Submission S042
Received 12/10/2015
Family and Community Development Committee

DistinctiveOptions In Life

Submission to the

Inquiry into Abuse in Disability Services – Stage 2

Prepared by:

Murray Dawson-Smith
Chief Executive Officer

12th October 2015.

Executive Summary.

Addressing the issues of abuse, neglect and exploitation within the disability sector is complex and enormously challenging.

The complexity in this sector is compounded by the very difficult question of defining abuse, neglect and exploitation. In most instances and in the general community there is a reasonable clear picture of what we mean by abuse and neglect and this can be relatively easily determined within a framework and criteria that are accepted by most people.

In the disability sector the application of the criteria can be problematic. Clearly where the abuse or neglect is obvious then the response should be relatively straight forward. However in the disability sector there are many instances in which the issue of abuse and neglect is much more difficult to define and thus respond to.

Examples of the challenge may include where a service takes individuals out in a bus for a day excursion. In one case the excursion is well planned with a range of activities and learning opportunities included in the outing whilst in another service the same proposal may lack any plan, service users effectively sit on the bust all day and do not have any learning.

In both instances the service users have been out for the day but in one case the service users have had opportunities to learn whilst in the other the service users have arguably been neglected and exploited.

Another example involves the community residential unit sector. In one unit, staff encourage residents to actively be part of the normal activities of a house. Staff encourage residents to prepare meals, clean up after the meal preparation, and undertake the daily tasks of house maintenance including housekeeping and gardening and to generally function in the same way as any other share house model. In the second house staff do not encourage active participation but rather perform all of these tasks and residents are passive observers rarely engaging in any but the most perfunctory of tasks.

Staff in the first house have adopted a strong position of person centred positive behaviour support and actively promoting independence among residents whilst in the second house staff have taken the role of disempowering residents based on the view that it is quicker, cleaner and more efficient if they take on these tasks rather than the residents.

There is a strong argument that staff in the second house have denied the residents the opportunity to develop and grow. Is this a case of neglect and abuse? Staff in the house and even the organisation may argue that this is not a reasonable interpretation as they had no intention or aim to neglect or abuse the residents.

It is for these very reasons that the sector must be better prepared within the context of developing the workforce and equally that the auditing and certification process must be more rigorous and based on a quality of life rather than a quality assurance model. Likewise the importance of educating residents and service users of their rights and to encourage and support individuals to raise concerns is critical if issues of abuse and neglect are going to be tackled effectively.

Workforce training must focus on key elements of best practice and be able to recognise the critical needs of service users and be developed within a quality of life framework focusing on independent living and built around a person centred framework and positive behaviour management.

Equally the sector needs a more robust and vibrant audit process that looks beyond system models built around quality assurance and the presentation of policies and procedures. The audit process needs to be flexible and able to audit a service provided by an individual as well as a service provided by a medium to large organisation operating as a not for profit or for profit organisation.

The audit process must be well resourced and enable auditors to observe practice across all service types in a comprehensive and constructive way. Identifying where practice is of a high quality but also where it lacks rigour and then be able to advise the service how to better support service users.

It is acknowledged this is resource intensive both in terms of time and financially, however without this commitment the ability of the sector to meet the needs of individuals and to avoid the issues of abuse and neglect will not be addressed.

Further adding to the challenge of the audit process will be the need to ensure auditing staff are well trained and competent to not only perform the auditing role but to also be able to identify when practice is not appropriate and to be able to support and advise a service on how to better deliver support.

It is certainly true with a better educated and trained workforce and a skilled and comprehensive audit/certification process the opportunities to identify and respond to poor practices that result in abuse, neglect and exploitation will be fundamentally enhanced however this in itself will not be sufficient.

At the same time as these enhanced initiatives are introduced it is argued there is a critical need to provide greater education and awareness for individuals with a disability with regards their rights and how to raise their concerns. The use of new communication methods and to provide an easy process for raising a complaint must be urgently developed.

