Submission to the
Victorian Parliament Family and Community Development Committee
Inquiries into the Provision of Supported Accommodation for Victorians with a
Disability or Mental Illness

This submission attempts to address some of the issues in the Terms of Reference, in particular — standard of accommodation, service model, the process for managing service quality, the impact on families of the current service provision of accommodation, and the adequacy and appropriateness of care and accommodation.

The submission addresses the Community Living Options Project (CLOP) that was set up in 1992 to negotiate with the Victorian Government to have a facility built to provide supported accommodation for five young men with acquired brain injury (ABI) to discontinue their institutionalisation or to avoid aged care placement. It is presented purely from a consumer (individual and family) point of view.

The submission explains: -
- Reason for the project and the difficulties experienced
- The problems associated with the on-going operation of the facility

It is taken as a fact that there is still an enormous unmet need for supported accommodation in Victoria (see Victorian Auditor-General’s performance report on Accommodation for People with a Disability March 2008). Simplistically this could be improved with increased funding for physical facilities and support staff employment.

This submission suggests that the underlying structure of law, culture, social integration and contemporary attitudes to human rights is seriously flawed. The consequences of this not being addressed will be a continuing dysfunctional and inefficient supported accommodation operation with resources wasted on adversarial individual attempts to seek redress.

It is understood that CLOP is a very small subset of the overall support of people with a disability in Victoria. However the principles addressed, such as the lack of tenancy rights, the enduring culture of institutionalisation, etc are applicable across the whole sector. It is also acknowledged that this submission points out perceived problems with the system without necessarily offering solutions. Some of the broad solutions are already addressed by the Department of Human Services (DHS) Secretary’s response to the Auditor-General’s report on Accommodation for People with a Disability. Other solutions could mostly be achieved via better implementation of basic management practices. The exception may be the DHS poor cultural attitude to people with a disability which is a paradox.

This submission is critical of DHS, specifically the DisAbility branch. Systemic development may address some issues but at a local level fundamental issues need also to be addressed. Some of these include: -
- Lack of an effective complaints mechanism
- "We know best attitude"
- Institutional, paternalistic culture
- Untruthfulness
- Excessive secrecy
- Poor communication and lack of consultation
- Policies that deny rights
• Rejection of family involvement
• Lack of consistent interpretation of policies across DHS regions
• Lack of meaningful consumer input into the quality monitoring system

REASON FOR THE PROJECT AND DIFFICULTIES EXPERIENCED

In 1992 I was one of four parents of two young men at that time hospitalised with acquired brain damage (ABD), seeking to support their respective sons’ rehabilitation.

Because the deficits sustained by these two young men were significant, they were assessed as being unable to live independently. As they were non-compensable, i.e. not supported by such as Transport Accident Commission or Workcover insurance, there was no system to support them. Consequently the hospitals demanded of each of them that they accept transfer to an Aged Care Nursing Home (ACNH).

Because we were unable to accept our young sons being sentenced to a life of living with the dying, we began to search for an alternative.

Teaming with a number of advocacy organizations we applied for funding to build and operate a facility to communally house what turned out to be five such young men. Working with the DHS and the (then) Office of Housing, the project took five years and eventually a unique facility, both architecturally and operationally was produced and occupied. See attached specification sheet

The primary observations made by the families during the project and still believed to be valid 15 years later are: -

a. Fragmented Information and communication about disability support
b. Expectation that the public service was knowledgeable found to be invalid.
   Families often knew more
c. Little architectural design experience
d. Little experience of operational models for support by both DHS and non-
   government agencies
e. Little experience of operational model design and definition (give us the money
   – all right on the day)
f. Little experience of tendering process
g. DHS inability to control non-government support agency
h. DHS inability to implement and monitor quality of support services
i. DHS reluctance to work with families

A short explanation is provided below for each of these points.

**Fragmented Information and communication about disability support**

There are many organizations, both state and federal trying to assist with disability issues. With the development of the Internet accessing information from these organizations is easier with more information available quicker but often due to the lack of services on the ground this does not help.

For anyone seeking information about disability support for the first time, perhaps due to a family tragedy, they find the system fragmented (disability specific, service providers, advocacy groups, government, not-for-profit, etc) with myriad programs
and initiatives and lots of jargon and acronyms. Frequently such initiatives are the flavour of the time and are abandoned by DHS or morph into something else.

