Disability Services Commissioner

Consultation Paper – Institutional Responses to Child Sexual Abuse in Out-of-Home Care Submission

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It's OK to complain

1. About the Disability Services Commissioner

The Victorian Disability Services Commissioner (DSC) commenced on 1 July 2007 under the *Disability Act 2006* (Victorian Disability Act) to improve services for people with a disability in Victoria.

This independent statutory office works with people with a disability and disability service providers in Victoria to resolve complaints.

Our complaints resolution process is free, confidential and supportive and we encourage and assist the resolution of complaints in a variety of ways including informal approaches to resolution, assessment conferences, conciliation processes, or under certain circumstances through investigations.

We research ways to improve outcomes for people with a disability and improve disability services' complaints systems. We also provide capacity development activities for people with a disability, their families and disability services through a variety of education and information. Our approach to our work reflects the objectives of the Victorian *Disability Act* 2006 and our values and principles that are aligned to the *United Nations Convention on the Rights of Persons with Disabilities*.

Since the establishment of this office we are able to provide comments and proposals based on the evidence and knowledge we have gained in responding to over **5,500 enquiries and complaints to date**. Victorian disability service providers also readily contribute to our growing body of knowledge by reporting each year on the number and types of complaints they received and how they were resolved (as provided for by the Victorian Disability Act. The almost **12,500 complaints reported** to date provide valuable information to assist in identifying systemic issues and inform the ongoing development of the disability service system.

2. Summary of key areas addressed by this submission

Strengthen regulation and oversight mechanisms.

The consultation paper seeks views on whether regulation and oversight of OOHC systems across Australia should include:

- Independent oversight of complaints handling, conducted by a body independent of the lead department and all service providers. That is, a 'reportable conduct scheme' be implemented in each jurisdiction.

The DSC was implemented to support the transition towards more person centred service delivery, and to influence the behaviour of the composite parts of the sector.
The approach of DSC has seen the volume of complaints reported and dealt with by DSC rise significantly. Complaints reported by service providers to DSC through the annual complaints reporting process have risen 66 per cent since the establishment of the office in 2007, and there continues to be a rising trend. An evaluation of complaints reporting process conducted by ORIMA research in 2012, showed 59 per cent of respondents agreed the process improved the level of awareness of the importance of complaints reporting in their service. Complaints dealt with by DSC have also risen by 200 per cent since 2007. This reflects the changing attitudes in the Victorian sector about people having a right to speak up about their services.

We believe that an independent complaints mechanism provides an opportunity for the person receiving services and family to feel heard, exercise choice and control or address misalignment of expectations. DSC has an accessible and person-centred model, and undertakes much of our resolution work in both early conversations (enquiry stage) and the assessment period (assessment stage). This is reflected in the high number of enquiries and complaints in which DSC:

- coaches and/or assists people to raise issues with their service provider in the first instance
- provide consultation to service providers on how to address issues
- brings people together to talk about issues and expectations.

Taking this approach develops the capacity of the person and the service in how to raise and address issues related to service delivery, and often supports them to resolve concerns as they arise in the future.

Oversight of critical incidents

One of the most disturbing issues that can occur in disability service provision is the alleged assault or abuse of people with a disability by staff who are entrusted to provide care and support. It has a devastating impact on those affected and undermines the confidence of other clients, families and staff in the disability service system. It is completely unacceptable.

Since June 2012, DSC has been providing independent review and monitoring of Category One incident reports relating to allegations of staff-to-client assault and unexplained injuries for the Victorian Department of Health and Human Services. In August 2012, this arrangement was extended to include community service organisations. Through our role in monitoring and reviewing incidents, we influence policy to improve prevention and responses to abuse; and provide advice on individual matters where the concern for the person with a disability is not apparent.

- In 2012-13 the Disability Services Commissioner reviewed 281 incident reports.