The current system reminds the writer of the old story:

There was an important job to be done and everybody was sure that somebody would do it. Anybody could have done it, but nobody did it. Somebody got angry about that because it was everybody's job. Everybody thought that anybody could do it, but nobody realized that everybody wouldn't do it. It ended up that everybody blamed somebody when nobody did what anybody could have done

At present there are too many organisations involved in the monitoring of the sector. For a system of support to be effective it is the position of the writer that one organisation should be responsible for the oversight of the sector and that organisation oversee and manage all aspects of the service system from the auditing of services, the training/qualification demands for support staff, the management of the community visitor program, the input of the Senior Practitioner and the handling of complaints of neglect, abuse and exploitation.

Experience of disclosing or reporting abuse

As a service provider there are processes we are required to follow with regards any incident that occurs within our service. These requirements are detailed by DHHS and are expected to be followed.

The question this raises however is how does DHHS ensure that all incidents are categorised appropriately and then reported effectively? Equally what strategy is employed by DHHS to follow up on issues and how does the department ensure all matters are dealt with within the construct of fairness and equity to the individual with a disability as well as the staff and organisation accused of abuse.

At the current time it could be very strongly argued DHHS does not have an effective system in place. The current system is reactive and does not have an effective investigative process when issues are raised.

The Department does not actively visit services and spend time "on the floor" determining whether a service has good practice as it relies on the certification process to somehow identify services that lack good practice. This raises a number of key issues and to suggest the current model of measuring services through the certification process works well should not be accepted on face value based on the "pass" rate of current services.

Apart from the processes determined by DHHS the importance of ensuring good practice in the service sector is critical in the prevention of abuse and neglect and supporting individuals to be confident in reporting incidents of abuse.

Good practice is related to the training, support and supervision of staff as well as the provision of appropriate and well directed information and advice to service users with regards the definition of abuse and neglect and equally how to make a report if an individual believes they have experienced abuse.

An effective system must include not only systems and processes but these must be underpinned by the production of resources that support individuals to exercise their rights through a transparent and supportive reporting process.

Recommendation:

A safeguard system be developed that focuses on practice rather than process and includes material presented in appropriate formats to support awareness raising for individuals with an disability.

Human rights and safeguards

Organisations funded via DHHS will continue to be subject to standards as determined by the department through the transition period. The question is will the department be able to maintain a staffing regime that ensures organisations will continue to be held accountable (even if this accountability is not as effective as it could be).

The challenge from our perspective is that DHHS must commit the resources necessary to be able to monitor and respond to claims of abuse and neglect if they are to continue to provide the necessary degree of monitoring and safeguarding for individuals with a disability.

This is particularly important as the possibility of more and more arrangements occur outside of the traditional service system. How are individuals going to be supported to avoid abuse if they employ support staff directly with no oversight except through the perceived ability to raise their concerns?

The implication in this system is that somehow through some, as yet to be clearly spelt out process, individuals will be able to identify when they are being abused and/or neglected and will be able to understand the system in place to make a report without support from a service or other support mechanism.

It is strongly argued this is highly unlikely and the risk within the notional model of self-managed services is that individuals with a disability may well be exposed to enormous risk with little or no checks and balances in the system.

Recommendation:

DHHS ensure staffing levels are maintained at a level that enables any complaints of abuse or neglect are able to be investigated adequately.

Independent oversight body

Much has recently been made of the role of the Disability Services Commissioner and the apparent lack of action by this office with regards responding to complaints. Without making comment on their role and whether this is effective or not it is acknowledged that clearly there is a public perception not enough is being done at the present time to safeguard individuals with a disability.

It could also be argued the other bodies that have a greater or lesser role to play in safeguarding individuals are also failing to fulfil their obligations. DHHS does not take an active role in visiting services whether they be CRU accommodation or Day Services and given they have overall responsibilities to ensure organisations are meeting their determined standards then clearly it could be argued they are failing to safeguard individuals with a disability.

Given DHHS is also a major (the most significant in dollars in Victoria) provider of services it is argued they should not also have responsible for the management of complaints particularly where they relate to their own service provision.

