

Submission on the
proposed National Disability Insurance Scheme (NDIS)
quality and safeguarding system

# Introduction

NDS appreciates the opportunity to comment on proposals for the NDIS quality and safeguarding system. Disability service providers have a strong interest in developing a system that: drives quality; provides risk-based safeguards for participants; minimises red tape; and ensures that regulations do not unfairly advantage some providers over others.

Recent NDS work that informs our submission includes the Zero Tolerance initiative, a policy paper on staff screening and a discussion paper on Quality and Safeguards (2014) which proposed a co-regulation approach.

The proposed framework is structured around three domains: development, prevention and correction. All are important; however, NDS would like to see a stronger focus in the prevention domain on ensuring capable and high-quality services. Investment that fosters positive organisational cultures which value the rights, aspirations and individuality of people with disability is an essential foundation of an effective system.

This submission begins by setting out how NDS thinks the quality and safeguarding system should look. We then answer each of the consultation paper questions.

# Summary: The NDIS quality and safeguarding system

The following nine principles introduce the core features and institutions that NDS believes will provide an effective quality and safeguarding system.

## Regulation has a minority role in promoting quality and safeguards

Evidence gathered for the NDS Zero Tolerance initiative highlights the importance of development and prevention strategies instead of overly relying on regulatory measures. Beyond a certain point, regulation simply generates red tape rather than improved quality or safeguarding. This means the system must invest properly in:

* the knowledge, capacity, social networks and personal resources of participants and their families
* disability provider and workforce knowledge and skills for creating high-quality service cultures with robust complaints and feedback systems
* broader community knowledge and awareness of disability rights to enable inclusion, personal advocacy and bystander interventions.

## Choice is a necessary but not a sufficient driver of quality

Increased consumer choice will help to assure quality, if there is investment that promotes informed choice and enhances the quality and range of services from which participants can choose. However, choice alone cannot replace standards and monitoring. The point can be illustrated by considering a different consumer-oriented market—restaurants. Consumer choice helps drive quality and diversity among restaurants, but the public rightly expects some standards to be monitored and enforced to protect them from harm. They do not believe that choice should expose them to the risk of food poisoning. Similarly, as important as choice is in the design of the NDIS, it should not be so broad that it puts participants at risk of harm.

## All disability providers should comply with a code of conduct based on the National Standards for Disability Services

In December 2013 the Disability Reform Council of Ministers adopted revised National Standards for Disability Services which have a stronger emphasis on human rights, person-centred approaches and choice and control than their predecessors. These Standards must form the practice foundation for all disability support providers including universal application of core safeguards such as appropriate staff vetting and supervision, complaints systems and incident monitoring.

NDS proposes that:

* all organisations that provide disability support to NDIA participants (including participants who self-manage) are required to register with the NDIS and adhere to a provider code of conduct based on the National Standards for Disability Services
* a mandatory national human services system for staff and volunteer screening is established, including a properly resourced and empowered barred worker scheme
* NDIA prices recognise the costs for providers of implementing mandatory safeguards.

Providers of generic services (for example, gardening and house cleaning) should not be required to comply with National Disability Standards unless it is specified in a participant’s plan (arising from the participant’s risk profile).

Where a participant directly employs their support workers the NDIA should not require them to register as a provider. However, the NDIA should monitor their compliance with minimum standards and legislation such as work health and safety, tax and industrial law.

## Compliance monitoring should be proportionate to risk, assessed in relation to the risk profile of the organisation and the risk profile of the participant

While all registered disability providers must adhere to minimum standards (through a provider code of conduct), the level of monitoring and compliance burden should depend on risk profiles. This means that compliance monitoring should be less for an organisation that has a long and unblemished record of supporting people with disability, skilled and qualified staff, sound governance and a quality assurance system than for an organisation that has none or only some of these characteristics. Similarly, compliance monitoring should be less for an organisation that supports participants with a low-risk profile than for organisations that support participants who, for example, have intellectual disability, require assistance with personal care and/or have few natural supports.

