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10 January 2015.

Committee Secretary
Senate Standing Committees
Community Affairs
PO Box 6100
Parliament House
Canberra ACT 2600

Abuse and neglect grows from the failings of all levels of service management

We refer to your proposed inquiry into the review of abuse and neglect of those in our society who have an intellectual or multiple disability - those who are unable by reason of their disability to make reasonable judgements in respect of all or any matters concerning their personal circumstances and/or estate.

This latest review of services for people who are especially vulnerable because of their limited intellectual capacity has grown mainly out of such peak cases as the Yooralla abuse incident which is one of the tips of the iceberg.

Tips of the iceberg are those which easily catch the media's short attention span. Whereas, entrenched in the massive area of the iceberg, below the surface and hidden from the public and often from consumers, is the massive and very complex array of disconnections between service intent and service delivery which occasionally bursts through as tips of the iceberg for everyone to see.

These tips of the iceberg are here today, and frequently forgotten tomorrow. What remains under the present service provider's captive market philosophy, DHS Victoria especially, is the failure of all levels of service provider management to ensure there are no disconnections between service intent and service delivery, by management ensuring direct care staff work value expectations are consistently set, monitored and maintained.

Undesirable staff culture/lore was set by direct care staff in the institutions, as staff were not properly supervised or managed. The resultant staff lore filtered into the group homes which emerged from the closure of the institutions.

This undesirable culture/lore promotes such undesirable factors as:-

"Residents and their families are pests we could well do without. Residents and their families are bludging on the government, and we staff are doing them a big favour, for which they should be very grateful and not complaining. If we have to suffer them, we don't have to respect them. There must be no dobbing (whistleblowing). The work is 'appearance'- we are paid just to be here, where our main concern must be the end of our shift. We certainly do not do active support (engagement and interaction with the residents). Any staff who comes here to do active support and good work, must be discouraged, or we all might be expected to do similar. If we consider all domestic, personal care and administration has been done before the end of our shift, we can go home, as we do not do active support (engagement and interaction) with the residents".

Such a culture seriously discourages those who have just done the Certificate-4 qualification course in disability services. Most come from such a course with motivation to work with, and improve the lives of the residents of group homes and similar. Whereas, many such staff get dragged into the said undesirable culture. Others either seek a better group home, look for a better service provider or join a casual staff or agency pool, so they have minimum contact with undesirable cultures.

Abuse (physical, sexual, emotional, restrictive, financial, Systemic) and neglect (physical, passive, deprivation, emotional) of very vulnerable people behind closed doors with little or no proper management or supervision, and when other staff know they will not be supported by management if they speak out, is easy for perpetrators.

Heather worked as a Cert-4 qualified direct care worker for four years. Not for the money, but like police undercover. This was two years for the department (DHS Victoria), and two years for non-government, not-for-profit service providers. Whereas the non-government service providers almost exclusively set, monitored and maintained work value expectations on her, the department (DHS Victoria) rarely did.

Within department group home services, Heather saw lots of abuse and neglect, where staff were not prepared to risk reporting this. Incidents such as:-

"A bucket of water thrown over a resident by a staff member; A resident tipped out of his wheelchair by a staff member; A resident forced to stand in the corner for 30 mins; Residents provided with food the staff would not eat themselves; Residents given pizza as their main meal most days; Residents having to wear poor clothing and shoes, as staff considered it was not their problem, yet the residents had plenty of finance; Residents do few activities, as staff can't be bothered to take then out or do activities with them, yet the residents have plenty of finance and department policy is for active support to frequently occur in contrast to minder-care". And, these are just a few practical aspects of abuse and neglect Heather witnessed.

Both the department (DHS Victoria) and the Disability Service Commissioner (ODSC Victoria) categorically refuse to accept or investigate the systemic aspect of complaints – giving no reason for not doing so. Therefore, individual issues of concern go around and around in the revolving door. Similar complaints being, therefore, across facilities and regions – adding to the

administrate cost of service provision. Rather than investigate the failing of all levels of service management to proactively monitor service provision to ensure there is no disconnection between service intent and service delivery. And, ensure service providers are not in instant denial of the consumers' complaint/s, in contrast to seeing complaints as 'tools to service improvement'.