Likewise the question could be asked of how effective is the Community Visitor program and do they need additional resources and/or training and even if this is provided does it ensure the question of safeguarding of individuals with a disability who do not attend an accommodation service will be identified and acted on.

Further the current roles of the Victorian Equal Opportunity and Human Rights Commission and the Victorian Ombudsman have not provided the necessary engagement with the service sector to have any discernible impact on safeguarding of service users.

It is the contention of Distinctive Options the real question is not whether there should be a new body, the allocations of responsibility to a single existing body, or an improvement in the integration of existing bodies to fill gaps and address overlaps on the boundaries.

Rather it is argued the current failure of the system is the absolute lack of accountability for the existing and proposed service system that will evolve out of the role out of the NDIS.

The current quality framework is based on the DHHS standards and all funded services are expected to be compliant with the standards. Within this certification process is the expectation service providers will meet not only quality systems processes but will also be able to demonstrate quality practices based on best practice "quality of life" service outcomes.

At present this is a flawed system in so far as it is based on a number of assumptions when looked at closely fail the test of best practice.

At the current time certifying bodies are predominately approved by Jas-ANZ and these organisations then conduct an audit of a service provider based on very small statistical numbers. In many instances the audit is primarily a document and process audit rather than a critical focus on practice and quality of service. Compounding the failure of focus on service is the failure to undertake broad based assessment of the services provided across organisational service models.

In line with requirements as determined by Jas-ANZ the auditor is required to meet with a very small number of service providers and families along with little observation of practice. Where a service has multiple sites then service observation becomes even more problematic and limited and thus the ability to determine good practice rather than good systems is significantly compromised.

Compounding the lack of observation is the knowledge and experience of auditors to be able to observe practice and make comment on what they are seeing and is this good practice or not.

It is suggested the committee may wish to undertake a table top audit of the reports produced by auditors and when reviewing auditor notes of services it would be illustrative to make note of how often in the reports produced do auditors actually make comment about practice and how a service could improve outcomes or program enhancements. The writer would suggest audit and improvement reports provided by these auditing bodies focus almost entirely on processes, forms, structures etc. and rarely do these reports have significant sections dealing with practice.

This failing is the result of the ongoing focus on measurable standards such as the quality of systems and documents and in many cases the skill and knowledge level of auditors with respect to best practice coupled with the limited time and locations in which observations take place.

Distinctive Options would argue this issue will become ever more critical as the NDIS roles out across the state and a broad number of small and self-managed services emerge.

The challenge in these small and self-managed services will not only be compliance with systems and practice but also fulfilling legislative obligations with regards employment, superannuation and other employee entitlements. Where a service fails to meet their employment obligations, particularly where an individual is employing directly or an individual is exploited, harmed, abused or neglected by an employee onus for safeguarding the service user will fall back on the NDIS or potentially State and/or Federal Governments.

Recommendation:

Establish a single independent oversight body to safeguard the rights of individuals with a disability.

The body should have a Board which oversees its functions and which comprises of professionals and individuals with a disability with a clear charge to oversee, monitor and licence all parties involved in service provision. The oversight should include a charter to observe and comment on practice in all setting in which that party provides service and where practice is not appropriate be able to recommend, advise, support and ultimately deregister parties who fail to meet quality of service standards.

This body could be charged with developing a set of standards that focus on quality outcomes rather that quality assurance and the standards expected if individuals wish to manage their own funds and employment arrangements.

In effect it is argued the new body could develop standards with levels of compliance based on the size of the workforce and/or employment structure of supports. Critically it is argued that whether support is provided by an organisation through to a self-managed model all services would be required to demonstrate a level of competency and skill to provide the appropriate model of practice and support for quality of life outcomes.

Disability advocacy services

As with much of the system in terms of support to individuals with a disability the advocacy sector is littered with services both funded via government contract arrangements and less well governed independent operators both “fee for service” and volunteer.

As with the service system itself, there is little quality control on the type of advocacy available or the ability of the advocate to appropriately support and engage individuals with a disability in the advocacy process.

