

**TRANSCRIPT OF PROCEEDINGS**

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O/N 98337

**FAMILY AND COMMUNITY**

**DEVELOPMENT COMMITTEE**

**MR J. PERERA MLA, Chair**  
**MR J. SCHEFFER MLA, Member**  
**MRS J. POWELL, MLA Member**  
**MS M. WOOLDRIDGE, Member**

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

**Witness:**

**MR IAN McLEAN**  
**CEO – Golden City Support Services**

**BENDIGO**

**WEDNESDAY, 19 NOVEMBER 2008**

THE CHAIR: Good morning. Thanks very much for coming along. My name is Jude Perera. I am the chair of the parliamentary Family and Community Development Committee which is conducting this inquiry, and to my right is the deputy chair of the committee, Jeanette Powell, member for Shepparton, and Mary Wooldridge, member for Doncaster, and on to my left is Johan Scheffer, member for Eastern Victoria region. All evidence taken at these hearings is protected by parliamentary privilege as provided by the Committees 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 provide a proofed version of the transcript to each witness at the earliest opportunity, so please introduce yourself for the Hansard and also give a brief description of your organisation which you represent today, then make your verbal submission followed by some questions. Thank you.

MR I. McLEAN: Thank you very much. Thank you. I've never found myself in such a privileged position to almost say whatever I want without consequence. It's quite a unique setting.

MS WOOLDRIDGE: There's always consequences.

THE CHAIR: Very good.

MR I. McLEAN: My name is Ian McLean, and I am the CEO of Golden City Support Services. That is a support organisation that was founded almost 30 years ago within the greater Bendigo region. It was founded on the aspirations of families when the opportunities to start up the first community residential units came about. It was started by families who had chosen to keep their family members out of institutions as being the only option then for them. And so the aspirations of people having a good life in the community, one that is both a sense of independence, of involvement, and of a sense of purposefulness, is at the very core, still, of the organisation's aim and goal.

We have as an aspiration the sense of saying that we wish to enhance the quality of life of the people that we support, and that used to be a motherhood statement of the organisation for a very long time. We, in the last eight years, have come to understand far more how to provide support to actually impact and affect the quality of life of the people that we support. It would be possible for me to be hooked into some of the previous comments that Peter made in regard to institutionalisation and you might give me the opportunity to respond to that at the end of my conversation, and I might just mention that the research out of the UK that says they have completely deinstitutionalised – although they still now find that they have people in 12 month schools that haven't been deinstitutionalised – but the research on the people there is that the people with highest needs, with intellectual disability and challenging behaviour, are shown to benefit the most from community living.

And that is counter to some of the, in fact, position, and – in fact, Professor Mansell from the Tizard Centre at the University of Kent, who is said to – within the UK terms

– has just updated what is referred to as the “bible” on supporting people with high needs in, in fact, the UK, has done an enormous amount of research on this as has Eric Emerson, as has other core – it’s a very researched area, so there is some good data there. So I just would like to make quick mention. I suppose, as an act of discipline, I want to talk to some of the slides, but I could come and speak about us having a good Act, good policies, and a good disability plan within the State of Victoria, but government doesn’t seem to have put it – placed a high enough, in fact, priority on them to fund their implementation.

I could talk about a totally crisis-driven service. I could talk about the need for a link between accommodation and support for people with high needs, if it’s going to work, as a crucial link. I could be talking about aging carers. I could be talking about population-based funding similar to aged care and the need for that. I could be talking about the unmet needs that we see within our Victorian community that is largely masked because we don’t collect data on it. I could talk about the need for a parity between the workforce of DHS staff and community services organisations. I hope you have heard presentations on all of those things, and I’m not going to repeat.

The dilemma is that in solving any of these crises, we may actually lose what is core and important to people with disabilities in the way that we respond to any of those crises, and so in some ways I hope this is novel to you, that I’m going to come at it from a different point of view and talk about how – what we have found, the dilemmas in actually pulling off for people, who require support to have a quality of life in their community, what needs to be in place to achieve that. And unless we fund that capacity, no matter how we respond to any of those crises that I’ve just named, we may fall short of actually people getting their own life in their own communities.

I’ve introduced the organisation, in fact, already, so the first slide goes by in regard to that – a sense of us as an organisation, wanting to – having the aspiration of people being part of their own communities within residential neighbourhoods similar to everyone else with opportunities to develop their own independence and visions, personal relationships and abilities. Research within quality of life has been going on since, well, probably the late ‘70s, early ‘80s, particularly in the area, in fact, of disability services, and Bob Shollock is one of the founding writers on this and has been prolific, as Professor Bob Brown has – there’s a whole range of people, and I’m sure that you will have access, if you wish.