Another matter which can lead to stress of staff, and the corresponding abuse and neglect of residents is, the DSR (the department's "Disability Services Register Team") placing incompatible clients with compatible sitting residents. In most cases, staff and families can do little against the despotic DSR, and staff can do little more than attempt to support their sitting residents who's quality of life is being disrupted by the incompatible client.

The very rare occasion was where all the families of a department group home in stuck together and battled for the removal of a very aggressive client dumped on the house by the DSR. There was so much resistance by the DSR, that families were forced to take the matter to court, where they won the removal of the very incompatible client.

The department has little real provision for proper behaviour management of those who are initially unsuitable to live with others in a group home situation. There is a need for behaviour management facilities and properly remunerated and motivated staff to undertake proper and meaningful behaviour management, with meaningful expectations set, monitored and maintained.

A further matter which can lead to stress of staff and the corresponding abuse and neglect of residents, is the department's management above house supervisor having a culture of reluctance to praise and support good direct care staff, and not reprimand questionable staff. Good staff get frustrated if no one cares if they do good work or not.

Line-in-the-sand complaint resolution philosophy

The approach taken by such public service, captive market organisation's as the Department of Human Services (DHS) Victoria, and the Disability Services Commissioner, Victoria, in dealing with complaints, is mainly avoidance and denial.

Every effort is made by these and similar organisations to show, (a) the person making the complaint/s is wrong, (b) the service provider is right and, (c) no one is to blame for the matter occurring or not occurring.
This complaint resolution philosophy is all about drawing a line-in-the-sand from which a reported problem may be considered resolved, whilst previous happenings which led to the complaint are ignored/dismissed – this is reactive management.

Support service management who do not see themselves as responsible for service level and quality monitoring, rather they actively practice problem avoidance and denial - reactive management. Such managers draw a line in the sand from where any changes might occur. Responsibility for what occurred before the line in the sand, is dismissed/ignored.

This reactive management process takes no responsibility for any failure to properly monitor service level and quality, or any breach of service level and quality agreements and standards –

believing if it addresses the individual problem from the line in the sand, previous happenings and management systemic failings can be ignored/dismissed.

In practical terms:-

1. Reactive management is blind to a perpetrator of abuse and neglect. When such a perpetrator is reported by consumers or staff to such management, their style of management relocates the perpetrator from the line in the sand. That which occurred before the line in the sand, and that which the complaint was really about, is ignored/dismissed.

2. Reactive management is blind to breaches of service agreements and standards. When these breaches are raised with such management as a complaint by consumers, the manager draws a line in the sand. That which occurred before the line in the sand, and that which the complaint was really about, is ignored/dismissed.

3. Consumers and direct care staff with good integrity who report questionable activities are at risk from reactive management who wish only to have the matter go away and to punish/embarrass those who dared raise such a matter or matters - so they will be reluctant to do so again.

Seeking Rights, Not Avenues. Rights are Service Entitlements as Defined in Care Policies, Standards and Values. Avenues are the Nightmare of Bureaucratic Mazes Families have to Negotiate

People with intellectual and multiple disabilities, their families, guardians, advocates and friends have been seeking and battling to realise their reasonable human rights since time-immemorial.

Reasonable rights for those with special needs is not rocket science, but just plain common sense in most cases. Most of these rights are well defined in care policies, standards and legislation.

Yet we find disability service providers, government department bureaucrats and politicians using a huge percentage of their energy and resources implementing every trick in the book to block people from reasonable rights and needs. Forcing them to burn-out seeking compromise avenues through defences better than the green zone in Baghdad - or they give-up and accept the charity hand-out rather than entitlement.

The Department of Human Services in Victoria (the department) produces enormous volumes of very comprehensive care policies, standards and values defining the needs of people with disabilities. This is the show case, the front window, the firecrackers and balloons.

Whereas, behind this façade is a black-hole of hooded bureaucrats with master degrees in defence of the public service status quo to beat-off consumers who have reasonable service expectations that there shall be no disconnection between service intent and service delivery.

State government service intent for people with disabilities in Victoria is extensive and extremely comprehensive - being the Department of Human Service's very extensive range of care policies,

standards and values, in addition to their range of personal care standards for residents of supported accommodation group homes.

