



Inquiry Into Abuse In Disability Services

[REDACTED] to: fcdc

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History:

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I have been employed in the disability "service" provision "industry" for 20 years. I have had exposure to it for 35 years.

Abuse includes direct physical abuse, mental abuse, neglect (left unattended) and financial abuse. Abuse is covered up via the inbuilt mechanisms that have been within the culture of disability "service" provision since the time of Charles Dickens.

Charles Dickens was not a novelist but a social commentator. Stories with happy endings made money for Dickens and soothed the social conscience of the day. Such is the "disability service culture" of today. It is dark, and it is dirty.

The first "mechanism" or barrier in the systemic abuse culture is present in every service provider: The only people who report abuse are "frontline" staff. It may be the house supervisor/Unit manager/Activities Manager or the direct care worker. Each of those levels will develop and understand between them as to what is reported and what will cause them to be scrutinised and what is likely to be acted upon by "middle management" or government body.

The next level of systemic abuse denial is:

When management doesn't understand or care about what happens at "house level" unless it is a danger to them; and the possible damage to "the brand". If you complain or report an "issue" to management above House Supervisor/Unit Manager level you are re-directed back to the House Supervisor/Unit Manager, to be "hoisted by your own petard" - otherwise known as "follow line management". This will involve you being isolated and ridiculed by your peers - bullied.

The next level of abuse denial is:

If you take the issue to the media you are subjected to discipline because of the policy, where if you expose the service provider to public media attention you will be sacked (resident/participant care comes after everybody else's needs - if at all).

The next level of systemic abuse denial is equally the worst, as it has the power to change culture but chooses to ask for more funding, more legislation, more

The culture of reporting (advocate) bodies, including politicians (on either side of the fence), non-government advocates (which are mostly funded by the government therefore only partially representative of people with a disability) and government service providers/funding organisations who are outside of the actual service provision (DHHS is both) are able to "cherry pick" which issues they will respond to in order to justify their existence. Across service provision, all issues are treated singularly and often referred to as "spot fires" - all the different types of abuse are in all areas of service provision.

Another form of systemic abuse is, when ever I have reported issues I have provoked the ire of both managers and staff because as a parent working in the disability sector, I have the increased burden of resentment - which is always present when a "parent" complains (a number of people outside the service sector, have understood this, including politicians). Parents are denied information about their family member on the grounds of privacy. Issues of abuse and neglect are not reported to families, before they have been "sanitised" or they are not given the information at all. Privacy is used to hide abuse and neglect.

If you make a habit of reporting issues and "run the full gamut" of what I have described, you will have an idea of what it is to be someone with a disability and/or a parent. You will be bullied, you will be marginalised, you will be defamed, you will be targeted and you will be hated.

How do I KNOW this?

I have worked at a day placement service provider, supervised 11 SSA's, been an operations manager, I am at present a direct care worker and I am a family member of someone with an intellectual disability. I can relate actual instances where complaints have been ignored, "painted over" and simply denied and then been allowed to continue. You are more likely to be receive unwarranted scrutiny if you are a known complainer, than if you are a known abuser.

The culture can only be changed by accountability at all levels and across all service provision. Respect people with disabilities, respect their families and take action to stop the abuse - at all levels.

There needs to be a Royal Commission to investigate "abuse in disability services", across the whole of Australia,

Colin Bayne

[REDACTED]

People with disability

Abuse of people with disability

In the context of abuse of people with disability, abuse can include:

- physical, emotional abuse and/or neglect
- financial abuse
- sexual abuse offences, such as rape or indecent assault under the Crimes Act 1958 (Vic)
- an incident that has resulted in a serious outcome, such as a client death or severe trauma
- forced treatments and interventions
- violations of privacy and wilful deprivation.

Submission S068

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Family and Community Development Committee

Questions for Stage 2

Experiences of disclosing or reporting abuse

1.1

What experiences have people with disability, families and carers had when disclosing or reporting abuse?

The “experience” is often/sometimes shared by the person with a disability and their family/carers. The reason for this simple and obvious statement is to emphasise the need for empathy rather than the sympathetic rhetoric which is the common response when reporting abuse. Our son’s first experience of abuse was at secondary school where he was assaulted by two other students. They were immediately suspended and we met with the Principal who apologised and told us the culprits had been suspended. After a couple of weeks they returned to school and that was the end of the issue as far as the Education Department was concerned. I went to the Reservoir police station and spoke to an officer about taking further action. His response was to ask did I think our son could stand in the witness box and give evidence (?).