NDS proposes that:

* all registered providers report regularly with evidence of self-assessed compliance with the provider code of conduct
* independent inspections or audits of compliance are undertaken by an industry regulatory body where specific risks are identified such as: a particular pattern of complaints and incident reports; recent entrance to the market and a lack of a relevant service record; a lack of quality systems and a thin market where participants have fewer service provider options
* independent quality evaluation with a focus on outcomes is required (and funded through higher prices) in higher-risk support situations such as:
	+ one-to-one support for people who require decision or communication support to exercise choice and control
	+ circumstances where restricted interventions may be required
	+ service settings such as shared supported accommodation where clients are more isolated from natural support
* where a service is already subject to professional registration requirements (such as therapy services), or where a provider has third-party quality accreditation, this would reduce or eliminate the need for other auditing or quality evaluation
* the results of independent quality evaluations or third party accreditation reviews should be publicly available to inform consumer choice
* to avoid duplication, there should be cross-recognition of quality systems across human services; providers should be able to choose the quality monitoring arrangement that suit them best.

## Some risk can be managed through individual planning

If restrictions on risk-taking are overly-broad, it can diminish a person’s quality of life. This will be addressed by a more individual approach to risk management through individual plans that enable participants to take reasonable risks and make choices on the same basis as the rest of the population.

Building risk management into participants’ plans recognises that risk profiles vary markedly according to a person’s disability, their preferences, the nature of the support and the circumstances in which the service is provided. It requires skilled planners with access to reliable information, including information from providers and information about the individual’s history with support services and their family circumstances. This planning should principally be provided by specialist planners outside of the NDIA.

## Co-regulation recognises a shared responsibility for standards

NDS proposes a co-regulation approach to oversee quality and safeguards in the NDIS. This should include a national non-government disability industry regulator empowered by legislation to:

* develop and monitor a provider code of conduct which must be complied with as part of the NDIA registration requirements
* operate a system for addressing complaints about breaches of the code that providers are unable to resolve
* monitor and report on serious incidents and the use of restrictive practices
* promote high-quality practice and provide expert practice advice on how to reduce or eliminate the use of restrictive practices.

It makes sense for the industry to hold itself accountable for quality practice similar to many professional practice bodies. However, there must also be checks and balances. NDS proposes that an independent statutory body is made responsible for ensuring the industry body fulfils its responsibilities and addresses any perceived conflicts of interest. This body must have powers to address escalated complaints and initiate investigations as it sees fit. This could be achieved through expanding the functions, powers and independence of the Aged Care Commissioner or Commonwealth Ombudsman.

## Restrictive interventions require independent legal authorisation

Sometimes restrictive interventions are necessary to prevent serious harm, but high quality services can reduce or eliminate the need to use these interventions. The fundamental human right to liberty must be protected through ensuring:

* a formal process overseen by civil administrative tribunals is established to monitor and authorise restrictive interventions that breach the right to liberty
* positive behavior plans are in place wherever restrictive interventions are authorised
* expert practice advice is available to inform both the authorisation process and provider practices to help reduce and eliminate the need for restrictive interventions.

NDS’s position is based on the view that an independent legal process is the proportionate level of authorisation for a potential breach of the right to liberty, as occurs in the mental health and criminal justice systems and in the disability system in some jurisdictions. All Australian governments have already committed to a national approach to the reduction and elimination of restrictive practices. However, practice still varies considerably. Urgent investment is required to develop the details of a workable national system. Clarity is required on where the responsibility for seeking authorisation sits, recognising that a participant may be using several providers with a restrictive practice in place (such as pharmaceutical restraints).

## Disability safeguards should enhance – not replicate universal systems

Universal quality and safeguarding institutions, including the Police, Courts, Human Rights Commission, Consumer Affairs, Safe Work Authorities, Public Advocates, Ombudsman and the Fair Work Commission, should be responsive to people with disability. However, the complex array of disability-specific and universal systems across different jurisdictions sometimes overlaps and obscures the roles and responsibilities of various core institutions. Currently many stakeholders report that they do not know where to go if they have disability concerns.

The NDIS provides an opportunity to create an easier-to-navigate and nationally-consistent system. This should be a system where disability-specific institutions do not duplicate the functions of universal regulators, but do interact with them within a clear hierarchy of functions, where issues can be escalated as appropriate.

It is also important that competent independent advocacy is available to assist complainants to access both universal and disability specific systems and to raise disability awareness and enhance the effectiveness of universal systems.

## Ensure quality and safety throughout the transition to a mature market

The risks during the transition phase will be different from the ongoing risks in a mature market. The steep growth rate creates a risk of undersupply of both providers and workers which in turn, risks deterioration in quality. There is also a risk of safeguarding system gaps occurring as responsibilities for disability services transfer from governments to new and emerging systems. To mitigate these risks, all governments must take extra care to ensure the quality and safety of services in their jurisdiction throughout the transition. This should include early investment to promote worker knowledge of the rights and values that underpin the NDIS, as well as ensuring providers have the knowledge and tools to create organisational cultures that support customer feedback and continuous quality improvement.