- In 2013-14 the Disability Services Commissioner reviewed 309 incident reports.
- In 2014-15 the Disability Services Commissioner reviewed 332 incident reports

Through these reviews we consistently identify the following themes:

- a lack of focus on people's outcomes and safeguarding people's rights during investigations
- the need for proactive engagement with Victoria Police
- further clarification on the scope, conduct and guidelines for Quality of Support Reviews
- the requirement for advocacy organisations to report critical incidents
- a lack of clarity and shared understanding of the definition of 'assault' and 'poor quality of care'
- the need to regulate the suitability of staff who work in disability services.

The common thread through all of these themes is the right of people with a disability to be heard, to be proactively supported along with their family members, to participate in any investigations relating to allegations and to access the justice system. Our reviews consistently highlighted concerns about whether investigations into incidents give equal weight to substantiating an allegation regarding a staff member and considering the potential abuse of the person's human rights and the impact of the trauma they experienced.

In 2014 we published *Investigations: guidance for good practice* (Attachment 1) and associated information sheets and practice guidance to support services to promote consistent good practice in investigations to address the experience of the person with a disability while conducting a fair and thorough investigation.

Better approaches to preventing child sexual abuse.

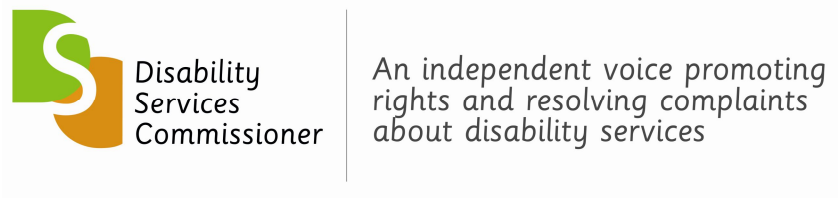
DSC notes that the Royal Commission is aware that children with a disability in out of home care are at a greater risk of sexual assault compared to children without disability, and that you have been told that children with a disability in OOHC face unique challenges as a result of services and support not being adequately tailored to meet their individual needs.

Responding to and eliminating barriers of violence, abuse and neglect

One of the most significant barriers to address in regard to abuse and neglect is the culture of service delivery. While DSC does not deal with criminal matters, people are encouraged to raise complaints about the quality of care they receive in the provision of disability service including the handling of critical incidents, communication and planning issues that surround issues of alleged abuse. DSC has sought to enable cultural change through empowering people to speak up, and ensuring issues raised by people are listened to and to see complaints are a learning opportunity for service providers.

The capacity of people with a disability and their family to raise issues, be heard and respected in the delivery of their service has been enhanced through the DSC:

- coaching people to raise issues directly with their provider or another entity
- facilitating a warm referral to other complaints entities
- providing education sessions to people with a disability, families and carers and to service providers
- developing campaigns of 'It's OK to complain!' and 'Speak UP!'
- producing easy English communications
- providing an accessible complaints resolution process (including bespoke resources)
- having a person-centred alternative dispute resolution model.



The voice of children and adults with a disability will be better heard when services employ a positive attitude to people making complaints and recognise the value of learning through complaints. A critical component of cultural change is the ability, through reflective practice, to identify and redress issues that have arisen from service delivery that does not align with human rights and relevant standards or principles of the *Disability Act* 2006.

DSC has contributed to enhancing the capacity of the disability services sector through:

- developing training on the Four As of complaints handling (Acknowledgement, Answers, Action and Apology) providing organisations with a tangible responsive approach to handling complaints
- embedding person-centred practice and organisational reflection within the online complaints reporting process
- coaching services in their response to people raising issues
- providing feedback on service providers complaints policy and processes
- providing resources and publications to support staff and senior executives in good practice complaints handling
- providing organisational complaints culture stock take tools
- questioning the lessons learnt and organisational improvements that can be made as part of the complaints resolution process
- issuing *Notices of Advice* highlighting areas for improvement

Much of our knowledge about the experience and impact of abuse or neglect of people with a disability has been shared broadly with a view to influence practice and policy. Given this we provide the Commission a number of publications.

