8 October 2008.

73 Nepean Street,
WATSONIA 3087.

Family and Community
Development Committee
Parliament House
Spring St,
EAST MELBOURNE 3002

Dear Committee,

We understand that under the Parliamentary Committees Act 1968, the Family and Community Development Committee has wide powers to review, consider and conduct investigations and report to the Parliament on matters associated with the family or the welfare of the family, as well as a range of social issues. This includes examining matters dealing with community development or the welfare of the community, in addition to the role of government in community development and welfare of the family.

We also understand the Family and Community Development Committee is to inquire into the provision of supported accommodation for Victorians with a disability and/or mental illness and, in particular, the Committee is asked to report on the current situation in Victoria and compare it to best practice in other jurisdictions. Report due 30 June 2009.

We would, therefore, like to present the following for your consideration in relation to the aspect of your inquiry into the provision of supported accommodation, especially that directly provided by the Department of Human Services for Victorians with an intellectual or multiple disability, especially those with high support needs.

The areas of our submission are:

- the adequacy and appropriateness of care and accommodation provided in DHS direct care community facilities because of poor management and a captive market mindset,

- the impacts on families as a consequence of the current provision of supported accommodation and,

- the adequacy and appropriateness of care and accommodation provided in DHS community facilities because of insufficient places in the current supported accommodation system.
1. **No Choice and Questionable Quality**

There is a conflict between need for more accommodation (unmet needs – the Disability Support Register/DSR) and the quality of that accommodation and its services to those who have high support needs (those who need extensive support to live in that accommodation). Quality is often compromised where the consumer is desperate to get a service. With this compromise compounded where the service provider knows this, and has a captive market.

Elderly caring parents who have given their family member with a disability, a quality life, including that of maintaining, developing and enhancing their family member’s skills, often have to accept a service offer where they know their family member’s skills and quality of life will decline. They are forced to compromise their values in their desperate need before departing this world.

Whereas, elderly parents should have peace of mind seeing their family member in a quality of life accommodation service - in contrast to a minder service.

2. **Implementation of Care Policies, Standards and Values**

The Department of Human Services, Head Office, produces and promotes an extensive range of excellent care policies, standards and values to direct and guide the department’s direct service provision, and that of the non government sector – NGO, not-for profit services.

The Department’s Regions do not however see themselves as needing to provide services within departmental care policies, standards and values which have a consumer/customer focus. Unlike health services, disability services do not see the consumer/customer as having an “entitlement” to services, rather an expectation the consumer must accept that of the service provider without question.

Many parents/families who have managed to secure an accommodation placement (supported accommodation group home/CRU) for their family member, are fearful of questioning any part of the service, that they and/or their vulnerable family member may be intimidated by a service provider mindset of, “The consumer must accept that of the service provider without question”.

Many times we have been told by DHS management and staff, “If you don’t like what we do, take your kid away!” And there is no choice due to both demand on services, and that the DHS controls the placement DSR (“Disability Support Register”) state wide. The DHS/Region refused our request to move a totally incompatible client from our son’s group home – a client they introduced without consultation. When we subsequently requested our son be placed on the DSR for relocation, they refused that as well prior to us seeking IDRP support.
3. **IDRP (Intellectually Disabled Review Panel) Intervention/Support**

At our IDRP Hearing, the department had senior managers and a barrister! The IDRP were not impressed. Their findings were damning against the department, in a 16 page report. The department thumbed its nose, with a half page response.

4. **Revolving door management and staff in High Support Needs**

The impact of ‘revolving door’ DHS/Regional management and direct care staff on the level and quality of care and service for the residents of the supported accommodation group homes where the department is the direct care service provider, is especially devastating on those residents with high support needs.

Those residents with high support needs frequently have challenging behaviours which are often very stressful on direct care staff. Without meaningful support, encouragement and incentive, most staff don’t stay long in these group homes.

Where there is high staff turnover, there is little or no consistency of ‘Active Support’ (Interactive, Developmental and Social Activities) to maintain, enhance and develop the residents’ quality of life.

Department and public service philosophy determines all staff are equal. Therefore, those who work with residents who have high support needs and challenging behaviours are treated equally with those staff who work with residents who have very low support needs.

Direct care staff who are willing to work in a meaningful and developmental way with residents who have high support needs, and/or challenging behaviours, need to have special support, encouragement and additional remuneration, if we are ever to see residents in this intellectual category have a consistent quality of life through meaningful and sustainable ‘Active Support’.

At present, this is solely dependent on direct care staff integrity. The care level and quality fluctuates with staff changes. Those with limited intellectual ability need a very consistent level and quality of care to ensure they have even a basic quality of life. In contrast to a meaningless one, as happened in many Instructions.

DHS/Regional management do not set, monitor and maintain staff work value within staff job descriptions and departmental care policies, standards and values.

The inconsistency of service processes is constantly demonstrated through direct care staff taking for ever to accept and implement processes - it took over four years for our son to have his finger protection tapes applied and replaced consistently.

The DHS N&W Metro Region ignored the good service benchmark produced over a
two year period by an exceptional staff team at our son’s group home. The region’s senior management refused to consider, replicate or promote this benchmark.

5. Monitoring Service Level and Quality

The ability of families, with a vulnerable family member in a DHS group home, to monitor their member’s quality of life care is limited per se, but is specifically limited by bureaucratic restrictive practices. Practices such as, overzealous privacy of both residents and staff, and restrictions on access to documents such as Progress Notes and Staff Rosters.

Families are frequently intimidated for questioning the service level and quality. They are given misleading and covert responses to their questions. Indeed, we have a ministerial approved restrictive practice directive against us for daring to question the department’s actions. For example, we are unable to contact the Senior Practitioner by Email due to an electronic redirection/block at the department’s firewall.

This ministerial approved DHS/Regional restriction, BRI/06/811, on our communications and correspondence with the DHS as a whole, clearly demonstrates the extent the department will go to suppress those who dare to question them. The message being sent to families and advocates is, that you may suffer the fate of the Tregales if dare to assertively question us.

When we questioned our son’s quality of life care, when he first went into a DHS group home at 20, because we were getting no younger to provide 24/7 care, DHS/Regional management told us we did not know what we were talking about.

Therefore, Heather did 12 months full time TAFE, got her ACRACS (Cert 4) qualification, and subsequently worked for both DHS and NGOs, at the service points for four years. In DHS, she worked in Institutions, group homes and PRS. Much of what she saw and experienced was both questionable service and horrific.

6. Reactive, Inconsistent, In-Denial and Crises Driven Services

Extensive correspondence from the DHS/Region shows they are in total denial of their inconsistent and in-crises services. When they respond to us with unrealistic answers, we are persecuted for persisting for persisting to ask the same question again and again.

The book and DVD entitled, “Bye, Bye Charlie” shows the practical aversive impact of this restrictive practice public service attitude on very vulnerable people and their families is still in vogue through the level of in-denial and manoeuvre every which way correspondence we receive from the DHS/Region.