On another occasion, he was subjected to heckling and verbal abuse while travelling on a bus to his “day placement”. I complained to the Mill Park Secondary College and was told that students would be “spoken to”. Another time, he was assaulted while travelling on a tram to his day placement, by students of Reservoir Secondary College. The perpetrators were identified and the Principal apologised on their behalf. The police were informed but no further action was taken due to one of the culprits having “lost” his grandfather (this was the reason given for the behaviour) as well as our son was considered partly responsible, by responding to their verbal abuse.

On another occasion our son was suspended from day placement for swearing at an instructor. We had no issue with the response but as the “swearing” was out of character we requested a meeting with the CEO of the day program. We also requested that incident reports (there were none) and case notes (recent and hastily written – I was emailed a copy) be presented at the meeting. It was evident that our son’s response was in response to “pressing” questions from the instructor. At the meeting the incident report/s and case notes were not presented and the CEO refused to discuss the issue. The presence of an appropriate person from DHS was requested and this was refused from the person whom we had contacted at DHS. It took 7months to get any response from DHS when I pursued the matter further. The response did not cover all of the issues raised and was completely inconclusive and unsatisfactory.

As a direct care worker, I have reported issues of abuse (neglect, assault, financial) during 19 years of service. The responses range from being ignored, bullied, persecuted, and laughed at, to less than “lukewarm” action. Another “ploy” is to refer you back to “line management”. If you take this option, it will take a long time to get a response (if at all) and when they respond you will have to relate the whole story again and again (this is also the response when complaining outside of the service provider). The response will sometimes be to try and minimise the importance of the issue or to ask “What did you do about it? (response – I am reporting it to you).

You will be marginalised during that time by your peers, your own work performance will be scrutinised and criticised, you will be given extra duties with less than realistic timeframes and no support, you will be misquoted, you will receive intimidating emails, you will feel the pain.

I have seen family members bullied, disparaged and their privacy breached, when they make a complaint. This culture is inherent in all disability service providers as both government and NGO’s have “ownership” of the system – there is no one else to whom you can complain. Ministers will rarely, if ever, intervene.

This is clearly demonstrated by the limited accountability described in stage 1 of this Inquiry.

With “ownership” comes entitlement and this breeds nepotism and cronyism which underpin the “abuse” (neglect, financial, assault, emotional). I can provide many examples of these cultural deficits but I do not feel that including them in this document is appropriate as they are only partially my experience therefore not respectful of others affected by the issues. One of the problems with reporting abuse, from “line management” to the media, is that if the issue is about neglect that can be remedied, misappropriation of funds, conflict of interest, nepotism/cronyism, minor assault - then no one is interested as these issues are not salacious enough for the public interest. This means the service provider is subject to minimal scrutiny and there is no threat of being held to account and the person reporting these issues is labelled as a “troublemaker”.

“Collective fear stimulates herd instinct, and tends to produce ferocity toward those who are not regarded as members of the herd.” -- Bertrand Russell

1.2

What systems and processes do disability service providers have in place to prevent abuse occurring in their organisation or to respond to any allegations of abuse or neglect of people accessing their disability services?

Any systems and processes to prevent abuse or to respond to allegations are cosmetic as demonstrated too many times by people identifying issues and subsequent reporting in the media. Service providers (both NGO's and government) have control of their own complaint system/s (ownership).

This was clearly demonstrated with the issues at Yooralla. Warnings from staff were not heeded. The assault was reported. The "whistleblower" staff member was sacked for accessing internal emails ie. reporting the issue, with evidence to a third party. He was interviewed by police but not charged. He took it further ie the media, and eventually a response/investigation commensurate to the crime, was instigated. Has the "system" rewarded him for his courage and responded with a media release totally exonerating him from any blame or wrongdoing? Have the persons who made aware of the issues before and after the assault, been charged as accessories? Has the service provider been penalised and subjected to rigorous, objective scrutiny by a totally independent government body? In disability service provision, this is not the exception, rather it is the rule. Any complaint is dealt with, in the context of "protecting the brand", and is often referred to as "spot fire" (referred to in stage 1 of the report). Management failed the victim before, during and after the abuse, yet it is treated as a "spot fire" in the "cosy culture" of disability service provision, rather it is an example of the culture that exists within disability service provision. The "Joyce Report" was the DHHS response to improving the operations at Yooralla. It was written by an ex-DHHS employee who held an executive position. It is indeed a sad irony, that DHHS has its own similar issues but who writes reports or recommendations on improving their service delivery? - Certainly not people with a disability or their families/advocates.

