

**FAMILY AND COMMUNITY
DEVELOPMENT COMMITTEE**

**MR J. PERERA MLA, Chair
MR W. NOONAN MLA, Member
MRS J. POWELL, Member**

**INQUIRY INTO SUPPORTED ACCOMMODATION
FOR VICTORIANS WITH A DISABILITY OR
MENTAL ILLNESS**

**MS WENDY MITCHELL, REGIONAL INFORMATION AND
ADVOCACY COUNCIL**

SHEPPARTON

RESUMED

[1.48 pm]

THE CHAIR: Welcome to the public hearing. I'm the Chair of the Family and Community Development Committee and to my right is your local member, Jeannette Powell, who is also the Deputy Chair of the committee and to my left is Wade Noonan, member for Williamstown, member of the committee and Dr Tanya Caulfield, research officer, and Bridget Noonan, assistant clerk of the Parliament. The Committee is looking into issues such as the standard, range and adequacy of care and accommodation currently available, the appropriateness of the current service providers, how unmet need is managed in Victoria, accessibility and appropriateness of accommodation for rural communities, ethnically diverse communities, indigenous Victorians and the impact of the current service provision on families and carers.

The committee is an all-party investigatory committee of the Victorian Parliament and is due to report to Parliament by 30 June next year after which the Government has up to six months to reply to the Committee's report and recommendations. All evidence taken at these hearings is protected by Parliamentary privilege as provided by the Constitution Act 1975 and further subject to the provisions of the Parliamentary Committees Act 2003, the Defamation Act 2005 and where applicable, the provisions of reciprocal legislation in other Australian states and territories. Any comments a witness makes outside the hearing may not be afforded such privilege.

We are recording the evidence and we will provide a proofed version of the transcript to each witness at the earliest opportunity. So for the Hansard, please introduce yourself and the name of the organisation you represent and a brief description of the organisation and then make a verbal submission. It is informal.

MS MITCHELL: My name is Wendy Mitchell. I work for Regional Information and Advocacy Council. We provide advocacy to people with disabilities and their families and carers. Our definition of disability is anything that in any way impairs somebody's role in society so not too many that we can turn away. We cover all of Loddon Mallee and West Hume. I'm the team leader of the advocacy services, so I manage all of the advocacy and the advocates within the organisation. I'm actually based in Bendigo so I can't tell you a lot about Shepparton but certainly Loddon Mallee, where I cover, I can give you a fair indication of what's going on.

We also are quite proactive. As well as being issue-based advocates, we provide self-advocacy courses at SRSs, community residential units, at adult training centres and various other community sectors. We would like to be able to make it so that people don't get to crisis point when they come to us. So, yes. Probably I would think that the issues that we have mainly with SRSs is the actual attitude of staff and management. We find it really, really difficult for the clientele to have everybody believe that this is their home, rather than a workplace.

Such instances of things that we have had, really, really simple things like we had a gentleman come to us that didn't like lettuce in his salad sandwich, you would think it would be a really simple thing to take it out but the attitude of staff was that, well, he can take it out. Everybody else has lettuce so why should we make it different for him. I mean, it's a real simple sort of thing. A similar sort of thing with locked cupboards. Another client that we had had got quite hyperactive when he would have coffee and sugar. He had an acquired brain injury and so couldn't remember how

many spoons of coffee or sugar that he had put in so the kitchen was locked to all clientele in that house. We now have in place that they have sachets so he see that he has a sachet of coffee and a sachet of sugar.

Other things that we have had where clients are more dependent. We have had an instance, at change of shift, clients who are perfectly capable of knowing whether or not they need to be toileted, are all toileted at the one time. All put on, toileted and they sit until the changeover of staff has finished, regardless of whether or not they had finished, whether they need to go or not to go. They were all clients who also needed support and didn't necessarily have that support on the toilet and nor did they have any access to buzzers, bells or anything that if they were in trouble that they could actually get assistance from anybody.

These are just a few of the things but they are very common sort of examples of the types of things. Probably privacy is another huge issue. If clients are in their room that staff don't knock before they enter or they knock as they're halfway through the door sort of thing. They just don't give them the respect that - you know, they may be doing something that they don't want anybody else to see them doing. They may just want to be able to have the choice of saying, yes, come in or no, don't. And that is very common. Very, very common.