Additionally there is often considerable change brought about by government – new legislation such as the Disability Act, the Charter of Rights and Responsibilities – reviews and enquiries such as the review of the Equal Opportunity Act, the Exemptions and Exceptions Review and this Inquiry.

This quest for information can be made more difficult by the lack of uniformity of interpretation across DHS regions.

**Expectation that public service knew all found to be invalid. Families often knew more**

As naïve parents we expected that the Victorian public service would know all about disability housing design and all about landlord operations, leases, etc. To our surprise we found that little original thought had been given to innovative projects.

**Little architectural design experience**

The Department of Housing (DOH) had very little if any experience with the design of a facility to assist people with disabilities. Practicalities such as wide doorways for wheelchair access, space for shower trolleys and personal hoists, charging points for equipment, unobstructed paths, roofing insulation, climate control, robust toilet suites, electric doors, security gates, and non-visual barrier floors were some of the items families introduced to the architectural team. Notwithstanding this the DOH was enthusiastic and helpful.

**Little experience of operational model design and definition (give us the money – all right on the day)**

DHS had little experience or understanding of the accommodation model proposed. Fundamentals of the separation of accommodation (landlord) and support were not well understood. The CLOP model is very much a social model with residents having a lease for accommodation and paying individually for utilities (water, electricity, gas, telephone) and a share of communal activities such as food but having support staff always available to provide co-ordination of operation and personal care support. Although this is a very simple concept it is different from the usual congregate care model where each resident pays a set fee for a share of all the operational costs for a facility.

Because this was not understood by DHS it was difficult for them to explain it to prospective non-government service providers at the time of tendering for the support service. The non-government organizations were primarily of the opinion that “give us the money and it will be alright on the day”.

This social versus institutional model is a fundamental of contemporary attitudes towards disability accommodation. The building was architecturally designed to facilitate this social model and would work well if accepted as such by DHS. Regrettably DHS demonstrate difficulty in understanding that they are not operating an institution and running and controlling every aspect of resident’s lives. This subject was highlighted in the Victorian Auditor-General’s report on Accommodation for People with a Disability (see later).
Suggestions by families that the selected support service provider should detail the service they were to provide to each resident was ignored as an absurd suggestion. After all these were only people with a disability. This defining of the service to be provided is now a requirement under the Disability Act for new clients. However, being existing consumers, residents in the facility still do not know what service they can expect.

**Little experience of tendering process for support services**

Families with considerable experience on the commercial world with tendering of projects and services were surprised at the unprofessional process of tendering.

**Inability to Control Non-government Support Agency and No Quality Control**

Once the DHS funded support contract was assigned there was no system to monitor the implementation or the quality of the service being provided.

In one instance the service provider blatantly refused a resident the agreed share of government allocated establishment funds. When a family complained, DHS management supported the service provider and refused to even discuss the complaint with the resident. The same organization used thousands of dollars of funds set aside for a maintenance fund for other purposes.

Residents and families expected a level of service approaching that detailed in the Standards for service delivery but service provision did not get anywhere near this standard. Family complaints resulted in another non-profit organization taking over. An ex-DHS employee joined this agency and complained that the agency had insufficient control over the resident’s lives. Shortly after this the agency withdrew.

**DHS Reluctance to Work with Families**

DHS attitude has always been defensive and "we know best". Managerial staff who are prepared to rationally consider complaints and suggestions are almost nonexistent. Coupled with the absence of a proper complaints mechanism (although now mandated by the Disability Act) the preparedness of DHS to either ignore complaints or reply with obfuscation or blatant untruths is very distressing to both residents and families.

**ON-GOING OPERATIONAL PROBLEMS**

**Accommodation**

**No Tenancy Rights**

The property was the subject of a master lease to a community-housing organization (the then Supported Housing Development Foundation). Residents were then offered individual leases for their unit. These leases were based on the Residential Tenancies Act (RTA). This respondency to the RTA was still being used by the organization until recently notwithstanding that the RTA (s23) is not applicable to a health or residential service. This non-respondency is further reinforced by the Disability Act s56 (2).
Under the Disability Act tenancy rights and recourse to VCAT are only applicable to accommodations that are declared as Community Residential Units (CRU) under division 2.