DHHS is both a service provider and overseer of NGO service providers. This is a conflict of interest and is indicative of a "gatekeeper" culture. Monitoring incident reports is irrelevant if the incident reports don't get written, are ignored or classified incorrectly and if there is no transparency or a response at the highest possible management level directly down the "chain of command" to actual service provision.

Yooralla has "lists" (website) of improvements to improve outcomes – which is no change in the fundamental issue which promulgates these crimes – "culture".

Human rights and safeguards

3.1

How can the rights provided under the Charter of Human Rights in Victoria be maintained for people accessing disability services in the transition to the NDIS once it has been fully rolled out.

"Recognition and equality before the law

People have the right to recognition before the law.

People have the right to enjoy their human rights without discrimination.

People have the right to equality before the law and equal protection of the law without discrimination. Measures taken to assist people who are disadvantaged because of discrimination will not constitute unlawful discrimination under the Charter"

The Charter of Human Rights needs to be a binding legal requirement and included in the standards of every service provider including the police and the justice system. Assault, theft (including misappropriation of funds, financial advantage gained by deception, conflict of interest, etc.), neglect and deliberate false statement, should be dealt with by the same legal processes as it is for everybody else as well as with the full implementation of "Measures taken to assist people who are disadvantaged because of discrimination ..." This has not been the case for people with disabilities or their families since "time immemorial" and is still the status quo. It needs to be implemented, not merely "talked about" in places (where refreshments are provided, along with "self-promotion") far removed from where the discrimination and abuse is "de rigueur" in every day service delivery. Crimes need to be punished within the law that applies to everyone. This type of culture also appears in the application of the law when dealing with "domestic violence". Domestic violence is the same as any other violence and should not be tolerated. The sympathy always extends to the perpetrators which is unacceptable. Coward punches have been deemed a crime – there is no greater coward than those who prey upon the women, children and disabled community members.

Independent oversight body

3.2

During the interim period of transition to the NDIS from 2016 to 2020, should the Victorian Government:

- **create a new body under new legislation**
- **allocate the responsibilities to a single existing body**
- **improve the integration of existing bodies to fill the gaps and address overlaps on the boundaries?**

I have experience in the responses from existing bodies and their integration of responsibilities and ineffective outcomes. They have had many chances to prove their worth and failed miserably and with great expense – fiscal and social, which have led to a moral debt owed to people who are marginalised due to their disability or the disability of a family member. People with disabilities are defined by society according to their disability rather than their ability – this has to be changed in every way, by every service provider.

The creation of a “new body” with clear objectives and responsibilities, coupled with far reaching powers of investigation, is desperately needed. When criminal activity is detected it needs to be investigated and prosecuted by the police and the judicial system with “Measures taken to assist people who are disadvantaged because of discrimination ...”

However, it needs to be free of the proponents and propagators of the existing culture (the “gatekeepers”). Cultural change has to be instigated at the top echelons of any organisation but the need for it is often self evident at the service delivery. To understand what is needed for disability service provision, the culture needs to be “turned upside down” so that “management” of service delivery organisations and politicians are made aware of what needs to change and are ultimately responsible for making sure the determining culture is service driven. A new body with “bullet proof” powers would/should be more cost effective for all concerned as the current system is fragmented and therefore difficult to negotiate, causing further distress. If the “new” body identifies an issue which needs attention outside of its powers eg: criminal behaviour, it can then inform the appropriate existing “bodies” to take action whilst still ensuring an appropriate result - not just a response (“Measures taken to assist people who are disadvantaged because of discrimination ...”) The creation of a “new body” needs to have an on-going existence in a new culture with new funding. New funding does not belong to the state governments to enable them to re-direct, re-allocate and misappropriate NDIS funds for other purposes. The Ombudsman’s office, OPA, IBAC and DHHS, all have other responsibilities other than disability service provision and would not be objective enough to maintain the sovereignty that “disability” has in regard to those funds.