Choices in menus is fairly significant. There isn't a lot of input often from the clientele as to what might be something that they would like to eat. Certainly for our younger clients, the issue of what time they've got to go to bed. We have had some clients who - well, in Bendigo we have three - five maxi taxis so if they want to stay out a bit later at night, they have to pay for the active overnights. There is no negotiation around adjusting shifts on weekends to where it might be more needed. Because of the lack of taxis, if the time they need to be home by is 10 o'clock so that staff can put them into bed, they would need to start ringing a taxi at about 9 o'clock which, for your 20 year olds, 30 year olds, is really inappropriate and very, very restrictive to their social options, really.

Also weekend staff, again particularly with the younger group - when I say "younger" I'm talking like teenage through to sort of probably 40. Some clientele will have activities on the weekend and although some of the others can stay in the house on their own, they're not allowed to sleep in and stay in the house on their own. They have to be up. So even though they have nothing on on that day, even though they don't have anything that they need to be ready for, out of bed for, they're still up at 7 o'clock in the morning because that's when the staff are there to get them up.

And with often up to six in a house, it can be that, you know, to get them up by seven so that everything else is going it can be even half past four or five o'clock that they're being woken in the morning to get the routine out and that certainly isn't a choice that they make. It's definitely something that's imposed on them. It's not so bad now but certainly we have met quite a bit of opposition around actually having an advocate on board for clientele if they've got an issue for something, particularly within the house and the staff or that sort of stuff. Quite a few clients have been told that they don't need to bring any support people, that they'll get a fair hearing anyway. So, you know, just really basic stuff like that that they're being denied quite regularly.

Certainly, as we talk about these sort of things within our team meetings of our advocates - we have advocates in Mildura, Swan Hill, Shepparton and Bendigo – and there is a general consensus that this is the sort of thing that is going on quite regularly. As to what you do, I'm not really sure that we've got a lot of solutions other than chip away at changing that attitude. As to alternative, as to where to live, there's not a lot there either. This is at least a house, a roof over their heads. The built environment is certainly a huge issue. At the moment, in Bendigo, we have quite a few severely disabled – well, were children – approaching that 18 years of age.

The parents really are looking to seek accommodation and there just isn't anything for them out there and a lot of those families are heading towards crisis. It's been a fairly torrid trail for them and it's not going to get any easier as the clients – and there are behavioural issues as well as physical ones so quite significant issues around that sort of thing. And that's probably the most of it, you know. Like, it's very general but it's very consistent across the board.

THE CHAIR: Okay. Thank you.

MRS POWELL: Wendy, when you were saying that the clients are toileted at the same time, what sort of facilities are you talking about? Are you talking about the group homes or - - -

MS MITCHELL: Yes. Yes, group homes particularly with that, around the five or six people in them. Staff do the changeover. There's usually two staff on a shift. So two staff will – the four staff will lift everybody on because all of the clients in the three houses I am thinking all require lifts. So they're all popped onto the toilet and changeover of around about the half hour, 20 minutes to half hour takes place, and then the clients are removed from the toilet.

MRS POWELL: And have there been complaints from those people to - - -

MS MITCHELL: There has been. There has been.

MRS POWELL: To who?

MS MITCHELL: We have approached the houses on several occasions and certainly there were some bells given to the clients at one point but often they don't get given to them. They'll be in their room but they'll still be out of reach. We find that they're quite vigilant for a while and then it becomes convenient to put them all on together, do their changeover, take them all off again. So it would be something that we had broached with the houses. Probably – I've been working for six years in this organisation and I'd say probably we've been about six times to sort of, you know, say, okay, we've discussed this.

You agreed that it really wasn't good practice and yet here you are back again doing that and yeah, as I say, I don't know. Clientele are a bit reluctant to go to the likes of the Disability Service Commissioner. It's a huge decision for them to go to that step and certainly, although in a perfect world, repercussions don't happen, that ain't the case in our world and clients are very, very concerned of that sort of thing, that they'll

be left longer or you know, they won't be allowed privileges on Saturday night to stay out that extra time. They're subtle things but things that they feel quite significantly.