Setting Rental Levels

Accommodations that have not been declared as a CRU, both Government and non-government, are not the subject of specific legislation and if operated privately or by a community housing organization there is no procedure to set rent levels and no resident recourse to challenge rent increases.

In particular the right to include confiscation of a resident's Commonwealth Rental Assistance (CRA) is unclear. This practice is morally wrong, as it is confiscation of an allowance provided by the federal government for the purpose of a citizen maintaining a base level of standard of living.

Support Services

The facility has had two non-government support services funded by DHS. Currently resident support is provided by DHS North and West Metropolitan Region Disability Accommodation Service (NW DAS).

The five residents have varying abilities associated with varying physical, sensory and intellectual deficits. However families have always expected that, in line with contemporary philosophy, that each would be supported to live as independently and as fulfilling a life as possible. Families expected this to be achieved under the auspices of the Standards for Supported Accommodation and the DHS policies relating to rights of persons with a disability.

The following comments are related to DHS and specifically NW DAS service provision.

DHS have a conflict of interest in that they are a service provider; the main funding body for support services, and also have the responsibility to monitor the quality of service provision (Disability Act Division 3—Standards and Monitoring of Performance).

The monitoring system is basically a set of Standards and a Quality Framework setting out broad principles based on a social inclusion philosophy. A system of self-assessment by service providers is supposed to also involve consumer input (100% where five or less consumers receive the service) but I have never seen the situation where consumers have been asked to participate.

My experience is that DHS and specifically NW DAS simply do not comply with many of these standards. This is not an isolated view. Any gathering of families where there is an expectation that someone independent of DHS might listen (e.g. the KPMG review of NW DAS) elicits a flood of complaints. Concerns about the system generally are also raised in the Office of the Public Advocate (OPA) Community Visitors Reports, the Auditor-General's reports and reported VCAT hearings.

Examples of DHS not complying with standards include: -

- Petty restrictions and rules
- Policies restricting resident rights
• OH&S
• No complaints mechanism
• No residential statement
• Agreements broken
• DHS paternalistic culture and the dignity of risk
• Excessive secrecy and inquiries
• DHS above the law

**Petty restrictions and rules**

DHS NW DAS (NW DAS) have a set of rules related to operation of their accommodation services. These appear to relate only to residents who would have been subject to the now repealed Intellectually Disabled Persons’ Services Act and mandate staff action in response to varying situations. An example is instructions when a resident may need hospitalisation. This requires DHS staff to support the resident in the hospital setting but completely ignores any wishes of the individual or their family. This creates conflict because the individual and family resent the interference by the DHS staff who in turn believe it is mandatory for their involvement. It is understandable that where a person has no other support that DHS should undertake that role. But where a person can direct and manage their own medical care or where families are assisting the person to do this or even where case managers may be involved, the support staff should be aware that they may not have a direct role to play.

Other petty rules include:
- Storage of medication – in locked container (See the freezer tale)
- Discarding items on reaching “best by date” even if benign items such as toiletries (See the lip balm tale)
- Myriad OH&S requirements (See the washing machine tale and the suction machine tale)

**Head Office Policies restricting resident rights**

An example of this is the policy that “only a medical practitioner can cease a medication”. Consequently if a resident decides to refuse or reduce a medication there is a problem as staff insist that the medication be administered which can lead to a resident being forcibly medicated against their will. (See the refusing medication tale)

**OH&S**

Occupation health and safety is becoming a big issue amongst service providers. DHS have issued practical guidelines and OPA is active in promoting a practical approach

Unfortunately the safety of the staff has become paramount and the safety of the person with a disability has become secondary. (See the washing machine tale)

**No effective complaints mechanism**

There is no known current documented (NW DAS) complaints mechanism. Written complaints are ignored, obfuscated, delayed or answered with untruths. (See the electric door tale)
No residential statement

My family member has never had an explanation of his entitlements in his accommodation.