3.3

If the current safeguarding responsibilities were allocated to a single existing body, should this body be:

- Disability Services Commissioner
- Victorian Equal Opportunity and Human Rights Commissioner.
- Victorian Ombudsman
- another existing body?

It would have to be a newly appointed Disability Services Commissioner (the current one is ex-DHHS) with powers to fine and prosecute recalcitrant service providers (both government and NGO’s - the fines should be similar to the fines for non-delivery of train services). The “new and improved” DSC would have the legal requirement to report “matters” to the Victorian Police (matters not already reported by service provider/s) and to instigate legal representation for the victim. The Disability Commissioner would need to be answerable to a Committee of Management- comprised of service delivery recipients or their immediate representatives and advocacy organisations including OPA, as well as regular reporting to the minister responsible and the minister “reporting” to the public.

3.4

Should the state maintain responsibility for some elements of the safeguarding system during and after the transition to the NDIS?

The “state” has a responsibility to safeguard its citizens and in regard to the NDIS transition and its continued efficacy, there has to be a totally independent body ie. not any of the current service providers or government “bodies”. A new “clean break” is required so as not to taint the direction of service provision and its subsequent capacity to “safeguard” the people affected by the NDIS.

3.5

If a single oversight body were established in Victoria what governance, accountability and oversight arrangements would need to be established to ensure it is accountable in safeguarding people who access disability services?

See 3.2, 3.3 and 3.4

Disability advocacy services

3.6

What would be the most appropriate approach to the administration of funding disability and advocacy services, bearing in mind there are both state and federal funding streams?

Funding for advocacy needs to be independent of service providers including DHHS and NGO's.

- Should an existing or new body have responsibility for this role?**

Advocacy needs to be "local" to provide immediate response and efficacy. OPA (Victoria) has experience in this area but is limited by its funding and its "outlook" - not proactive. It needs to be given "powers" to advocate and funding to train staff/organisations for the purpose.

Funding disability services is done through ISP's and by way of client choice. Day services and employment services will evolve according to needs and funds available through NDIA/State funds made available through ISP's but NDIA/State funding for accommodation is the "elephant in the room", as no one has a plan for accommodation for people with disabilities, either currently in care or those seeking accommodation now and in the future. If it is left to "supply and demand" market forces for accommodation, then the NDIS/State funding will never be enough.

3.7

In undertaking a comprehensive assessment of advocacy needs, what components of the advocacy system need to be evaluated or reviewed?

I have not worked for an advocacy organisation but I have seen very little evidence of their existence at the "cliff face". What I have seen is ill-informed, lacks diligence, easily bluffed and self serving. Their funding needs to be independent of government "influences". It is also a conflict of interest if they provide accommodation services, day placement, employment or any service which compromises their impartiality.

Primarily education of advocates (Government/NGO's) is an urgent requirement. There needs to be adherence to the Human Rights Charter and industry standards, in all service provision eg.: accommodation, day placement, employment, community inclusion, public transport, public building access, access to legal representation, consumer representation.

Prevention, screening and accreditation

4.1

Should the Victorian Government develop a prevention and risk management strategy for the Victorian disability workforce from 2016 to 2019?

- If so, what specific components would comprise such a strategy?**

All services should be put on notice that as the transition to the "new system" progresses, cases of abuse will factor heavily when it comes to funding and accreditation. There are already systems in place ie: Working With Children card, Police checks and the exclusion register. There are times where these have failed but only when due diligence is not taken. More checks are redundant if the current checks are ignored or fail to be undertaken. Police checks are not always done and Working with Children checks are not required for all levels of disability care – this needs to be changed now.

4.2

In Victoria, what would be the most preferable screening system to establish:

- a legislated disability worker exclusion scheme**
- a legislated working with vulnerable persons check**
- a combined version of an exclusion scheme and a working with vulnerable persons check?**

Any system is pointless if the checks are simply not done – it happens. The disability worker exclusion scheme is open to manipulation, depending on who maintains and controls it. If a worker's details are on that system for exclusion then they need to know and be able to challenge it. If details include exclusion for a reason then there has to have been action taken under the law. A police check should have details if a person has been excluded due to criminal behaviour if this isn't the case then that needs changing. Assault, drink driving, sexual assault, domestic violence, theft are all crimes.