Advocacy services, particularly in the non- funded sector appear to take a much more aggressive and confrontational approach to advocacy in comparison to the funded advocacy services that take a more conciliatory model of advocacy focusing on the goal of a positive, negotiated outcome.

It could be argued and proposed that advocacy services are a critical part of the checks and balances necessary for the sector and should be subject to the same levels of compliance as direct service providers and must be able to demonstrate a level of understanding and knowledge regarding the process of advocacy and mediation as strategies for problem solving.

Individuals with a disability are entitled to accessing advocacy services that can truly represent their views and provide the appropriate level of support and empowerment when responding to issues of abuse and neglect.

The existing services such as VALID provide a range of advocacy models including advocates employed by the service and training for individuals to learn the skills of self-advocacy and it is recommended that this service approach be explored and developed further.

Recommendation:

Advocacy services should be subject to a certification process that captures the critical elements of advocacy.

Prevention, screening and accreditation

Distinctive Options would suggest at present there is one constant in the provision and funding of disability services and that is the involvement of State Government but over the next 4 years there will be a shift in this constant from State Government to the NDIS.

Assuming this involvement includes a connection to the safeguarding system then all workers should be subject to a registration process managed by the one registration body. This should be a national entity as support staff has the capacity to move from one State to another and a national body would be better able to monitor this than individual State bodies.

It is recommended all staff should be required to obtain a National police check and a working with children/vulnerable persons check as pre-requisites for employment in the sector and this information be maintained by the national body.

In line with comments in the Independent oversight question above Distinctive Options strongly supports and encourages Government both at the State and Federal level to actively pursue the establishment of service standards and accreditation as long as the focus is on service delivery and quality of life outcomes and not purely on the capacity of an organisation to have clearly documented policies and procedures.

Achieving the accreditation of services built around the quality of practice demands the body overseeing the accreditation process has the competency within the staffing regime to ensure when visiting a service they are capable of both recognising good and bad practice and the ability to support services and direct them on how to improve quality of life outcomes.

The accreditation process should apply to all service provision entities whether they be large "not-for-profit" or "for profit" entities through to sole worker positions.

At the end of the day this new world order being developed via the NDIS must still hold to the notion that many individuals with a disability will be at risk of abuse and /or neglect and there is a responsibility on the service system to ensure risks are managed and reduced as much as is possible.

This can only occur when the system is based on the philosophy of "quality of life" practices and service provision is adequately monitored and workers accredited according to skill and competency levels that provide the best opportunity for a quality system devoid of abuse and neglect.

The role of professional development in the evolution of the service system is discussed in the next section.

Recommendation:

A certification/audit model be developed that is able to make all service providers meet a set of minimum standards.

For the information of the committee the writer has developed a set of standards for large, small and sole worker entities built around the supports to individuals with Autism Spectrum Disorders and could be made available to the committee if requested.

Professional development

Under the current system there is an expectation organisations will seek to employ individuals with a Cert. IV in Disability services as a minimum requirement for the sector.

In many senses of the word this is a generic certificate that does not in itself ensure staff are well equipped either in terms of work place skills or the necessary empathy and compassion required to work in the field.

The current statistics emerging from the various NDIS trial sites are highlighting the concerns our organisation has with regards the demand for minimum qualifications and the expectation the Cert IV will deliver on these demands. The statistics from the trial sites indicate in the order of 26% of all packages are for individuals with a primary diagnosis of Autism Spectrum Disorder (ASD) with a further 27% of all packages being for individuals with a primary diagnosis of an Intellectual Disability and it is argued of this 27% approximately 50% of this number have a secondary diagnosis of ASD.

Assuming these figures are correct then almost 40% of all package recipients in the NDIS have ASD and yet very few of the Cert. IV courses have Autism as a core subject but rather ASD is an elective subject for students to select who have, in many instances, limited knowledge of the workplace.

Given the numbers and challenges in supporting individuals with ASD it is concerning that in many cases staff are arriving ill-equipped to deal with this significant cohort of service users. The potential for service users to not receive an appropriate level of support may lead to abuse or neglect and should not be underestimated.

