REPSPONSE BY SCOPE (VIC) LTD TO

NATIONAL DISABILITY INSURANCE SCHEME

CONSULTATION PAPER:
PROPOSAL FOR A NATIONAL DISABILITY INSURANCE SCHEME QUALITY AND SAFEGUARDING FRAMEWORK

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ABOUT SCOPE

Scope is one of the largest not for profit organisations in Australia, with the Mission "to enable each person we support to live as an empowered and equal citizen".

Scope provides disability services throughout Victoria to thousands of adults and children with cognitive and physical disabilities. Many of these people have a complex mix of high-level disability and communication impairments. Scope provides a wide range of services including early childhood intervention, supported accommodation, day and lifestyle programs, respite, individual support, therapy, and supported employment.

Scope is actively engaged in the NDIS Barwon Trial site and supports many adults and children who have transitioned into the NDIS, and are purchasing individually tailored 1:1 and group supports and early interventions.

Scope works to improve opportunities for people with a disability by influencing public policy, increasing understanding, and breaking down barriers to social inclusion. Scope is a leader in researching new ways to create a better life for people with a disability. Scope is a membership organisation with over 6,500 individual and organisational members. Scope employs 1,870 staff and has an annual turnover of $87.6 million (FY13-14).

PART 1: PROPOSED QUALITY AND SAFEGUARDING FRAMEWORK FOR THE NDIS

INFORMATION SYSTEMS

- **How can the information system be designed to ensure accessibility?**

Include Plain Language and Easy English: "Accessible Information" is not limited to large print, Braille and audio. The paper does not highlight the need for simplified documents in Plain Language and/or Easy English for people with limited literacy skills. 44%of Australians do not have functional literacy skills-(ABS-2013)

Easy English is a style of writing that has been developed to provide understandable, concise information for people with low English literacy. It focuses on presenting key information. Words are combined with appropriate images to enhance the message for the reader

It should be recognised that low literacy may also be an issue for "natural supports" – families and carers.

Scope's current experience of supporting people from CALD backgrounds includes providing translated information from the Easy English. There are a significant number of people from CALD backgrounds who also experience low literacy in their first language. Several language groups do not have a word for 'disability' and it will be difficult to convey the conceptual basis of this material to people from such backgrounds.

Multi-modal approach to access the system is critical: As described in the Consultation Paper, multi-modes of interaction with clients via written, face to face, health professionals, website and social media is essential to supporting the range of information needs.

Face to face communication and consultations are essential for people who have complex communication needs (little or no speech)

Information that is individualised and targeted is ideal. People process information more effectively when they receive it in a targeted and timely manner.

The proposal to work with users who can utilise social media will limit the reach to a range of users and therefore the type of feedback that will be gathered. People with lower levels of literacy typically have limited access to online and social media forms of communications.

Learn from Health Literacy: There is a commitment in the health sector to target literacy in a coordinated way.

Central to this is "People are able to access, understand and act on health-related information". Feeding into this are

- Embedding health literacy into systems
- Ensuring effective communication
- Integrating health literacy into education (for staff)

NDIA planners, in particular, need a good understanding of signs of low literacy, impacts of low literacy and appropriate strategies.

In practise, it is common place to have strategies for health care professionals to identify people who may have limited literacy and the pathways for appropriate strategies to use.

Reference: Health Literacy: Taking action to improve safety and quality. Australian Commission on Safety and Quality in Health Care August 2014.

The needs of children and adolescents also need to be considered in providing accessible information. In addition to recognising various levels of literacy, information needs to be age appropriate and presented in formats that will engage the child or adolescent. Relying on families members to inform children is not consistent with NDIS principles.

NATURAL SAFEGUARDS

- **General comments**

Each person accessing the NDIS will be in a unique position when it comes to access to natural supports and safeguards. Any safeguarding arrangements need to be individualized and take account of each person's unique circumstances and also consider safeguarding family members. The NDIA could run focus groups in different regions to explore how to support people with a limited number of family and friends. Acknowledging that there is not going to be one answer, rather, a number of locally and individually driven solutions.

Key elements to consider in the framework for building natural supports:

- The Participant should decide on who acts as their support for any decision or service.
- Some participants will require education and support to assist them to enhance and extend their relationships and social networks
- Any framework for natural supports should be built around tools such as an Eco map[1] to ascertain all supports a person has both formal and informal and the strength of these relationships.

- **Are there additional ways of building natural safeguards that the NDIS should be considering?**

Supported Decision making model: All participants should be supported to communicate their goals, expectations and concerns. For those with communication difficulties an independent communication assistant should be accessed to engage and enable an individual to have their say.

Sexual education: All people with disabilities and their families must be provided with sexual education so they are able to understand what consensual sex is and that they can say no. This education should include discussion about who the person could tell if they experienced sexual harassment or abuse (of any kind).