Families have to bang on the door of DHS because the Regions see themselves as having no commitment or obligation to provide services within the direction,
intention and spirit of departmental care policies, standards and values.

DHS/Regional management have more problems with direct care staff than with residents. Therefore, management spend more time and energy on staff demands, than resident needs.

DHS/Regional management are in total denial over major systemic issues (see attached list entitled, “Questionable Activities”. They are also reluctant to accept “Whistleblowers”, as they do not want the task of investigation, and the political ramifications thereof. So they treat “Whistleblowers” with contempt, to drive them away.

Almost all correspondence we receive from the DHS fails to provide a meaningful answers to questions directly and indirectly relating to questionable level and quality of service. Their responses manoeuvre every which way to avoid providing a meaningful answer.

The catch phrase is, “We have responded before, so we will not do so again!” Whereas, the reason for repeatedly questioning their answers is, their answers are frequently not meaningful or credible.

The cost of “constantly in denial” and “manoeuvre every which way” correspondence and actions, must be astronomical in comparison to a “problem solving and issue address” management policy.

Meetings with the DHS have to be on their terms. They have no sense of customer service, the customer is right or the customer may criticise them. They have a sense of, “They have a captive market, so the customer is a pest”.

7. **The Public Service and DHS Management Processes uses Parent and Family Complaints as a Prop to their Management of Direct Care Staff.**

Many parents/families are not only in fear of intimidation and retribution of their family member and themselves if they complain, but see their complaints presented directly to house staff within the context of management isolation.

DHS management frequently take parent/family complaints directly to house staff, inferring, “We are on your side, these complaints are not ours!” In contrast to quietly looking at the service provision within the contest of the complaints, and developing an action plan to reduce the potential of the justified complaints occurring again.

8. **Ineffective Complaints Processes**

There is no effective independent complaints process! The present process for DHS residents and their families is “public servants or pseudo public servants checking on
public servants. The DHS, Ombudsman, OPA, HSC, ODSC and VCAT are all public servants or pseudo public servants. Even the latest innovation, the ODSC, has no teeth to take on the DHS, all it can do is “Conciliation”!

There has never been an effective complaints process. The present ODSC (Office of the Disability Services Commissioner) has no power to question or challenge the department. The best they can offer is “Conciliation”! This means in practice, that the little people still have to take-on a very bureaucratic and all powerful government department.

There is no complaints process which is totally independent of government, but with the legislative authority of government to take positive action. A process where those on the panel are from outside industry not associated with care services. Like, for example, having executives or senior managers from say, BHP, Telstra, Motorola, Myer, David Jones, Coles, etc, etc. Usually, organisations of this stature are happy to provide pro bono support to such a community service.

An effective independent complaints process for residents with the DHS as their service provider must be staffed by executives from industry..... Telstra, David Jones, Myer, Coles, BHP, etc, etc, for example.

9. **Community Visitors**

The Community Visitor’s Program has proven to be quite ineffective in addressing and/or resolving detailed quality of life care problems. Where the families have proven the house to be shocking, Community Visitors have given it a good report, focused mainly on mechanical issues.

Where Community Visitors visit a group home, where the residents have no meaningful communications, they are able to speak only with the service provider staff. Yet they have no obligation to contact the families of the residents immediately following their visit, that the families may represent their family member, Consequently, these residents are unrepresented!

Our request to meet with the Community Visitors who visited our son DHS group home was denied in writing by the Office of the Public Advocate (OPA). When we legally challenged their decision, they backed down. However, when we made the same request again, they said the actual Community Visitor (person) declined to meet with us. The OPA said they could do nothing about this, as the Community Visitors are volunteers.

10. **Payments to State Trustees**

Regular payments can result in excessive surpluses, which illustrate a resident is not receiving the quality of life care shown as funded in their “Financial Plan”.
The DHS financial structure, within CERS ("Client Expenditure Recording System") and State Trustees, for the residents of its group home is, in principle, excellent.

The structure has basically three areas of expenditure, "Rent, Housekeeping and Personal Expenditure". It is the "Personal Expenditure" area where excessive surpluses can occur.

The resident’s administrator makes regular payments to State Trustees, to be deposited in the resident’s trust account. State Trustees send regular amounts from the trust account to the group home in accordance with the resident’s financial plan.

However, where the resident is not taken to the activities defined in their "Financial Plan", the money accumulates. On many occasions, the surplus has reached on or near $1000, over a period of 12 months. Although this money is eventually returned to us, as our son’s formal administrators, it shows he is not receiving the agreed quality of life activities.

Naturally, as caring parents and administrators, we can question this. But we question who monitors the build-up of funds as a result of the failure of the service provider to provide the agreed quality of life for those residents who have State Trustees as their administrators.

In addition, we question the integrity of “informal administrators”. We question why the DHS do not insist that all administrators are “formal”

11. **The “Bye, Bye Charlie” Book and DVD**

This illustrates a mindset of the public service power over people, which held people in unreasonable and unnecessary poor living conditions. A similar public service attitude is illustrated now, in the reactive, inconsistent, in-denial and crises driven services demonstrated by the extensive correspondence we receive from the department, together with their attempts to silence us by their extensive, ministerial approved correspondence and communications restriction against us personally.

12. **No Consultation – Hostel or Home?**

There was no consultation when the department decided to move a new client into our son’s DHS group home.

There was no consultation on major changes to the internal physical structure of our son’s DHS group home. The group home is therefore a “Hostel”, not a HOME.

13. **Incompatible residents reduce the quality of life of compatible residents.**
The residents of DHS group home are forced, without consultation, to accept incompatible clients from the DHS controlled statewide DSR (Disability Support Register) which reduce the quality of life of the sitting residents.

Our son's DHS group home was good until the residents and staff were despottically forced to accept a totally incompatible client. Over two years later, the staff can still do little more than disaster manage the group home.

NGOs are also forced to accept incompatible clients from the DHS controlled statewide DSR (Disability Support Register).

This despotic action by the DHS means that neither the incompatible clients or the sitting residents receive the right level of care – both are disadvantaged.

Clients who have such challenging behaviour as to make them incompatible with most resident groups, need to be placed in a behaviour management unit, similar to that at PRS (Plenty Residential Services), to receive or allow them to receive the level and quality of behaviour management and modification that they may eventually be suited in a regular community group home.

14. **Sympathy of Medical Professionals with direct care staff**

Although this is slowly changing, there are still many medical professionals, especially in hospitals, who have more sympathy with the staff, than the needs and rights of the residents.

15. **DHS management has little sense of responsibility for the mechanical items of service quality, in their poor support for essential domestic equipment.**

In a high support needs group homes, staff struggle to maintain basic care when electrical equipment fails. and repair or replacement takes weeks to occur.

