Ageing and Disability Commission

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Submission to the Royal Commission into Violence, Abuse Neglect and Exploitation of People with Disability

Issues paper: Group homes

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Background

The NSW Ageing and Disability Commission (ADC) commenced on 1 July 2019. The ADC is an independent statutory body, which is focused on protecting adults with disability and older adults from abuse, neglect and exploitation, and protecting and promoting their rights. Its roles include:

- Responding to allegations of abuse, neglect and exploitation of adults with disability (18 years and over) and older adults (65 years and over or, if Aboriginal and/or Torres Strait Islander, 50 years and over), including by providing advice, making referrals and conducting investigations.
- Following an investigation, taking further action that is necessary to protect the adult from abuse, neglect and exploitation.
- Raising awareness and educating the public about matters relating to the abuse, neglect and exploitation of adults with disability and older adults.
- Inquiring into and reporting on systemic issues relating to the protection and promotion of the rights, or the abuse, neglect and exploitation, of adults with disability and older adults.
- Meeting other obligations as outlined in the *Ageing and Disability Commissioner Act 2019* (the ADC Act).

The ADC also has a general oversight and coordination role in relation to the Official Community Visitor (OCV) scheme in NSW. Responsibility for administering the OCV scheme transferred from the NSW Ombudsman's office to the ADC in August 2019. OCVs are independent Ministerial appointees who visit:

- 1,764 accommodation services where an adult with disability or older adult is in the full-time care of the service provider
- 270 accommodation services where a child in care is in the full-time care of the service provider
- 17 assisted boarding houses.

Our submission has been informed by the OCVs who visit accommodation services (primarily group homes) supporting people with disability, and the work of Visitors over many years in relation to the disability sector.

Introduction

Issues relating to the quality of support of residents in group homes, and resident safety, are frequently identified and raised by OCVs. For example, in relation to disability supported accommodation services in 2018-19:

- Issues relating to individual resident development accounted for 29% of issues (1,344 issues) – including residents not being actively involved in decisions about their lives; poor behaviour support practices; and the use of unnecessary or unauthorised restrictive practices.
- Issues relating to a safe and supportive environment accounted for 22% of issues (950 issues) – including inadequate assessments to inform placements; insufficient action to assess and address issues of resident incompatibility; and inadequate incident recording, reporting and follow-up.
- Issues relating to the accommodation environment accounted for 13% of all issues (622 issues) – including a lack of choice about day-to-day routines (eg: bed and mealtimes); and a lack of a homelike environment that reflects the individual and shared needs and interests of residents.

In relation to group homes, OCVs have identified in this submission a range of factors that can influence the existence and continuation of violence, abuse and neglect of residents. The main issues raised by OCVs in response to the issues paper highlight the importance of:

- providing a broader range of supported accommodation models, to enable real choice for people with disability
- residents receiving appropriate support to maximise their ability to make decisions about their lives and the delivery of support in their accommodation, including decisions about who they live with, and the staff who provide in-home support
- strengthening the governance and oversight of group homes by disability providers, including greater direct oversight of individual houses
- providing comprehensive induction and regular training for staff, including on-site and face-to-face training
- monitoring the implementation of behaviour support and communication strategies by staff
- undertaking comprehensive compatibility and risk assessments, and transition planning – guided by the will and preference of the person(s) with disability
- ensuring continual reinforcement of, and monitoring of compliance with, reporting requirements in relation to serious incidents involving residents, including abuse and neglect.

Leadership and a culture of active support

A consistent theme raised by OCVs relates to the critical importance of leadership and culture in individual group homes and across the broader service. These factors are interlinked, and have a defining impact on the sense of 'home' that residents have, how actively they can participate in the life of the home, and how fully and independently they can live their lives more broadly.

OCVs note positive examples in some group homes, with residents who are actively involved and at the centre of how the house runs. When Visitors arrive at these premises, they tend to find that it is a resident who opens the door, welcomes them into their home, and offers them a cup of tea. It is evident at the outset that it is the residents' home, not a workplace, and this is reflected in the residents' engagement and the physical environment.

In these houses, OCVs find that residents are much more likely to receive 'active support', wherein staff support the residents to participate in activities of daily living in the house, rather than undertaking the tasks on their behalf. This includes preparing meals, cleaning, doing the washing, and other regular house tasks. Active support is designed to maximise the ability of the person with disability to be fully engaged and participating in their lives, and to receive the right range and level of support to be successful.[1]

Visitors stress that a high quality group home is difficult to assess on paper, and is embedded in how staff act, and whether the home is organised around the needs and preferences of the residents or the needs and preferences of staff.