We are working, and working out, how to evidence, and the evidence on – how to work so that the evidence of quality of life can be seen, both objectively and subjectively within people’s lives. We have had a go at shaping the whole organisation of Golden City Support Services with the end in mind of people having independence, a productive and purposeful life, and being part of their local community, and I want to share some of the dilemmas of that journey as it may provide insight in what I think is important to, in fact, present today. The key dilemma is that within a quality of life framework, support provided by staff should enable people to be self-determining to experience a sense of productivity, a sense of contribution to both their family, to their friends, and to the community, to have a sense of purposefulness and to be functional.

The support should be the difference in a person being able to achieve to be functional in whatever their endeavour is, whether it's making a cup of coffee, whether it's making their bed, whether it's at work. It's the difference between the ability that they're able to actually do themselves and learn to do, and the gap to actually achieving it successfully, and this idea of support to be functional, compared to caring for people with a disability, so that they're well cared for, is key and core to what I'm going to talk about today. Eric Emerson – this graph was written up by Jim Mansell, in fact, Professor Jim Mansell from an earlier work of Professor Eric Emerson's, and what this is doing is – I find this graph really challenging and speaks to the core of the benefits and possible struggles of providing support in local communities.

We have here work that looked at how much people were engaged in their own lives, supported to be engaged in their own lives, in institutions – and this was institutions of 100 or more, small institutions which were 20s, 30s, 40s, and community living which, in this case, was group homes in the English context of, in fact, five people in a local residential neighbourhood. The bar – the end of the bar that you see, not the line – indicates the level of average that the setting acquired over the total populations in those institutions. All the institutions that they looked at, all the small institutions they looked at, and all the community living settings. The - - -

MR SCHEFFER: Sorry, I didn't understand that.

MR I. McLEAN: The end of the bar is the average that people are engaged in their life. So in a large institution, it would show that, on average, people are involved in about 12 per cent of their day to day life. If people live in a small institution, they're involved in about 25 per cent of their life on average, and if they live in a community setting, they're involved in about 48 per cent of their life.

MR SCHEFFER: Okay, yes.

MR I. McLEAN: The really challenging and telling thing for a community-based organisation with the aspirations that I just outlined is that the line shows the level of difference that was found amongst the different settings in that same category. So what it's showing there is that living in the community, in staff-supported small homes, you can have at the same level – or, in fact, lack of support to have your own life – as in a large institution. So just living in the community is no panacea to getting a life that is rewarding and has quality of life, but the potential that the setting of living in the community brings brings about a higher potential to have a quality of life than a large institution if done well.

And so it's the capacity to do it well that I'm going to be talking about today. I want to say clearly that the research is in, and Epstein-Frisch delivered this paper at a conference based in Melbourne in 2006. They did this on behalf of a parent-based group within New South Wales, a fairly significant literature search:

*As the number of people supported in accommodation setting rise, then the amount of privacy, personal possessions, self-determination, personal relationships, physical activity, and engagement in your own life diminish. There are a few things that increase and were shown that I didn't include here, and the amount of medication that you increase goes up as the number of beds go up*

that you live in. I'm going to talk about the difference between care paradigm – not care as in being caring – and a support paradigm. The debate has not been had within Australia. It's been had within the UK and the United States, and it's a very important debate that informs what I'm saying today. I'm putting forward that if staff provide just a model of care, then again, we see – and it's been researched from the Netherlands – that the amount of privacy, personal possessions, self-determination, personal relationships, physical activity, and engagement also diminish.

So the way staff provide support is key to whether the outcome of being functional in a sense of quality of life occurs. I've given you work by Isabel Duvall, who did this for her PhD and made a presentation at a conference in Montpellier in 2004, and these are just two graphs from her paper that look at the outcomes, the best outcomes, of a quality of care framework to the next stage, the best outcomes of a quality of life or a quality of support framework, and it looks at both the community, the organisational and also the individual level. I want to, I suppose, highlight in the care chart within, in fact, the micro, well cared for dependency is an end in itself in a construct of care.

People are dependent on being made meals, on having their houses cleaned, on people for transport, and even if a person has a capacity to make a phone call themselves, the staff are likely to think it's their job to do it for them anyway. Even if a person can read and write, it's likely that their own diary and their own life will be managed by staff in a care model. I don't wish to be derogatory about people's experience within hospital settings, but for me, it correlates to the misfortunate times I've had in hospital where you don't feel in control of the ebb and flow of life. The institution that is around you has a structure that it needs that takes over the ebbs and flow of life, and so without being person-referenced, in a framework of care, staff tend to, I suppose, emulate that sense of care where things are done for people without a lot of, I suppose, reference to them.