NDS also notes the importance of effective engagement with the sector to ensure timely identification of any unanticipated issues and ongoing co-design.

# Response to questions in the consultation paper

## What are the most important features of an NDIS information system for participants?

Participants and their supporters should be able to recognise and choose the quality of support they want and be in a position to reject providers that do not meet their needs, or treat them with respect. This can be achieved in part through ensuring effective information, linkages and capacity building (ILC) services.

Market information products and individualised funding will enhance choice and quality but will not be sufficient on their own. Investment in the following ILC products is required to protect and promote informed participant choice:

* information and advice including from specialist disability associations and information networks
* information about independent advocacy services
* research, evaluation and dissemination of reliable educational products about what works, for whom, under what circumstances and at what cost
* contract-based quality control for block funded ILC services
* education on human rights, quality and legal capacity –the Victorian Disability Commissioner’s ‘it’s OK to complain’ campaign is a good example.

It is important to recognise that ILC products are not just about information for participants. Broader community disability rights awareness across all stakeholders will enable both stronger personal advocacy and also bystander interventions. Anyone who experiences or witnesses a breach of rights (including abuse or neglect) should recognise it, and know how to respond.

The development domain and information systems are also canvassed in the consultation on the ILC framework. Therefore, the attached [NDS submission to the ILC consultation](http://www.nds.org.au/publications) is relevant to this discussion.

## How can the information system be designed to ensure accessibility?

To ensure the most effective NDIS information system, the NDIA should:

* ensure multiple formats and platforms of delivery are available (e.g., pictorial, Easy English, read to speak, multilingual, mixed media, apps, face to face, access for Auslan users and video conferencing)
* identify key community partners to facilitate access and circulate information such as specialised disability associations and local government
* draw on existing ILC services that have a community focus and are locally responsive as these services inherently build local, informal and accessible networks.

## What would be the benefits and risks of enabling participants to share information, for example, through online forums, consumer ratings of providers and other means?

There is great potential for social media and other internet formats to spread market information. However, to protect consumers and ensure productive use of consumer rating forums the NDIA should fund a moderation system provided by a third party. Otherwise subjective and anonymous opinions or reviews could provide misleading, unhelpful or damaging information. This is particularly important in the early stages of market development.

An effective way to ensure consumer rating forums offer useful information is to ensure they include random sample surveys of client views, not just volunteer contributions.

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

To help build social connections, natural safeguards and decision support for participants the NDIA should invest in:

* peer support groups for people with disability as well as mentoring and volunteer coordination services
* support for enhanced planning and supported decision making when natural support is not enough, made available outside of NDIA staff
* community inclusion support in plans that is designed to help build networks.

Where a lack of natural support networks is identified, participants should be put in touch with independent advocacy services through local area coordination services or through their planners.

## What kind of support would providers need to deliver high-quality supports?

The rapid implementation of a new disability support system that makes many existing quality and safeguarding features redundant raises the risk of eroding standards. However, NDS is confident that with strategic investments, governments can raise the bar on quality standards. The following features should be available in advance of the transition to the NDIS to promote high-quality support that is sensitive to different levels of risk and able to enhance the positive influence of participant choice on the market.

## Investment in provider and workforce capacity: Sector development initiatives led by industry and research organisations should be funded by the NDIA. In particular, they should promote worker knowledge of the rights and values that underpin the NDIS as well as organisational cultures that support customer feedback and continuous quality improvement. It’s also important that organisations have the know-how and tools to create internal quality systems where:

* + the voices of participants and their families are heard and respected
	+ organisations record and respond to complaints and incidents in a timely way and implement strategies to reduce negative incidents
	+ providers collect information on customer satisfaction
	+ standardised tools for measuring outcomes for providers would be valuable
	+ providers engage and listen to participants about their quality preferences, perception of outcomes, and as witnesses in any allegations or incidents.

## Provider quality systems should be reinforced by clear standards: The sector development initiatives should be aligned to the achievement of quality standards.

## Fair and risk-based quality compliance systems: To help providers to deliver high-quality support, there needs to be market regulation that protects minimum standards. This requires consistent and fair application of compliance with quality standards, including for self-managed plans to ensure that market competition is not at the expense of essential safeguards (such as appropriate staff screening). The NDS proposals for provider registration support this feature.