In a very large home for 6 residents and 3 or 4 daily support staff, we have witnessed staff having to use a pan and brush when their vacuum cleaner went faulty.

On two occasions, we loaned them a vacuum cleaner, which they were forced to keep for weeks. When we suggested arrangements whereby the region could have spares available, we were ignored by DHS management.

In the same home there are two incontinent residents. Yet the staff were forced to struggle for weeks in the winter with no clothes dryer.

In the same home, they were without a dishwasher for weeks. This may not seem a major problem, until considering all domestic chores reduce the time available for
staff to spend quality time with the residents in providing quality of life activities like, Interaction, Developmental and Social Activities – “Active Support”.

16. **Public Service Workplace Agreement is that direct care staff shall do no physical activity.**

We have seen residents having to be showered/bathed by the glow of a hall light, because the bathroom light globe has blown, and staff are not allowed to replace the faulty globe.

Curtains remain off their hooks, because staff are not allowed to get-up to re-hook them.

17. **Pay differences between DHS and NGO direct care staff.**

The hourly pay rate for DHS direct care staff is higher than NGO direct care staff. Yet DHS management are unable to set monitor and maintain their staff work values, due to the traditional public service captive market resistance to any form of expectation being placed on public servants. Therefore, the DHS should not be a direct service provider, especially for disadvantaged and vulnerable people.

In contrast, Heather’s practical experience of working for NOOs, is that they do set expectations on their direct care staff.

**In conclusion:**

During a two year period, a select team of dedicated DHS direct care staff proved to us that the service could be a million dollars if they resisted following the traditional restrictive practice culture of the public service.

The traditional public service management not only resisted providing this dedicated staff team with meaningful support, but made it as difficult as possible for them to provide real quality of life support for the residents, and meaningful involvement for their families.

DHS/Regional management not only destroyed this staff team, but they categorically refused to consider the good work of this team as a benchmark to overall quality improvement - as tools to service improvement.

Most organisations in the market place are keen to replicate services which receive good customer feedback and reviews.

Although the attachments (listed below) provide some practical examples of the philosophy of our submission, we have many more which we would be delighted to present to the Inquiry on request.
Attachments:

1. DHS Questionable Activities,
2. Why caring parents have to live for ever.
3. Copy of letter to those in privileged positions of social influence.
4. Copy of notes of a recent meeting with the DHS/Region.
6. Intellectual Ability Avenue.
7. DHS Reactive Service versus Customer Service,
8. Consumer Rights,
9. Real Home or Program.
10. Home or Hostel.
11. Congratulations! You are a House Supervisor!
12. Bound to Care by Rescare UK.

Forwarded for your attention and consideration please.

Yours sincerely,

Tony & Heather Tregale
Plenary Guardians & Administrators
Tel: 9434-3810.
Email: vk3qq@optusnet.com.au
Department of Human Services, Disability Services, Questionable Activities in Official Denial by DAS Management, but for which they and staff are well aware.

It should be noted that the following list is not exhaustive, and is not exclusive to any one location. Many of these practices, directly or indirectly, restrict the residents’ quality of life.

1. Many direct care staff rostering their rostered hours..... Arrive late, leave early!
2. Many direct care staff rostering work hours on private business (phone calls, etc), watching TV, chatting and drinking coffee with other staff for long periods, etc, etc.
3. Direct care staff rostered on a shift where there is no specific work, as a result of some questionable HACSU agreement.
4. Direct care staff lore negating management’s right and role to manage service within departmental care policy, standards and values.
5. Erroneous bullying claims on House Supervisors by staff as a work avoidance tool.
6. Direct care staff “Factional Division and In-Fighting”.
7. Direct care staff peer pressure to work at the lowest common denominator.
8. Direct care staff using “Client Choice” as a work avoidance tool.
9. Poor man-management of direct care staff by unsuitable managers and house supervisors.
10. Managers not adequately supporting House Supervisors.
11. Managers (above house supervisor) rarely visiting the houses.
12. Managers (above house supervisor) failing to ensure the house staff are compatible and work as a team.
13. Managers (above house supervisor) failing to ensure all staff in an “Active Support” house are fully supportive, in practice, of the defined “Active Support” principles for the residents.
14. Managers (above house supervisor) have insufficient “Industrial Training and Experience” to support the House Supervisor to fully implement departmental care policies, standards and values, in the face of HACSU supported staff lore.
15. DAS management issue avoidance and sweep-it-under-the-rug tactics when facing families questioning service level and quality.
16. Families having to continually repeat their stories on questionable service provision, in the face of revolving door DAS management (above house supervisor).
17. Direct care staff withholding from, or claiming client refused to take their (psychotic) medication, so the client’s behaviour gets worse, and the staff can persuade the doctor to prescribe a higher dose.
18. Food items in house, going missing.
19. Staff having Bistro food at client expense.
20. Little accountability for pharmacy items.
21. Time sheets signed for every day, at the start of the roster period.
22. Residents’ personal cash vulnerable to pilfering, and management not concerned as the department is responsible for its replacement.
23. Direct care staff at PRS allowed to do 12 hour shifts. They could not possibly provide QOL care after 8 hours!
24. House Supervisors say the residents are no problem, it’s the staff who create most strife.
WHY CARING PARENTS HAVE TO LIVE FOR EVER

Caring parents having a son or daughter with an intellectual or multiple disability need to live for ever because almost all services, supported accommodation, in-home support, respite day services, sheltered workshops, education, etc, etc cannot, at present, be relied upon to get it right for those with little or no ability to adequately advocate for themselves.

Just some of the reasons why (If you know more, let us know):

1. Clothes being mislaid or lost, even when clearly marked.

2. Wearing the same shoes all the time, especially runners (has a range of shoes)

3. Washing quality poor - stains frequently not removed with Preen – woollens ruined in hot water, etc, etc.

4. Clothes not ironed, or consistently ironed.

5. Inappropriately dressed for the weather and environment.


7. Bed made up when wet.

8. Top sheet not consistently put on bed.


10. Meals poor – lots of takeaway

11. Cut lunches, for day activities, poor.

12. Poor grooming, including teeth cleaning and nail cutting.

13. Shoes not cleaned.

14. Reluctance to use generic services for medical, hair care, etc, etc.

15. Very little meaningful interaction, developmental and social activities – loss of skills.

16. Failure to make or attend medical and dental appointments – Not in the staff diary, no one read the diary, no staff or no one wanted to go.

17. Staff infrequently attending a resident admitted to hospital.

18. Injuries frequently not noticed or reported.
19. Reluctance to treat minor abrasions and rashes.

20. Residents needs have to fit in with staff needs, mood and availability.

21. Delays in taking residents to a doctor (Example: Sector manager visiting a CRU on a Friday, observed a resident with a streaming cold. On asking when the resident will be taken to a doctor, the staff said, “On Tuesday when his key worker is back!”