Agreements broken

This seems to relate to individual managers who negotiate policies and procedures but because there is no co-ordinated system of recording these they get lost with successive managers not knowing the history. (See the PRN medication tale)

Paternalism and the dignity of risk

Regrettably the culture in DHS is one of paternalism. This is partly a reflection of society in general where anybody in a wheelchair is often automatically assumed to have an intellectual impairment. It is also partly due to the DHS institutional, medical model attitude as commented on in the recent Auditor General report. The so called dignity of risk is much used phrase purporting to recognize that those with a disability should have the same right to take reasonable risks as other members of society. Simple examples are crossing the road, driving a car or swimming in the sea. Regrettably the DHS attitude of “Duty of care” operates to restrict this right to an absurd degree. (See the banana tale).

Secrecy and inquiries

In a response to the complaints by (CLOP) families about the poor service provision the DHS has undertaken two reviews of the facility (that we know about). The first of these was by a DHS employee and the result is unknown but believed to be neutral. The second review was said to be by an independent person and the result was to be available to residents and families. In reality it was undertaken by an ex-DHS regional manager who, with the best will in the world, came to the review with a background of DHS paternalistic culture. In spite of promises to the contrary at the commencement of the review process, the final report was not available to residents and families. We were told that the report findings were accepted by DHS HQ but the final part of the review – designing and implementing a method for residents and families to raise concerns, was conveniently not done.

When the heavily censored report was finally obtained under FOI it was found that the fundamental assumption about the support model for the facility was total nonsense. However this false assumption was the genesis for the Region diligently working to change the model much to the confusion of families. To say that the whole review process was a fiasco and a total waste of time and resources would be a kindness.

DHS Above the law

DHS staff seem to believe that DHS has the right to act in any manner they think fit and any such action can be justified by their “duty of care”. To whom this duty is owed is sometimes unclear. Examples of their actions that seem to not comply with relevant legislation include: -

- Privacy Legislation. Investigate and collect family personal information. Collect information about resident visitors — such as who and when. Divulge
personal resident information to others without knowledge or consent of the resident

- **OH&S** Specifically the safety of third parties in this case the residents. Lack of concern regarding passive smoke and seatbelt issues in wheelchair transport are specific issues.

- **Charter of Rights and Responsibilities**. Denial of resident rights has previously been addressed. However the restrictions imposed on the residents and their visitors is a gross violation of natural justice with residents and or families being given no opportunity to individually respond to accusations of poor conduct

- **Disability Act**. Section five of the Act sets out the principles of the legislation. In particular s 5 (1) Persons with a disability have the same rights and responsibilities as other members of the community and should be empowered to exercise those rights and responsibilities. The subject of denial of rights has been previously discussed. The important role of families in the life of a person with disabilities is addressed in the Act but DHS have consistently tried to exclude and even vilify families.

**Effects on Persons with a Disability and their Families**

In the CLOP experience all of this poor service delivery has understandably resulted in anxiety by residents and particularly families where they become alarmed at the perceived neglect, abuse and denial of rights of their resident family member. DHS, rather than fixing the underlying problem has instituted a regime of denying visitors access to their resident member and forcing residents to accept a form of restraint and seclusion. This has been done with the threat of withdrawing services to the resident. In particular the resident is refused services when a family member is present. This results in considerable anguish and loss of dignity to a resident who may need urgent assistance but is refused point-blank.

Consequently in trying to stand up for the rights of people with a disability, families have experienced DHS retribution and gross denial of rights for both themselves and their family member. This occurs in the face of residents supposedly having tenancy rights through a lease, and DHS professed attitude of duty of care to support the resident.

Worse still there is anecdotal evidence that suggests some not-for-profit supported accommodation service providers consider the existence of families when deciding on candidates to fill house vacancies. The criteria being that prospective residents without families are preferred as families are trouble makers.

This occurs together with the background of residents and families living with the unending anguish of the tragedy resulting in the person sustaining the disability in the first place.

**OFFICE OF THE DISABILITY SERVICES COMMISSIONER**

The Disability Act allows for the appointment of a disability commissioner and an associated mechanism for complaints about service provider performance. However the Act does not provide for any powers of enforcement or redress against service providers. The Act provides for conciliation but where a service provider refuses to
change their attitude or practice, the process of conciliation is of no use to a complainant. (See the refusing medication tale)

**VICTORIAN AUDITOR-GENERAL’S REPORT**

Much of the resident and family complaints about DHS as a service provider are related to the perception that DHS is trying to run an institution on a medical model whereas the facility was conceived as an independent living, community access and inclusion (social) model. Although this concept will mean different things to each resident relative to their abilities, it is never the less the ideal to be strived for. This has not been embraced by DHS and hence their efforts to try to exclude and vilify families.