Yet this government department's service delivery is almost totally dependent on the integrity of their direct care staff, rather than the direction of their management above house supervisor. Hence, service level and quality in department managed group homes fluctuates markedly.

All levels of department management, above house supervisor, are unable and/or unwilling to actively ensure there is no disconnection between service intent and service delivery. This almost entirely results from very long standing public service lore, and public service union lore that work expectations must not be set on public service staff.

Consequently, many department managed group homes provide little more than basic minder care for the residents – staff doing just domestic duties, personal care and administration. Little or no "Active Support" or "Positive Behaviour Support" – few if any interactive and developmental activities with and for the residents.

Where complaints are made by residents and their stakeholders regarding the lack of quality of life care, the department's extensive complaints area often advise consumers to take their concerns to such pseudo government departments as the 'Office of the Disability Service Commissioner (the ODSC)' or the 'Ombudsman', rather than properly self-monitor their service level and quality is fully meeting departmental service intent and take positive, pro-active action is it is not.

In total contrast, most marketplace services do all in their power to avoid their customers feeling to need to go to 'Consumer Affairs' or 'ACCC'.

Whilst non-government, not for profit CSOs are realising they must move away from their traditional block funded service mentality to stay viable within NDIS ISP style funding, the department is attempting to retain its traditional captive market culture by subsidising itself to remain a service provider within the NDIS.

A recent complaint brought before the ODSC, shows just how ineffective they are against the department's traditional captive market culture. The ODSC refuse to investigate the reason for questionable occurrences – being the failure of department management. Rather than address the cause, they just look at the symptoms. The symptoms can, and do frequently return.

The cost of these government and pseudo government departments spending enormous resources on their in-denial and manoeuvring every which way to avoid pro-actively monitoring their service provision for credibility and accountability, is costing a fortune in both the financial and the moral aspects.

The financial aspect does little for those on the service waiting list, and the moral aspect does little to ensure all residents of supported accommodation group homes receive care and support which is well within the direction, intention and spirit of departmental care policies, standards and values.

Researchers at Scope, a leading no-for-profit disability service in Victoria, are testing surveys capturing the outcomes associated with disability services and social inclusion as experienced by people with disabilities in Australia. This

national research is part of a multi-year project that will result in outcomes surveys that can be used by organisations involved in providing disability services in the future..... LINK.

The move towards NDIS holds little for existing residents of group homes.

The two NDIS factors are, (a) a reduced waiting list for services, especially group homes and, (b) improved level and quality of care – better accountability resulting from ISP funding - money in the pocket of the consumer.

Factor (b) is fine in theory but not in practice, as residents with high support needs and autism do not move easily. And initially, at least, there will be insufficient service providers for consumers to have effective choice.

If the Department of Human Services, Victoria, remains as a service provider within the NDIS, as it is currently in the Barwon NDIS trial site, little will change from the current department problems outlined throughout this paper

The department continues to run its existing group homes in the Barwon region, funded by the same department block funding, as part of the in-kind agreement with the NDIS. So although the residents of these houses are, in principle under the NDIS, their support service funding is block from DHS Victoria.

In conclusion, we include the following papers in this submission:-

- Our presentation to the 2008 Parliamentary Inquiry into disability services in Victoria (2 pages) and,
- Our paper, "Congratulations, you are now a supervisor" (one page)
- Our paper, "The way residents of DHS (Victoria) group homes are dressed is often shocking, considering their finances!",
- Definitions of Abuse & Neglect: http://www.disabilityhotline.net.au/what-is-abuse-and-neglect/formal-definitions-of-abuse-and-neglect/

Tony & Heather Tregale
Coordinators, LISA Inc.

NOTES FOR THE PARLIAMENTRY INQUIRY HEARING ON 28 NOVEMBER 2008.

1. DHS supported accommodation group homes are "Hostels not Homes", as residents and their families are frequently not consulted over changes, and as the direct care staff consider the group home is their workplace and they cannot be moved if they do not wish to be.

   Most of us here today have control of who comes into our home. When we become elderly and need the support of HACC services, if we do not like a particular HACC (Home & Community Care) worker from the local authority, we can call the HACC office and request that particular person not be sent to our home again. This is NOT so for the residents of DHS Group Homes! They do not, therefore, have reasonable rights in their long term home!

