Submission
No 10

INQUIRY INTO SERVICES PROVIDED OR FUNDED BY THE DEPARTMENT OF AGEING, DISABILITY AND HOME CARE

Name: Name Suppressed

Date received: 25/07/2010

INQUIRY INTO SERVICES PROVIDED OR FUNDED BY THE DEPARTMENT OF AGEING, DISABILITY AND HOME CARE (ADHC)

Submission written by

Submission includes: ADHC's failure to follow their own policies and procedures leaving their clients at risk of harm.
The lack of accountability for ADHC leading to poor decision making, unwillingness to admit mistakes and a culture of blame shifting
Failure to provide a safe home for the most vulnerable in their care.

TABLE OF CONTENTS

INTRODUCTION

Our submission is based on the dealings we have had with ADHC in regard to our sister [A] who is currently a part of the [B] which is funded by ADHC.

Our sister [A] has been a member of [B Community] for about nine years and until recently lived in a group home in . With the death of one of the residents from cancer about two years ago there was a vacancy created in the house for a new resident. After a period of some months a new resident was trialled by ADHC with [B Community] but [B] itself was not consulted in the choice of resident.

TERMS OF REFERENCE

1 A)

HISTORICAL AND CURRENT LEVEL OF FUNDING AND UNMET NEED

[A's] unmet needs are as follows:

i) When a vacancy became available in the household through the death of a resident (female) [A] requested that the vacancy be filled by another female as there were already two males in the house. This request was ignored.

ii) ADHC proposed a much younger autistic male as a 'more suitable' resident. During the transitioning process [A] became fearful of the proposed resident. However, despite the documentation of significant incidences involving [A] and the proposed resident the transitioning process continued and her needs and objections were ignored.

(Please see the attached documented incident list)

iii) After the resident had been fully transitioned into the house there were an increasing number of unacceptable incidences perpetrated on our sister by the new resident. However, [A's] needs were again ignored and she had to be removed to another house for her own safety. This is despite the fact that she had been part of the [B Community] for nine years.

iv) It is our observation that ADHC has invested enormous funds into making an untenable situation work rather than admitting their mistake.

1 D)
COMPLIANCE WITH DISABILITY SERVICE STANDARDS

i) Despite concerns expressed by [B] as to the suitability of the choice of the new resident proposed by ADHC, the transitioning process was begun at their insistence. The transitioning was continued even though this contravened ADHC's own documented standard for service entry where it states on ***Page 1.1.2*** under ***EXAMPLES OF GOOD PRACTICE "An Agency has a procedure to involve existing residents of a group home in deciding overall compatibility and in selecting new residents."****

In this case the service provider [B] and the existing residents (one of whom is my sister) all objected to the new resident. The existing residents stated clearly that they did not want the new resident to join them in the house. ADHC persisted in the transition of the new resident even though they claim that [B] are the hands on managers and they (ADHC) are only there to provide support. ADHC therefore denied the rights of the existing residents to have any say in whom the new resident should be. It would appear to be poor practice on the part of ADHC to insist in this way on a service provider taking a service user that the service provider clearly believes is unsuitable.

ii) This manner of choosing the new resident also goes against ADHC's ***STANDARD 3.0 DECISION MAKING AND CHOICE*** where it states that , ***"Each person with a disability has the opportunity to participate as fully as possible in making decisions about the events and activities of his/her daily life in relation to the services he/she receives."****

Late in the transitioning process there was an incident between the proposed resident and our sister which really alarmed us and our siblings. The proposed resident entered the bathroom

even though the door was shut. Our sister was preparing for her bath at this point and was near naked. Fortunately there was a staff member present who, with the aid of another staff member was able to assist the proposed resident from the bathroom. This incident distressed my sister, and, even though there were incident reports and formal complaints made, ADHC insisted that the transitioning process continue.

The proposed new resident was fully transitioned into the house in early

Since that time there have been several incidents where the new resident has made his way uninvited and sometimes forcefully into the bathroom and my sister's bedroom, even though the doors have been shut. He has also pinned her up against the wall to examine her socks and laughs when he sees that she is frightened.

The service provider has done all that it can to maintain the privacy, dignity and confidentiality of the pre- existing residents. Unfortunately, the new resident is totally non-compliant and does not respect personal boundaries. He is also larger and much stronger than anyone in the house and will push staff out of the way when they attempt to intervene in incidents the staff deem to be unacceptable.

iii) In this way, and by their insistence on the choice of resident, ADHC has contravened another of their own standards, ***STANDARD 4.1 THE RIGHT TO PRIVACY DIGNITY AND CONFIDENTIALITY 4.1.9 "Service Users are provided with private space to carry out their personal activities such as showering, dressing and toileting."****

[B] has placed locks on the bathroom. However, locks on the bedroom are unacceptable in this case. Our family and I are concerned as to whether my sister could manage a lock in a case of emergency. There is also the danger of being locked in the bedroom with the new resident.

Our family and I have raised our fears for our sister's physical safety and well-being with [B], who to their credit are doing everything they can to ensure her safety and well-being. However, the non-compliant nature and size of the new resident combined with his unpredictable behaviour make it impossible for them to guarantee the safety of our sister. The fact that her safety cannot be guaranteed was attested to by two Psychologists at the meeting we had with ADHC on

Concerning my sister's situation:

iv) In our opinion and that of our other siblings and our father, our sister [A] has been placed in an abusive situation by ADHC's own definition found in ***STANDARD 10.6 "Abuse refers to threatened or actual physical, sexual or verbal assault, including physical and medical restraint."*** * Our sister [A] definitely feels threatened and often says that the new resident is 'very big.' This alarming situation has occurred, in our opinion, because of a serious failure on the part of ADHC to uphold their own standards in the choice and placement of the new resident into an existing [B] household.