And I can point – I'm going to put the postulation to you that staff in support settings, even in people's own home supporting one person, left to their own devices tend to put in a model of care and not support, and I want to build on that just a little bit more as we go, and I'm prepared, if you wish, to – you obviously – if it isn't of interest to the panel, then that's okay, but if it is, we can come back and have further discussion. What I'm saying here is that the outcomes for people living in the community has got to do with the settings that they're in, but it's also got everything to do with support that listens, that enables, that makes possible, and that creates, compared to a care model that controls, constrains, and fosters dependency.

In fact, institutionalised sees a lot of the issues that we would see within the old institutional settings. I want to quickly highlight that within the accommodation support area, especially in the area of people – for people with cognitive disabilities – we still, in Victoria, have no assessment tool. It staggers me. There are assessment tools that actually measure the – not the adaptive behaviour or the amount that people can do, and therefore guesses at the amount of support that someone actually requires to be functional. There's assessment tools that actually assess the gap between people's ability and the support they require to be functional, and therefore also flow on to the amount of funding of support that is required.

And this is just one model, but one that I find and would tender to you for your consideration. The Supports Intensity Scale is a well researched and implemented document. It's not just from the United States. It's implemented in Italy, in some of the provinces of Spain, in Japan, and in many of the states in the United States, and there is now a research background to it, and this looks at the domains that people need to be supported in, to have a full life in the community. So if you look at the support that is required in each of these domains, and assess the support that an individual actually requires to be functional, you can work out the amount of support that they need to be a contributing member to their own life, to their family, to their friends, and to the community, to their jobs, etcetera, to their education.

It also has other scales at the end which I find, as a service provider, incredibly worthwhile, because there needs to be, in fact, a weighting if someone has very high medical needs for support, or has high needs due to, at times, not understanding their environment and responding to that with challenging behaviour, and so I put that to you as one model. There is one other Australian model that I'm, in fact, aware of, that tries to do the right thing. I just forget its name now, so I apologise for not being able to bring that to you. But most other models of support look at the deficits that a person has. What we need to do is look at the abilities that they need to have for a life in the community, and the planning that we do needs to not just have a good person-centred plan, which is now embedded within our new Disability Act - which is a profound thing if we pull it off - but we also need to then assess how we actually - what supports are required to achieve those aspirations, and it's more than that.

The staff involved if they're employed by families, the staff involved if they're employed by organisations, the staff involved if they're employed by the person themselves, need to have a service plan of what they are expected to provide. So there are three levels of planning that's really required to really pull off good support services for people with a disability. It's not a question of care, it's a question of support. And so in a model of support, staff don't just go in and say, "Now, where's the vacuum cleaner? I need to do the vacuum cleaning. I can start preparing the evening meal this morning because I think we'll have it at about 6." The issue of support is to ask the first question of: can the person do it themselves? Because they may not actually require staff assistance.

I put to you that in many of the supported accommodation places that we have, staff do things that are actually de-skilling the people that we already - that we are supporting, supposedly towards independence. And it's because we don't have a paradigm that is clear of support that asks: can the person do it themselves, can they do it if we just put in a piece of adaptive technology? If you put a cradle to pour the kettle because someone can't bear the weight, then they become independent in making their cup of coffee if they can do all the other steps of filling the kettle, turning it on, and getting the cup out of the cupboard and filling it with coffee etcetera, undoing the lid, I'm assuming.

But if you put adaptive assistance in any of those stages, they become independent in making their cup of coffee. Some people only require a microwave to open the other way, the door to open the other way, to be able to access a microwave. Are we looking at that level of adaption just so that they experience the level of independence without needing staff support? Then in a support paradigm, people might just need -

the other question is if you are supporting them in community activity – in a club or a church activity or in some other neighbourhood event or at work – are there natural supports there that can be trained and skilled to provide the supports people need in that setting for that time and are dependable?

The difference between care and support is whether it's natural supports or whether it's paid staff supports. If people need support to be functional, if they don't turn up on the day – if the support doesn't turn up on the day, then people aren't functional on the day. And so natural supports are an incredibly good way for people to be functional if the person who knows how to provide that support turns up on the day. Otherwise the person is completely – well, not completely. They are functional to the level of their ability. The other questions that staff need to be asking the person, if they do require staff support, is: do they just need some information? That because of their lack of exposure to the information that is out there that they don't know.