Along with the challenge of appropriate training, for many organisations outside of metropolitan Melbourne, there is also the challenge of even finding potential staff with the Cert. IV let alone a Cert. IV that includes study units in ASD. As a regional centre based in Sunbury this is a continuing and ongoing challenge for our organisation and it is assumed for many other services in regional and rural locations.

Distinctive Options has taken a different pathway in which staff are recruited on the basis of values and practice models which includes a period of shadow shifting and observation by highly experienced staff to determine if, in the first instance, potential employees possess the necessary empathy, compassion and enthusiasm for the support role.

If staff can demonstrate the attributes our organisation seeks they are then supported to attend training in core units including ASD, Person Centred Positive Behaviour Support and Effective Communication skills.

Training is provided to our staff by organisations and individuals with established records of knowledge and competency such as Amaze (formerly Autism Victoria) and Gary Radler, internationally recognised for his work in Person Centred positive behaviour support practices.

Additional training is provided on the basis of identified need and includes training in such areas as sexually and disability, medications and manual handling etc.

The reason for taking this approach is this organisation is keen to ensure all staff have received the same training (ASD, PBS etc.) so any behaviour management strategies that are employed are not only understood by all staff but equally all staff understand the importance of consistency of message and following established behaviour management strategies.

Along with these core units of professional development staff are also encouraged to pursue the acquisition of the Cert. IV and to support the professional development of all staff this organisation commits approximately 2% of the gross income to training.

Recommendation:

Training services to be subject to auditing on the content of course material and competency of training staff to effectively deliver training.

The training regime for disability workers must reflect the support and developmental needs of individuals with a disability.

Workforce culture

The development of a workplace culture that does not tolerate abuse, neglect or exploitation is complex, time demanding and in many cases expensive.

To understand the current culture existing in many services it is important to note the historical development of the service system and how this continues to influence a significant section of the sector and the workforce itself.

At the time of the move to de-institutionalisation the sector went through a process of moving service users from institutional settings to community based models of accommodation and the Adult Training and Support Service (ATSS) system.

At the same time as the shift to community settings for service users there was also the shift of staff from institutions to these community based service models without any real effort to look at the practices staff were bringing across to this new service model. In effect many of the practices that existed in the institutional settings where simply practiced in the new service system but in a smaller setting of a Community residential unit and/or ATSS.

In many cases this system has been perpetuated to either a greater or lesser extent depending on the service provider and their capacity to address organisational culture.

It is also true to say in many instances even where the old institutional models of practice no longer exist many organisations use buses as a therapy tool and/or are unwilling to provide opportunities for service users to actively participate in opportunities on the basis of “Duty of Care” arguments or more disconcerting the O.H & S arguments.

It is argued here that if the service system is driven by the external demands of accreditation and the monitoring and evaluation is built around quality of life measures then service providers will be obliged to change their culture or they run the very real risk of losing funding.

The process should be built around accreditation and all services whether organisational or sole worker should be subject to same expectations and accreditation benchmarks for real and long lasting change to be achieved.

Complaints handling

A constant complaint from service users and families is the frustration they experience in a system that is both complex and difficult to manoeuvre. It is a system, they argue, in which they are required to tell their story to numerous people over and over again. Certainly this experience relates primarily to the funding cycle but is equally as complex when attempting to report abuse, neglect and exploitation.

If the system is going to support people and encourage the raising of concerns with regards abuse and neglect then the reporting process must not only be easy to follow but must also be supportive of the individual with a disability. It is also argued for effectiveness the system developed must ensure the body receiving the complaint is skilled in communicating with individuals with a disability and is able to follow up on the complaint and conduct an appropriate investigation with recommendations for action at the conclusion of the process.

It is strongly advocated the body receiving the complaint have a very particular focus on keeping the individual and their family engaged in the process in order to feel the system is supportive of their concerns and takes every allegation very seriously.

It is the position of this organisation complaints handling and investigation of complaints, along with accreditation and oversight be managed by the one organisation. The organisation could operate along the lines of a triage system and this would mean individuals and their families would have a one stop process in which the story does not need to be retold with the potential for causing additional stress to all parties.

