Response to the
National Disability Insurance Scheme
Public Consultation Paper

Proposal for a National Disability Insurance Scheme Quality & Safeguarding Framework

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1. Introduction

The Australian Psychological Society (APS) welcomes the opportunity to provide feedback on the *Consultation Paper: Proposal for a National Disability Insurance Scheme Quality & Safeguarding Framework* (Consultation Paper). This submission has been informed by feedback from psychologists working in the disability sector. The APS also draws the attention of the Disability Reform Council to the APS (2011) guidelines on the use of restrictive practices in the disability sector[1].

The APS congratulates the Disability Reform Council for their diligent efforts in developing the Consultation Paper, particularly their comprehensive overview of the quality and safety issues associated with a new model of delivering disability services in Australia and the range of options posited to address these concerns. In this submission, the APS addresses several (though not all) of the consultation questions and concludes that the Framework should set high quality and safety requirements, and the recommended options are generally those of the higher order. There are a number of human rights and evidence-based principles that underpin this recommendation:

- While it is vital to acknowledge the ability of individuals with a disability to exercise personal choice, it must also be recognised that there is considerable variability among individuals with a disability in terms of their capacity to make considered judgements and decisions about the quality and safety of providers. Failure to take this into consideration when establishing the Framework could render some individuals at serious risk of physical and/or psychological and/or financial harm.
- Any safeguards implemented by the NDIS should recognise the actual level of risk faced by a person. However, the assessment of these risk levels is complex and will vary across the lifespan of the individual. There are multiple inter-related variables that are likely to impact on the degree of risk to which an individual might be exposed at any point in time. These include the type of disability; the adequacy of family and carer supports; the nature of the interaction between consumer and disability service provider; the presence of comorbid physical and/or mental health issues and/or substance use issues; and the presence of other stressors. The Framework must be able to support this level of complexity.
- People with a disability, regardless of where they live, should be able to expect the same level of safety and quality in NDIS services. The quality and safety mechanisms implemented for the NDIS must therefore operate in an equitable manner across all of Australia to ensure safety for all consumers.

2. Response to consultation questions

What are the most important features of an NDIS information system for participants? How can the information system be designed to ensure accessibility? What would be the benefits and risks of enabling participants to share information,

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[1] Australian Psychological Society (2011). *Evidence-based guidelines to reduce the need for restrictive practices in the disability sector*. Melbourne: APS.

for example, through online forums, consumer ratings of providers and other means?

The APS supports the general principles for an information system outlined in the Consultation Paper but flag the need to consider the requirements of health professionals regulated by the Australian Health Practitioner Regulation Agency (AHPRA). AHPRA has stringent requirements that prohibit the use of testimonials and advertising and the use of a 'trip advisor'-type information website is likely to contravene these regulatory requirements.

The APS has several concerns about the possible adoption of a 'trip advisor'-type information service for consumers. Such a system would require monitoring for spurious reporting, be of questionable reliability, and be limited in its capacity to reflect the full range of consumer experiences because of variation consumer capacity to input to the system. Individuals with the most severe disabilities that impact on communication skills would be least able to input but perhaps most in need of reliable information. The costs and disadvantages of such a system may outweigh any potential benefits.

The APS questions the value of using the existing plan development process (between consumers and NDIA planners) as an effective mechanism to enhance the capacity of people with disabilities to make choices. The feedback from APS members is the planning process, as it currently operates, offers limited opportunities for informed choices to be made by consumers. The feedback from psychologists is that many consumers are overwhelmed by the planning process, feel anxious and pressured, and struggle to be able to have the necessary information to make choices between services. This process can also be complicated by families and carers who sometimes have different priorities to the person with the disability. Thus it is not clear how the planning process, as it currently operates, could support the development of decision-making and assertiveness skills amongst consumers.

In summary, it is apparent to APS members engaged at the pilot sites that considerably more attention is required to ensure consumers, families and carers have adequate access to high quality, trustworthy and easily understood information about services and providers than currently exists. No one information-sharing system will meet the varied needs and capacities of all consumers; rather a mix of systems is required that may include telephone, face-to-face, online and written hard copy. Relying on provider agencies to deliver information on their own services does not offer consumers sufficient guarantee of safety and quality because of the lack of independence of the information. It is likely that to achieve a sufficiently trustworthy information system will require considerable investment from the NDIA.

Are there additional ways of building natural safeguards that the NDIS should be considering? What can be done to support people with a limited number of family and friends?

