

FAMILY AND COMMUNITY DEVELOPMENT COMMITTEE

**Inquiry into the provision of supported accommodation for Victorians with a disability
or mental illness**

Melbourne — 5 November 2008

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Witness

Mr M. Potocnik.

The CHAIR — The next witness is Matthew Potocnik. Welcome to the public hearing. You have 10 minutes.

Mr POTOCHNIK — Thank you. I live at the coalface, as service providers put it. I am Matthew Potocnik, and I have a seven-year-old son who has the condition known as Angelman syndrome. I am an executive committee member of the Western Region Disability Network, which represents over 800 members. I am on the disability advisory panel of Moreland council and the Yooralla Acacia Street respite committee.

I know what is wrong with the disability sector. I have been touched by some of the previous speakers who have spoken to me about their needs in relation to having their child, who may be an adult child, cared for and taken up by the service provider in disability accommodation services. I have cared for Patricia's son — Patricia was a previous speaker — working as a carer in DHS. I am ashamed to say that the current government is not delivering on its legislation.

The identification of fundamentals include initial numbers on incident reports; independent internal advocates; training and education; mutual responsibility and mutual accountability between direct-care staff and management; the support and implementation of the legislation; and staffing and service specific to the act and the person-centred plans. Person-centred plans are not acted on; they are not supported. Most people in the community do not have a person-centred plan. One of the women spoke earlier about her son and how she had minimal respite. Her son is entitled to participate in the community, and he deserves to be supported in relation to his wishes under the person-centred plan in order to be integrated into our society.

Even in the disability accommodation services these person-centred plans are not supported. Direct care staff are not allocated any time — any hours — to implement and manage the person-centred plans. When we look at the group situation, where Patricia's son is living in a house, his care specific to his needs is destroyed by the relationship of residents to one another. Throughout the disability accommodation services mismatched balances of residents live together. Some live in abusive situations. It is not good enough.

The Auditor-General's criticism of the DHS is that it is unable to provide support for all those requesting it, yet demand is increasing by around 4 per cent to 5 per cent annually, and DHS has not accurately quantified future support needs or the associated need for resources.

There needs to be a recognition and implementation of a national disability levy to support the legislation that is not being delivered and the identification of levism, which is not to be indifferent or apathetic, where policy, action and client focus are paramount. DHS starts with a conflict of interests. Not only does it control the funding for the service providers, write the policies and their standards and values, and implement the act, but it does it at its own discretion. The standards of the department's values are easily discredited, and if I had more time I would shoot them down one by one. I have witnessed staff abusing their clients. I have been excluded from an investigation and so was the client. I pointed this out to the Office of the Public Advocate and to David Sykes of the disability commissioner's office.

I wrote to the DHS before the Disability Act 2006 was initiated to inform it of major flaws in its foundations which would undermine the integrity of the act and ultimately the care of the individual. I was ignored. I am doing this from within DHS as a direct care support worker.

One of the values is collaborative relationships. I spent the following four years trying to make one change: initial numbers on incident reports. I submitted a draft to the quality sector director and to the manager. I also submitted a draft for an internal advocate who would work in direct care and in the office alongside middle management, and who would be independently employed. Patricia talked about the servicing and the monitoring of CRUs and disability accommodation services. There needs to be that independent monitor. It needs to be understood that the culture of the disabled, unlike any other minority, does not have one thing — that is, a voice. They cannot

self-advocate to the same level as other minorities, and sadly our bureaucracy works on department barriers and jurisdiction.

This environment of the disability sector only builds apathy and indifference, two of the most destructive and non-inclusive attitudes. The managements of service providers need to understand that their primary task is to support the client and the direct-care worker and not to be a law unto themselves.

The purpose of the internal independent advocate was to help support and implement the understanding and practical application of the act and the human rights charter within the Department of Human Services. This person would also be used as the independent person for the senior practitioner's office. This would mean that people using disability services accommodation would not just be recipients of a service but directors and participants — an objective of the act.

It would support change and positive culture development at a grassroots level in direct care through the practical example of actual implementation. These advocates — because there needs to be more than one — would change the level of care from reactive to proactive. It would empower direct-care staff and it would empower the clients by providing support via the internal advocate through to management and management responsibility and accountability.

I do not know if that made too much sense. What I am trying to say is that if direct-care staff were provided with this support through the internal advocate, there would be accountability both to the direct-care people — the people looking after people with disabilities — and there would be the responsibility of management. It would be a two-way street; it would not be the totally linear line management we see today, because direct-care staff and management would be involved in supporting one another through the independent person.

I followed the traditional line when I submitted a draft of the client-focused incident-recording system, which is logged from the point of place of the incident by the support worker and registered with an initial number that directly individualises the client. This is probably the most practical example of a direct-care support worker supporting the client and the direct-care worker having management accountability to develop a quality service through the accurate logging of incidents and a client-focused development of a quality framework. It provides procedure, empowerment and structure to the direct-care worker, and the client benefits directly.

Management's job in this role is to support the client by supporting the direct-care worker. In the relationship, management and the direct-care worker are accountable to each other. Yooralla and other service providers are restricted by the DHS incident-reporting system because they must comply with it. It is not client focused, and it gives ultimate power to DHS to allow it to avoid accountability and responsibility and to preserve a cultural status quo, all at its own discretion.

The CHAIR — I am conscious of the time; I would like you to conclude your presentation.

Mr POTOCHNIK — The incident report was knocked back — the idea of the numbers on it. I submitted a draft. I took it through to Parliament. There were about a dozen questions on it that I submitted on notice at Parliament, and Lisa Neville did not answer them. They have had an electronic system that has been in development since 2002. I asked how much has been spent on that. I was told that that was too difficult a question. I have since found that \$237 million was spent on the HealthSMART system, which is a government electronic system, before the people walked away and said they could not work with DHS. I think there needs to be more responsibility and accountability for these developments. It is not good enough.

The CHAIR — You can send a written submission to the committee later on, if you like.

Mr POTOCHNIK — I can continue?

The CHAIR — No, we have run out of time. Could you please conclude, and later you can send a written submission.

Mr POTOČNIK — Yes. Occupational health and safety — I would like to say a lot more publicly. I appreciate your time. I have not got the time to put in other submissions. I have a little boy who has high needs. I can only work part time. I have been denied my annual leave, even though I have a double amount accrued. The department has got to get its act together. It has got to support direct care. Are you still recording?

The CHAIR — Yes, everything will be recorded.

Mr POTOČNIK — I have got to say this other bit; I really do. I am sorry. The adverse events policy that the commissioner of disability has is wrong; it is criminal. It actually states that you cannot complain about operational procedure. I submitted my complaint about the initial numbers, and I was told it was an operational procedure and they could not do it. If my son or anyone else's child is injured or comes off second best in whatever way in relation to a breakdown in operational procedure and we cannot criticise operational procedure, that is criminal, and that is where levism needs to be recognised and identified with. Thank you.

The CHAIR — Thank you very much.

Witness withdrew.