22. The “Key Worker” is intended to represent the resident’s interests with the service provider, especially where the resident has no family or effective family. Yet key workers frequently do little more than the average workers (staff). And the key worker’s loyalty is naturally with their employer – the service provider.

23. A “Case Manager” is also intended to represent the resident’s interests with the service provider. Yet, again, the case manager is employed by the service provider!

24. Apart from parents, family and friends, there is no provision for purchasing or replacing items and equipment which would help to enhance the resident’s lifestyle. The resident’s finances build year after year, with the resident having few possessions. Whereas, even these residents can benefit from such items as, a trampoline, an exercise bike, balls, talking toys, communication aids, TV, video recorder, drawing boards, etc, etc.

73 Nepean Street,
WATSONIA 3087.

Mr Laurie Harkin, Disability Services Commissioner, ODSC
Mr Des Pearson, Auditor General of Victoria.
Ms Anne Brinsden, Manager, Standards & Outcome Measurement, DHS
Mr Shane Beaumont, Systemic Improvement Unit, DHS
Ms Kathryn Lamb, Director Quality and Sector Development, DHS
Ms Mary Wooldridge, Opposition member for Community Services
Ms Colleen Hartland, MLC, Member for Western Metropolitan.
Ms Janice Kronberg, MLC, Member for Eastern Metropolitan.

Ladies & Gentlemen,

The Family and Community Development Committee of the Victorian Parliament, under the Parliamentary Committees Act 1968, together with the Auditor General, have openly recognised the need to inquire into the provision of supported accommodation, especially that directly provided statewide by the Department of Human Services (DHS) for our very vulnerable citizens – people with intellectual and multiple disabilities.

As you are all in privileged positions of social influence in service and society, you have been sent, over the past few months, a range of documentary evidence showing the adverse effect, and potential adverse effect of “captive market government department direct service provision” on people with an intellectual or multiple disability, and their families.

The evidence we provided shows the Head Office of the Department of Human Services produces excellent care policies, standards and values, and promotes these very well. But, the direction, intention and spirit of these is not fully implemented at the regional service points, for those it was intended - people with an intellectual or multiple disability, and their families.

Our extensive evidence shows, that under public service philosophy, DHS Regional Management is unable to manage and implement its direct care services with a consistent customer/consumer focus. Indeed, the evidence shows a standard public service introverted service philosophy, defending itself against those it is intended to serve.
With the DHS regional management’s massive “power over people”, clearly demonstrated by the evidence we have provided, together with the fact that families have no choice of service provider, it is understandable that most families give up against such overwhelming odds. Which is exactly the intention of this captive market government department – “Leave your kid, and go away”, remains their underlying message to families.

Yours sincerely,

Tony & Heather Tregale
Tel: 9434-3810.
Email: vk3qq@optusnet.com.au

COPY: Ms Kerry Presser, State Manager, National Disability Services
NOTES FOR A GENERAL ISSUES MEETING WITH MS JEAN STREET
DHS DOMAIN MANAGER N&W METRO REGION ABOUT THE LEVEL AND
QUALITY OF CARE AT DHS GROUP HOME PEUGEOT PURSUIT
TUESDAY 30 SEPTEMBER 2008 AT 2PM

Although the following list of concerns starts in October 2007, there have been significant
concerns since the “A Team” were destroyed by DAS Management, and especially since the
totally incompatible client, defined below as “Fred”, was forced on the sitting residents of
Peugeot without consultation in October 2006, by the very despotic DHS Client Services.

1. Paul had no effective Key Worker for the first 9 years he was living in a DHS CRU.
   His first real Key Worker was soon after he arrived at Peugeot, although this lasted
   just two years, until December 2005, it was first class.

2. Paul had no effective Key Worker at Peugeot from December 2005 until October
   2007, when John Hammond was appointed at our request. Yet our request for an
   official meeting with John Hammond was refused, and we still seek one.

3. In consequence of being denied a meeting with John Hammond, communication
difficulties occurred for a period of 3 months. This was especially noticeable in John
   being given a bath spa mat to evaluate for Paul. This has collected dust since 10 May
   2008!

4. There has been no key worker report since the end of 2005.

5. Staff names removed from Paul’s “Progress Notes” – No accountability!

6. Paul has lost significant skills from entering a DHS group home in January 1995 until
   April 2004, when he recovered some as a result of the excellent work of the “A
   Team” at Peugeot.

   However, Paul has lost skills again since late 2005, when DAS management
   destroyed the “A Team”. There is little sign of meaningful and consistent “Active
   Support” program since. Paul’s minimum skill loss areas are: Ball, Swing,
   Treadmill, Trampoline and communications.

7. Since late 2005, there has been no evidence whatsoever of “Working with Families”
at Peugeot. The atmosphere is clinical, and matter of fact!

8. The La Trobe medical centre dietician’s recommendations for food supplements for
   Paul, were implemented only for a very short period.

9. A subsequent dietician appointed by DHS looked at, and made recommendations
   regarding the meals at Peugeot. When we requested a copy of the dietician’s report, it
   was sent to the wrong GP by the house staff.
10. We have little evidence of the Podiatrist’s recommendations being implemented consistently, as per Health Management Notes.

11. Paul to pack and unpack his day program bag - inconsistent.

12. Washing procedure for towels leaves them extremely rough – not using “Softly”.

13. Not only is Paul losing skills, but he is learning bad behaviours from the totally incompatible client – Not keeping socks and slippers on, and frequently taking his singlet and shirt off.

14. Staff show little interest in attending medical, dental and psychiatric appointments. And casual staff are useless for the appointments!

15. Service inconsistency demonstrated by:- On 23 Jan 2008, at 4pm, whilst Heather was visiting Paul, as usual on a Wednesday, Paul went into a SIB episode. Some well established BMSs were attempted, but did not work. However, the then staff (Jodi Ryan and John Hammond) would not let Heather cover Paul’s head with a towel or soft helmet - both of which were well established BMSs. These staff members cited the actions Heather proposed, as being “restraint”. Yet, BIST directions supported Heather’s proposals. These were subsequently supported by the Senior Practitioner.

In addition, Paul had been living at Peugeot long before these staff members arrived there, and these BMSs were well established at both Peugeot and Morname. Although these staff members had been at Peugeot over three months, they did not question the well documented BMS procedures prior to the said incident!

The incident culminated in Paul being given Midazolam by the said staff members, in contrast to using well established and document BMSs.

16. An example of privacy gone insane:- Jodi Ryan (2i/c), on 28 Jan 2008. 4:15pm, refused to tell us if there was a male staff member on duty on the following Thursday. Yet all we needed, was some physical assistance with a TV/Video cabinet for Paul’s room........ As it happened, Heather assisted me, as the male staff member on duty on the said day, stood and watched us - citing a workplace agreement which restricted staff from lifting anything.