Community capacity building: Education and support of universal / community based services will be important. They have a role in becoming participant's natural supports, but also need clarity around their responsibilities and reporting mechanisms to report concerns. A framework within the NDIS should be developed providing structure for universal services to take on this role.

Ongoing support role for NDIS: The Local Area Coordinator role in community capacity building will be important to improve longer term opportunities to access the community and therefore provide opportunities to develop relationships and supports. However there is also a role to provide individual participants with opportunities to develop more natural safeguards. Natural supports rely on interests, access, capacity, as well as goals. Participant needs, interests and circumstances will change over time and therefore will require an individual approach, as well as more general community capacity development.

Minimum standards for goal setting and outcome measurement: There needs to be a minimum set of documentation that is provided by any service provider. Goals should be identified and measureable and signed by both the participant and provider. Random auditing of all service providers should occur.

All information should be provided in easy English formats and be accessible not only by web but also in print and face to face information sessions.

- **What can be done to support people with a limited number of family and friends?**

There is an ongoing role for the NDIS to fund a structured safeguard support framework with a role to monitor and support participants, and to act in the role of the community support in the following groups, including but not limited to:

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[1] McWilliam, R.A. (2001). *Understanding the Family Ecology*. Chapel Hill, NC

- Participants who may not want to expand their social network to provide a more expansive group of natural safe guards. Here formal frameworks should be able to provide these safeguards. Formal supports should be independent and should be skilled communication interpreters
- Regional and remote participants may have more barriers to the development of natural supports through geographical distance and reduced choice in interest availability. There is a more limited number of people with which to connect to develop relationships with.
- Families are often the first and principal natural safeguard for people with a disability. For a range of reasons some families will be less able to fulfil this important role and some families will be overprotective. Unfortunately, in some cases family members do not have the person’s best interests at heart, and can be the perpetrators of abuse. In other cases, the person with a disability can be the perpetrator of abuse on their family members.

Some ways in which a person can increase their natural supports include:

- Provision of targeted support to develop a circle of support around the individual or expand the person’s contacts with other community members, advocacy organisations, peer support services, link the person into local groups (based on their interests etc.)
- Facilitating people with a disability to spend a night a month with a host family or similar or if the person’s home has a spare room to consider establishing co-tenancy arrangements.
- KeyRing support models can also be useful in building mutual supports between people with disabilities living in a geographical locale.

SUPPORT FOR PROVIDERS

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

  The discussion material provided for this question refers to a number of factors that contribute to creating high-quality supports, including strong governance; policies and procedures; and effective feedback mechanisms. Each of these factors is important, although the list is not exhaustive.

  There are several other important factors, and numerous related activities, that shape perceptions of service quality in the current disability services environment. The priority of these activities may increase or decrease with the full implementation of the NDIS, depending on the nature of services being provided. Specific activities that have a particular bearing on service quality include the following:

    - Supporting clients to achieve the personal outcomes they want
    - Upholding duty of care to clients consistent with the basic principles of anti-discrimination, human dignity and autonomy
    - Safeguarding clients from unreasonable risks of harm, injury or damage
    - Ensuring clients have access to advocacy support
    - Developing and implementing plans for the use of restrictive practices with clients who have behaviours of concern
    - Supporting clients in accommodation services with their health and wellbeing needs
        - Making appointments
        - Keeping records

    - Managing the interface with generic health services
  - Maintaining compliance with legislative, regulatory and funding requirements
  - Parents need to know what quality looks like and to feel comfortable questioning when they don't feel like things are right.
  - Identified best practice to support service offerings and to inform participants

Ongoing professional development is a requirement of allied health professionals in maintaining registration with professional bodies and maintaining best practice based service provision. The cost of ongoing training needs to be considered in the NDIS funding.

While existing funding includes some provision for the cost of undertaking these activities, the greater proportion of quality management activities remains unfunded. Funding all of these activities under the NDIS is not clearly defined, and providers will need to be mindful of how they allocate limited resources to ensure they are delivering high quality supports. The corollary is that providers may not have the resources to deliver high quality supports in their service offerings.

At the same time, the principles underpinning the NDIS shift the locus of choice and control to participants, and it will be participants and their support networks who ultimately decide the meaning of 'high-quality supports'. For providers, this is fundamentally about a change in mindset; there will be a move from being responsible for clients to delivering supports in accordance with participants' wishes.

Understanding the altered parameters of provider responsibilities vis-à-vis participants' wishes will be one area where providers need support and guidance.

The support that providers require throughout the transition to the NDIS may need to be staged. There will be an initial requirement for education and information around the conceptual differences between the current disability services environment and the role of providers under the NDIS. Later, once new and existing providers have adjusted to the system, the support would be about ensuring there were tools and resources for providers to self-assess against mandatory standards, if any.