Do they just need a watchful eye to participate? Do they need just a voice prompt because they get stuck at some part of the task and need a prompt to move on? Do they need assistance with part of the task but not all of it? Do they need hand-on-hand assistance? Because it's still engagement and involvement in your own life. Or does the staff person need to do the whole task for them, at this stage, to be functional? And then I think it's important in a setting where we're working on people's being, in fact, functional, to ask the question: does the person want to learn to do this activity themselves in the future, whether that takes two, three, or five years? I've included in here – and don't wish to talk to it just because of the limits of time – what we have put in - - -

MR SCHEFFER: Sorry, which page are you on now?

MR I. McLEAN: I'm sorry, I've not numbered them.

MR SCHEFFER: All right. Yes, okay.

MR I. McLEAN: Okay. I'm on the page that is headed:

*What needs to be in place to achieve the three goals of independence, a productive purposeful life, and community inclusion.*

We have put into place everything on this page. It's taken us over eight years to get there, and this is the capacity of the organisation and what we, at the current time, have found to be important for an organisation to respond to have outcomes of independence, a productive and purposeful life, and community inclusion. We have information that we collect and act on, and we have to emphasise to our staff, it's not just a person-centred plan which is great for learning aspirations, but fostering and listening to self-advocacy, the decisions of someone day in, day out, is an important skill that needs to be attended to. You see the modifications and assistive technologies there.

We've selected these practice frameworks as examples of best practice frameworks from the UK and the States and of, in fact, Western Europe, and we're now at the stage of having our replication of these researched here. And we look at the – and we

collect evidence to ensure what's happening, and we also have a part of it that is community development.

MR SCHEFFER: So when you – your organisation is researching your practice when you're saying "We have - - -

MR I. McLEAN: In fact, La Trobe University – we've just been successful with an Office of the Senior Practitioner grant that is looking at whether the anecdotal and observable – from our point of view – in fact, difference our support makes with people with high needs with challenging behaviour living in the community, ie, a reduction in the severity, a reduction in the amount, a reduction of challenging behaviour, a reduction within, in fact, the medication that they are using for chemical restraint. We believe we have examples of that through our practice – over 10, 12 years' practice. And that is about to be researched by La Trobe in regard to community-based living.

The people – there's some people – might see – can't be functional living within the community and need to be within institutions have a great life in the community. Not without a lot of work going into the type of support and a lot of work going into supporting the staff that provide support. I want to talk about that, because the variability of staff support practice – the difference between staff providing care and providing support – has to be put in by the capacity of someone, I believe, because staff come to us to be employed, whether they've come from another organisation where they've had training in the current Cert IV system, and they come with an expectation of caring for people. They come with their own parenting framework and they come with the same prejudices toward disability as the communities that they come from.

So we have an internal base training and advanced training that works to provide the skills that people need, but the values and the motivation to apply those skills all the time gets tugged by those other three things: the sense of care, the strong sense of wanting to parent the people in the way that you've been parented or that you've parented others, and a sense of the prejudices of the communities that you come from and that you live in yourself. We tend to be tugging against that all the time in regard to providing, in fact, motivation.

So if staff become dissatisfied with the organisation for a time, or a team becomes dissatisfied within themselves, you tend to see care starting to come out instead of, in fact, support. So within an organisational context, continually providing the motivation for staff to provide support and having that capacity has been core to being able to provide support that then provides the level of independence and involvement, not settling for care that is going to just be consuming and is going to not be, in fact, enabling. So the dilemma is that, as Eric Emerson puts very starkly to us – and everyone says this can't be true – in his research of the impact of training of staff on the quality of life outcomes of people with disability, he showed very little correlation between the training of staff and the correlation of increase of quality of life.

I don't know about you, but for me as being, in fact, responsible for a group of staff, almost 200 staff, providing support within our different guises, approximately 100 people in their accommodation and in their living in the community and up to 800

within mental health support – in fact, community based mental health in regard to respite services to, in fact, families and also planning and facilitation services – this is a challenge. Jim Mansell goes further, I think, as part of the explanation. Staff need more than skill that they're trained for. They need motivation to put their skill into practice. And so I think the reason why Eric Emerson's research shows that there is very little correlation between training and quality of life outcomes is because the application of that skill is limited.

They have also shown, within the same research by Mansell and Emerson and others, that if you do practice coaching on shift, then the skills will be implemented for up to about three to nine months. But if you stop practice coaching, then that skill actually wanes again. And we, observably, see that. We actually see, within our staff, that people's application of the skill they have will change if, for some reason, the levels of motivating and supporting staff to provide service are not implemented on a weekly basis. We see their practice and therefore incident reports with people with challenging behaviours flowing through between three days and about two weeks.