[1] See Centre for Disability Studies: https://cds.org.au/education-training/active-support-train-the-trainer-project-adhc-residential-setting/.

Case study – OCV Annual Report 2018-19

An OCV visits a house where six men with disabilities live together. Every night, staff would cook the evening meal, and when dinner was ready they would call the men to the table to eat.

During a visit, the OCV noticed the residents watching a cooking show and discussing the show, while their own dinner was being cooked by staff. The OCV joined the conversation and asked if they were interested in cooking food for themselves. The men answered by saying they wouldn't mind 'having a go', but didn't think they were allowed to, as it was the 'staff's job' to cook. They believed staff would get upset if someone made a mess in the kitchen.

The OCV knew that the men contributed to the weekly meal plan, each nominating a favourite dish for dinner on different days. However, the choices were often the same from week to week. The OCV raised the issue of meal preparation in her visit report. She followed up by speaking to service management about residents being supported to help with the daily meal preparation. Service management were surprised to hear that the residents weren't helping to prepare meals, as it was a regular activity of daily life, and they assumed staff were encouraging their participation.

Service management worked with the house staff to trial residents being involved in cooking dinner each night. The trial worked well. New staff had been recruited to work in the house and they were keen to support residents to build their skills. All of the residents became actively involved in the preparation of dinner each night.

On her next visit, the men told the OCV how staff made it fun to cook, and 'plate up' creatively. Some of the staff from culturally diverse backgrounds were introducing the men to spicier food and helping them 'spice up' their dishes. The men began to score each other's dishes, in a good humoured way, and new dishes were becoming household favourites.

The atmosphere in the house had changed because of this new found activity. The men were more supportive of each other and the house had become more relaxed, jovial and engaging.

With the OCV's last visit, not only were two residents cooking the evening meal, but they were competing with another home (some blocks away), with their interesting and varied menu planning and meal choices.

Visitors note that a culture of active support is not commonly seen in group homes, and they rarely observe residents doing things for themselves or having meaningful involvement in making decisions that affect them.

This approach to support is highly influenced by the assistance and guidance staff receive from a frontline manager, or 'practice leadership'. Under the NDIS, Visitors now see that Team Leader positions are often spread across four or five group homes (rather than previously one or two houses). They note that this management role is critical, but now tends to be further away from the residents and staff, which adversely affects their ability to monitor staff practice, the quality of support, and resident wellbeing. More broadly, OCVs advised that they tend to see disconnection between what management believes is happening in the group home, and what is happening in practice.

OCVs noted that the better group homes they visit typically have a committed, skilled, and often passionate Team Leader in place, which had a flow-on effect to the approach that support workers took in their role, and created a person-centred culture in the home.

Group home workforce

Visitors have advised that the level of training and qualifications of group home staff, and the length of time they have been employed at the service, are key factors affecting the quality of support in a group home, and have an impact on the day-to-day experience and wellbeing of residents. OCVs advise that they often see a staffing base that is casualised, with minimal training and low-level skills. In the experience of OCVs, this has become more prevalent under the NDIS, with financial constraints and uncertain funding leading to increased engagement of unskilled and casual staff.

In NSW, there are currently no formal requirements required to gain employment as a disability support worker, unlike the aged care sector in NSW and the disability sector in Victoria. OCVs note that, while many people with disability value staff attitude and approach over qualifications, there are high risks involved in the provision of certain supports required by some individuals with more complex needs if staff do not have some level of training and prerequisite knowledge. For example, the management of more complex health concerns. Visitors emphasised that a qualification (such as Certificate IV in Disability) in and of itself is also insufficient, noting that: a) the qualifications do not cover all aspects (eg: enteral nutrition), and b) it must be complemented by on-site training so that staff understand the specific needs of individual residents.

Visitors note that they have seen a significant reduction in staff training since the introduction of the NDIS – including a lack of evident staff meetings, access to training courses, and quality on-site training. OCVs advised that the lack of access to training is particularly the case in smaller providers. Where training is provided, it tends to be online, with staff completing online modules in the office while on shift – reducing the support for residents. OCVs also advised that online training can be completed by ticking boxes; it is rarely evident that this has been complemented by comprehensive hands-on induction and training.