17. 25 Jan 2008. Staff took Paul to Austin Outpatients as they thought he had eaten some soap. Paul was kept waiting three hours. This would have been extremely stressful and traumatic for Paul! Whereas, in 2004, a similar incident occurred, but the staff then called the “Poisons Info Centre” to establish there was no need to do more than monitor Paul. Nevertheless, we question why staff did not call “On Call” before proceeding to the hospital.
18. 1 Feb 2008, 10-30am.... DHS Preston cancelled our scheduled meeting, half an hour after we arrived!

19. Service inconsistency: 1 Feb 2008. We were suddenly told by staff that Paul could no longer be given Sustagen if it was not on the “Treatment Sheet”. Staff intended to put an instant stop! Yet the policy had been there since 1 July 2007!

20. We need a meeting with John Hammond to resolve some inconsistencies and misunderstandings.

21. There is no indication of Paul being encouraged to go on the Treadmill, yet he was doing well on this between 2004 -2006. And, this activity is in Paul’s IPP. And, the Treadmill has now (August 2008) been folded up and put away, without any consultation with us.... The house is, therefore, not the residents’ home. It is a HOSTEL and staff workplace!

22. 6 Feb 2008, 4pm. There were 6 staff on duty when Heather arrived, and the same 6 an hour later when she left. This is a one to one staff ratio..... Clearly on account of the totally incompatible client!

23. Despotic Restrictive practice: 15 Feb 2008, 4pm. A permanent staff member said. “We did not know you were visiting Paul today, we understood you had been directed by DAS management to ring first!”

24. 15 Feb 2008, 4pm. Two casual staff standing around not knowing what to do, as they were not being directed.

25. 15 Feb 2008, 4pm. Permanent staff member said, “I must go outside, I can’t stand “Fred’s” noise any longer, I’m at breaking point because of his continuous noise and continuous attention demanding. NOTE: If the staff are at breaking point, and they can go home. What about the other residents, who have no break from the excessive and unreasonable trauma?

26. 15 Feb 2008, 4:30pm. Whilst Heather was giving Paul some (light food) treats, another resident indicated a wish for some. Unfortunately, Heather was forced to ignore Paul’s house mate, because of the despotic and totally unreasonable silo mindset the department forces on residents and their families.

27. 19 Feb 2008, 8am. Collected Paul for his regular generic haircut, and then on to Alpha North Day Centre. In doing this, Heather noticed Paul’s sandwiches had no butter on the bread (plain bread), no salad filling. Just meat and cheese. Also, no fruit and no drink! NOTE: We question how often this happens, as we are not there often!
28. 20 Feb 2008, 4pm. Extreme noise, rage-about and attention seeking from “Fred” during the one hour period Heather was there. Mickey was copying the noise, and Paul retired to his room. NOTE: The excesses of “Fred” has not reduced since being placed by DHS in Oct 2006!

29. 25 Feb 2008, 5pm. “Fred” very, very noisy. Regular casual staff person said that “Fred” is the worst she has heard him!

30. 23 Mar 2008, 9am. “Fred” very, very noisy! No Easter Eggs like the last four years. Clearly the staff are too stressed to do much other than minder care!

31. 27 Mar 2008. A pair of Paul’s light trousers turned up in Paul’s wardrobe, after being missing for 3 months!

32. 30 March 2008. 9am, “Fred” very, very noisy! Small toilet door locked, again! Tony asked house supervisor who Paul would be travelling with to the Day Centre in the new Taxi transport. The House Supervisor said I am not permitted to tell you, because of privacy……. NOTE: Privacy mindset gone mad!

33. 2 April 2008. There was a bad storm! On the 3 April, we observed the drive was a mess. And on 5 April the driveway was still a mess! Clearly, staff did not consider this was their job!

34. 5 April 2008. “Fred” very, very noisy!

35. 16 April 2008. Staff were all casuals both today and yesterday, as the region claims the few permanent staff were on a training course……. A training course for what?

36. NOTE: Since “Fred” has been at Peugeot, the QOL of the other residents has dropped like a brick. With staff totally stressed by his noise, rage about and attention seeking, it is unreasonable to expect staff to do much except minder…. There has been no BBQs, Picnics or Christmas Parties for residents and their families!

37. 27 April 2008. “Fred” very, very noisy and pushy with other residents and staff around the breakfast area this morning.

38. 4 May 2008. “Fred” exceptionally noisy today when we collected Paul for the day with us!

39. 7 May 2008. We were asked by Jodi Ryan (2i/c to take the Treadmill away, without any consultation. This was the unit we supplied to support the Active Support Program between 2004 and 2006.

40. 13 May 2008. “Fred” very, very noisy, and set Paul off!
41. 13 May 2008. We supplied a “Spa Bath Mat” (converts a bath into a Spa). We asked Paul’s key worker to trial it, as we are using ours, and Paul loves it. But it is still packed in its box (Sept 2008).

42. 5 June 2008. “Fred” hammering the screen door with his fists, causing Mickey to bang his head on the table until it bled. Yet, casual staff seemed unconcerned in even rendering first aid to Mickey. Clearly, they were too stressed themselves!

43. 6 June 2008. Following the department removing the hall carpet, which made the acoustics shocking, a casual staff person remarked that it is nice to see you put a carpet in Paul’s room. This certainly helps to reduce the adverse impact of “Fred” on Paul.

44. 11 June 2008, 4pm. Paul arrived home. He went down to the kitchen, where all staff were busy dealing with “Fred” being out of control. Paul went to his room to get away from the noise and hullabaloo, and no one came to get Paul for his afternoon tea.

45. 15 June 2008, 4:45pm. “Fred” very, very noisy and rage-about. We observed four large male staff having great difficulty in controlling “Fred’s” exceptionally excessive raging for the whole period we were there – some 20 minutes. This hullabaloo set Paul off with his SIB. We subsequently called later to see how Paul was. His key worker said he was fine, and was having his evening meal. This was 6:20pm! Clearly, Paul had to wait for his food, because staff had major problems with “Fred”.

46. 20 June 2008. A new permanent staff member gave us a pathology blood test request sheet which was dated 26 May 2008. Clearly no one at Peugeot had actioned this directive from Paul’s GP, despite the GP calling Peugeot and being assured it would be done. The GP was not impressed to discover the Peugeot staff had done nothing, and that WE had to take Paul to pathology.

47. 26 June 2008. Paul’s Key Worker was very abrupt and unfriendly towards Heather. Some of this is as a direct result of the stress on staff by “Fred”, and that the region has been restrictive on us having a official meeting with John Hammond.

48. 26 June 2008. Paul was given his medication in yoghurt, despite that everyone knows Paul takes his medication from a clean plate with a glass of water.

49. 23 June 2008. Direction of Paul’s Podiatrist not being implemented by staff. Clearly, they are too busy with “Fred” to bother with the other residents!