MRS POWELL: Can I just – while on this, just one brief one, you were also talking about invasion of people's privacy, the knocking on the door. Were they made aware of that and is that something that the client has been complaining about?

MS MITCHELL: Yes, it is something that quite a few of our clients complain about and again it's something that – with changeover of staff, that you go back again and again and again and again changing the attitude that, yes, you've got a job to do and that's fine and you've got timelines to do it in and that's fine but these people still deserve respect and privacy and a knock on the door takes 30 seconds by the time you get approval. Yes, it seems that very much attitudes sort of slip regularly. We have made huge inroads though.

I should tell you a good story perhaps. We have had an experience with a young couple who – and the privacy issue was where we started with them that they were having a relationship and constantly they were invaded, as they said, simply not knocking on the door, not letting them know that they were coming in. We now have broken down the walls and those two clients now have beds that they can push together, that they can share their room together. They have a curtain that they can, if they want to be separate and private, but yes, so there are good stories out there as well.

THE CHAIR: So these complaints came from the clients to you?

MS MITCHELL: Yes. Yes. Predominantly offered through the self-advocacy groups that we work with. The clients will approach us either during or after those sessions or ring us but more often usually with contact through - - -

THE CHAIR: Did you make those complaints to the Disability Services Commission?

MS MITCHELL: We are client driven so we give that option to the client, if they want to take that track. A lot of them don't want to. Certainly our reporting gives feedback to the Disability Service Commissioner, that we've had this many issues but without the consent of the clients it's just another number sort of thing. There's not that backup information because they don't want to go that extra step.

MRS POWELL: Sorry, Wade, I just – could there not be – I mean, I've seen some of these group homes where they have protocols and things that, you know, what your responsibilities are, look after your room, do all those things, could there not just be simply a protocol that before anybody enters somebody's room they must knock on the door as a courtesy issue.

MS MITCHELL: Yes. Yes. We have suggested things like little signs: please knock before entering and that sort of stuff. That did not go down particularly well. They didn't like that idea. It was around the fact that they would have lots of stuff hanging on the wall then if they started letting one sign on and at that point the client decided that they – we had got them to knock but there wasn't a sign up and the client

decided that that was enough. They were happy to stop there and we didn't get a direct no, that there was not repercussions happening so we're unsure as to whether that was the reason why but, as I say, we're actually client driven. We're issue based. We come in with an issue. We deal with it to where the client wants to go to. As soon as the client says, no, this is too hard, I don't want to do it any more, that's where we cease. Certainly if there's danger and those sorts of things, you know, we would have to report it but yes, it's still the client's choice to have – pursue the action.

MR NOONAN: Look, I don't think it will be one of our recommendations but I think common sense should prevail in that situation so I think all on the committee here would suggest that knocking would make sense and be reasonable but anyway, I don't think our committee will get to that micro level of recommendation but you can take that feedback back. I suppose I'm interested in your council initially. How are you funded and how are you structured?

MS MITCHELL: Okay. We're funded through FaHCSIA (Dept Families, Health, Community Services & Indigenous Affairs). We're also funded through the HACC program. We have a HACC Aboriginal advocate that covers Swan Hill, Gannawarra and Mildura. We have an ATSIC worker here in Shepparton that covers Shepparton, Campaspe, Murrindindi and Mitchell. That is also state funded. We get some funding from Disability Rights and that is a small bucket of funding. We also are Federally funded and any other little pocket we can pick up at any time we do. We have 6.4 EFT covering the whole of Loddon Mallee and West Hume.

MR NOONAN: And how many people would you service in that catchment through your advocacy work?

MS MITCHELL: How many would we service each month sort of thing?

MR NOONAN: Yes. Whatever the terms you use.

MS MITCHELL: We report quarterly. Look, it's really hard to actually say because advocacy – you think you will pick this simple one that will run for three or four years and other things are – probably we would – each of the advocates – and there are eight advocates – would probably have about 20 cases going at any one time.

MR NOONAN: Across the eight or 20 each?

MS MITCHELL: Twenty each.

MR NOONAN: Right, 20 each. The last question before I move on, and I'll have some more for you, is what interaction do you have with the Office of the Public Advocate?