OCVs advised that the increasing casualisation of the disability support workforce has had a negative impact on the quality of support provided to residents. While OCVs identify many staff who are highly engaged, creative and passionate, they also increasingly note a lack of commitment from staff to the role long-term, and to the people that they are supporting. Residents are often not ‘known’ by the staff that are supporting them, including their health and support needs, their likes and dislikes. Handovers between staff are often inadequate. Residents may have an excellent communication plan or behaviour support plan in place, but due to inconsistent staffing the plans are not routinely implemented, or staff are unaware of them.

Options and choice

Group homes housing 5-6 people with disability have been the dominant model of accommodation for people with disability in NSW in the wake of the progressive and necessary closure of institutions. While the group home model can provide a useful option for some individuals, a key issue is that it has often been the only option on offer. There is a vital need for people with disability to have a variety of accommodation options and real choice.

Overall, people with disability entering a group home currently have very little or no choice about a range of factors that directly impact on their lives, their safety, and their wellbeing. Among other things, prospective residents typically:

- do not get a choice about where they live
- do not get a choice about who they live with
- do not get a choice about the staff who provide in-home support.

Importantly, OCVs advised that residents have little to no access to decision-making support to

maximise their ability to make decisions about their lives and the delivery of support in their accommodation. Fundamental day-to-day decisions are frequently made by support staff without the involvement of the person(s) with disability; without support, opportunities for residents to build and strengthen decision-making skills are lost.

OCVs consistently highlight the significant and ongoing issues that exist in group homes associated with the incompatibility of residents – particularly violence, abuse and cumulative trauma. Visitors note that group homes with residents who have been living together for a long time, consider each other to be friends, and who have consistent staff providing active support tend to be settled, home-like environments, with low levels of incidents. Conversely, group homes with high levels of serious incidents, including violence, are regularly noted to have residents who have been placed together without adequate consultation and involvement of the person with disability, no or inadequate placement matching or planning, and no or inadequate assessment of risk and compatibility. At times, individuals are placed together based primarily on their support needs, such as complex behaviour needs, instead of their interests, likes and dislikes – this can result in highly volatile environments that present significant and ongoing risks to both residents and staff.

Visitors indicated that accommodation decisions sometimes place individuals at greater risk of abuse and repeated trauma. For example, a man was moved into a group home with three other male residents. The OCV identified a document on one resident's file that indicated that he had been sexually assaulted by the new resident many years ago when they previously lived in a group home together. The Visitor found that this information had not factored into the accommodation placement decision or assessment of risk, and no support had been provided to the resident who had previously been assaulted.

Despite the implementation of the NDIS, OCVs raised concerns that they often see residents who are primarily supported by only one provider – including residents who have the same provider for their accommodation support, day program and support coordination. The provision of supports across domains by a sole provider requires the participant to have made an active choice for that to occur. Visitors indicated that the choice of the resident is not evident, and the existing arrangement increases risks to the resident and makes it more difficult for the resident to raise concerns and to make alternative choices.

Other key factors

Transition planning

Visitors advised that they tend to see inadequate and rushed transition planning and implementation in group homes. They note that group home staff are often unable to find the transition plan when the Visitor asks for it. When plans have been developed, they can focus heavily on staffing requirements associated with the move, and do not always address how the person will integrate into the house or outline contingency arrangements in the event that the transition is unsuccessful.

Visitors have observed transition plans that are at odds with placement matching principles. For example, in one case, a person with a history of trauma was placed with a resident with assaultive behaviour. The plan outlined a range of concerns relating to the match, but was nonetheless signed off by management.

OCVs advised that providers are typically under pressure to fill vacancies quickly due to funding arrangements. This can compromise the placement matching and transition process, often leading to issues once the placement commences, placement breakdown, and further movement for residents.

Visitors have identified some positive examples of transition planning, including where residents have met prospective housemates on a number of occasions ahead of the person

moving in. However, Visitors note that this is not across the board, and it is not always clear the extent to which the current and prospective residents have a meaningful choice.

While the below case study relates to villa complex accommodation, OCVs note the same issues in group homes they visit.

Case study – OCV Annual Report 2018-19

After being allocated a new disability accommodation service to visit, an OCV was keen to call in and meet the residents who had recently moved in. After calling in and speaking with four of the residents, it appeared that they had settled in well – while there were some initial issues around food, cleaning rosters, and accessibility to social activities, they were quickly rectified. The OCV felt that the new living situation was positive for the residents.

However, within two weeks of the OCV's initial visit, things changed. The OCV began to receive calls asking them to visit again as a new resident had moved in and this had caused serious conflict. When the OCV returned, they found that things had become unsettled and the residents were distressed, including the new resident who had recently moved in, Gary.