In March 2008 the Victorian Auditor-General released a report into Accommodation for People with a Disability. This addressed amongst other things, this concept of a social model — “Some SSA houses operate from an ‘institution’ mindset, catering for residents’ physical needs rather than operating like a home where residents are encouraged to develop an independence limited only by their own capacity”.

It is felt that this vindicates the concerns that families have been expressing.

The A-G report also raises other significant issues regarding availability, funding, quality, planning etc. My concern in regard to this is that if facilitated by DHS, families could be an enormous resource to assist with some of these issues at a local (house) level. This is an enormous and inexcusable waste of resources. Family members could assist with, amongst other things, informal staff training, documentation and (non confidential) record keeping, facility maintenance and beautification, general communication, etc. Additionally families have the potential to improve the job satisfaction of support workers by working together with them as an informal team for the overall benefit of the person with a disability.

Instead of this teamwork approach the attitude of DHS is to exclude families.

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SOME EXAMPLES OF POOR SERVICE PROVISION
IN SUPPORTED ACCOMMODATION

THE FREEZER TALE

A resident had a small amount of personal medication in the form of tablets stored in the freezer in his kitchen. This was a convenient place to store such an item, as it is dry environment. Additionally it was a secure place as this was the only item in the freezer and would not normally be accessed by anyone. Although children are not normally in his unit the freezer was the top compartment of an upright refrigerator and as such not accessible by children.

A support worker apparently cleaning the refrigerator discovered this medication in the freezer.

The resident was told that it was DHS policy that all medication had to be stored in a locked container and therefore this had to be removed.

There was no danger to anyone in having these items secured in the freezer. They were the resident’s personal property and not related to any medication normally consumed by the resident.

This contravenes the resident’s right to have quiet enjoyment of his home and make decisions about his own life. Insisting that the items be removed is overly officious by DHS

THE LIP BALM TALE

A resident uses lip balm to prevent his lips from becoming dry. This is a non-medicated toiletry product purchased from pharmacies and some supermarkets. The tubes are permanently sealed with a twist off moulded-in stopper which is torn of prior to first use. The tubes also have a recommended use by date marked on them. The product is a gel type product and shows no evidence of degrading or altering even after many years past the use by date. The resident was in the habit of buying these by the box as supplies are sometimes difficult to obtain. Consequently he would sometimes use a tube which had passed its use by date.

The DHS site manager discovered a tube, which had exceeded the use by date and advised the resident that this could not be used, as it was DHS policy not to administer medication that had expired. The resident was not given the choice of deciding whether it was acceptable to him to continue using the product or to decide whether the efficacy of the product had changed.

After family intervention and complaint to DHS regional management it was reluctantly agreed that this product would not be defined as medication and that dispensation would be given for the resident to use the product.
This overly officious action by DHS denied the resident the right to make decisions about his life and manage his own care.

THE WASHING MACHINE TALE

DHS arranged to have an OH&S inspection of all resident units. One resident had a front-loader washing machine that support staff used on his behalf for clothes and linen laundering. The inspection determined that the washing machine had to be elevated about 300mm by placing it on a box structure. Presumably this was to avoid staff having to bend to access the front door of the machine. This assessment was curious as millions of these machines are used in homes all over the world and theoretically allow the user to access the door with a straight back by bending the knees whereas top loaders require a back bending and stretching/reaching movement to unload washing. The OH&S problems in lifting a heavy washing machine onto the proposed box and getting it off again in the event of requiring servicing were not addressed.

DHS advised that they would arrange for the box and it duly arrived and the machine installed on top.

The box was observed to be just that – a plain enclosed box made from white melamine coated chipboard. When the washing machine entered the spin cycle and had an unbalanced load, as often happens, the machine vibrated and the box also vibrated in sympathy. Consequently the machine moved across the top surface of the box which had nothing to prevent the machine, when it inevitably reached the edge, from toppling off. The possibility of someone being hurt by the machine literally falling on them was now a reality.