2. The public service culture of job security through captive market government funded services having no reason for, and no reliance on customer service and satisfaction, is not conducive to the provision of consistent quality of life care for the very vulnerable residents of its supported accommodation group homes. The department should not, therefore be providing direct care services.

   It appears the main reason the department's direct care services have not been handed over to the "Non Government - Not For Profit" sector is the pay differential. Department staff get paid more than NGO staff!

   So whilst department staff get more pay, and department bureaucracy is extremely wasteful, there is far less accountability for the provision of quality of life care for very vulnerable and disadvantaged people – the residents of DHS group homes.

   Service inconsistency, as reported by the Auditor General, is further compounded in DHS direct care services by the department's trend towards the reduction of central management, in favour of autonomous House Supervisors. Most DHS group homes have offices equipped to run BHP! There is now even less central supervision to ensure all houses provide consistent QOL care within the direction, intention and spirit of the department's care policies, standards and values. Different house supervisors interpret these policies differently!

3. There is a current trend towards support packages and individualised funding for those with the ability and support to seek generic services. Yet the residents of DHS group home are denied individualized funding of their government funded support costs, and any form of residential tenancy rights. The residents' choice of service provider is, therefore, totally restricted. Yet another restrictive factor is the department's despotic control of the DSR (Disability Support Register). Yet another is availability of services.

   Without these restrictive practices and factors, the residents of DHS group homes

could say that we don't like the DHS service, we are going to City Mission, Nadrasca, etc, etc. They would have choice! Many times we have been told by DHS staff, "If you don't like what we do, take your kid away!" They can say this, because they know we have no choice, and that their job is not dependent of customer service and satisfaction.

4. With the few service accountability factors available to the residents of DHS group homes, residents and caring families have to look at every available avenue available to them. Yet Community Visitors are not obligated to contact parents/families following their visit to a group home where the residents have no meaningful communications.

5. Thousands of very elderly parents, struggling to care for their disabled family member at home, are being both blocked from access to reasonable respite, are queue jumped by able bodied parents who abandon their disabled family member on respite services.

   Dumping on the few available respite services is an epidemic. Most respite houses cater for 5 or 6 residents, yet most have at least two places taken by abandonment. Some have all but one place taken by abandoned family members.

   With the Department of Human Services under extreme pressure to free respite places for their legitimate use in giving a well deserved break to families doing it tough 24/7, the department is dumping totally incompatible people on the very compatible residents of existing group homes. One incompatible person can totally destroy the quality of life of 4 or 5 others.

   The department is moving the problem around, rather than solving it. Apart from allowing respite facilities to become blocked from their legitimate use, they are effectively moving an incompatible member with whom the family cannot live, on to a compatible group of already disadvantaged people in a group home.

   The problem is compounded as respite places become depleted for those doing it tough in caring for their family member at home. Families are therefore driven to the despair of now having to consider abandoning their family member at respite because there is little hope of their family member ever getting into a permanent group home.

CONGRATULATIONS! "YOU ARE NOW A SUPERVISOR!"

House Supervisors are expected to be totally responsible and accountable for everything in the house. Yet they have few rights and little authority They are unlikely to be supported by line management when attempting to set, monitor and maintain direct care staff work value within departmental care policies, standards, guidelines and values, and within staff job descriptions!

If a House Supervisor comes into the house at times when not "rostered-on", stays after their shift, comes in early or phones staff at the house when he or she is not on duty.... This is frequently grounds for a successful harassment complaint by direct care staff with HACSU support against weak DHS management who are also intimidated by direct care staff into not visiting a house without giving prior notice to staff.

So although held responsible and accountable, a House Supervisor is rarely permitted to be a pro-active and responsible supervisory person. And, is not sufficiently empowered to address the needs and aspirations of the residents for whom he/she is responsible

People promoted to the position of supervisor should be made aware that:-

"Although you are now officially a House Supervisor, under no circumstances should you attempt to supervise!" This is because:-

1. In most circumstances, you are unlikely to be supported by your line management!

2. You will have to fight the public service management issue-avoidance bureaucracy alone, in every way, to support your residents to receive the care and quality lifestyle set by the department's own care policies, standards, guidelines and values.

