



Youth Affairs
Council Victoria



Family and Community Development Committee
Parliament House, Spring Street
EAST MELBOURNE VIC 3002

Submission S052

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Family and Community Development Committee

28th October 2015

To the Family and Community Development Committee,

RE: Victorian Parliamentary Inquiry: Abuse and Neglect in Disability Services

I am writing to you as the Manager of the Youth Disability Advocacy Service (YDAS) in response to your request for submissions to the 2nd stage of the Victorian Parliamentary Inquiry into disability abuse and neglect.

YDAS is a Victorian advocacy service that works alongside young people with disabilities between the ages of 12 and 25 to raise awareness of their rights and to support them to achieve what they want. YDAS is a partner agency of the Youth Affairs Council of Victoria (YACVic) and is funded by the State Government of Victoria.

YDAS provides one-on-one support through our individual advocacy service and we also work on broader policy issues affecting young people with disabilities through systemic advocacy. This broader work is directed by the YDAS Steering Committee which is made up of young people with a range of disabilities across Victoria. YDAS also provides education to young people with disabilities about their human rights. In both our individual and systemic advocacy work, we work with young people with disabilities who have been subjected to violence, abuse and neglect, particularly in segregated residential care, disability day programs and in schools.

Experience of disclosing or reporting abuse reporting abuse

Young people with disabilities are most likely to be abused and neglected by those who they rely on for support. This poses a major barrier to them reporting issues of abuse and neglect because of the resistance of authorities to admit failure in service provision in institutional and residential settings.

Case Study

Kelly, a 22-year-old woman living in a Community Residential Unit who has physical disabilities and requires full assistance with toileting, menstrual care and showering, made multiple complaints to staff about the lack of female support workers. It is unacceptable to her, and an abuse of her right to bodily autonomy, to be forced to have her personal care needs attended to by male staff. This has resulted in her foregoing showers and delaying bowel movements, leading to multiple and very serious health problems. Kelly was very anxious about staff finding out that she is accessing advocacy services for fear of retaliation and further neglect but could not attend meetings outside the Unit to discuss her case because she needed attendant care to leave the house which is not provided for her. (YDAS client, February 2015)

Young people with disabilities and/or their families who make complaints to disability service providers about abuse and neglect are often ignored or ridiculed. Many are categorised as troublemakers, as unnecessarily combative, or even mentally ill, for refusing to withdraw complaints about poor treatment. Some are told that if they do not withdraw their complaints, the service or government will apply or challenge for guardianship so that they can have ultimate decision-making control over the young person's life.

Case Study

Jack, a 17-year-old male living in a Community Residential Unit, who has autism and uses non-verbal communication, was one-of-two people allegedly sexually assaulted by a new co-resident with a well-known history of sex offending, not long after he moved in to the Unit. The families of the existing residents made multiple complaints to the service provider and to the DHHS about the inappropriate placement before the alleged assault took place, but were dismissed as over-zealous and intolerant. Jack's family were not informed by the service provider about the alleged assault but from the family of the other victim, who needed medical attention for his injuries. The staff member working at the time of the alleged assault did not take steps to prevent the attacks, hiding himself in the locked staff area. He was not dismissed by the service provider despite admitting negligence. Jack's family are lobbying to have him moved into more suitable housing but must negotiate these new arrangements with the same DHHS staff who have threatened to apply for guardianship if they persist with their complaints. (YDAS client, April 2015)

This case also demonstrates how young people with disabilities with high and complex support needs, who do not have a formal or recognised means of communication, are both at the highest risk of abuse and neglect, and the most likely to rely on institutional and residential settings for their care. They are also typically considered as unreliable witnesses by service providers and police, and therefore

most assaults do not lead to a criminal conviction. In these settings, young people with disabilities are most likely to be isolated from their community, further cementing the possibility that they will be targeted by abusers who know that the young person does not have the means to make a complaint and that no one will be watching.

Young people with disabilities who make a complaint about service provision to the Victorian body responsible for investigating complaints, the Disability Services Commission (DSC), often see no improvement in their circumstances and feel discouraged from making further complaints. There are many situations where conciliation, the primary method taken by the DSC to resolve complaints, is an inappropriate, ineffective and unacceptable approach when it comes to reporting abuse and neglect

Case Study

Alexander is a 25-year-old man with intellectual disability who also has brain injuries from the decade-long use by service providers of sedation, and other psychotropic medications, to manage his behaviour. He lives in semi-independent, supported accommodation and reports that staff intentionally provoke him to violence and then seek his arrest by police. These reports are verified by his family who have also made multiple complaints to the service provider. Staff enter his unit without permission, his belongings often go missing and he comes home to find his front door unlocked or wide open. Alexander will not make a complaint to the DSC because he does not believe conciliation will result in the changes necessary; he wants to move into a different housing arrangement where he can control the hiring and firing of the staff paid to support him. (YDAS client, September 2014)

The abuse, neglect and death of people with disabilities are systematically minimised by the lack of required reporting measures, with much poorer data collection than is mandatory in Australian prisons, mental health units and child protection agencies.