50. 13 July 2008. No entries in Paul’s Communications Diary form Peugeot staff since 31 June 2008. Entries have always been poor, but this is exceptional! Entries from Paul’s key worker erratic!
51. 15 July 2008. We have just received this Paul’s personal expenditure (blue) sheets. Paul has clearly done little again this month. He has not gone out for a meal or a spa in the past two months. Little wonder his personal expenses frequently build up to around $1000, in around 9 months.

52. NOTE: That which does not get done, and why caring parents have to live for ever! No procedure for getting clothing repaired. Curtains in a mess on the runners. Communication Diary not repaired – let to fall apart.

53. Dishwasher out of action for 2 weeks!

54. No clothes dryer for a month!

55. 23 July 2008. When Heather visited Paul, she observed “Fred” raging about, as noisy as ever, and again stripping off all his clothes for attention seeking. Heather had to stop Paul copying this behaviour.

56. 30 July 2008. “Fred” very, very noisy, and Paul was clearly quite agitated as a consequence!

57. NOTE: Paul’s bag is frequently not unpacked. Clothing travel back and forth, if Heather does not check on this!

58. 6 August 2008. Stewart wanted to use the toilet (main), when Paul was. This clearly illustrates that staff are not encouraging the resident to get used to using the small toilet!

59. 10 August 2008. Acting House Supervisor handed us all Paul’s VCR information tapes, on the basis that they no longer have a VCR. These tapes are intended to be reference information for staff.

60. 13 August 2008. Heather observed that when “Fred” is taken out, all the other residents are calm and content!


62. Note: When a new resident came to the house, he had the same colour towels as Toby. Staff asked if we could replace Paul’s towels with a different colour, as it would be easier for you guys to do this, as for other residents we have to deal with State Trustees.

When we took six replacement towels to Peugeot, beige in colour, we noticed that as staff put these in the linen cupboard, there were other residents towels in shocking condition.
63. 17 Aug 2008. We noticed the Treadmill which we gave to Peugeot was folded up in the spare room – obviously not being used, or intended to be used.

64. 20 Aug 2008. Whilst Heather was at Peugeot, a DAS manager arrived at Peugeot. This manager said to Heather, Paul and “Fred” are not compatible, I could not work here with this level of noise, and went on to say that “Fred” should be in a purpose built unit with two or three others and high support staff.

65. 23 Aug 2008, 4:45pm. Only one staff person appeared to be there, a casual. The person said, other residents had been taken out. It was clear that there had been a major incident with “Fred”, as the only permanent staff member was busy with “Fred” all the time we were there.

66. 26 Aug 2008. NOTE: Regarding Paul’s PCP, Jodi Ryan (2i/c) made up communication cards, on a key ring, showed these to us at Paul’s PCP back in Nov 2007. Yet nothing ever materialised!

67. Note: A casual mentioned to Heather that staff had been instructed to write in “Fred’s” Communication Diary every day. Heather naturally asked if similar applied to Paul – The answer was, No!

68. 7 Sept 2008. When we collected Paul for the day with us, we noticed the shirt he had on, had three buttons missing down the front – Yet there is a mending box in Paul’s wardrobe!

69. 10 Sept 2008……. All casual staff!

70. 17 Sept 2008. “Fred” still excessively noisy. He stripped twice whilst Heather was there. He defecated and was incontinent in the hall and in his room. All staff were flat out dealing with this devastating situation to the detriment of all the other residents, who clearly had to be ignored for the period “Fred” secured the attention of all staff.

71. 23 Sept 2008, 7:30pm. All hell was letting loose! “Fred” was so noisy and rage-about, there clearly had been a major incident with him, as he had his arm splints on.

When we inquired with Paul’s key worker about a hair clipper he had requested we got for Paul, if he found it ok. He said he had, had no time to look at it. Clearly, most of his time is spent dealing with the major behavioural problems of “Fred”.

72. 26 Sept 2008. When Heather requested to know if Paul’s new PRN sleep medication had been used yet, she was told by a permanent staff member that only the night staff would know this. Heather had to say, “Well look in the medication folder and/or check the PRN pack!”
73. NOTE: Paul’s Behavioural Support Plan (BSP) STILL not finalised!

74. We are Paul’s Plenary Guardians and Administrators for the very good reason that Paul has no ability to manage his own affairs. Yet despite we were forced to take the matter to the IDR, of the DHS Client Services refusing to place Paul on the DSR for potential relocation, we were not given a copy of the letter sent to Paul at Peugeot by Client Services on 13 November 2007.

The failure of the Peugeot management to alert us of correspondence received for Paul, means that they either believe Paul has the ability to understand this correspondence, or they are irresponsible and not acting in Paul’s best interest..... Similar irresponsibility as Item 46 above.

75. We request a meeting with the new House Supervisor at Peugeot and John Hammond.

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A Captive Market Classic Cop-Out!

- DHS HO has high expectations regarding meaningful services for all residents of group homes, including those with high support needs!
- Yet, Service Outcomes do not match Service Intentions”!
- The following would not occur, if the Consumer had choice of Service Provider!

We receive a continuos stream of "cop-out" from the department, and always have done!

When public servants read a letter (request, suggestion, etc), they look for how they can avoid doing things. Whereas, good business, in the market place, looks for how they can do things to please and retain the customer….. Here is the latest example of a DHS COP-OUT:-

All the guys (males) in Paul's group home (in the City of Whittlesea) are physically fit, but they have no meaningful communications or ability to understand. As in all homes of this nature, all clothing needs to be, as it is named (discretely, of course).

When, at times, the department uses a lot of casual staff, Heather gets sick of lots of clothes getting mixed up, mislaid, etc. As she likes Paul to be well dressed at all times, and makes sure his wardrobe is very comprehensive!

A statement made to DHS was:-
"Mislaied clothing is an increasing problem. Not only do items of Paul's clothes find their way into the wardrobes of other residents, but visa versa."

There appears to be three major contributing factors, (a) that the clothes of most other residents are not labelled/marked with their name (as all Paul's clothes are), (b) that casual staff are not generally discouraged from putting clothes away or educated to do it right and, (c) that most other residents do not have their name (a nice decorative emblem) on their room door (as Paul does) to help casual and new staff."

The response from DHS was:-
"In response to the issue regarding labelling of resident's clothes and rooms, the department is committed to supporting residents to live in a home-like setting and does not consider it appropriate to require all residents to put their names on their doors or to label every item of clothing if they choose not to. It is also expected that casual staff working within the house undertake similar roles and responsibilities as regular staff members including collecting and/or putting away clothes, to assist in the day-to-day running of the residents' home. Ongoing staff are expected to guide and support casual staff in these various activities."

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Lifestyle in Supported Accommodation (LISA) Inc.
The majority of us in the general community have an absolutely massive intellectual ability avenue, limited basically by just our imagination, motivation and resources. We use but a fraction of the intellectual ability we have. There are few objects and activities which are meaningless to us for very long, as we maintain and enhance our intellectual ability by everyday learning and experiences throughout our lifetime.