And we can link those incidences largely to a change in the practice of our staff, and we get back to basics and things are okay again. In fact, they're good again. So this is a key issue. We've come down to the bottom lines of the frameworks of our support. We've simplified them as the absolute priority for our staff. They're non-negotiables that slide in regard, in fact, to the bottom line. People need to actively listen to the people they are working with and supporting so that it's their point of view that dictates what occurs for support in the moment – in fact, by moment. People need to be engaged in everything to do with their life, and all the work with people with higher support needs due to challenging behaviour, one of the key reasons for challenging behaviour is boredom.

If people aren't engaged in their own life – if they're plonked on a chair to be cared for – then simple boredom causes challenging behaviour. We don't have anyone that enters into challenging behaviour when they are actively engaged in things that they want to be doing. It's not that simple, but it is – that is a very core component. Choice and control is really important. The feeling of being control of your own life and having some say over it is important, in fact, to us all, and using positive language and not punitive – not punishing people for not doing as staff want, which is common within the care and parenting model that staff usually come with – is a very – the punitive statements from staff is things that we have to actively coach against.

And so using positive language, clear, unambiguous, and supporting great behaviour, encouraging and, in fact, praising, is a key to what we do. Making sure each person has their own plan of the day or their own diary that they keep themselves, not a staff diary that their life is in, also is a way of, in fact, emphasising that it's their day, their outcomes, their life. So the differentiation between staff activity and staff work life and the person's own day that we're supporting is really important, and this is something of what we have put into place and found to actually work, and they come from the frameworks of person-centred active support, from positive behaviour support, and from active listening.

I've given a bit of an outline of the organisational capacity that we've built of the organisation, and I don't wish to talk to, but just to say that it is complex and has

taken a lot of resource and energy to focus on how to ensure the outcomes for people, not just look like we're providing care. So I've already indicated that our aim of support staff is that people should be independent, engaged in their own lives, and be functional in their own, in fact, endeavours, and in their own environments. However, our experience shows that staff – left just to their own devices, staff do the opposite, and they make decisions for the person that is being supported. They cloister them in their own home and don't get out and they don't engage people in their own lives.

Coaching practice, leadership, the sense of assessment of what we're doing on the job, is of key importance for our organisation to give feedback to ourselves in our service delivery and our staff to whether we're achieving what we are setting out to do. So without investing and having a service system that is prepared to invest in, practice frameworks of support that staff get skilled in, training that includes not just training that is upfront but job coaching on an ongoing basis to maintain the application of skill – we also do shadow shifting in regard to orientation of new staff and things like that, but I haven't included that here. And the constant recognition and feedback - - -

MR SCHEFFER: What does that mean, though? Shadow shifting?

MR I. McLEAN: Okay. Shadow shifting is where you go to the extra expense of linking a new staff member to a trained staff member to do a number of shifts to see how it works on the job, instead of just throwing them into, after some verbal orientation and say, "Go for it," because they're more likely to naturally put in care and parenting than the level of support that someone needs. Now, all of my conversations, in fact, today – I'll just finish this bit for the record. So engaging and – we need to, in fact, invest in, also – so the practice frameworks, the skilling up of training, and the coaching, engaging and being able to motivate staff at the beginning of every shift, and being able to observe and monitor and give feedback.

Now, where does that come from? When we're getting – we are starting to move towards much more – in fact, the opportunity for person-controlled services. Unless either the person themselves, if they have the cognitive ability and the self-assurance to direct their own staff and to motivate their own staff, then they are able to give this motivation to staff on a day by day basis. If someone has a cognitive disability, though, where does this day by day motivation of staff come from to provide support and not care? If they're family-run and family-directed services, families need to know that this is part of the core role that they need to do with the staff group that they've employed, I believe, because otherwise their family member is going to get care, not support. Not be supported to be functional, but be closeted and, in fact, not necessarily, in fact, I suppose developed.

I'm being black and white here, and I apologise for the vastness of that, in fact, dichotomy. But if it's through organisations, it's the same question. Where is their capacity to motivate their staff day in, day out to support and not to care? Because in the end, if staff do care, ie, do the practice of care, and not support, then the potential that community living offers is actually not realised. The sense of people being self-determining over their own lives, engaged in their own lives, having their own role, their own job, their own contribution, being part of their own community.

That is what doesn't get realised. My concern – back to the very start – is that we are in such a state of crisis in so – or we seem to be in so many areas in regard to disability application, that in solving the – for instance, the aging carers crisis. Some of the solutions is to go to 15, 20, or 30 bed places in some parts of Australia. In fact, New South Wales has changed their legislation to, in fact, allow the rebuilding, in fact, of small institutions again. My concern is – and the argument is that we will never be able to meet the need of the number of people that are currently being supported by aging carers when those carers end up being too frail to support, or they end up passing away.