Intervention by a family member resulted in DHS install a metal guard around the periphery of the top of the box to prevent the machine from toppling off.

THE SUCTION MACHINE TALE

A resident had a suction machine used to assist his teeth cleaning. This machine was wall mounted in his bathroom. This mounting avoided it cluttering the bathroom vanity bench top and positioned it at a convenient height for support staff to use. The mounting was a quick-disconnect fitting enabling the machine to be detached easily and used as a portable device if required.

After a number of years use the machine malfunctioned and a replacement was obtained. This was placed on the vanity bench. The resident asked that it be installed on the wall in a similar manner to the previous machine. He was told by DHS that the bracket to secure it to the wall was hundreds of dollars and in any case it was not agreed that it be installed on the wall as it would prevent it from being used as a portable unit.
The resident's family intervened to indicate that the information available on the internet suggested that the wall mounting bracket which was again a quick release arrangement to facilitate portable use was available for tens of dollars not hundreds.

DHS indicated that they would have to have an OH&S assessment done – of what and for what purpose was never revealed. This must have been somehow favourable as the machine was eventually installed on the wall.

This was an overly officious attitude by DHS. Residents are supposed to be supported and encouraged to make decisions about their life not recklessly given false and misleading information.

**THE ELECTRIC DOOR TALE**

The building has electric doors for each unit's internal access to the common room and one electric door for building external access. In the event of a mains power failure these doors automatically open via a battery powered back-up system. This ensures evacuation access in the event of a fire. These doors have a manual override system that quickly disengages the door from the electric open/close mechanism.

A family member visited a resident on a hot summer day when a blustery north wind and a temperature around 40°C had made conditions very unpleasant. Bush fires in Gippsland had resulted in a mains power failure and the electric doors had all opened as designed. This resulted in the building being exposed to the very hot North wind and bush fire smoke, dust and wind borne debris. Had the external electric door been manually disengaged from the mechanism and closed at the time of the power failure the building would have remained relatively cool and the air clear.

This family member asked management why the door had not been closed and whether the staff perhaps needed a procedure or training in the manual shutting off the door. After a host of excuses about requiring fire department advice, manufacturer advice, installation of different doors, etc it was eventually stated that a written procedure was now in place. A copy of this procedure was requested to discuss with the resident to satisfy him that the situation would not be repeated. After repeated unfulfilled requests for this it was eventually admitted that a procedure was in fact not in existence. Further complaint by the family member was answered with the advice that the manufacturer was to be commissioned to service all the doors and that a procedure had been prepared.

After almost two years such a procedure has still not been provided.

**THE PRN MEDICATION TALE**

A family member complained that the procedure for a resident to obtain and use a PRN medication was too cumbersome and that residents who could make their own decisions about their health care or those with a guardian empowered to assist them make such decisions should not have to adhere to these procedures. PRN medication is medication that does not require a medical practitioner prescription and
is consumed as required – examples are analgesics, antihistamines for hayfever, eye drops, etc.

A DHS regional manager prepared a policy document that addressed these issues and stated that resident procurement and use of PRN medication was to be facilitated and set out a less cumbersome procedure for approval and recording.

This was provided to all residents and their families and was accepted.

This procedure has ceased to be used by house management and repeated requests for it to be found in agreed operating policies and procedures have elicited a "don’t know anything about it" response.

THE BANANA TALE

A resident has a fondness for eating bananas. This is a grown man and capable of making decisions for himself. He frequently requests a piece of this fruit in the evening after dinner and is often told he cannot have one. The support staff response is – "The doctor said you should not have it, you are putting on too much weight". The resident often becomes angry and upset and then sometimes gets the fruit or otherwise sent to his unit. DHS will maintain that they have a duty of care to ensure that the resident follows medical recommendations.

This same man is a smoker and the support staff happily take him outside and light his cigarettes.

If DHS have a duty of care to stop consumption of bananas why do they not have a duty of care to prevent the deadly act of cigarette smoking?

There is much anecdotal evidence of this type of dictatorial behaviour by support agencies leading to a resident becoming upset by this degrading treatment, being labelled as "non-compliant", and ultimately suffering restraint or seclusion – treatment that society believes only happened in the distant past in now abolished institutions.