Examples

- *Despite around five deaths occurring in residential care facilities every week in Victoria, the DHHS refuses to make available the actual numbers and reasons for the deaths. Conversely, the Victorian Child Death Review Committee, a ministerial advisory body, is required to report on every death of a child under Child Protection, and submits an annual report to parliament each year; a requirement of the Child Wellbeing and Safety Act 2005.*
- *The Victorian Department of Health and Human Services Medical Committee on Client Mortality reviews and analyses records of residents who pass away while in state-funded services. The Committee formed in 1990 and meets regularly to review records*

however it has produced only one known report ('Disability Services – a Review of Client Mortality 1999- 2001', published in 2004).

- *While there is a relatively high rate of death for people with disabilities under 50 years of age living in residential aged care, 'cause of death' data is not part of the data set collected by the Commonwealth government and therefore service providers are rarely held to account for abusive or neglectful practices that may have led to the resident's untimely death.*

Human rights and safeguards

It is essential that Victorians with disabilities who are accessing disability services have available the protections of the Victorian Charter of Human Rights now and into the future. We recognise that this poses challenges with the NDIS falling under federal jurisdiction but strongly recommend that the necessary reforms are made to the Charter to include NDIS participants who are living in Victoria.

We also believe that there is a need for an independent oversight body to respond to allegations of abuse and neglect and to be responsible for other relevant safeguards in the system. This oversight body should have the power to conduct own-motion investigations into areas that require systemic reform, such as abuse in group homes. This body should have responsibility for developing and overseeing a standard set of mandatory standards for responding to allegations of abuse and neglect in disability services.

We also believe that this body should oversee paid inspectors who visit group homes and day services (not private homes). These paid inspectors must have training in communicating with people who have severe cognitive and communication impairments and be required to speak directly with residents and service users. These paid inspectors should be in addition to the current Community Visitors Program that is run through the Office of the Public Advocate. If a new oversight body is established, it should take over responsibility for the Community Visitors Program.

Another function that should be the responsibility of the independent oversight body is the role of the Office of Professional Practice/Senior Practitioner. The current positioning of this Office under the Department of Health and Human Services poses a conflict of interest that needs to be removed.

For this oversight body to be effective, there must be mandatory reporting obligations regarding the abuse and neglect of people with disabilities. Considering that it is

often staff who are in a position to report abuse and neglect, they must be protected and afforded confidentiality and protection from victimisation by the oversight body. Mandatory reporting requirements should apply to all workers in registered disability services.

We believe that further investigation is needed into the different models of oversight. Our view is that consultations should be undertaken with people with disabilities and other experts after the risks and benefits of different models of oversight are understood and explained. The results of this investigation are needed to enable organisations such as ours to provide an informed view on this. One of the organisations that we believe should be considered for this role is the Victorian ombudsman.

We believe that with the rollout of the NDIS it is important that Victoria maintains and improves its safeguards and that these are not watered-down by a federal system. We need a combined version of an exclusion scheme and a working with vulnerable persons check. We do not see any benefits of imposing a Disability Worker Registration Scheme and have concerns regarding what this may impose on the flexibility and costs of support.

We need a Disability Services Commissioner (or another independent oversight body) who undertakes investigations (not conciliation) when there are allegations of abuse and neglect and who has powers to direct services to undertake service improvements wherever they are required.

It is important to remember that the people who most vulnerable to abuse and neglect are those who are least able to report such incidents. We need to strengthen advocacy in Victoria to enable outreach and engagement with people with disabilities who are currently silenced and unable to report abuse. We also need to remember that the most important safeguard for people with disabilities is to be socially connected, with family and friends, so investment into the social inclusion of people with disabilities needs to be at the forefront of any strategy to address abuse and neglect.

One of the most effective ways of preventing the abuse of young people with disabilities is to provide them and their families with timely and necessary supports. Families are too often forced to relinquish a child with a disability into state-care because of the refusal of government to provide adequate supports in the family home when they are needed. Most teenagers and young adults with disabilities who are relinquished are placed in congregate residential care; the setting where violence, abuse and neglect most often takes place. They are more likely to have poor educational experiences, disconnected relationships with family members and poor health and social outcomes in these settings. Young people with disabilities, who have been abused and neglected, often demonstrate behaviours of concern as

a result of their mistreatment. These behaviours, including violence towards themselves and others, are frequently punished with seclusion, the withdrawal of 'privileges' (including food), and far too often, with chemical restraints. These behaviours are typically attributed to the person's disability diagnosis rather than as the result of trauma in institutional and residential care.