That is a level of truth in that, but what is the outcome for the people that require support? Are they going to be supported to be functional, contributing members of their community, or are we going to put them within an institution of care, whether it's community living institutional care or whether it is bed-based with larger beds. Thank you for hearing my submission today.

MRS POWELL: Could I start? I really think it's great that we've got all of your information about staffing and the best practice on record, because what we're hearing around – particularly in country Victoria – is the problem with trying to attract skilled staff into some of these community-based organisations, or to retain them, and when you're talking about best practice, we've been hearing from some carers about the lack of privacy, not even knocking on somebody's door as they enter, the fact that the carers need to understand – or the workers need to understand – that it's a home, not a workplace.

MR I. McLEAN: Absolutely.

MRS POWELL: So some of those issues – so what you're talking about is best practice, but what we're hearing is, in some of those areas, it's very difficult to even attract staff, let alone those who are motivated to not just care for those people, to support them. I'd be interested in your view of how we deal with that, because that has been an issue as we travel around, an issue of trying to even attract staff in some areas, let alone qualified ones who are motivated that their primary care is to make sure this person gets a quality of life.

MR I. McLEAN: Yes. Through the experience of our organisation, we have come to the decision that it is the very rare staff person that comes with the skills and the values and the application that we think that we require, in fact, of our staff. So we have, in fact, invested in both orientation and base training and advanced training in the skills that we require. The industry training framework that has just been reassessed within Australia for training Certificate IV has not taken on the submissions from national disability services in regard to where the field is in what they require from staff and the changes within the training framework that may be required to actually modernise towards support.

It didn't fall on deaf ears, but it almost did, so we still have staff coming out of the training institutions, or training, in fact, places, with less than what – with not an understanding of what our organisation and many organisations, in fact, require for support. So we have to do that in-house. But even if they did come that way, we too – we – I don't want to be recorded as saying the wrong thing, even though I'm under

parliamentary privilege. We still have – we are very fortunate to have the immediate feedback of some of the people that we support, and that is not from people with cognitive, in fact, ability necessarily, it's people from when they don't get something that is going on, or something that is going on that is inappropriate in their mind, they exhibit challenging behaviour.

They are actually the ones that give us the quickest feedback to the standard of our support, because if we get it wrong, they tell us immediately, and we have a structure, of course, as all agencies do, with an incident, in fact, reporting of challenging behaviour to see that very quickly. When we go and assess what needs to occur for that piece of challenging behaviour to be rectified in the future, ie, how do we change our support so somebody doesn't need to exhibit that behaviour, what we found at times is that we, too, have staff that will forget to knock on someone's door and who has been asked to take their medication in a staff timeframe and they're working on the computer, and they have said that they want to work on the computer for the next half hour.

Staff member have gone into the room, not knocked, given them, in fact, the medication, and we get an incident report, because they've given us an immediate feedback that we have just crossed their self-determination, what they had planned to do in their life and what we agreed to support them in. Now, it's not that they won't take their medication. It's just that we got it wrong within our support. So we are actually supporting our staff and actually managing and investigating to that level on a day by day basis. Without that, people don't get the support that they require, and that is in, in some ways, a simplistic example, but there's many and varied examples that are very similar.

MS WOOLDRIDGE: Can I ask, then, how does the current DHS funding model fit with this approach that you're talking about, and obviously, any thoughts, about, you know.

MR I. McLEAN: Yes. We have eked out this capacity because of strategic decisions of what to fund within the organisation and what not to fund. We haven't got as many senior managers as what the funding would allow us to have, because we've invested in the training and the practice coaching of staff. Does that make sense? So we have gone short on some things because of the priority there – and I say that because the department at the moment doesn't fund support. You can do care and you can get away with what it is. They are now, of course, to be quite fair, expecting some quality of life outcomes, but there is no current, in fact, analysis from my point of view of how to move the industry that may be doing care to support, and that is the only way we're going to see those quality of life outcomes that are great aspirational statements within our disability legislation and within the state plan.