4.3

Should a disability worker registration scheme be established, similar to the Australian Health Practitioner Regulation Agency (AHPRA)?

- **If so, should this be a national or state agency?**

Yes, nationally. It is the most obvious, urgent and pivotal requirement for all service provision.

Nobody should provide any service to people with a disability unless they are registered with such an organisation. This would obviously be linked to any "checks" done on service providers by maintaining a database. Health Professionals need to be included in this scheme as well as "traditional" service providers.

4.4

Should an independent body be established to oversee service standards, accreditation and registration?

- **If so, should this be a national or state agency?**

Professional development is always undervalued in disability service provision. HACSU had to push for Certificate IV as the standard for DHHS staff. It was resisted, but having worked in the industry for 19 years and having been exposed to it for 35 years, my observation and experience is that it is only a baseline qualification. Most staff gain nursing, counselling, dietary, psychology, financial management, staff management, disability education, etc. simply from experience at the "cliff face". This is always varied and often aptitude is lacking.

4.5

Should minimum qualifications be introduced for all disability workers?

- **If so, what should be the minimum qualification?**
- **Should this be a state or national requirement?**

For baseline workers a Certificate IV with some improvements to the curriculum is enough. For any supervisory position (and above), a diploma or Advanced diploma should be the baseline. There is also the need for serious, "in depth" training in psychology, nursing, bookkeeping, staff management, legal training re: duty of care, use of restraint/exclusion, and all levels of service provision need to also study ethics. These added requirements should attract higher rates of pay. At present a House Supervisor is required to write/assess behaviour management strategies (which is supported by the use of drugs prescribed by psychiatrists) and other forms of restraint while having only reached the baseline qualification of Disability certificate IV. This is totally unacceptable.

4.6

Should there be compulsory requirements for professional development for disability workers?

Yes. It is crucial. Police are trained, firemen are trained, doctors are trained – disability workers from executive positions up to direct care staff need to be trained and including advocacy staff. Training for family members would also be desired outcome as they need to be able to advocate effectively.

- **If so, what core components of ongoing professional development would be required?**

All people involved in disability service provision, need to understand the issues, as change is slow, so training needs to be current, relevant and ongoing. Technology is also changing practices throughout service delivery and training needs to be provided (4.5 - There is also the need for serious, "in depth" training in psychology, nursing, bookkeeping, staff management, legal training re: duty of care, use of restraint/exclusion, and all levels of service provision need to study ethics.)

Workforce culture

4.7

What does the Victorian Government need to do to support a disability workforce culture that does not tolerate abuse, neglect or exploitation?

*Real accountability - Not ministers/public servants/managers/service providers who are inaccessible.
Zero tolerance – get rid of the Gatekeepers.*

4.8

What do Victorian disability service providers need to do to promote and achieve a workforce culture that does not tolerate abuse, neglect or exploitation?

*Real accountability - Not ministers/public servants/managers/service providers who are inaccessible.
Zero tolerance. Make serious changes – get rid of the Gatekeepers.*

Complaints handling

5.1

If the Victorian Government introduces an independent oversight body, should it have responsibility for handling general complaints about disability service providers, as the Disability Services Commissioner currently does?

Yes, self-evident.

5.2

If there is a new independent oversight body with responsibility for complaints handling and responding to serious incidents, should it have the power to conduct own

- motion investigations?

Yes, why not? We all have a duty of care and a moral duty, to do so.

• Should these powers relate to both complaints and the investigation of allegations of abuse and neglect?

Yes and it should also be responsible for reporting to the police anything that is criminal and also to the Commonwealth and State Human Rights Commission/s. It should also inform the complainant of these actions.

Guidelines for responding to abuse

5.3

If an independent oversight body is established in Victoria, should that body have responsibility for developing a standard set of guidelines for responding to allegations of abuse and neglect in disability services?