The Consultation Paper proposes that NDIA staff work with participants to identify risks and safeguards and to ensure that the safeguards are proportionate to their actual level of risk, as based on the capacity of the individual. This is an important aim but in order to achieve it the Framework must address the issue of the assessment of risk and capacity. It is noted that this is currently given limited attention in the Consultation Paper. The assessment of risk and capacity may be relatively straightforward in some instances, but for consumers with complex issues, the assessment of capacity and risk requires experienced health professionals who possess high level knowledge, skills and experience in assessment of people with disabilities. This is unlikely to be within the scope of practice of most NDIA planners. A clear protocol for assessment will be required that specifies when additional expertise is required and which health professionals should be able to undertake the assessments.

What kind of support would providers need to deliver high-quality services? Should there be an independent oversight body for the NDIS?

As indicated in the Consultation Paper, the area that requires most attention to ensure quality services and consumer safety is the service delivery level where there is direct interaction between consumers and providers. It is important to note that quality monitoring and safeguards are required at both the organisational and individual service provider level.

Organisational level At the organisational level, a real concern to the APS is the impact of a marketplace culture on the ability to ensure quality services. In a competitive market, the Framework must ensure that agencies chose to engage the right person with the right knowledge and skills for the job. There will be considerable pressure on agencies to recruit a cheaper workforce with inadequate knowledge, skills and experience to undertake the more high level services that might be required by a person with a disability. For example, moving complex behaviour management interventions typically provided by senior highly experienced psychologists in state-based disability services to an open marketplace may reduce access to quality services because new service provider agencies may seek to deliver such services by non-qualified staff that may or may not be under the supervision of an experienced and regulated health professional. It is apparent that such actions would place consumers at risk from receiving an inadequate service that does not provide effective outcomes.

The APS recommends that agencies providing services under the NDIS be required to be accredited, and that the delivery of certain skilled interventions be required to be delivered by appropriate health professionals. The Framework should define the appropriate workforce to deliver a particular service. As part of accreditation, organisations should be required to have in place adequate governance, policies and procedures. While the process of acquiring accreditation may appear burdensome to providers, it is a necessity to avoid the potential disadvantages of operating in a competitive marketplace. Where there is market failure (e.g., in rural and remote regions), it is even more important to have accreditation to avoid ease of operation of less scrupulous agencies. The NDIA may need to financially support smaller organisations or those in areas of market failure to meet the costs incurred in accreditation to ensure service accessibility in non-urban areas.

It must be noted that for an accreditation process to achieve the stated aims of driving safety and quality it must be accompanied by effective external monitoring with sufficient powers to be meaningful. This is particularly the case in areas of market failure where quality could be compromised without sufficient external monitoring mechanisms.

In addition to accreditation and monitoring, organisations will require an independent complaints management system and process for addressing serious incidents. Again, internal systems will be ineffective for managing both complaints and serious incidents, particularly in areas of market failure. Power imbalances between providers and consumers, fear of retribution or of the only service in a region being closed down are very real obstacles to any internal complaints/incident management processes. Serious incidents, in particular, must be reported to a national body that can ensure an appropriate response and collate national data and drive improvements. There also needs to be an independent body to investigate complaints against the NDIS/NDIA itself, for example, in relation to the consumer-staff planning process. It is not appropriate that consumers who have experienced poor quality or unsafe care from staff are required to rely on the NDIS (or the NDIA) to assess complaints and provide oversight.

The complaints mechanism that is established must ensure that individuals (and organisations) that receive ongoing complaints about their services are required to address the issue or be placed on a barred persons list or accreditation be removed.

The APS is concerned that there is a potential conflict of interest should a body such as the NDIA be granted a national oversight role in the management of complaints and serious incidents. There is a strong case for this component of the Framework to be undertaken by an external entity such as a Disability Complaints Office within the Office of a National Disability Service Commissioner who would have sufficient power to investigate and respond to complaints/incidents that occur both in NDIS-funded and non-funded disability services, as well as the NDIS itself. They may also play a significant role in preventive education. This oversight and monitoring role would render a Commissioner ideally placed to manage the accreditation process for disability provider organisations.

A useful addition to the complaints system could be the capacity for community members who witness something of concern to be able to report a worker. A community education campaign could flag the importance of reporting concerning behaviour and the mechanism to do so.

It is noted that the community visitor program in Victoria may offer an additional level of safety for consumers. Visitors provide an external and independent monitoring of disability organisations (not consumer homes). However, to be effective this model requires visitors to be trained, adequately remunerated, and to have the capacity to enter organisations unannounced.