So back to the question. We have eked it out of our own block funding. One of the risks that we run in the really great benefit of individualised funding that is coming up, that is beginning to be implemented, where the emphasis of control and of decision-making is on the person with disability and their family – the struggle there is that the same, as you individualise each individual, in fact, moment of support, we may not be able to eke out the same infrastructure capacity to provide this level of support to our staff in regard to outcome. It's a strange paradox at the moment for us,

because the degree of capacity that really is required to be funded to motivate staff to do support is not recognised or funded, and so therefore with individual support coming on, families also don't really attest or understand or even sometimes want the difference between care and support. So it is a very interesting transitional period, Mary, for our organisation, and - - -

MR SCHEFFER: So how – sorry, can I say, how did – because that is a really, really important issue. How do you get what you're on the way to attempting to achieve, you know, and the - - -

MR I. McLEAN: Yes, and achieving within moments of time.

MR SCHEFFER: Yes, sure. With all those sorts of qualifications, but nonetheless, an important thing that you – how do you get that through to the larger system? I mean, what's the mechanism? Do you just do that through your funding arrangements and - - -

MR I. McLEAN: Well, we have various things. I was part of a group of three that then became larger, that started off the intellectual disability round table discussion every year, and part of that is to have fair and fearless, in fact, debate about disability, in fact, policy, and the last one was actually on the strengths and some of the warning signs within individual – within individual, I suppose, funding.

MR SCHEFFER: Okay, so just background the round table for us, all right?

MR I. McLEAN: Okay. The round table is initiated through La Trobe University, where leaders of the field within the intellectual disability field are asked together to, in fact, deliver papers and then to discuss with – in Chatham House Rules, the particular policy emphasis that is being looked at for that time. And there has been three now, and those outcomes have been published, and they have formed a very good, in fact, basis of debate, and supported accommodation and, in fact, community living, has been one of their focuses, so it will be good for us to put that into your, in fact, inquiry. That is one thing that we've done. I have been part, up to this year, of the peak organisation's work NDS, and I've also been part of the national body of NDS that looks at accommodation and support in Australia. So that is another way to influence and to talk about the need for capacity, and NDS have put forward within their policies the importance of support attaining quality of life outcomes for people, which is in line also with the federal, in fact, goals of support. It's an aspirational goal there. But you don't just get there – we also have set up, in fact, communities of practice. We've been at the core of the person-centred active support community, in fact, community of practice in Victoria. That is a number of organisations, now including the department, that are implementing first the person-centred active support framework, and we bring out, in fact, Professor Jim Mansell every year and from – in fact, from the UK, and we've done that for four years now.

That informs debate but it also informs that community of practice. I have brought out Professor Bob Shollock in regard to the quality of life framework, so I suppose I work at trying to influence the thinking within the disability field, and certainly

Professor Shollock, back four and five years ago, did influence things in regard to quality of life outcomes.

MS WOOLDRIDGE: But flipping that round then, what role, then, could government play? How would – if, you know, for us sitting here from a committee perspective wanted to say, “This appears to be a track that we should be thinking about going around,” flip that set of actions that you’ve done through to government. What would government’s catalyst be to driving this sort of change?

MR I. McLEAN: Yes. I’m not sure if I’m answering the question, but the key catalyst for the government is to work out what outcomes it really wants from support. If it doesn’t really want the independence of, in fact, the person to be functional in their own lives, if it doesn’t really want real community, in fact, involvement and participation, if it doesn’t really want for people to have a sense of control over the day to day decisions of their life, then let’s keep doing exactly what we’re doing now.

THE CHAIR: But what if - - -

MR I. McLEAN: If we want to do something different, we need to build a capacity of both the individuals who might be controlling this service, the families, if they’re controlling the services, or the CSOs or the government’s own services, needs the capacity to look at the motivating of staff shift by shift, because from our experience, our staff need that – they’re great people. It’s not that they do care because they are not good staff and good people, or that they haven’t been through training. There seems to be this homeostatic pull back to a sense of care and parenting people with disability, and we all the time have to put energy into motivating something else. It will be the same for the department. The debate about care and support needs to be understood and, within that framework, fund what needs to occur to actually get support.

THE CHAIR: What do you recommend the inquiry or the government to do to achieve that? A change of training, or what sort of mechanism to be put in place to achieve that?

MR I. McLEAN: Just because you fund a process doesn’t mean that you get the outcome. That is the first real learning that we have made and that, I suppose, I’ve in fact presented, and it’s the same for government. But I do believe that you need to set up the potential for community services organisations to achieve and to maintain support, and to do that, then practice coaching and the sense of leadership of, in fact, practice support, needs to be funded. There needs to be no argument that staff meetings, where consistency of day to day support is discussed, needs to be a legitimate funded item of the Department of Human Services instead of organisations having to go cap in hand to try to justify that even a once a month staff meeting should be funded.

