review of Community Visitor Schemes and how they may or may not operate in the future following the implementation of the NDIS.

I received informal advice that if there was a will or intent for the scheme to continue, this could be enabled by drafting regulations under our current *Disability Inclusion Act 2018*. Counter to this perspective, senior officers in the DHS have advised that the Commonwealth Laws under the NDIS Act and the Constitution override our state laws and the ability to visit and have 'right of entry'. This advice came back after the CVS and NGOs had co-designed 'Visitation Agreements' that were aimed to provide the right of entry to houses where they provided support services to individuals on the clear understanding that any resident had the right to say yes or no to speaking to CVSs.

I find it impossible to understand how (or why) the NDIS regime could undermine NGOs' procedures for quality assurance and continuous improvement.

Put simply, my understanding is that the 'Occupier' (person living with a disability) is entitled to invite into the premises persons involved in the provision of support services related to his or her disability.

The organisation(s) providing those support services are entitled (and expected) to maintain service provision of at least adequate quality. In order to do this each organisation will have in place a range of service quality assurance mechanisms, supported by continuous improvement practices. These are all *integral and necessary* to their service.

It is reasonable to expect that some aspects will involve input from parties who are not employees of the service provider/NGO. For example, they may be independent instructors, inspectors, mentors or auditors. Their role may necessarily require them to attend premises, to meet with workers and clients (if willing), complete their function and report back.

We might consider that quality assurance and continuous improvement are especially important in this sector, given the client group includes some of the most vulnerable citizens of South Australia. In addition, the evolving climate of competition between providers has made their explicit inclusion an expectation, to give clients confidence when selecting support.

As such, quality assurance processes are an *integral* aspect of service provision by the service provider/NGO, **I am unclear why the NGO would not have legal authority to invite people involved with these processes into premises where services are being delivered.**

In terms of the CVS, I would suggest it could be argued that CVS visitors contribute directly to quality assurance and continuous improvement of service delivery. Where an NGO wishes to include them, they are therefore, integral to its systems whilst remaining independent and at arm's length.

I am not a lawyer but I have had many years of experience developing regulatory standards and implementing policies and programs under both commonwealth and state legislation and subordinate regulations and policies. I do feel a sense of frustration at not being genuinely engaged in the process to consider how best to transition the CVS into the disability sector that is subject to the full rollout of the NDIS.

It is because of this distance and not being involved in a co-design of a future CVS disability visitation program (unlike the ICAC review and response that was developed in collaboration with OCP), I have struggled to fully understand and accept that there are no means for us to continue our visits to the NGO and SRF accommodation facilities where there are approximately 2,200 people with disabilities. This is also in the context that other existing visitor programs in other jurisdictions will be continuing and working through various protocols to refer matters to the NDIS Quality Safeguard Commission.

I remain astounded that, as far as I'm aware, the government and DHS has not acted upon the national review of Community Visitor Schemes. The report highlighted the value of Community Visitors and how these visits are quite different to the role, powers and functions of the NDIS Quality Safeguard Commission. The national review clearly highlighted the capacity building that CVS provides for individuals and organisations they visit. The report further highlighted how visitor schemes could greatly assist NDIS Quality and Safeguarding Commission by referring matters directly to them.

The DHS and the Minister have stated that they do not want to rush into a policy response and that they believe there needs to be a national response that is consistent with the new arrangements under the funding and the NDIS implementation being completed.

Key to this is the national review of visitor schemes and the associated report which highlighted that a number of visitor schemes have been in place in various states and territories and that they operate under different legislation, have various models, and quite different reporting requirements. For instance, in Victoria they are incorporated into the Office of the Public Advocate, in Queensland they are in the office of the Public Guardian and in NSW, they are administered within the Ageing and Disability Commission that has been established. They are also within larger visitation schemes that visit clients within mental health facilities, children in secure care and/or foster care, and adults in Corrections facilities.