THE REFUSING MEDICATION TALE

A resident, due to his disability, cannot take food orally and his intake is entirely via a gastrostomy tube. His medication is provided by a pharmacy dispensed normal tablets into a dosette box. This is a container with compartment for each day and each part of the day (lunch, evening, etc). Support staff administer his medication by removing it from the appropriate compartment in the dosette box, crushing it to a powder, and flushing it through the gastrostomy tube.

The resident occasionally wants to alter the medication he consumes by refusing or reducing a particular tablet quantity. This can occur if for instance a new medication has unexpected side effects or appears to be too strong a dose initially. To ensure that staff do not simply crush all the tablets in the dosette compartment and administer this without asking he wishes to remove the not required tablet from the
dosette in advance. He is prepared to document that he has done this and takes responsibility for the reduced dose.

DHS insist that only a medical practitioner can cease a medication and that the resident cannot remove his own medication from his own dosette box. They insist that he must have the medication and dose recommended by the doctor. Consequently on the occasion that the resident does not want the prescribed medication he is forcibly medicated against his will by having the medication administered through his gastrostomy tube.

This appears to contravene the rights conferred by the Charter of Rights and Responsibilities, which states that a person must not be subjected to degrading treatment; or to medical treatment without his or her full, free and informed consent.
Attachment to Submission to FCDC Inquiry on Supported Accommodation

THE CLOP ABI ACCOMMODATION PROJECT

DESCRIPTION OF THE FACILITY

Location: Harper Street Northcote
Build date: Completed December 1996
General description: Five self-contained one-bedroom units co-joined to a communal kitchen, dining, recreation area.

Each of the five units contains:
- bedroom c/w built in call / emergency wiring and wardrobe
- ensuite bathroom with shower area, vanity, toilet, provision for washer & dryer
- kitchen c/w cupboards and sink and provision for refrigerator
- gas furnace ceiling ducted heating
- window mounted air conditioning
- (fire) sprinklers / smoke detectors
- video conferencing wired to each unit
- set temperature on-demand anti-scald gas HWS
- separate meters for electricity, gas and water
- external doors with auto unlock in event of fire
- internal 900 wide doors (electric actuation for common room access)
- doorway to garden area electric actuation.

The common area contains
- gas furnace ceiling ducted heating
- evaporative ducted and window mounted refrigerative air conditioning
- (fire) sprinklers / smoke detectors
- set temperature on-demand anti-scald gas HWS
- separate meters for electricity, gas and water
- external doors with auto unlock in event of fire
- kitchen area with sink, cupboards, cook top, oven, refrigerator, dish washer, island bench

The staff area contains
- office c/w large glass observation window viewing back door

Storeroom
- built in cupboards

Visitor / staff bathroom laundry
- shower
- toilet
- trough

Security
- external sensor lights to each unit
- external pathway / garden lights
- perimeter completely fenced with mesh fencing c/w one lockable childproof gate and one electric actuation gate
Safety
- fire sprinklers
- auto unlock external doors (in event of fire)
- anti-scald HWSs
- anti-skid wet area floors

Parking
- five single spaces adjacent to roadway (resident & staff)
- covered load / unload bay within the perimeter fenced secure area

Location
- end of as quiet street
- approx. 300 metres from Westgarth rail station
- perimeter adjoins pedestrian pathway alongside rail line between pedestrian rail crossing at the end of Harper Street and the station

PHILOSOPHY
- The facility has been developed to enable the residents (the target group is young persons who have sustained ABI - it is not intellectual or psychiatric disability specific) to live as independently as they are able consistent with significant support.

BASIC FRAMEWORK
- The facility is designed with five separate units conjoined to a communal / staff area.
- The facility will have a housing agency appointed to collect rent from the five resident in the same manner as other public housing, and in return maintain the property.
- Each of six areas are separately metered for utilities (gas, electricity, water). The residents of the five units are individually to pay their own costs, and the communal /staff area costs are to be paid jointly by the residents as a body, and the support agency.
- Every day living support is to be provided for the five residents by an agency appointed to manage the operation of the facility on behalf of the residents. This agency will contract with the Department of Human Services to provide personal support to the residents by means of attendant care workers, therapists, and case managers together with an overall management and co-ordination role.