MS MITCHELL: We're regularly in touch with them. They give us lots of advice. We are often referring to them. People often confuse us with them and we have to do a lot of explaining that we don't have anywhere near the teeth that they do. But, yes, we're often seeking advice from them. We actually have a case just at the moment where a family have been admitted to hospital and don't want to have any of the medication, do not want to seek active treatment and so we've supported them in

getting them in with OPA and applying for medical power of attorney and the avenues that are open to them there. So yes, quite regularly in touch with them.

MR NOONAN: Thank you.

THE CHAIR: You made a lot of complaints about staff. What's the cause – the issue? What's the core problem? Is it that staff is not properly, professionally or any ideas?

MS MITCHELL: I think in some areas it can be attitude of management. We do find that we have more problems with staff that are older that have worked in institutions. That is a really rash generalisation and I don't like doing that but it does tend to be true.

THE CHAIR: They came from institutions?

MS MITCHELL: Yes.

MRS POWELL: Wendy, I was really keen on your comment before about the importance of making the department understand that it's a home rather than a workplace when they're doing work in a home.

MS MITCHELL: Yes.

MRS POWELL: A number of people have said to us over this inquiry that the reason they don't take support is because of, you know, the need to maybe modify the home because of the occupational health and safety of the department staff that come in and they don't believe they need that because they don't use it themselves. How do you have that fine line between having workers coming into your home to provide the service that mum or dad do that don't need the modifications and yet the worker has to have those modifications which changes the whole house.

MS MITCHELL: Look, it's a constant battle. Families for the most part can't afford the equipment that is required to meet the occ health and safety standards for workers to come into their home. So applications are made to aids and equipment but that's like nowhere near enough funding to cover the sorts of things, the hoists and those sorts of things, bathroom renovations. Predominantly they're the areas that you find that the changes are needed in. Often we find that families just keep going and keep going and keep going until they have – we have carers that have stress fractures of their backs and all sorts of things like that because of the constant lifting and the fact that workers can't come into their homes because of exactly that. It's trying to negotiation where is the best option.

We have had issues where one of a couple has needed support and there has been a push from the service providers that single beds be purchased because double beds are too hard to work on and cause injury and that sort of thing but the basic human right is that you're able to sleep with your own partner so, yes, it's a real fine line of – occ health and safety is a huge issue at the moment. It's very much in the news and its very valid, absolutely very valid, but it's also not cut and dried. Again, it's a round attitude of let's look at what can work. How can we make this work rather than that

won't work so we just won't do it and that's often the attitude that we find, that it's just too hard so we'll just not give service to these people.

MRS POWELL: Can I just go one step further than that. Do you believe they're going over the top with the requirements of occ health and safety for the person that comes into the home and not enough support to the family who might be having to lift somebody and they get the fractures and they get all of the issues but they're not getting the support because they can't afford it and yet they're having to put it in place for the carer, and maybe there's some subsidisation.

MS MITCHELL: Yes, definitely. Definitely. It seems to be that it's all viewed from the point of view of the worker and I mean, the limited services that are available for carers that need respite – there's not enough respite out there, there's not enough money out there. We all know those sorts of things but as I said it seems very cut and dry that, you know, no, we can't do this so it's just not done. There are some but not a lot of people coming thinking, okay, so we can't do it this way so how can we manage to do it. What can we work with to make this a viable proposition for the family? How can we better service the family, basically. Yes, it is changing a bit but certainly a long way to go.

MR NOONAN: Do you service or advocate for people who receive the ISP packages?

MS MITCHELL: Yes.

MR NOONAN: What's – because they're relatively new in the state.

MS MITCHELL: Yes.

MR NOONAN: What is your council's view about that as an initiative? Is that going in the right direction?

MS MITCHELL: Absolutely. Brilliant initiative but for everybody to actually truly have an individual plan, to truly have the choices, there probably needs to be a little bit more money out there for them to be able to do it. It's still fitting around that housing, that you can't stay home sick from - because there is no staffing 9 until 3. You know, those sorts of basic things where people with disabilities are made to feel very guilty about actually not feeling well and almost forced to go to work because it's a big hassle to get somebody in for those few hours to actually work one on one with them and the cost as well.

MR NOONAN: In your region, have you got any case studies where people have changed their circumstances by the use of an ISP?