The OCV reviewed Gary's client file and noted that he had moved from his previous home due to incidents with staff and housemates. The stress of the move to the new house meant that Gary continued to be unsettled and had been lashing out at staff and the other residents. This situation made it difficult for residents to use the common areas, such as the kitchen and living rooms. Residents were scared and upset.

Gary has a condition that causes him to often feel fearful and to act in a way that made it difficult for others to interact with him. Consequently, he was very isolated. The OCV reviewed what strategies the provider had in place, and found that there did not appear to be anything in place to help Gary and his co-residents to interact with each other in a supported way. The provider had only just engaged a specialist team to work with Gary, and no information was yet available on how to best support him.

To the OCV, it appeared that the service had hoped that moving Gary into his own unit would assist him with his anxiety and agitation. However, he needed to be able use the shared spaces as well. The OCV raised his concerns in the visit report and organised to meet with management to discuss the situation.

Over several months, while continuing to visit and speak with management, the OCV noted big improvements in the house that meant that all five residents were now living well together. The changes made by the service included comprehensive health assessments and health care planning for Gary, a behaviour support plan with clear strategies on supporting Gary when he is agitated, and a roster of staff support that allows all residents equal time in the common areas. The service has set up weekly resident meetings where all residents have a say in how the accommodation is run. Overall, the service is working to have issues resolved quickly and equitably.

Inadequate behaviour support

OCVs advise that issues relating to access to, and the quality of, behaviour support for residents in group homes is a factor in prolonging unsafe and violent living situations.

- A shortage of behaviour support clinicians has resulted in delays in residents being able to access necessary behaviour assessments, strategies and reviews.
- Training for group home staff in behaviour support strategies – and monitoring of implementation – is often inadequate. Visitors note that staff in some group homes have been unaware of the existence of a behaviour support plan, despite ongoing and

significant behaviour concerns in the house.

OCVs also advise that some of the behaviour support plans on resident files are of poor quality, or are a 'cut and paste' of another person's plan.

Case study – OCV Annual Report 2018-19

An OCV visited a disability accommodation service that had a mix of residents with well-established daily routines, stable staff and involvement from their families.

The OCV noticed there was physical damage in the house – holes in the walls, windows covered or boarded up, and damaged furniture sitting in the front yard. The OCV asked about the damage to the property and was told that one resident had been having outbursts of disruptive behaviour, which included punching holes in the walls, throwing furniture through windows, and assaulting other residents and staff.

The staff told the OCV that the service had sought specialist behaviour support, but had been told that there were delays in having a clinician attend the house and provide strategies.

During the visit, the OCV saw the resident kick and punch a staff member and attempt to punch and kick another resident. The other resident uses a wheelchair and was not able to move quickly out of the way. Staff intervened in this incident to keep the second resident safe and redirected the first resident away.

The OCV raised the issue of the lack of positive behaviour support strategies and the risk of ongoing harm to residents and staff in their visit report. Using the OCV's visit report, the provider escalated the issues of concern to senior management. As a consequence, the resident is now receiving significant behaviour support services and has an updated behaviour support plan which outlines clear strategies for staff to use to better support him.

The service has also rostered on additional staff during periods when all residents are at home. Staff are being trained in the new positive behaviour support strategies. The OCV hopes that these new interventions will create a safer and more stable environment for all residents in the house.

Communication needs

Visitors emphasised the critical importance of appropriate communication support for residents, noting that frustrated communication is a key factor in behaviour concerns and violence in group homes. OCVs advised that, while at times they observe communication plans and tools for individuals, they very rarely see any evidence that they are used; they are often kept in a drawer out of sight.

Visitors also noted that NDIS Plans rarely include communication support needs, and group home staff are not always aware that the NDIS can cover communication supports, or their ability to advocate for a review of a person's plan.

Physical environment

OCVs advised that the physical environment of many group homes is not conducive to quality support of residents, and can contribute to incidents of violence and exacerbate risks to individuals. This includes houses with blind spots, narrow hallways or small spaces that bring residents into close contact and make it difficult to make a quick exit to safety. Visitors noted that the level of violence in some houses, and lack of evident safe spaces, had resulted in some residents locking themselves in their bedrooms to try to protect themselves.

Case study – OCV Annual Report 2018-19

Jones Street is home to four people who moved out of a large residential centre. The residents are older and have increasingly complex health and medical needs. They don't use verbal communication.

One of the residents, Adam, has been getting more unsteady on his feet and has progressed to using a walker and now a wheelchair. The OCV noticed that the house has a narrow corridor between the lounge and kitchen areas which was creating congestion for the residents, and making access difficult for Adam. As well as frequently getting stuck in the hallway, Adam's wheelchair was inadvertently damaging the walls.