Working through a scenario that involves quality and compliance activities may clarify what support may be required for providers. In supported accommodation, for example, providers administer medication to clients who do not have the intellectual capacity to do so safely themselves. This involves a lot more than taking medication from the container. Tasks for which providers currently have responsibility include:

  - Liaising with general practitioners and other health professionals authorized to prescribe medication
  - Ensuring that prescribers' instructions for safe administration of medication are clearly documented
  - Receiving deliveries of medication and checking deliveries against relevant medication authorities
  - Storing medication safely (including controlled drugs)
  - Administering medication in accordance with prescribers' instructions
  - Completing records of medication administration
  - Responding to any medication incidents
  - Disposing of unused medication

Providers would need clarity around their responsibilities if they were to continue with any of the above tasks. This may be detailed in participants' plans. But even if plans explain provider responsibilities, this raises further questions e.g. whose responsibility would it be to develop and maintain the forms and other documentation related to medication management? If there were multiple providers supporting participants with their medication, how would these providers interact? Would they use the same documentation? If not, what would ensure consistency between providers? The same series of questions will need to be answered in unpacking how all support tasks will be managed.

It is practical matters like these that will concern providers in the early rollout of the NDIS.

Quality management entails a lot more than meeting compliance requirements. There will be ongoing consultation with participants and their support networks. This will be more challenging with some groups of participants.

The genuine engagement of participants who use augmentative and alternative communication requires substantial time and effort; it will not simply be a matter of asking people with complex communication what they want from a provider. The provider will need to be skilled in supporting participants with their individualized communication systems; an interaction with a person who has complex communication may take up to ten times longer than an interaction with a participant who is verbal and independent in the community. Some providers will require support in consulting with a variety of participants with whom they have had no previous interaction.

To be safe, some participants require workers with specialist skills. This could include participants with health conditions or behaviours of concerns. To deliver high-quality supports providers will need to access high-quality training, have the capacity to release staff to attend training and have the resources to monitor and support the development of these specialist services.

PART 2: DETAIL OF KEY ELEMENTS OF THE QUALITY AND SAFEGUARDING FRAMEWORK

PROVIDER REGISTRATION

- **Considering the options described above, which option would provide the best assurance for providers, and for participants?**

  From a provider perspective, the best assurance will come from having greater transparency around participants' experiences of the supports they receive. This is described under Option 4.

  Providers registered by the NDIA will operate in a competitive marketplace. The objective for providers will be to attract a sufficient volume of participants to use their services in order run a sustainable business. Having a published dataset of indicators (i.e. safety, staff management, timeliness etc.) that compares provider performance should incentivize providers to maintain high quality standards.

  The risk to providers will be that if their quality standards are inadequate, fewer participants may choose that provider. The evaluation process would act as a regulating mechanism that is consistent with NDIS principles. Providers with inadequate quality standards and/or adverse indicators may nevertheless continue to attract participants.

It would be necessary, therefore, for the evaluation process to include a baseline standard. If providers did not achieve this standard during their evaluation then their registration would be suspended. This would mean there would be a need to support participants to move to another provider.

The indicators that form the published dataset will need to be crafted with input from a body that establishes/oversees the standards. This may be part of the NDIA or an external body e.g. Standards Australia. Under either arrangement, there will have to be procedures that describe how the standards are to be applied; along with rules about the accreditation of evaluators; and criteria that providers can monitor to ensure they are delivering to the standards. These criteria would be then be assessed by evaluators to develop the indicators for the provider to be included in the published dataset.

From a participant perspective, the added assurance of an independent assessment as described under Option 4 would be likely to enhance confidence in the capabilities and performance of a provider.

In the case of children and families there is additional vulnerability of service providers offering families a ‘cure’ instead of functional outcome focus. Providers who focus on a deficits based model may offer outcomes that are not aligned with NDIS principles or those of best practice. The NDIA will need to have access to verified proof of efficacy before approving funds for these types of services.

The drawback of Option 4 may be that providers start to focus on compliance, and meeting certification requirements becomes a ‘tick the box’ exercise. There would probably be packages developed by management consultants available for use by providers to ensure they had everything in place to meet auditors’ expectations, but with a compliance focus, the provider’s system may not be embedded in a way that benefits participants.

The estimated cost of undertaking certification assessment (Page 41) is significantly less than the actual cost. The market rate for third party audits of larger providers, for example, is closer to $25,000 than $5,000. This rate could be anticipated to increase with additional providers entering the market. Moreover, the $25,000 does not include the significant continuing costs to develop, publish, implement, review and maintain quality management documentation; the program of internal audits required with any quality management system; the sponsorship and funding of continuous improvement initiatives; or the conduct, analysis and reporting of regular feedback and satisfaction surveys.