If you have a staff group of 14 or 15 staff providing support, that’s a cost of 15 or \$16,000 a year just for a three hour staff meeting once a month. It doesn’t come out of the unit price for an hour of service, and it’s not seen as legitimate or it’s seen as expendable unless you understand that you need that to motivate staff to provide

support, and you don't want to settle for the outcomes of care. But you see how we're not there yet?

THE CHAIR: Yes.

MR SCHEFFER: I just wanted to come back through, just a question of information for me, I guess. Going round in my electorate – quite separate from my work on this committee – talking to groups that are providing housing for people with disabilities, they talk to me in very similar terms to the way you have. They don't talk in a care paradigm, they talk in a support paradigm, and just on Monday, I was doing a bit of a tour around a part of my electorate where they were showing me some of the houses that either they had rented or they had built, and they were talking about, for example, how one man has a carer come in and together they do the gardening, because I was commenting on how terrific the garden looked.

MR I. McLEAN: Exactly.

MR SCHEFFER: In other instances, they described how they had a project worker in a similar kind of caring situation, and they had been a short of the electricity and they – the parents talked about how grateful they were the project worker had the foresight to make sure she rang all the people living in the houses to remind them where the candles were, because that had been set up before.

MR I. McLEAN: Yes.

MR SCHEFFER: So very much - - -

MR I. McLEAN: So just providing information.

MR SCHEFFER: Yes. Very much what you're talking about, so one could walk away from that getting the impression that things are pretty hunky-dory and what you are telling us is more solved than not solved, but of course, that is not the case.

MR I. McLEAN: No.

MR SCHEFFER: So have we got to the point where there is a language going on, where people are using the language of support, but you – I think you used the term "homeostasis", sort of sinking all the time back into it. What's going on there in the discourse?

MR I. McLEAN: I can only give you my own understanding of that, of course. It's why I'm here. But I believe that like all of us, we judge individually. You and I tend to judge ourselves by our intentions, and we judge others by their performance. We judge ourselves by what we think we want to do and what we intend to do and others by their performance. Organisations do the same. As a CEO – but you also lead change by talking about it first. Change doesn't occur without talking. The trouble is, change can stop at talk and never – so those two things, I think organisations do tend to talk about what they intend to do first, and may not be, in fact, doing it, but also we talk about our intentions as an organisation.

We have often strategic plans that outline those things, and we tend to live in that space as we are achieving it. Does that make sense? So unless you actually look for the outcome on the ground, you say that you're doing it because you have started – let me be quite facetious for one moment here. Just like we talk about having achieved the state plan, but the state plan in some ways has been achieved by publishing it. Does that make – and that is what organisations can also do.

MR SCHEFFER: Which is necessary, but not sufficient.

MR I. McLEAN: You need to fund the implementation of it as far as the state plan, and you need to put the capacity into achieving this day in, day out, if you're an organisation. Or if you are a parent-controlled service or a person-controlled service. Don't let me just, in the current environment, talk about just CSOs. The other thing to add to the question of getting there is, I think there is a movement that occurs of change, and I'm not just going to go through it. It is almost the traditional change process, but people actually move from uncertainty to interest in a practice framework or a support paradigm.

They then move towards implementing it. So from interest to implementation, and you get the good news stories then of the impact of when it works, and it may be only one or two staff in a particular team that are championing it, have got it, and the outcomes on their six hour shift are really great and they're talked about, and the rest of the staff team for the rest of the person's week life is the pits – not the pits, but is ordinary. I'm too black and white sometimes. But then you can move an organisation from implementation to actually competency, and in the implementation side, you talk about moments in history, and you celebrate when they get right that you're trying to provide leadership.

Within the competent phase, you actually insist that when it's not happening, it does. So it's working with the staff group that don't get it, then, and working out whether they have a place in the organisation if they don't do it this way and have these outcomes. Does that make sense?

MR SCHEFFER: Absolutely.

MR I. McLEAN: And so each one of those three stages is quite legitimate, and organisations will be at different phases of those, but until we get to the funding and the ability to be competent, to be able to train ourselves and to be able to train others – but that is the level of competency that we're aiming for, and that we're almost to – then I don't think we're in that competent phase. Does that make sense? And that is the capacity that needs to be built within, in fact, the service system, I believe.

THE CHAIR: Thank you very much.

MR I. McLEAN: Thank you for the interview.

THE CHAIR: Very interesting..

MS WOOLDRIDGE: Thanks, Ian.

MR I. McLEAN: Thanks, Mary.

MRS POWELL: Thank you.

MS WOOLDRIDGE: Can we have a two second stretch?

THE CHAIR: Yes.

**ADJOURNED**

**[11.22 am]**