Case Study (*All case studies are actual cases of recent YDAS clients)
Dimitris, a 13-year-old boy with autism was relinquished into state-care due to violent behaviour at home. His family made many pleas over 10 years to the Department of Health and Human Services for assistance, but none was provided. Dimitris was placed into a Community Residential Unit (CRU) for adults with 'behaviours of concern' and as a result, became distressed and increasingly violent towards residents and staff. Staff at the CRU had the child admitted to a hospital mental health unit in mechanical restraints, where he was prescribed sedation medication by a doctor who did not meet him in person, despite his family's objections. On discharge from hospital, Dimitris was placed into a single-resident unit with a small team of support workers, where he quickly settled; sedation medication was not required and he and his family were very happy with the arrangement. Dimitris was then returned to the Community Residential Unit by the DHHS, where his violent behaviour returned and escalated, and a Behaviour Support Plan submitted by the service provider and approved by the Office of Professional Practice, allowing staff to administer sedation medication as required. He is no longer attending school and is routinely sedated throughout the day. (YDAS client, November 2014)

Mandatory training and the importance of choice and control for people with disabilities

Any approach to the protection of people with disabilities needs to balance duty of care with dignity of risk.

We know that young people with a disability want to have maximum choice and ultimate control in relation to who provides their support. Having an across-the-board, mandatory requirement of a minimum qualification would place limitations on the ability of young people to decide who works with them. We are also aware that young people with disability generally want to be supported by people close to their age and with whom they have common interests. These young people are unlikely to have specific disability qualifications while still being an appropriate and suitable person to provide paid support to a young people with a disability. For example, a young person with a disability may be studying medicine at University and would like a classmate to provide them with personal care. A mandatory requirement to hold a disability qualification would be unreasonable and nonsensical in this case and

furthermore it is probably against the rules to complete a university degree and a certificate level qualification concurrently.

YDAS is opposed to mandatory qualifications for disability support workers because we believe that the training that would be required to support one young person is likely to be different to what is required to support another individual who may have very different support needs. For this reason we advocate for tailored and individualised training that includes competencies that are specific to the individual who is being supported. For one young person this might include training in manual handling, supported decision-making, and training to assist with communication. For another young person, a different skill set may be required such as the ability to communicate through sign language and/or training in behaviour support.

In summary, a mandatory minimum qualification should not be required of all disability workers as it will restrict young people with disabilities in being able to choose who supports them. Furthermore, the need for training needs to be determined by the needs of the client. Therefore every client should have an individualised support plan that states the nature of the training that is required to work with that person and all service providers must be required to meet the individual's stated training requirements.

The importance of disability advocacy

We support the recommendation for a significant increased investment into advocacy for people with a disability that has emerged from this committee's interim report and that of the Victorian ombudsman's investigation. But this advocacy needs to be very different to what we are currently able to provide. We need to be doing genuine and effective outreach to get to people who can't get to us. We need advocacy that reaches those who are isolated, and unable to call out for help. We need to be able to reach young people with disabilities and build their capacity to understand their human rights and know what to do when these rights are infringed. A comprehensive assessment of the advocacy needs would examine what is required to undertake effective advocacy outreach for people with disabilities who are not having the advocacy needs met under the current arrangements.

We believe that the administration of advocacy funding needs to be separate from government and service providers in order to avoid conflicts of interest. We believe that the Victorian Ombudsman is such a body and their experience with complaints and upholding human rights and the law are especially relevant to disability advocacy. We believe that the current arrangement of the Department of Human Services funding advocacy has a significant conflict of interest with disability advocacy as does the Office of the Public Advocate and the Disability Services Commissioner.

We are well aware of the unmet need that exists in relation to advocacy support for people with disabilities and any evaluation of the need for advocacy should focus on

the capacity of current services to undertake outreach to those who are most vulnerable to abuse and neglect. This approach is more relevant than examining waiting lists for advocacy services as these lists do not provide an accurate representation of the demand for advocacy or the need for it among people with disabilities who are isolated and who are unable or afraid to ask for help.

I would like to commend the Family and Community Development Committee for undertaking this important investigation and would be happy to discuss this further, so please don't hesitate to contact me on (03) 9267 3755 or by email YDASmanager@yacvic.org.au

Yours Sincerely,



Dr George Taleporos

YDAS Manager