In total contrast, those in our community with an intellectual disability, no matter the degree, have a significantly reduced intellectual ability avenue, and significantly reduced ability to maintain and enhance this narrow avenue without consistent assistance. They have little self motivation, and need consistent motivation.

Meaningful quality of life objects and activities are seriously limited, even for those with a very mild intellectual disability. Those with moderate to severe intellectual disability may be limited to the only meaningful objects being just a ball and a beanbag, for example.

Caring parents/families spend significant time and resources improving the ability avenue of their young family member who has been diagnosed with an intellectual disability. They constantly seek to widen and maintain the range of meaningful objects and activities their family member is able to appreciate.

Families, therefore, have significant concerns in respect to the quality of life activities. Interaction, developmental and social activities ("Active Support"), their family member will receive, if ever they find themselves no longer able to provide care in the family home - perhaps through age or illness of the parents.

Most supported accommodation group homes now provide a very reasonable level of basic care. Many do not however cater well in respect to quality of life activities. There is more concern with BMS ("Behaviour Management Strategies") being well defined, documented and crises driven, than there is with the measurement, maintenance and enhancement of the person's intellectual ability avenue.

There is little acceptance that maintenance and enhancement of a person's ability avenue helps to moderate the person's behaviour. A person with a expanding quality of life, through having as many meaningful objects and activities as possible, is often far more contented.

A quality of life is a basic human right! It is no longer acceptable to have care consisting of "Bed, Breakfast and an Evening Meal", and look at four walls/TV 24/7.
THE DHS REACTIVE, IN-DENIAL AND CRISIES DRIVEN CAPTIVE MARKET SERVICE VERSUS CUSTOMER SATISFACTION

A recent business survey showed the top five reasons someone buys a product, are:-

1. Confidence that your products and services will meet their needs
2. Quality of the product and service
3. The level of service that is provided
4. Selection or range of offers
5. Cost

NOTE: Cost is number 5! **Confidence is number one!**

The top reason is that they believe that you can deliver a solution that it will take away whatever the pain is that they are currently feeling, and produce the pleasure they are seeking.

- The pleasure caring families with a member living in a supported accommodation group home are seeking, to feel they do not need to live for ever, are numbers 1, 2, 3 and 4!

- This is just what departmental care policies, standards and values offer, but not what the regions deliver!

- With a captive market, the department/regions have little reason to consider that customer experience leaders say that working with customers is a privilege, not an entitlement! They recognise their competitors also offer great products and services; and that to retain and attract customers, they will need to delight them every day at every organisational touch point.

Indeed, the Disability Act 2006, Policy & Information Manual says:

- At the centre of any support strategy are people with a disability, their families and carers, guiding the way that support is provided in their homes and communities.

- “Rights and Accountability” outlines how to support high quality services, better accountability and make practice more transparent.
• Services for people with an intellectual disability should be designed and provided in a manner that ensures that a particular disability service provider cannot exercise control over all or most aspects of the life of a person with an intellectual disability.

**All staff providing disability services need to:**

• Consider and respect the role of families and other people who are significant in the life of the person with a disability.

• Acknowledge the important role families have in supporting people with a disability. Acknowledge the important role families have in assisting their family member to realize their individual physical, social, emotional and intellectual capacities.

• Where possible strengthen and build the capacity of families who are supporting people with a disability.

• Have regard for the needs of children with a disability and preserve and promote relationships between the child, their family and other people who are significant in the life of the child with a disability.

*Nevertheless, the DHS Regions remain:*

"Reactive, In-Denial and Crises Driven"

**Independent monitoring may:**

• Assure compliance of disability service providers with the Standards.

• Involve people with a disability who receive services, their families and carers.

**Whereas:**

In most fields of service provision, customers are able to purchase from those providers who are offering high quality service.

**However:**

In the disability field, consumers of services are often vulnerable or unable to 'shop around' for the best quality services.

**In order to:**

Protect consumers rights and interests, the processes and activities of service providers must be open to scrutiny by key stakeholders, particularly consumers and their representatives.
8.

CONSUMER RIGHTS

The Department of Human Services is a public service direct service provider. Its Regions across the State of Victoria provide supported accommodation for the residents of department owned group homes.

Although the residents of these group homes pay realistic rent, housekeeping and personal expenses, the department denies them residential tenancy rights under the “Residential Tenancy Act”, and the right to Individualised Funding.

The residents of department owned and controlled group homes therefore have few reasonable and realistic rights in the home the department calls their home, but which is in effect a hostel/staff workplace. Staff cannot be moved, residents can!

Although the department permits the residents and their non government representatives to question individual service provision, it restricts the residents and their non government representatives from questioning the systemic service provision of this public funded service provider.

The department claims the residents and their non government representatives have no right to question and/or expect answers to the systemic aspect of the service they are receiving. The department claims the systemic aspect of service is none of their business!

Whereas, a major impact on individual service is systemic service. Individual service will repeatedly fail, if systemic service is not correct. And, it is the democratic right of all members of the public to scrutinise all aspects of public services. The public are effectively share holders of all public services.

The residents of supported accommodation group homes, and their non government representatives, are members of the public with a right to, therefore, question any aspect of a public service.
The Choice Between a "Real Home" and a Program
[Home or Hostel]
by Michael Kendrick PhD

One of the challenges agencies face when they provide housing for people with disabilities is how to create a true home for the people who live there. Too often, unless there are proper safeguards in place, there is a danger that even the most well-intended homes can become a "facility" rather than a "real home."

To foster a true sense of home, we should think of the features we all strive to instil in our own homes. These qualities vary but they are based on a rich cultural heritage that underlies the true concept of a "real" home. These features may include a place where we can be ourselves and feel comfortable, a place that expresses our personality, a place we choose that has a sense of family, intimacy and privacy, a place to contain our personal relationship and social life; a place of our own where we can feel safe and secure. While some may emphasize one feature over another, these attributes are all within the range of what most people would consider essential for a home and home life.

Turning a facility into a home can only occur if staff and the agency are committed to maximizing the idea of "home" as a priority in residential services. Agencies should believe that the needs of disabled persons are largely the same as other people. The primary reason for residential settings should be that they are the home of those served, rather than a setting for treatment programming, or any other professional activity. When professional services are needed they should be offered in such a way that the integrity and normalcy of the home is not compromised.

The list in the box accompanying this article offers some points people should consider when they create homes for consumers.

Management staff, consumers, and families, and guardians should search for their own strategies that stress the importance of a real home. This is an ongoing process where the DMR, consumers, families and provider agencies need to consistently reassess our initiatives and established programs to guarantee that the proper home environments permeate our residential programs.

Making a House a Home

The following are points for consumers, families and staff to consider as they strive towards building a proper and rich sense of "home" into their residences.

- The residents served should assist in the selection and location of the home.

- They should help to decorate and furnish their home environment.
• They should decide who they want to live with.

• They should have a voice in staff selection.