The OCV raised these issues with the house manager at the time of the visit. The house manager advised that he had been trying to get home modifications approved by management, but it had been a slow process to work with service management and the housing provider.

The OCV raised the issues in her visit report. At a recent visit, the OCV saw that the hallway had been modified, with the adjoining rooms renovated to make them more open plan. The doorways had also been widened. Staff reported that this made access much easier for Adam and the other residents.

OCVs advised that they visit many group homes that are in a run-down condition and with ongoing maintenance issues. Visitors have found that it can take an extended period of time for repairs to be made, resulting in residents living in unsuitable and unhomely environments, with impacts on their safety and independence.

Abuse and neglect in group homes

Visitors advised that they regularly see incidents of violence and abuse in group homes – particularly client-to-client and client-to-staff physical assaults. Incidents also include subtle, daily occurrences of neglect associated with poor care practices; and forms of systems abuse, such as residents not being involved in decision-making, and residents being put in their pyjamas mid-afternoon to suit staff schedules. The mix of residents, the suitability of the configuration of the home, and the approach of frontline staff and management are key factors affecting incidences of abuse and neglect.

OCVs noted that, in their experience, young men are more likely to be victims and perpetrators of physical abuse in group homes. They advised that people who have been previously accommodated in institutions can at times be more vulnerable to neglect, due to higher support needs, communication difficulties, institutionalisation, and a lack of access to external supports and advocacy.

Incidents of abuse and neglect are often underreported in group homes. OCVs note a lack of awareness in some services of reporting obligations, a culture of protecting other staff members or concerns about retribution if staff do report, a lack of oversight and monitoring from management, and a lack of action from management when a report is made. OCVs stressed the need for drop-in and spot checks from management, and regular reviews of incident reports, progress notes and communication books.

Visitors also raised concerns about the lack of choice and control that group home residents have to make changes to their living situation, even when they are subject to assaults from other residents. A lack of available alternative accommodation options means that some residents remain living in violent environments, being subjected to or at ongoing risk of assault. The needs and wants of the victim who is required to continue residing with the perpetrator,

and whether the group home model is suitable for the perpetrator, are not always given enough weight in the process.

Restrictive practices

OCVs regularly observe the use of restrictive practices in group homes, and have indicated that the use of these practices appears to be increasing. In 2018/19, OCVs raised 275 issues about the use of restrictive practices that did not comply with consent, authorisation and review requirements in disability supported accommodation.

Visitors noted that the incompatibility of residents, resulting in behaviour support issues and conflict, is a key factor contributing to the rise in the use of restrictive practices. OCVs also identified that insufficient staffing levels, inadequate behaviour support plans and implementation, poorly trained staff who do not know the resident well, and lack of oversight from management influence the use of restrictive practices in group homes.

Visitors observe a range of restrictive practices, including kitchen barriers, locking fridges and external doors, and locking up cleaning products, often without sound risk assessment.

Case study – OCV Annual Report 2018-19

An OCV visited a disability accommodation service that had not had a visit from an OCV for a number of years. On entering the house for the first time, the OCV saw a number of physical barriers installed that restricted resident access to the kitchen, outdoor paved area, and one of the two living rooms.

The OCV noted several residents asking staff for permission to go outside into the backyard and another resident waiting for some time until a staff member provided her with access to the kitchen to get a drink of water. The staff member on duty with the only key to the kitchen and the back door had been engaged in other tasks around the house.

On speaking with the manager, the OCV was told that the physical barriers had been installed to restrict the movements of a previous resident, who had left the service at least five years ago. The physical barriers remained despite not being needed for any of the current residents. The behaviour support plans for the current residents did not require any physical barriers to any rooms in the house or to the backyard.

The OCV raised the issue in her visit report. The service acknowledged that the physical barrier had been in place for many years, there was no authorisation for the restrictive practice, and it was not needed in the current circumstances of the home. The service arranged for the housing provider to remove the physical barrier.

On the most recent visit, the barrier blocking access to the kitchen was gone and the OCV saw several residents using the kitchen as they needed. The OCV also noted that the backyard was now free for all to use as they wanted.

In relation to restrictive practices, OCVs also noted that:

- record keeping is often poor, including inadequate and inconsistent collection of data relating to behaviour support strategies and restrictive practices
- they do not always see ‘fade-out’ strategies in behaviour support plans to enable steps to be taken to reduce and potentially eliminate the use of restrictive practices for residents.