Therefore, it's not feasible to say how a new national visitor model within an NDIS disability environment will be implemented, which is why I believe these various schemes should be continued by the respective states and territories within the context and legislation that gives them authority. Although our current model of the Community Visitor Scheme has only been in place since July 2011, many of the visitor schemes were first initiated over a hundred and fifty years ago in various forms including South Australia's, where 'appointed Visitor' records to the old asylums go back 172 years.

History of Visitor Schemes

Comprehensive research into the first mental health asylums in South Australia by Susan Piddock, (Department of Archaeology, Flinders University, Adelaide, South Australia "The history of lunatic asylums" 2007) identified some of the earliest records and reports of 'appointed visitors' back in 1847. "A report of 1856 indicates that the first asylum had only five rooms but does not indicate their purposes (Bostock 1968: 154). It seems likely that these were primarily used by the inmates (sic) **as the Visitors, who had been appointed in March 1847 to inspect the asylum**, 'had noted the absence of accommodation for the keeper and his family (S.A. Visitors report 14/9/1847)".

That this asylum did not offer sufficient accommodation for the colony's lunatics (sic) is indicated by the fact that, in August 1849, there were eight lunatics again residing in the Debtor's Yard of the Gaol (S.A. Gov. Gaz. 16/8/1849). The lack of room in this asylum led the Lt. Governor to direct the Colonial Surgeon James Nash, to consider appropriate locations for the first planned lunatic asylum. Another significant and celebrated high profile visitor was Mary Lee (Suffragette, Secretary and Leader of Women's Suffrage League of SA 1888-1895) who was appointed as the first female official Visitor to the Lunatic Asylums in 1896 and served in that role until 1908 (for more information refer to Mary Lee's biography by Denise George released in 2019).

CVS Advisory Committee

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

In April 2019, the CVS held a strategic planning day, and from this process the team established the following priority areas for 2019-20 across all sectors. Progress against these issues and their strategies are presented at CVS Strategic Advisory Committee meetings as required. The larger task of developing a work plan is on hold until work is completed on the CVS extension to visit those under guardianship.

Priority Areas – All Sectors
<ul style="list-style-type: none"> • Complete an assessment into the effectiveness and structure of visits
<ul style="list-style-type: none"> • Have sufficient number of Community Visitors to meet legislative requirements to cover all sectors
<ul style="list-style-type: none"> • Monitor and report on hospital discharges to all those providing accommodation services
<ul style="list-style-type: none"> • Systemic issues and appropriate approaches across sectors are identified
<ul style="list-style-type: none"> • A visitation service is provided to the disability sector, SRF's and DOP
<ul style="list-style-type: none"> • Continuously improve systems and processes for effective and efficient information flow across CVS
Mental Health
<ul style="list-style-type: none"> • Forensic patients and DCS clients receive improved access to mental health services
<ul style="list-style-type: none"> • Psychosocial supports for NDIS clients are transitioned appropriately
Disability
<ul style="list-style-type: none"> • Specialist services under the NDIS are retained
<ul style="list-style-type: none"> • Policies and procedures for supporting Disability Clients during hospital admissions are developed by LHN's
<ul style="list-style-type: none"> • Accommodation and support is available for clients with complex needs and challenging behaviours
SRFs and Day Option Programs
<ul style="list-style-type: none"> • Clients living in SRFs are supported to live independently
<ul style="list-style-type: none"> • Residents of Rooming Houses have access to the CVS
<ul style="list-style-type: none"> • Day Option Programs are visited

7.1.1 Reviews of the CVS

The commonwealth government has undertaken 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 aimed to 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 PCV was provided with an embargoed copy of this review report by Westwood-Spice and it is hoped that this report will be released to the public as it is in the public interest and appears to have listened to a range of stakeholders. However, the PCV is unable to comment further due to the conditions that were placed on him in accepting an embargoed copy.