Service provider agencies would also be assisted by the provision of clear guidelines on ways providers can minimise the use of restrictive practices. The guidelines could describe therapeutic approaches across a number of domains. For example, home security and door locking could be included with a range of strategies that could be tried before resorting to the restrictive practice of door locking. The document could also describe when it is a reasonable security action to lock a door and under what circumstances this becomes restrictive. It would also be helpful if providers had access to a hotline where they could get high quality advice to manage a particular client issue, and if necessary, refer on to a psychologist registered with the NDIS and able to provide specialist advice on the use of restrictive practices. Such actions could have a preventive role and reduce the incidence of restrictive practices.

Individual level Quality and safety is also an issue that needs consideration at the actual provider level. Part of an accreditation process for disability provider agencies should be an adequate process for vetting staff. This needs to be a requirement of accreditation and hence be included in ongoing monitoring by an independent agency. The health sector takes serious steps to ensure that their employees are safe to work with people who are often very vulnerable and the disability sector must hold similar standards for its workforce. As a minimum, for all staff, this should include referee and police checks. Given the cross-jurisdictional potential for people to slip through cracks in these checks, it is also important to establish a national vulnerable people clearance.

As previously indicated, where tasks require a health professional, the appropriately qualified health professional should be engaged. Note that some health professionals are regulated under the AHPRA and some are self-regulating. The concern of the APS is whether or not new disability agencies in a competitive marker have sufficient knowledge of the health and disability sector to understand which health professionals are best placed to deliver certain types of services, and which services require a qualified health professional rather than a non-qualified worker. The Framework would benefit from the development of clarity regarding types of services and who is best qualified and safest to deliver them.

The safety of self-managing NDIS participants must also be addressed by the Framework. As a minimum, consumers must have access to information on a nationally-held barred persons list and be able to seek advice on service appropriateness for particular issues and quality. The latter is important to avoid consumers inadvertently choosing ‘cheap’ but low quality or inappropriate providers that fail to provide adequate service.

The use of restrictive practices: It is vital that the Framework address the use of restrictive practices and provide national standardised guidelines and protocols and a mechanism for monitoring and addressing breaches. The guidelines need to describe the range of restrictive practices and grade them for degree of seriousness, with the more serious activities such as medication use or extreme physical restraint requiring a formal permission process. The protocol for the use of restraints should vary by the seriousness of the impact on human rights, with the most severe activities requiring appropriate assessment and authorisation by at least three adequately skilled health professionals. For example, the use of medications to restrain people could require agreement from a GP, psychologist, and specialist. The use of physical restraints could require approval from three professionals such as a GP, physiotherapist or occupational therapist, and specialist. Consumer input must also be facilitated and used to inform the decision making; this may require ensuring the consumer has access to appropriate communication support and the inclusion of advocates or carers. Restrictive practices must only be used when all other avenues have been exhausted. The process must be documented and records available for scrutiny. The development of a national human rights charter should also be considered.

One particular area of concern is the use of PRN medications; because of the nature of this medication order there is considerable possibility of the over-use of drugs as an ‘easy’ option to manage an individual’s behaviour. There needs to be guidelines for using PRN medications and monitoring of usage over time.

Summary and review of options Of the four options for provider registration mentioned in Part 2 of the Consultation Paper, the APS prefers option 4. Option 3 appears to offer some level of protection for non-clinical/low risk service delivery but is clearly insufficient for higher risk services where quality assurance standards must be met. This option is preferred because it provides the highest level of quality and safe service to people with a disability. However, the APS recognises that this option may present significant costs to provider agencies and/or providers themselves. This cost would be in the form of preparation for accreditation as well as the accreditation itself. Many providers in the allied health sector who deliver services to people with a disability are small private businesses who could not afford substantial set-up or ongoing accreditation fees. The remuneration for work under the NDIS is not competitive for many allied health professionals who may perceive little benefit in seeking accreditation. The cost of accreditation for small allied health businesses in rural communities could be particularly prohibitive because they may only see a relatively small number of NDIS clients in their overall client base. They may therefore choose not to enter the scheme as a provider. Unless the cost of achieving accreditation is managed and/or subsidised it will significantly impact on service accessibility.

As flagged, the approach to provider registration needs to be stepped depending on the nature of the service. However, as indicated above, it is unclear what types of services present most risk and this determination might best be made by the National Disability Service Commissioner who can take an independent and external view of the disability provider landscape. The Commissioner would also have the benefit of access to national quality and safety data to ascertain the ongoing appropriateness of the ‘steps’.

References

Australian Psychological Society (2011). *Evidence-based guidelines to reduce the need for restrictive practices in the disability sector*. Melbourne: APS.