## We will know we have achieved the desired fair and contestable support market state when there is a strong connection between price and quality.

## Participant plans must respond to individual risks, including with appropriate prices: NDIA prices and related individual package sizes should recognise the intensity of support needed to ensure sustainable provision, consistent with quality standards.

## The skill, knowledge and access to information of planners will be crucial to the effectiveness of individually tailored safeguards. Planners will need to consider individual characteristics or circumstances as well as support needs to determine any need for extra safeguards to complement generic provider registration requirements.

## Safeguards may be supported in plans with differentiated prices that reflect specific worker qualification or professional registration requirements. Where there is no relevant professional safeguard, despite complex skill and supervision needs, differentiated prices are still required to enable provider organisations to ensure appropriate staff skills, such as for:

* + positive behaviour support and complex community inclusion support
	+ invasive personal care interventions (such as bowel and bladder care, prevention of aspiration, tracheotomy care, PEG feeding and administering medication).

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## Should there be an independent oversight body for the NDIS?

## Yes, there is a need for an independent oversight body for the NDIS.

## NDS advocates for a co-regulation model for achieving oversight objectives, which acknowledges and empowers the role of all stakeholders.

## What functions and powers should an oversight body (bodies) have?

## The NDS co-regulation proposal involves establishing a combination of oversight infrastructure, functions and powers to replace existing disability specific regulators:

1. **A national non-government disability industry regulatory body** empowered by legislation to fulfil the following responsibilities:
	* To develop, promote and monitor a provider code of conduct (consistent with the National Disability Standards) required for NDIA registration.
	* To sanction providers, including by recommending de-registration to the NDIA, where they do not comply with the code of conduct.
	* To receive, help to resolve and investigate complaints that providers are not compliant with the code, where necessary.
	* To monitor serious incident reporting and the use of restrictive practices.
	* To evaluate and approve other quality management or accreditation systems that will demonstrate compliance with the code of conduct and independent quality evaluation requirements of the NDIA.
	* To collect, analyse and disseminate data and evidence about good practice. This would further develop the evidence base for recognising and responding to allegations or incidents of malpractice in different risk environments.
	* To establish self-governance structures that address perceived conflicts of interest and independence from the providers it investigates. This could be similar to the independence achieved by professional registration bodies.
2. **An independent statutory oversight body** with the following responsibilities:
	* To ensure the industry regulatory body fulfils its responsibilities and properly addresses actual or perceived conflicts of interest.
	* To investigate as they see fit any complaints about providers which have been escalated from the industry regulatory body.
	* To undertake investigations as they fit in response to serious incidents, complaints or observed patterns.
	* To promote the awareness of universal regulators about disability issues.

This body could be established through legislation that extends the independence, functions and powers of an existing oversight body. For example, the Office of the Aged Care Commissioner could become the Office of the Aged Care and Disability Commissioner with legislation that also increases its independence as a statutory body. Alternatively the Office of the Commonwealth Ombudsman could have extended powers to enable it to oversee the industry body and investigate providers that offer services funded by the NDIA, in addition to its existing responsibilities with the NDIA.

1. **A legal process for authorising restrictive interventions** should be overseen by the civil and administrative tribunals, with advice from expert panels. This should be complemented by monitoring by the industry body and the provision of practise advice on reducing and ending the use of restrictive practices.
2. **A mandatory national staff screening system** that covers non-registered workers across human services including disability services, aged-care and those working with children. This would be empowered by legislation that:
	* requires employers to seek employee history information through a continuously up-to date national criminal history check (similar to some working with children checks where the police notify employers if there are developments related to an employee) and referee checks
	* identifies certain prescribed offences (as identified in aged care regulation at the moment) that prohibit a person from working with vulnerable people
	* establishes a properly resourced **national barred persons scheme to:**
		+ prohibit workers who have seriously breached standards (these should contain similar features to the Australian Health Minister’s Advisory Council proposals for a code of conduct for non-registered health care workers)
		+ formally investigate and make findings about when a breach has occurred on the balance of probabilities (i.e. when a court conviction doesn’t apply)
		+ provide sufficient natural justice processes for potential barred persons, including recourse to appeal a decision
		+ require that providers, the industry regulatory body, the police and courts refer alleged offenders to the scheme as appropriate.