Yes, and it needs to be “watertight”, no “ambiguity”. If the “guidelines” are found to be inadequate then they need to be reviewed. It also needs to have duty of care as the common definitive. If duty of care has been breached, then that is a “stand alone” breach of guidelines.

5.4

In view of the skills necessary in identifying and responding to abuse and neglect, should consideration be given to paid inspectors or paid official visitors in Victoria?

The Community Visitors program is antiquated and under resourced. Training does not give the Community visitors the “tools” they need. There are very experienced community visitors, who simply need relevant training. The issues identified in 5.6 (The provision of meals is an issue which is often overlooked.....”) are some of the many issues not immediately apparent to untrained or inexperienced staff (in all areas of service provision). Inspectors need to be paid, trained, dedicated, experienced and their “backgrounds” need to be checked as described.

5.5

If a paid inspector or paid official visitor role is introduced in Victoria, should they be located with an independent oversight body or other entity?

Yes.

5.6

In relation to visiting schemes and the existing Community Visitor scheme:

• Should volunteer Community Visitors continue to be part of the safeguarding framework in Victoria?

The Community Visitors scheme (OPA) lacks training and experience. The community visitors do not have experience in understanding what they see or the procedures which underpin the documentation.

*PCP's are an important document for service provision for those in residential care **BUT** they are not always indicative of the level of care provided.*

The provision of meals is an issue which is often overlooked - is there a menu? – are there recipes? - adequate choice and variety with resident input? – does it reflect cultural differences /experiences? – is it rotated/updated? - is the menu linked to the shopping list? – is the shopping done with the “budget” in mind? – is it nutritional? – are the residents involved in the shopping/cooking process? – do staff have a separate fridge for their food? are there resident meetings to discuss “house issues”?

There is also a “Service Schedule” document which they never ask to see. This document lists important dates for the year which are a mandatory requirement. A quick review of current medical issues would also be a good idea if it is supported by training in how to interpret the correlation between doctors'/specialists' appointments and follow up actions in Specific Health Management documentation and/or Treatment sheets.

- If Community Visitors continue to be part of a safeguarding framework in Victoria, should they be located within the Office of the Public Advocate, a new independent oversight entity or another body?

They need to be a part of a new independent oversight entity but failing that - OPA.

Mandatory reporting

5.7

Should the Victorian Government introduce mandatory reporting of serious or critical incidents to a new independent oversight body? If so:

- **What individuals and organisations should be mandated to make such reports?**

All service providers. The line of reporting needs to be “unbroken” without the ability to be terminate enquiries at some bureaucratic juncture.

- **What current functions of the Department of Health and Human Services regarding the management of critical incidents should be transferred to the new body? And should the Department retain any functions relating to critical incident management?**

All service providers have the responsibility of critical incident management. Each should be responsible for their service. They should have to report these incidents to an independent body with a uniform set of guidelines. This requirement should include all government and NGO service providers, so as to negate (as much as possible) conflict of interest. Conflict of interest has played too much of a role in the reporting of critical incidents which has lead to further abuse. It needs to stop now.

Oversight of restrictive practices

6.1

Should the Senior Practitioner be independent from the Department of Health and Human Services in its role in oversight of restrictive practices?

Yes, the current situation is a conflict of interest. The independent person process is an example of the conflict of interest.

The use of restrictive processes is an abomination. In its current form, in some cases, it is abuse. The Senior Practitioner is a token gesture to give credence to barbaric forms of behaviour modification. “Behaviours of Concern” are initially assessed by someone with a Disability Certificate IV and that is followed by the rest of the bureaucratic process. Causes of behaviours of concern are another “elephant in the room” issue with not enough resources.

Anyone who lives in a shared household will have difficulties with their fellow renters, their environment and in the case of those needing physical support – staff, staffing (constantly changing). If you add to that separation anxiety (families – mentioned earlier) everybody will exhibit behaviours of concern.

6.2

If the view is that the Senior Practitioner should be independent, what option would be most appropriate for the nature of that independence:

- **a specific entity with independent statutory powers and its own office**
- **a new single independent oversight body?**

Yes.

6.3

Should Authorised Program Officers in disability services have minimum qualifications for making decisions in relation to emergency restrictive practices, such as restraint?

Yes.