MS MITCHELL: Yes. Met a lot of hurdles though. We have a family who attends an adult day centre. Client is 24, severe cerebral palsy, non-verbal, quite severe contractures. Through lots and lots of consultation the best thing for that client is to get as much swimming as possible done. Through financial restrictions within the adult training centre, the swims were reduced from two a week down to one a fortnight. Client is female. So once a month is menstruating, usually on a swim day so it ended up being around about once a month. That was significantly noticeable to

the family how much stiffer the client became so the family has taken the funding from the adult training centre and has actually employed their own workers and the client is now having four swims a week.

The difference in the client is massive but again, as I said, a lot of barriers were put up that – although at the adult training centre, and that was the pool that they used, there was only one person needed to spot and one person in the pool with the client. However, when it was going to be this family that was actually operating it, they said that they needed two people in the pool, they needed an extra spotter, they would need somebody else to help them to get out and that can't be the spotter because if something goes wrong – so they were wanting four people there and, you know, if the spotter couldn't come for that 10 minutes the whole thing fell asunder.

There were lots of hurdles sort of put up and around that occ health and safety sort of stuff rather than looking at, well, how can we make this work. This is a really good example. Let's make it work sort of thing. But it is operational now but that's three years and it's only just started to be operational. It's made a huge difference to her though, so it can be done. It can be done. Certainly, as an initiative it's very applaudable.

MRS POWELL: One of our terms of reference is to look at how it affects people like Aboriginal community or the multicultural community. Is that part of your client base?

MS MITCHELL: Absolutely. Absolutely. We – as I said, we do have two ATSIC workers. We also have an equity and access worker at Shepparton that does multicultural training and we are very conscious of that within our communities. As I think, similarities with both ATSIC and multicultural communities, is actually tapping into them to get them to be confident enough to access our services. Certainly we're having success with our Aboriginal worker in Mildura and that is because she goes into the communities and she's really earned trust but it is building up that trust so that they're willing to come to us for services and realise that we are not always going to be able to give them exactly what they want but certainly are going to work towards achieving the best that we possibly can for them and if their rights are being, you know, held back then we will work as hard as we can to get them back on track.

MRS POWELL: Are their needs similar to the broader community or are there differences in the different cultures?

MS MITCHELL: There's definitely differences.

MRS POWELL: What are they?

MS MITCHELL: Mainly around the cultural sort of delivery of them that, you know, how we go about talking, how we go about presenting, how we try and tap into them is totally different depending on the cultures. It is simply things like eye contact, how we dress, all of those sorts of things need to be considered about how we go. The structure of the families, who is going to be in the house, what is expected, where the respect is – should be given within that household and those sorts of things certainly is an issue that you need to do.

Our worker – one of our workers has developed a cultural dictionary. That cultural dictionary has 64 nationalities in it. Within each nationality there is four pages. Those pages give you basic – the few words, hello, goodbye, thank you, those sorts of things. Basic customs around taking off shoes, whether you cover your face, all of those sorts of things around dress. Whether eye contact is a good thing or a bad thing. Whether it is considered insulting or not. So it just gives you a little précis of basically how you can get through the door without insulting them within that first five minutes and that certainly has been really valuable to us as an organisation and we've put it out there for quite a few other organisations as well.

MRS POWELL: Can we get a copy of that?

MS MITCHELL: Yes, absolutely. I can arrange that. We will have a contact detail that I got the email on so I can email it to you electronically. Yes, not a problem.

THE CHAIR: You run self-advocacy courses, you mentioned before.

MS MITCHELL: Yes.

THE CHAIR: How does it work for people with intellectual disable or?

MS MITCHELL: Basically we work in small groups. We talk about issues that they have and really its about their own management of how they go about complaining, the appropriate way to complain, the sorts of language you need to use, strategies for them if they're in a meeting if they're feeling overwhelmed or overcome or getting angrier, that sort of stuff, that they can call time out. That that's really quite a relevant thing that they can go out, you know, have a 10 minute break, come back in. So it's around those strategies of not burning bridges before, you know, getting any results at all.