3. At any time you could have HACSU supported, militant direct care staff undermining any attempt you make to have residents receive quality care and support. These staff wish to have "leisure time at work", and will claim you are bullying them if you make any attempt to direct them, or question their actions!

4. Management will most likely cave-in to your subordinates complaints and demands, no matter how unreasonable or unfounded these may be!

5. Management will almost certainly make you the scapegoat to help make the problem/s go away, and to cover their own backsides!

Are you still feeling lucky in getting the position? No! Maybe? Well, see how you feel after attempting to do just a fraction of what is in your job description!

Even with good staff, you are likely to battle every day against the entrenched management attitudes and practices described above. With entrenched staff - forget it! Either keep your head low and ignore what is going on around you, or move to the NGOs.

The way residents of DHS (Victoria) group homes are dressed is often shocking, considering their finances!

The residents of DHS group homes have always had a good financial deal. Even better since the department introduced "bundling" of the residential charges in 2013 - with free manchester and white goods in exchange for handing over the full CRA, which most residents were not getting anyway.

Therefore, almost without exception, the residents of department managed group homes throughout, have very adequate financial resources. However, almost without exception, these resident's finances are not being used to fully support their potential quality of life.

Frequently, 'Personal Expenditure' (the residents 'pocket money') is not used as intended in their 'Financial Plan', that of doing activities in the community - such as going to the pool or spa, cinema, dining out, mini golf, bowling, dancing, etc, etc. Rather, unused money is returned to the resident's trust fund

A resident supported by their family to always have the best clothes, has set an example for the other residents in the department managed group home. Whereas, the general direct care staff standard for their residents' clothes and shoes is often quite low and spasmodic.

If the said resident had no family support when moving into a department group home, the standard attire would have been 'tracky-pants', a cheap top and slip-on or Velcro strap shoes, or similar. As this is all quick and easy for direct care staff.

It is standard practice for department managed group homes to have no firm provision for clothing and shoe repairs or replacement, or shoe cleaning. It is all totally dependent on the integrity of staff, as there is little or no management direction and service level and quality monitoring.

Formal definitions of abuse and neglect

Forms of Abuse that the Hotline staff can assist with include (but are not limited to):

Physical abuse: Any non-accidental physical injury or injuries to a child or adult. This includes inflicting pain of any sort or causing bruises, fractures, burns, electric shock, or any unpleasant sensation.

Sexual abuse: Any sexual contact between an adult and child 16 years of age and younger; or any sexual activity with an adult who is unable to understand, has not given consent, is threatened, coerced or forced to engage in sexual behaviour.

Psychological or emotional abuse: Verbal assaults, threats of maltreatment, harassment, humiliation or intimidation, or failure to interact with a person or to acknowledge that person's existence. This may also include denying cultural or religious needs and preferences.

Constraints and restrictive practices: Restraining or isolating an adult for reasons other than medical necessity or the absence of a less restrictive alternative to prevent self-harm. This may include the use of chemical or physical means or the denial of basic human rights or choices such as religious freedom, freedom of association, access to property or resources or freedom of movement.

Financial abuse: The improper use of another person's assets or the use or withholding of another person's resources.

Legal or civil abuse: Denial of access to justice or legal systems that are available to other citizens.

Systemic abuse: Failure to recognise, provide or attempt to provide adequate or appropriate services, including services that are appropriate to that person's age, gender, culture, needs or preferences.

Forms of Neglect include (but are not limited to):

Physical neglect: Failure to provide adequate food, shelter, clothing, protection, supervision and medical and dental care, or to place persons at undue risk through unsafe environments or practices.

Passive neglect: A caregiver's failure to provide or wilful withholding of the necessities of life including food, clothing, shelter or medical care.

Wilful deprivation: Wilfully denying a person who, because of age, health or disability, requires medication or medical care, shelter, food, therapeutic devices or other physical assistance - thereby exposing that person to risk of physical, mental or emotional harm.

Emotional neglect: The failure to provide the nurturance or stimulation needed for the social, intellectual and emotional growth or well-being of an adult or child.

About Us
The National Disability Abuse and Neglect Hotline is an Australia-wide telephone hotline for reporting abuse and neglect of people with disability. The Hotline works with callers to find appropriate ways of dealing with these reports. Read more »

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