Members

Ms Maree Edwards (Labor) — Chair

Mr Bernie Finn (Liberal Shadow Parliamentary Secretary for Autism Spectrum Disorder)

Ms Cindy McLeish (Liberal) — Deputy Chair

Ms Emma Kealy (National)

Ms Chris Couzens (Labor)

Ms Suzanna Sheed (Labor)

Mr Paul Edbrooke (Labor)

My name is Colin Bayne. I have 35 years experience in working, living and supporting the disability cause. My family has risen to the challenge and I am proud of them. We were fortunate that we were not exposed to the “disability culture” in the early days of our family’s experience. We were not marginalised; we were welcomed into an environment of support and progressive attitudes.

At present, I am reading Kerry O’Brien’s biography of Paul Keating. Paul Keating describes how he “.. was always trying to work out where the balance of power lay in the bureaucracy”. He would either, engage them or go around them, to build a network of people who were useful in doing the actual work in the areas in which he wanted to make change. The only way to bring about change is to take control of the inefficient bureaucracy that doles out an inefficient public service.

The NDIS has a chance to bring about change at a time when change is desperately needed. What needs changing is the culture based on power over people. This issue is constantly a part of the submissions to this inquiry. This institutional culture is present in both government and non-government disability service provision - simply because of the symbiotic relationship between the two. The ability of staff to move between either employer or conversely be denied employment, is evidence of the cronyism which prevails.

This culture also produces “gatekeepers” who keep control using the “waiting list” presided over by the Disability Services Register. I have personally dealt with the DSR as a part of my job. It is a shadowy, nefarious device which is totally autocratic. It maintains control by manipulating the hope of families. Hope is about the possibilities and after a long journey the DSR leaves you at resigned acceptance. I spoke to a colleague recently who was once a case manager. She hated the job because it was a lot of paperwork and planning that she knew would not eventuate in outcomes.

Another gatekeeper device is the lack of accessibility to a consistent plausible response to your inquiry. I have had experience when trying to access someone/anyone in Disability Services to support my son in regard to a day placement issue. They never received any email so I re-sent the exact same email which was responded to with an apology (which I appreciated). The officer responsible to investigate refused to come to a case meeting and then it took a further 7months to respond when I complained. We attended the meeting unsupported by DHS and were confronted with a CEO who would not discuss any of the issues.

The over arching feature of the Disability Culture is bullying. The last two staff surveys indicated unacceptable levels of staff who have experienced bullying. I have been bullied in some bizarre ways. It is widely accepted within DHS that as a supervisor you are the meat in the sandwich. You have to appear to maintain an acceptable level of quality service delivery within the house you manage. This has to be done without offending the staff, your manager, your manager’s manager etc. If you annoy your manager you will be targeted by nitpicking, exclusion, isolation, surprise visits, increased workload, undermining and false accusations. Any of these can be applied to any staff member if the bully has “mates”.

Another golden rule, is don’t dob! You will be bullied, you will be marginalised, you will be defamed, you will be targeted and you will be hated. Even your friends will regard you with a leery eye because nobody follows policy. Policy and procedure is often supplanted by staff lore, ignorance, personal opinion, old information, misinformation, a lack of comprehension, laziness, prejudice or just the fact that nobody reads anything. This is not helped by the lack of credible dissemination of information. One cause of bullying is sometimes mentioned by managers but this does not mean it is

discouraged. It is referred to as "ownership". It is when the staff treat the facility as if it is their "home". This leads to consider it is their right to eat residents' food, determine what is watched on TV, where residents go on outings, holidays, etc. The most obvious one is the subscribing to Pay TV. In some houses it is resident choice in others it appears to be resident choice. Quite often the residents have a TV and a DVD player in their room and some will be hiring DVD's and Pay TV. My observation has been that shows watched are determined by staff.

I have seen family members bullied. I brought it to the attention of the Secretary (recently resigned) and he referred me to his "staff". No surprises there. Who else is going to say anything about the way parents and families are treated except another whining parent? Being a family member of someone with a disability and working in disability service delivery, you are regarded as an annoyance rather than a resource. Families (outside of DHS) often feel complaining will make it difficult for their family member in care. It is peculiar but this is not always the case. Sometimes it helps good staff get the job done. Yes, there are good, fantastic staff who have taught me, inspired me and supported me. The HACSU sub branch has had many local wins for residents and staff. One issue was OH&S items/toiletries which were paid for by residents and after the Sub Branch spoke up it was paid for by DHS. Another item was the use of government cars from the office being allocated to Shared Supported Accommodation houses for use on weekends/public holidays. The list is quite long hopefully HACSU has a copy.