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) caused 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 welcomed this review and as stated earlier, would like to acknowledge the very open and transparent process that has been undertaken to address, consider and respond to the recommendations made by the ICAC. The OCP has led this work and have been exceptionally open and genuinely consulted the CVS throughout this process and has been respectful of our independent, statutory role and function.

Likewise, Julian Gardner AM, was very clear and open with the CVS on the review process and consultation opportunities. He kept the CVS informed throughout the review and shared copies of his draft report and key findings. This resulted in us trusting and valuing this opportunity to have independent scrutiny of what we do as a scheme and actually expanding the independent review into our processes for recording, referring and monitoring of issues identified by our visits and/or complaints that individuals and their families have disclosed to us about services.

As a result of this and our own continuous improvement strategies, I can genuinely and confidently state that we now have a far better internal system that is efficient and effective for being accountable and responsive to our safeguarding role and our functions and powers described under the *Mental Health Act 2009*, and look forward to its participation.

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.

Disability

1. CVS be provided with a future mandate to continue to inspect disability facilities, both government and NGOs, and report on any concerns or inadequacies, especially where this has an impact on the provision of client centred care.
2. That the CVS looks into undertaking a focus on medication reviews including PRN.
3. The CVS continue to check on the use of restrictive practices and report undocumented or unusual practices to the PCV who will refer to the appropriate agencies.
4. That the CVS develop a revised MOU with the Office of the Public Advocate (OPA) to enable the CVS to visit all individuals who are under the guardianship of PA.

Supported Residential Facilities (SRFs)

5. That the review of the Supported Residential Facilities Act 1992 be completed post-haste and that Rooming/Boarding Houses also be considered as part of this review.
6. That the DHS in partnership with the NDIA establish a 12 month program to identify residents in Rooming/Boarding house facilities and develop individual support plans and applications for NDIS funding and plans.
7. That future mechanisms be put in place to enable independent visitation of SRFs to assess and monitor the five main domains (communication; environment; quality of client services and access; safety and rights and treatment and care planning).

Day Options Programs

8. That independent monitoring be put in place to ensure ongoing assessment of the five main domains (communication; environment; quality of client services and access and safety and rights) occur.
9. That there continues to be independent scrutiny of day options participant's choice and control over the model that enables them to reach their full potential through individual activities and experiences they want.

8. Acronyms

Acronym	Definition
ABF	Activity Based Funding
AGD	Attorney General's Department
AMHS	Area Mental Health Services
APY	Anangu Pitjantjatjara Yankunytjatjara
ATSIMHSPAG	Aboriginal & Torres Strait Islander Mental Health and Suicide Prevention Advisory Group
BSP	Behaviour Support Plan
CALD	Culturally and Linguistically Diverse
CALHN	Central Adelaide Local Health Network
CHSALHN	Country Health SA 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
DHS	Department of Human Services
DACSA	Disability Advocacy & Complaints Service of SA Inc
DOP(s)	Day Options Program(s)
ECH	Elderly Home Care
ED(s)	Emergency Department(s)
EHO	Environmental Health Officer
ENU	Exceptional Needs Unit
FFT	Fitness for Trial
FAIR	Feedback and Incident Review Team
FO	Forensic Orders
HCSCC	Health and Community Services Complaints Commissioner
ICAC	Independent Commissioner Against Corruption
ICCs	Intermediate Care Centres
ICP	Individual Care Plan
ICT	Information and Communication Technology
IHPA	Independent Hospital Pricing Authority