Depending on the group that we're working with as to how long a session will run for but we get the groups to actually do the activities around – you know, writing letters or, you know, how to word a letter, how to word what you're going to say to somebody, how – we do role plays around that aggression thing of coming in and talking to somebody aggressively straight off and what their reception is and how they feel about being spoken to that way. Even though what you're saying may be very right, it's about whether or not they will be listened to once they present that way. So it's really basic things around that. How do you complain and who do you go to complain to.

MR NOONAN: Wendy, your council, do you advocate for individuals who are in DHS run facilities?

MS MITCHELL: Yes.

MR NOONAN: On that basis then, when you talk about staffing issues, it would be useful for the council to actually understand the differences that might exist between DHS run facilities and non-government organisations or not-for-profit based facilities because we've heard during this inquiry various submissions which would suggest that DHS should move out of running any of these facilities.

MS MITCHELL: I would support that.

MR NOONAN: Can you then provide us with some information about – particularly the staffing issues which you started with in terms of the standards between – compare them between the two.

MS MITCHELL: They do vary greatly. Probably – another rash generalisation – probably a lot of the DHS ones tend to have a lot of the older staff in them, in my experience that is. Look, there's good and bad on both sides but I think the DHS ones are more conscious of the money side of stuff. So very driven by the dollar stuff rather than actually: this is a home. It's really around that attitude, that change of attitude that this is a home. That would have to be the biggest hurdle that we have anywhere any time we go in. It is getting people just to look at it from that point of view, this is their home.

MR NOONAN: But that's not necessarily just limited to DHS facilities?

MS MITCHELL: Oh, God, no.

MR NOONAN: Right.

MS MITCHELL: No, no, no. No, no. Absolutely not.

MR NOONAN: Right.

MS MITCHELL: No. That attitude can be across the board.

MR NOONAN: We don't get too many organisations that operate on a regional state and national level like your council does and particularly given you've got expertise in rural areas, in terms of advocacy, do you come together with other rural based councils in other states? Are you able to determine how Victoria fares against other states and if - - -

MS MITCHELL: In advocacy?

MR NOONAN: No. In terms of the supported accommodation sector.

MS MITCHELL: Look, probably we do meet – we have VDAN, which is Victorian Disability Advocacy Network and that meets rurally. We also have VICRAN, which is Victorian Rural Advocacy Network and we met quarterly with them. We have just had our national advocacy conference and certainly we are one of the agencies that are going to pilot JAS-ANZ, the accreditation system for advocacy. So through those sorts of connections we do tend to just hear on the grapevine, more than anything, what's going on. AFDO is another one, Australian Federation Disability Organisation, feeds back to us as well and - - -

MR NOONAN: So when you get - - -

MS MITCHELL: I wouldn't be able to say exactly how we compare because I wouldn't have the figures but certainly the same issues are coming up everywhere.

Whether they're more common in New South Wales and Victoria I wouldn't be able to give you an idea on that. We could probably find out for you though certainly.

MR NOONAN: Look, that's okay. It's just we don't get too many national agencies or agencies that can operate on a national level who can give us some comparison so when you go to a national conference, you know, you get presentations and you also get the anecdotal discussion about where Victoria might be placed in terms of the sorts of people that you're representing. You say it is inconclusive?

MS MITCHELL: Certainly it would seem advocates from all over Australia were talking about the same sorts of issues they were facing. I don't think we got down to the nitty-gritty of, you know, exactly how many; is it across the board; is it, you know, only a small percentage or that sort of stuff. Certainly it would seem - the sense that I would've got would be that it was pretty across the board and it's pretty national.

MR NOONAN: Yes.

MRS POWELL: In the issue of country Victoria, are there many different issues that you see happening as far as being advocates as opposed to say city? I guess what I'm saying is are the issues dissimilar and what are they?

MS MITCHELL: They are similar. The choices around solution are more limited. If you have a carer in a small country town that you don't particularly like, and you have the right to not like a carer, you may not have another choice of another carer. You may not have a choice of another facility to go to. We have a family at the moment that has had an issue with their care facility and their child has had to be moved 150 ks away to the nearest suitable accommodation. Now, we've just rectified that and they're now about 30 ks away at another facility that we've been able to access but that's a very regular thing within rural communities.

THE CHAIR: All right, thank you very much.

MS MITCHELL: Okay. Thank you.

ADJOURNED

[2.32 pm]