NDS proposals for a national staff screening system are also described in the attached NDS staff screening policy paper issued in October 2014.

1. **Market stewardship** will be carried out by the NDIA in cooperation with the proposed national industry regulatory body. This function should include drawing on the powers of universal market regulators such as Consumer Affairs, the Fair Work Commission and the Australian Competition Commission, to guard against abuse of market power or anti-competitive practices. To fulfil this function it will be important to collect and monitor data trends on the following variables:
	* consumer demand and preferences
	* structure and composition of the market
	* workforce sustainability
	* quality practice
	* outcomes and impact.

## Considering the options for provider registration, which option would provide the best assurance?

It’s important to strike a balance between enabling a reasonable level of risk for participants and due diligence in accordance with the use of public money and community expectations. NDS supports a nuanced version of Option 3 in the consultation paper which requires compliance with a provider code of conduct for all registered providers and external quality evaluation for some higher risk support types. NDS believes that a provider should be able to choose to have third party accreditation, and if they did so, would meet the external quality evaluation requirement.

However, there are concerns that if the extra cost of accreditation is not paid by all providers, then ‘cowboy operators’ will have an unfair competitive advantage which may put participants at risk. To address this risk, amongst others, NDS seeks to strengthen compliance monitoring of the code of conduct (as outlined below). We also recommend that providers that have third party accreditation are not subject to the same level of industry body scrutiny or independent quality evaluation as new entrants to the market, and that current duplication in accreditation requirements across sectors is reduced. The advantage for current providers will be increased flexibility to use the quality systems that suit them best and to focus on outcomes rather than process-focused audits.

## Should the approach to registration depend on the nature of the service?

## Minimum quality standards (such as adherence to health and safety legislation) are equally relevant to all disability service organisations whether or not the participant is managing their own plan. If they are not essential standards for providers of self-managed packages then they should not be mandatory for any providers.

## Therefore, all disability support providers should be required to sign on for minimum quality standards which are communicated in the provider code of conduct, covering human rights, staff screening and supervision, complaints systems, and incident monitoring.

## NDS recognises that some providers funded through the NDIS will not be disability support providers, such as cleaners, gardeners, taxi drivers and some technology suppliers. It may not be necessary to register these providers which offer services in a much broader market. However, if there are significant risks identified with these services for some individuals, then other safeguards can be put in place in the individual’s plan. For example, some individuals may require supervision and monitoring for their in-home cleaning staff to ensure they do not take advantage of the participant’s specific vulnerability.

## How can the right balance be reached between providing assurance and letting people make their own choices?

## One of the most difficult areas to resolve in this framework is an appropriate level of external quality control. NDS recognises the benefits of external quality systems. Moreover, it is very important that providers that have invested in third party accreditation are not disadvantaged in the new system.

## On the other hand, NDS also recognises that in some circumstances tightly prescribed quality accreditation regimes can restrict consumer choice. The success of the NDIS market and the ability for consumer choices to drive quality requires that providers can enter the market, or innovate, with relative ease.

## NDS recommends the following compliance measures to complement a vibrant NDIS market, minimise red-tape and assure non-negotiable quality standards. These proposals are designed to ensure providers that have invested in quality accreditation do not need to duplicate their efforts:

* All disability providers (including those operating with self-managing participants) should be required to sign up to, and be compliant with a provider code of conduct managed by the industry regulatory body.
* Monitoring of the code of conduct should include regular reporting on self-assessment (with relevant documentary evidence) by all providers. There should also be risk-based audits carried out at times determined by the industry body, such as in response to particular patterns of complaints or incidents, or for new entrants with a lack of a relevant service record or quality system or where there is a thin market. If a provider has third party quality accreditation this can suffice in terms of compliance reporting for the code of conduct.
* Providers should be required to report ‘serious’ incidents and complaints to the industry body, which will provide incident and complaints data to the NDIA and independent oversight body (‘serious’ includes deaths and criminal assaults).
* Providers can be required to improve their practice and systems or be ‘de-registered’ if found to be non-compliant with the code of conduct.
* Additional external quality evaluation will be required where there are more significant risks of malpractice, abuse or neglect, this includes:
	+ invasive and/or complex one-to-one support for people who require decision and/ or communication support to exercise choice and control
	+ circumstances where restricted interventions may be required
	+ service settings such as shared supported accommodation (i.e. group homes) where clients may be more isolated from natural support.
* Independent quality evaluation for higher risk supports, the results of which are made publically available, should be funded in NDIA prices. Providers should be able to choose the independent quality evaluators they wish to use (within guidelines) and if they have third party quality accreditation (including from other human service systems) this will likely suffice.
* The quality evaluation system should operate risk-based checks which mean higher ratings will result in lower auditing and review burdens.