- Our first Occasional Paper (2011) *Safeguarding people's right to be free from abuse* (Attachment 2) provides key considerations for preventing and responding to abuse informed by a comprehensive international literature review, lessons learned from complaints and an Inquiry undertaken that preceded our oversight of critical incident. The key considerations cited are:
    1. Understanding abuse
    2. Primary prevention: Promoting practices and safeguards which can prevent abuse
    3. Targeted prevention: Identifying and addressing particular risk factors
    4. Secondary prevention: Responding to incidents and allegations of abuse
    5. Tertiary prevention: Identifying and addressing underlying causes of systemic issues

- Occasional Paper No.2 (2013) *Families and service providers working together* (Attachment 3) highlights the challenges carers and families face when raising issues and provides practical suggestions for service providers to work more effectively with families to ensure improved outcomes for the person receiving services.

3. Issues identified in enquiries and complaints specific to this submission

Where funded disability services are not responding appropriately it is possible for someone to make a complaint to the Disability Services Commissioner on behalf of the child receiving the service. However, approximately half of the children with disability in out of home care in 2014 were not in receipt of funded disability services (instead receiving support from mainstream services), which excludes them from being able to make a complaint to us.

Further, children who are the subject of voluntary child care agreements and may be supported in contingency placements or alternative accommodation models are at risk of not being heard and not having access to oversight of the Disability Services Commissioner.

Common themes from the issues raised with our office include:

- Children and young people with disability and who have multiple and complex needs being placed inappropriately in residential accommodation that is not suitable to their own needs or the needs of others;
- Inadequate training of residential care workers to support young people who have both a disability and traumatic experience as a young child;
- Absenteeism from school and participation in education;
- Inadequate arrangements for young people with disability leaving care; and
- Inadequate support for foster carers to equip them to support the complex needs of children with disability.

Common themes from the review of incident reports also include

- Broader alleged perpetrator issues
  Where allegations are made against a staff member, DSC believes that there needs to be consideration of the possibility of other potential victims who were supported by the alleged perpetrator. This is particularly evident for other residents in group homes.

- Grooming
  DSC reflections on incidents related to sexual assault allegations identified that disability staff and management were not consistently recognising signs of potential 'grooming' behaviour. In a few cases service providers were not acting early enough.

  Grooming example

  - A client alleged that she was kissed by a staff member. It was noted that this staff member had been previously counselled about treating the client more favourably than other clients.

  The example highlights concerns about the supervision arrangements with staff when an issue has been raised and whether appropriate training has been provided to the supervisor regarding the identification of grooming behaviours. In sexual assault cases there may have been earlier signs of grooming that other staff may have witnessed but not discerned. In some cases disability workers have not been aware of potential grooming behaviours and therefore less likely to report and prevent potential abuse.

- Client outcomes and safeguarding client rights in respect of investigations

Often the main focus and outcomes of the investigation is whether the allegation regarding the staff member is sustained. As detailed in DSC's *Investigations: Guidance for Good Practice* document the focus needs to be equally balanced with the client's experience, outcomes and rights. The investigations undertaken for unexplained injuries often demonstrate a lack of rigour and robustness. This significantly impacts on the client and their right to receive appropriate quality support. There is also concern that by not investigating unexplained injuries, possible indicators of abuse or assault may be missed.

4. Conclusion/ Recommendation(s)

DSC is of the view that an Independent body to investigate complaints needs to have the necessary powers, resources and legislative framework to ensure children with a disability in Out of Home Care, their families and carers have a way to be heard and speak up about concerns regarding their care.

5. Attachments

Attachment One:	Investigations: Guidance for Good Practice: Investigations of incidents of alleged staff to client assault and unexplained injuries. Disability Services Commissioner, 2014.
Attachment Two:	Learning from Complaints, Occasional Paper 1, Safeguarding people's rights to be free from abuse: Key considerations for preventing and responding to alleged staff to client abuse in disability services. Disability Services Commissioner, 2012
Attachment Three:	Learning from Complaints, Occasional Paper 2, Families and Service Providers working together: Developing policy principles and strategies to support families of adults with a disability and disability service providers to work more effectively together. Disability Services Commissioner, 2014