IT	Information Technology
ITO(s)	Inpatient Treatment Order(s)
JNH	James Nash House – Forensic Facility
KOB(C)	Kenneth O'Brien Centre
KPI	Key Performance Indicator
LNH(s)	Local Health Network(s)
MHS	Mental Health Service
NALHN	Northern Adelaide Local Health Network
NDIA	National Disability Insurance Agency
NDIS	National Disability Insurance Scheme
NDIS QSC	National Disability Insurance Scheme Quality and Safeguards Commission
NEAT	National Emergency Access Target
NGO	Non-Government Organisation
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
OCP	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
PEEP	Personal Emergency Evacuation Plans
PICU	Psychiatric Intensive Care Unit
PT	Public Trustee
QLD	Queensland
RSL	Returned and Service League
S269 Clients	Section 269 of the Mental Health Act, 2009
SSU(s)	Short Stay Unit(s)
SA	South Australia
SA&NT	South Australia and Northern Territory
SACAT	South Australian Civil and Administrative Tribunal
SASP	South Australian Strategic Plan
SATSS	South Australian Transport Subsidy Schemes
SDA	Specialist Disability Accommodation
SICC	Southern Intermediate Care Centre

SEP	Supported Residential Facility Entry Point Assessment
SLA(s)	Service Level Agreement(s)
SRF(s)	Supported Residential Facility(s)
SRFA	Supported Residential Facilities Association
SRF HAT	Supported Residential Facility Health Assessment Team
SRF I&SS	Supported Residential Facility Intake & Support Team
TAFE	Technical and Further Education
TSI	Torres Strait Islander
UNCRPWD	United Nations Convention on the Rights of Persons with Disabilities
VIC	Victoria
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 clients, 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 clients and staff. Personal and respectful interactions between staff and clients/CVs. Adequate and accurate information provision about client's rights and entitlements.
Environment	How does the place feel? e.g. warmth, private and personalised spaces for clients? Are client's rooms and amenities reasonable? e.g. sufficient space, clean, temperature controlled, with well-maintained equipment and furnishings? Are clients happy with their food and is there a menu plan that clients have been consulted on and reflects their preferences and dietary requirements? Sufficient provision for space for clients to spend time in, participate in a range of activities as well as conduct confidential conversations with Visitors. Are client'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 clients 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 clients whose first language is other than English or who are unable to read, have sufficient access to alternative formats or supports including interpreters? Are clients or CVs provided with access to medication records, behaviour and support plans when appropriate?
Activity/entertainment provisions	Are the independence and training needs of clients being met? Are clients being assisted to obtain and maintain suitable employment? Is there provision for entertainment for clients 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 clients been asked what outside activities they enjoy and are they provided with sufficient opportunities to take part in such activities?
Treatment and care	Do clients feel engaged in their personal support plans, treatment and care? Do clients 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 clients). Is there a personal support plan for each client and if so, how frequently are they reviewed?
Grievances	Do clients 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 (example)

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

REPORT TYPE	
Select report type	Disability CVS - Scheduled Visit and Inspection Report to Principal Community Visitor
ABOUT THE SITE	
(D) Service Provider	
Address	
ABOUT THE VISIT	
Date 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	
ENVIRONMENT AND SERVICES	
Communication (5 = Excellent – 1 = Poor, Not Observed)	
Communication between staff and clients	
Staff responsiveness to client needs	
Quality of Site (5 = Excellent – 1 = Poor, Not Observed)	
Standard of building facilities	
Standard of equipment within the facilities	

Standard of facility grounds	
Appropriate emergency procedures	
Suitable privacy for clients	
Quality of Services (5 = <i>Excellent</i> – 1 = <i>Poor, Not Observed</i>)	
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	
Rights and Responsibilities (5 = <i>Excellent</i> – 1 = <i>Poor, Not Observed</i>)	
Client access to personal documentation	
Access to information regarding rights, complaints and advocacy	
Appropriate family/carer/representative involvement	
(D) 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	

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) Was supporting documentation available on the restrictive practice, including a behavioural support plan?	
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) Is there evidence of family/guardian involvement in development of the plans?	
(D) Is there evidence of the plans being implemented?	
(D) 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 and/or a short overview regarding this visit	
Please outline any issues for CVS office attention	
Please confirm that both Community Visitors have agreed to the content of this report	