## How important is it to have an NDIS complaints system that is independent from providers of supports?

Internal complaints processes will be a requirement of the code of conduct and ideally complaints will be resolved at the provider level. However, it is also important to have an external complaints system. This provides an additional incentive to providers to resolve complaints and it offers a quality safeguard that empowers consumers and does not create red-tape.

The NDS proposals for co-regulation provide an external complaints system through an industry body that receives complaints about registered providers. If these are not satisfactorily resolved, complainants or the party complained about can also appeal to a statutory oversight body which may choose to investigate either the industry body handling of the complaint or the complaint itself.

NDS also suggests it would be useful to continue to operate the national abuse and neglect ‘hot-line’ and refer on as appropriate. This has proven to provide a useful entry point for some complainants and advocates.

**There is also a need for well-functioning independent advocacy services to help resolve complaints.** These services should be funded from a source other than the NDIS and should be available to assist people with disability make complaints about all disability services (regardless of whether or not they are funded by the NDIS).

## Should an NDIS complaints system apply only to disability-related supports funded by the NDIS, to all funded supports, or to all disability services regardless of whether they are funded by the NDIS?

NDS recommends that the industry body should focus on disability support funded by the NDIA, while the statutory oversight body should have a broader scope for raising disability awareness in complaints systems across all funded disability services. This may include those in the education, transport, local government and justice sectors.

## What powers should a complaints body have?

The powers of the proposed industry and oversight bodies are described above.

## Should there be community visitor schemes in the NDIS and, if so, what should their role be?

Community visitors have played an important role in the past, especially for people who have been isolated from natural support. However, it is unclear how these schemes will complement the NDIS system which provides safeguards for more isolated participants through individualised planning processes, plan nominees where required and a broad ILC service framework.

NDS envisages that over the longer-term community visitor schemes could be evolved or phased out as strong peer support and independent advocacy services are in place and as the broader quality and safeguarding infrastructure takes form.

## Who should make the decision about whether employees are safe to work with people with disability?

Employers must have this responsibility. This is because employers have the duty of care, the detailed information about the client, employee, circumstances and also the necessary levers to appropriately manage identified risks. However, employers should be provided with the following guidance and limits to their discretion:

* employers must be required to seek employee history information through a continuously up-to date national criminal history check and referee checks
* if a check identifies certain prescribed offences (as identified in aged care regulation at the moment) they should be prohibited from employing the person to work with vulnerable people
* they should check with and refer to the proposed ‘barred person scheme’
* they should uphold Standard 6 of the National Standards, which expects staff to be inducted, suitably qualified, skilled and supported. This includes knowledge of the principles underpinning the NDIS as well as compliance with industrial and work health and safety legislation, such as ensuring training for manual handling.

## How much information about a person’s history is required to ensure they are safe to work with people with disability?

See the attached [Zero Tolerance best practice staff screening sheet](http://www.nds.org.au/projects/article/194).

## Of the staff safety screening options described, which option, or combination of options, do you prefer?

## A low threshold for entry to the disability support workforce will enable workforce growth to respond to increasing demand. However, there are risks that must be addressed. NDS recommends a combination of Options 2 and 4 suggested in the consultation paper, with the following additional elements:

* A national human service standard for criminal history checking for workers and volunteers working in disability services, aged care and with children. This should be continuously kept up to date, as occurs in some working with children checks. It is desirable to have a consistent screening approach across jurisdictions and adjacent sectors because the information that is gained from criminal history checks is equally informative about risks to vulnerable persons in all these sectors. Furthermore, providers and workers tend to work across sectors and state or territory boundaries.
* Contestability in terms of what organisations can provide the screening check. This will help ensure efficiency and prevent the delays and costs often associated with the compulsory use of centralised government schemes.
* Portability of checks so a worker can take an up-to-date check to various employers.

NDS does not support a system where a card is provided which determines whether a person can be employed or not. This does not give the employer sufficient information to manage any risks that may be indicated in a criminal history check.