• Agencies should hire staff whose personal orientation, commitment and attributes are targeted towards helping people make a home for themselves.

• Programming, treatment, and related practices are either kept out of the home setting, or if necessary blended carefully into the home-life so they do not disturb the home setting.

• Agencies should not bring their bureaucracy into the home. This means agency materials, meetings, offices, or equipment.

• Home sites should be integrated into their neighbourhoods. The houses should be attractive, well cared for, and similar in appearance to neighbouring households.

• The home should be close to work, family, recreation and convenient to other interests of the people who live there.

• Intimacy, sharing, personal ownership and possessions should be encouraged.

• Regulatory concerns of funding agencies should be addressed in such a way that the home remains a home.

• The house is at all times, legally and otherwise the home of the residents, and not the staff or the agency.

• The Agency should stress in its mission, and in its communication to staff, consumers and families that the concept of home in its residences is a worthy and pre-eminent goal of the organization.

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“HOME OR HOSTEL”

When the Victorian Government embarked on providing supported accommodation in the community for those with a disability who’s elderly parents were struggling to provide for them. Government intention was that these houses be group homes, not hostels.

Equally, when the Institutions were closed there was a determination that people who had been living in prison or barrack room like conditions for years, would now enjoy a group home in the community - Not a Hostel!

The general Australian definition of living in one’s home, is that of ownership and security. A place where one has rights of determination to decide who enters, or what they do or don’t do in your home. The general Australian view of a hostel is a place of temporary accommodation, where there is a manager who makes the rules under which the people who choose to stay there live.

The government department charged with translating government funds into group homes throughout the community, was the Department of Human Services. The Department, together with the Community Visitor’s Program developed excellent care policies, standards and values, with positive intention that these houses in the community be real long term quality homes for those with intellectual and multiple disabilities.

It is therefore disappointing that direct care staff lore, union pressure and bad overall management makes these houses in the community, staff work places where the resident’s have few if any real rights.

Although the residents pay rent, they have no rights under the Residential Tenancies Act! They have no rights to choose their support staff, say who comes into their home, be consulted about major physical changes to their home, or be consulted when there is a vacancy in their home for a new resident.

Group homes are therefore little more than Mini Institutions or Hostels!
CONGRATULATIONS! “YOU ARE NOW A SUPERVISOR!”

House Supervisors are expected to be totally responsible and accountable for everything in the house. Yet they have few rights and little authority. They are unlikely to be supported by line management when attempting to set, monitor and maintain direct care staff work value within departmental care policies, standards, guidelines and values, and within staff job descriptions!

If a House Supervisor comes into the house at times when not “rostered-on”, stays after their shift, comes in early or phones staff at the house when he or she is not on duty.... This is frequently grounds for a successful harassment complaint by direct care staff with HACSU support against weak DHS management who are also intimidated by direct care staff into not visiting a house without giving prior notice to staff.

So although held responsible and accountable, a House Supervisor is rarely permitted to be a pro-active and responsible supervisory person. And, is not sufficiently empowered to address the needs and aspirations of the residents for whom he/she is responsible.

People promoted to the position of supervisor should be made aware that:-

“Although you are now officially a House Supervisor, under no circumstances should you attempt to supervise!” This is because:-

1. In most circumstances, you are unlikely to be supported by your line management!

2. You will have to fight the public service management issue-avoidance bureaucracy alone, in every way, to support your residents to receive the care and quality lifestyle set by the department’s own care policies, standards, guidelines and values.

3. At any time you could have HACSU supported, militant direct care staff undermining any attempt you make to have residents receive quality care and support. These staff wish to have “leisure time at work”, and will claim you are bullying them if you make any attempt to direct them, or question their actions!

4. Management will most likely cave-in to your subordinates complaints and demands, no matter how unreasonable or unfounded these may be!

5. Management will almost certainly make you the scapegoat, to help make the problem/s go away, and to cover their own backsides!

Are you still feeling lucky in getting the position? No! Maybe? Well, see how you feel after attempting to do just a fraction of what is in your job description!

Even with good staff, you are likely to battle every day against the entrenched management attitudes and practices described above. With entrenched staff - forget it! Either keep your head low and ignore what is going on around you, or move to the NGOs.
EXTRACTS FROM "BOUND TO CARE"
AN ANTHOLOGY OF FAMILY EXPERIENCES
BY RESCARE UK

“It is a great shame when so much valuable time is spent on paperwork instead of where it really matters, providing a nurturing environment for our loved ones. Our family members are human beings, but because they serve no obvious useful purpose to the community, they are generally treated as second-class citizens!"

“There was a garden and play area, but it required staff to take the residents and stay with them. As the garden was out of sight of the house, this activity was never given high priority. Staff preferred to stay in the house and watch the television!"

“It has always been understood that caring for people involved encouraging social interaction, for example, through staff playing with residents. Shortage of staff resulting from lack of resources was always blamed. No one ever made it compulsory for staff to involve residents in activities!”

“A social worker from a child assessment unit said, You’ll have to get on our backs, it you want anything. I know it shouldn’t be like that, but we only take notice of those who really shout for what they want!”
RES CARE IS ABOUT REAL CHOICE FROM REAL OPTIONS

- Choice in education including properly resourced mainstream, special day and residential schools.

- Choice in housing including small scale ordinary housing, supported living and village and intentional communities as well as residential care.

- Choice in support services including day centres and respite care.


- It should not be a case of one type of provision versus another but a comprehensive service with each option having a part to play.

- It should not be a case of one family versus another but a united voice reflecting respect for the choice and wishes of each family who after all know their own dependent relative best.

After four years of Government funded research by Prof E Emerson resulting in ‘Valuing People: A New Strategy for Learning Disability for the 21st Century’ (2001) it’s Choice in housing options specified “small scale ordinary housing, supported living and village and intentional communities as well as residential care. None of these should be ruled out”, Secretary of State for Health Alan Johnson MP confirmed that ‘Valuing People Now’ (2007) stands by the commitment made in ‘Valuing People’ (2001).

DiES 25th July, 2002: “Inclusion is not an agenda to close special schools. Special schools are a vital part of a provision made for children with special education needs”.

The Report of the Special Schools Working Group 2003 said: “In the coming years we see special schools as being, along with others, at the leading edge of the government’s wider education agenda. We see them participating in the full range of Government initiatives and at the forefront of the wider education agenda. We see all types of special school – maintained, non-maintained and independent – working as equal partners with LEAs, mainstream schools, and other individuals and providers within health and social services. We see more heads teachers and teachers choosing to join the sector because of the opportunities that are on offer, and because the sector is one with a secure and long-term future. Special schools have much to offer the wider education, health and social services communities, and it is time for their unique contribution to be recognised and valued.”

Baroness Warnock whose report on special education 1979 began the move towards greater inclusion said in 2004 “Many children are simply unable to manage in the bewildering environment of a large school”. 