Now about the residents - one of the worst things you can do to someone living with a disability is simply to underestimate them. It is counter intuitive. Each support should be available as required. My training taught about the terminal objective which to me is "goal" focussed and must encompass empathy, compassion, rights and worth, to the recipient. People with a disability have a civil obligation to vote – whether it is physically possible is not the issue. To support someone with a disability you must be supportive rather than predictive. As a care worker it is within your duty of care to provide "active support". It is a part of the disability carer doctrine and is self explanatory. My son votes – his mother with no training other than being a parent, supported him without chemical restraint, physical restraint or the restraint of the institutional power over people. She took a chance and drove him to the polling booth. Focus on abilities and support.

The responsible use of restraint within the disability sector has been superseded by the ever present fascination for technology. The use of chemical restraint is an abomination and so is the process for approval. It is overseen by an independent person for each resident. It is quite often someone the resident doesn't know because some residents have no-one in their lives and you automatically get a "one size fits all" mentality. The responsibility of the independent person is not always understood. Psychiatrists depend on the information given by someone with a Certificate IV from TAFE when prescribing chemical restraint. Physical restraint is problematic for everyone in the disability sector. When I see the issue of domestic violence in the media, I think of people with a disability who experience "domestic violent" behaviour from other residents. It is hidden away and further denigrates the image of people with a disability and labels them different and dangerous. Physical restraint still happens but it is supposed to somehow not happen. If you are in a situation where someone is harming themselves, another resident or staff – what would you do? People who put themselves in the way of physical harm to protect others deserve support/recognition and above all meaningful training and supervision.

Incident reporting has been partially covered by an article in Thursday's Age. Before you change the method you have to make the criterion relevant to all issues which need attention/reporting outside of the immediate service area. You have to then make sure the incident reports actually get written and stop the process being interfered with by local management. Matthew Potocnik and I were lobbying DHS to put in a system where the incident report would be identified by an alpha numeric system created at the facility where the incident occurred because incident reports sometimes "get lost". We had discussions with [REDACTED] and [REDACTED] who made arrangement for us to see a computer based incident reporting system called ERIC. When the incident report was recorded and

had been “saved” it could not be altered. It could have further information added but the original remained intact. Matthew Potcnik and I asked why it was not in use but there was no reason given and the next meeting was cancelled by [REDACTED] and no further times offered.

The occasional quality/systems auditing by DHS is ineffective and is sometimes done by staff who obviously have no experience at “house level” or have long since forgotten. The sporadic visits from Community Visitors are overall ineffective and ill informed. They miss obvious items such as a decent menu and resident meetings which are often overlooked. A menu with recipes and instructions will determine the shopping list which covers nutrition, culture, resident input and variety. It also makes it easier to stop pilfering and reduce wastage – both of which are a common problem. Most reporting of issues still depend on “whistleblowers” which can be someone doing what is officially expected. They then face the prospect where their concerns are mitigated, sidetracked or simply ignored. This is commonly known as being “hung out to dry” and you have to face the culture that does not appreciate “dobbers”.

I have twenty years of direct care employment in various roles and some of my most recent experiences indicate that some things are worse than when I started, some have remained the same and some things have improved. When I started, Operations Managers (Cluster Managers) were a part of the day to day operations of every house in their cluster. Today, you are lucky to see them at half a dozen team meetings per year and only then for an hour or two. It is definitely time to consolidate any lessons learned and eradicate the institutional culture. One of my Operations Managers said at a team meeting “we treat them a lot better than we used to”. The staff asked me afterwards what did she mean? I couldn’t explain third world misery, abuse and neglect but if Daniel Andrews and Martin Foley are simply going to “open the gates” and leave residents to the “free market economy” – they will find out - because wars, poverty, neglect, and abuse happen every day to people who can protect themselves. What is the chance for the disadvantaged? Grief travels downwards very quickly.

I would also ask if my two previous submissions can be posted with my name indicated.