## As noted above, there is also a need to establish a national barred persons scheme. This is the only just and efficient way to prevent people who have offended, but who have not been convicted, from moving across providers, sectors or jurisdictions and re-offending. This is an essential safeguard that is missing in the current system. It needs to be properly resourced to ensure it can provide natural justice for potential barred persons.

## Should people who manage their own plans be able to choose unregistered providers of supports on an ‘at your own risk’ basis (Option 1) or does the NDIS have a duty of care to ensure that all providers are safe and competent?

All organisations providing disability support services funded through the NDIA should have to register with them and sign up to the code of conduct, including those only working with self-managed participants.

If a self-managing participant wishes to directly employ an individual then they should not be required to register as ‘a provider’ but rather be monitored by the NDIA to ensure they comply with some minimum conditions and the law, including:

* checking criminal history, referees and the barred persons list for their workers
* minimum legal standards including:
	+ work health and safety legislation such as the requirements for adequate employee screening and induction to ensuring the worker has necessary knowledge and skill and proper provision of work safety insurance
	+ tax and industrial rules to prevent sham contracting.

There must be a clearly understood duty of care at the point of plan development when assessing self-management possibilities which will require access to reliable information about the participant’s history, capacity and family circumstances. NDIS cannot extinguish this duty of care.

NDS does support a streamlined facility for a provider to register with the NDIA to provide support to just one participant where this might be appropriate, on an exceptions basis.

## What kind of assistance would be most valuable for people wanting to manage their own supports?

Education and training is required for self-managing participants on how to effectively direct support staff as well as worker rights and their legal requirements. This could be provided through a mentoring program where people with experience of managing plans and/or managing staff, are available to mentor self-managing participants.

## Who should decide when restrictive practices can be used?

There needs to be a legal and external authorisation and review processes for restrictive practices. NDS recommends this process is overseen by civil administrative tribunals. There must also be clarity on where the responsibility for seeking authorisation sits, recognising that a participant may be using several providers with a restrictive practice in place (such as sedation).

## What processes or systems might be needed to ensure decisions to use restrictive practices in a behaviour support plan are right for the person concerned?

## Investment in expert advice and service development is necessary to reduce the use of restrictive practices. The NDS recommends that the industry regulatory body should provide expert practice advisors who are tasked with both advising on, and monitoring the reduction and elimination of restrictive practices. The proposed expert practice advisers should be responsible for:

* advising the authorisation and review process overseen by administrative tribunals
* provider education on strategies that reduce restrictive practices
* monitoring implementation of positive behaviour plans and evaluating quality
* collecting, analysing and disseminating data.

## Are there safeguards that we should consider that have not been proposed in these options (regarding restrictive interventions)?

As some individuals who would be eligible for disability support will not approach the NDIS, the NDIA needs to consider how they will reach these individuals or their families through an outreach function. A proportion of these individuals or families will have very complex needs (including challenging behaviour) that may require support or intervention from a range of service systems. These supports need to be coordinated, possibly through quite intensive case management. Clear and effective protocols need to be in place between the NDIA and various government departments to ensure the service system best placed to coordinate or manage the supports for these individuals and/or families is identified and the appropriate responses are put in place.

## What kinds of support are providers receiving now from state and territory departments that you think would be helpful under the NDIS?

## Providers disagree about the value of senior practitioners in some states at present. The criticism that the advice of some senior practitioners is impractical, suggests that the role might be better performed through an industry body where concern about rights could be combined with access to practical expertise.

Expert advisors could also be made available to wider sectors that provide services to people with disability who have challenging behaviours (e.g. education and justice) and also to some families.

## Would you support mandatory reporting on the use of restrictive practices?

Developing and implementing a positive behaviour plan is essential wherever restrictive practices are used. NDS supports the mandatory reporting and monitoring of these plans whenever they contain restrictive practices – but not of every incident.

There needs to be a responsive online system with a streamlined process for reporting. Useful data should be disseminated and connected to benchmark reports and quality certification. It would be used by providers and the industry body to improve practice. While it may add to compliance costs in some jurisdictions, this monitoring has been shown to help prevent breaches of rights, reduce the use of restrictive practices and improve outcomes.

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**National Disability Services** is the peak industry body for non-government disability services. Its purpose is to promote and advance services for people with disability. Its Australia-wide membership includes over 1030 non-government organisations, which support people with all forms of disability. Its members collectively provide the full range of disability services—from accommodation support, respite and therapy to community access and employment. NDS provides information and networking opportunities to its members and policy advice to State, Territory and Federal governments.