* *"Standards in Action" Practice Requirements and Guidelines for Services Funded Under the Disability Services Act. Published by Ageing & Disability Dept*

1 E)

ADEQUACY OF COMPLAINT HANDLING, GRIEVANCE MECHANISMS AND ADHC FUNDED ADVOCACY SERVICES.

i) In our experience ADHC's first response to a complaint is to shift the blame to the service provider without examining the situation or taking any responsibility for their

own mistakes. It was almost impossible to get past this stage when lodging a complaint. Thus it was extremely difficult to get the complaint looked at objectively.

ii) The main problem with the complaint handling and grievance mechanisms put in place by ADHC is that there is no means of holding ADHC accountable for the consequences of their actions and decisions.

iii) To whom is ADHC accountable? When frustrated by the lack of progress with ADHC we sought legal action against [C]. It was only at this point that The Behavioural Management Team was introduced. This looked like progress. However, because [C] was not deemed to be accountable for his actions the legal process was thwarted. With no one accountable for [C's] actions and with no consequences for ADHC, ADHC remains free to pursue whatever path they please.

iv) The Ombudsman's office is only able to make enquiries and recommendations they have no power to enforce their recommendations. ADHC remains free to act in a discriminatory manner with no consequences.

v) The minister himself has dealt with our complaints by handing them back to ADHC, the very people who are causing the problems. Where is the accountability in this process?

vi) ADHC themselves solve the problem by holding many meetings with the complainants but sending representatives who have no power to make a decision. The representatives confer with their bosses which results in more 'ongoing discussion'

but no significant changes. This process is repeated often during ADHC's handling of a complaint. We can only presume that this tactic is employed to waste many hours of time over many months in the hope that the complainants will give up and the situation will not have to change so that ADHC remains unaccountable and free to pursue whatever path they please.

vii) The only exit plan available for an unsatisfactory resident is that there must be a formal request from the service provider to ADHC. In our case a formal request to exit [C] was made by us to [B]on behalf of our sister. This request was agreed to by [B] and forwarded to ADHC but was ignored because it is not in ADHC's interest to act on the matter. There is no means of appeal and so an unsatisfactory situation remains. ADHC once again remains unaccountable and free to continue with their discriminatory behaviour.

viii) In this whole process I cannot understand how the needs of one new resident can override the safety and well-being of the three original residents. I do not understand how ADHC can justify their decisions, sacrificing the quality of life that the original residents enjoyed, forcing them to live lives of intimidation and fear. The gross waste of funds that could be more effectively spent elsewhere and the apparent lack of accountability of ADHC have made the complaint mechanism frustrating in the extreme.

1 F)

INTERNAL AND EXTERNAL PROGRAMME EVALUATION INCLUDING PROGRAMME AUDITING AND ACHIEVEMENT OF PROGRAMME PERFORMANCE INDICATORS REVIEW.

Reviews are conducted but not acted upon.

On the a meeting was held between ADHC, [B] and the siblings of two of the residents from . At this meeting it was noted that the new resident, [C] had experienced some positive outcomes but the other three residents had deteriorated. There was not one positive outcome for any of the other three residents. They were all adversely affected. Despite this, ADHC have continued to implement their plans and the concerns of the siblings of the remaining residents have been acknowledged but ignored. We are left wondering about the purpose of the reviews.

As the situation has dragged on for several months with little change, we wonder how realistic the behaviour modification plans will be and how long they will take to effect the necessary changes. At the above review it was agreed that the current plan was to minimise (**not eliminate**) harm and risk to staff and residents. The plan to modify the unacceptable aspects to [C] behaviour cannot even begin to be implemented until the harm and risk has been minimised. ADHC cannot give a time frame for their current plan or for the following "Behaviour Modification Plan" This delay further disadvantages our sister and yet again ADHC remains free to pursue whatever path they please. ADHC 's plans have always been centred around [C] and apart from offering counselling to [A] have never come up with a plan for [A] so that she can return to her home and resume her once very happy life.

RECOMMENDATIONS

An independent tribunal to be set up that can look objectively at individual cases and assess each case with fairness and equality. From our experiences, the main problem in dealing with ADHC is that they are not accountable to anyone nor can they be made accountable as far as we can tell. Therefore ADHC can do more or less as they please even to the extent of not complying with their own policies. Any tribunal that is set up, to be effective, would have to have the power to hold ADHC accountable for the decisions ADHC make and the actions ADHC take. This is particularly important as ADHC is set up to care for the most vulnerable members of our society.

SUMMARY

Unmet Needs

Our sister was given no choice in who the new resident should be.

The resident chosen by ADHC was unsuitable.

Our sister became the target of unacceptable and intimidating behaviour.

ADHC were unwilling to admit their mistake

Compliance with Disability Service Standards

The failure of ADHC to comply with their own standards caused our sister and the other household members to be put at risk.

Adequacy of Complaint Handling, Grievance Mechanisms and ADHC funded advocacy services.

ADHC's culture of blame shifting.

To whom is ADHC accountable?

The Ombudsman's office has no power to enforce their recommendations.

Much 'ongoing discussion' without action leading to frustration on behalf of the complainant.

Internal and external programme evaluation including programme auditing and achievement of programme performance indicators review.

Reviews are conducted but not acted upon.

Recommendations

ADHC needs to be made accountable for their decisions and actions or lack thereof