Once the complaint is raised the organisation allocate the complaint to an investigator who conducts the "enquiry", provides a contact point and liaison role with the individual and their family, prepares a report and includes the remedial action they would recommend to address the concerns. The remedial action may include actions such mediation, program changes, staff professional development or in more serious cases referring the matter to the police whilst in others it may refer the service to the accreditation arm as the practices of the service may go beyond the specific complaint and be much more endemic to the practices of the organisation.

Recommendation:

Complain management should be a key role of the oversight bod.

Guidelines for responding to abuse

This question has been responded to in the various questions already written. In brief it is strongly argued a standard set of guidelines be developed as a national set of standards and these standards again ensure the response is built around the rights and needs of individuals with a disability.

The guidelines should also have a focus on service improvement as the first stage and a punitive response only where a service provider (whether large or stand-alone) has a history of complaints or ongoing failure to address matters identified during the complaint investigative period.

Visiting Scheme

Distinctive Options holds a very strong view addressing abuse, neglect and exploitation will only be successful when there is a very strong and sound foundation of checks and balances in the system.

The ability of any funded organisation to employ paid investigators to visit every program and individual support process is highly unlikely as this would be prohibitively expensive for any Government to manage. Having said that the Community Visitor program could fulfil a very important functional role in the total package of supporting the checks and balances process.

It is suggested that the Community Visitor program be part of the overall body responsible for managing all aspects of the complaints process. The CV's receive training in assessing service quality and they continue to visit accommodation service providers and expand the community visitor role to include day services and where possible individual support programs and if there are any concerns raise these concerns with their oversight organisation.

Likewise the Community Visitor could play a role in the complaints process and be the first stage when a complaint about a service is received. They could visit the service in their role as Community Visitor and if they identify any concerns or confirm the issues in the complaint then this would trigger the second stage of a formal investigation by fully trained and paid employees.

Utilising Community Visitors would ensure a greater level of compliance across the sector, the potential for a quick response to any concerns raised, the potential to maintain a watching brief on an organisation of concern and an additional resource of the oversighting body.

This would also ensure the Community Visitor program continues to provide opportunities for a volunteer program to remain in force, supports the ongoing aim to maintain connections to the community whilst continuing to encourage best practice in service provision.

Recommendation:

The Community Visitor program is enhanced through increased funding for training and communication tools.

That the Community Visitor program be co-located in the oversight body and be accountable to the body for its performance.

Mandatory reporting

In effect mandatory reporting is already part of the monitoring system service providers are required to comply with via DHHS.

The more important question would seem to be when a report is made how effectively does DHHS respond. Given they are a service provider, funder, quality controller, policy developer and monitor should this role remain with DHHS or for sake of confidence in the system and for ensuring an impartial response to claims particular where they relate to DHHS staffed services an independent body oversee the service system including services provided by DHHS.

It is strongly argued mandatory reporting would best be made to an independent body. This would support a system that can potentially identify service trends with regards quality of support and practice and where there are ongoing issues the overseeing body has a capacity to address the concerns.

This would ensure the oversight body could take action through a range of strategies and the actions could be through a request for training, changes to practice, provision of expertise or any other response deemed appropriate including punitive actions up to loss of practice certification.

Recommendation:

That DHHS not be part of the mandatory reporting process but rather all reports be directed to the independent oversight body.

The independent oversight body have a dedicated unit of skilled and competent staff to investigate all allegations of abuse, neglect and exploitation.

Oversight of restrictive practices

It is suggested the role of Senior Practitioner be located within the oversight body. The reasons for proposing this shift to the independent organisation have been discussed at length in a number of the headings above.

In brief the gains by having his role located in the independent body will ensure families have confidence the system is independent of Government, the Senior Practitioner role could then include remedial recommendations as per the discussion in mandatory reporting above and can take a more active role in addressing strategies in response to restrictive practices.

Recommendation:

The Office of the Senior Practitioner is located within the oversight body.