If there are to be equivalency provisions for certification to standards other than the National Standards for Disability Services, or any standards approved by the NDIA, these provisions need to be mapped so that providers are aware of any gaps in their quality management systems that may need to be addressed. Similarly, the delivery of some services to participants will entail compliance with other external standards e.g. Child Protection; Fire Safety. The particulars of responsibilities around compliance will need to be worked through.

- **Should the approach to registration depend on the nature of the service?**

  Consideration does need to be given to the nature of the service in framing the registration system. But the registration requirements should not *depend* on the nature of the service.

  The risks to participants, are not only related to the nature of these services; rather, the risks stem from the vulnerability of participants during direct contact with staff, particularly unsupervised staff, and the likelihood of the risks increases commensurate with the period of time over which a service is provided. As respite and supported accommodation both involve overnight support (i.e. support over longer periods of time), the risks to participants are greater in those services.

  There is an assumption throughout the Consultation Paper that certain services carry with them increased risks to the safety or wellbeing of participants. This includes services that involve more direct staff-participant contact or personal care support. Both respite and supported accommodation services are cited as examples of this type of service. The research evidence supports the assertion that there are more serious incidents involving violence, abuse, neglect or exploitation of clients in respite or supported accommodation.

  The approach to registration, however, should emphasize the vulnerability of participants ahead of the nature of the service. All providers delivering services that involve direct contact with staff must be required as part of their registration conditions to demonstrate safe recruitment practices. Any checks of staff will need to be renewed on a defined basis.

  The statement that “the majority of businesses operating in the general marketplace” would be exempt suggests that there are already safeguards in place to protect the safety and wellbeing of participants using generic services; the level of risk to the safety or wellbeing of participants using generic services is acceptable; or there is no requirement for safeguarding. The reality is there will be generic service providers seeking registration under the NDIS that will have direct, unsupervised contact with participants. Any generic services that seek registration as providers under the NDIS, and may have direct, unsupervised contact with participants, should be required to demonstrate safe recruitment practices as specified by the NDIA.

  There needs to be careful consideration given to the accreditation processes that govern various health and allied health industry bodies. It may be useful for the NDIA to specify the industry bodies that have implemented registration and/or accreditation processes for their members and whether this information is available to the public. This will enable both participants and providers to verify that professionals are registered with the appropriate industry bodies. If the registration and/or accreditation processes are not governed by an industry body, it may be useful for the NDIA to publish details of the minimum requirements of professionals in those allied health disciplines. This information would provide a measure of assurance to participants, their support networks and providers.

  For allied health professionals working in the specialized area of children and families there needs to be an assurance that professionals have experience in working with children and families not just registration with their professional body. Provide some minimum standards of Early Childhood Intervention around ensuring families know what quality service is.

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

  The best approach would be to develop an algorithm that was applied to all providers seeking registration regardless of the nature of the supports they provide. This algorithm would be risk-based and determine the level of checks required through the registration process; and what was required in order to maintain registration. If there were any change to the services offered by the provider there would need to be a determination as to whether this would affect the provider's registration. This determination may prompt the need for further (or fewer) checks to be performed.

  The NDIA would maintain a published list of providers along with the relevant indicators. While a provider satisfactorily maintained their registration it would be the choice of participants and their support networks as to which providers they wished to engage.

  The notion that there should be proportionality in assessing risk also applies here. If providers seeking registration will be delivering services that involve direct contact with staff must be required as part of their registration conditions to demonstrate safe recruitment practices. The required checks will need to be maintained and renewed and registration withdrawn if providers do not comply.

INDEPENDENT COMPLAINTS SYSTEMS

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

  Best practice in the delivery of any human service requires the opportunity for clients or their carers to provide feedback on the quality, timeliness and efficiency of services received. A robust system for the management of complaints is an essential part of this process, and Scope believes that the provision of an independent body is a key component of such a system.

  Scope already conforms to the requirement for an independent review of client complaints in Victoria, and has found this process to be both informative and collaborative, and has driven improved practices.

- **Should an NDIS complaints system apply only to disability-related supports funded by the NDIS, to all funded supports, or to all disability services**

  The purchasers of any disability services – either government or privately funded – should have the opportunity to complain to an independent body if they experience dissatisfaction with the quality of that service as part of an overall consumer framework.

  The degree of oversight and reporting requirements could be varied according to the level of registration held by the provider, as proposed in the Discussion Paper (p. 32); however no service should be exempt from some degree of independent oversight and accountability.

- **What powers should a complaints body have?**

  A complaints scheme will be ineffective if it does not have sufficient legislated powers to compel action.

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

  The Victorian Community Visitor Scheme enables independent volunteers with the power to make unannounced visits to accommodation facilities for people with a disability or mental illness at any time. The Community Visitors monitor and report on the adequacy of services provided, in the interests of residents and patients. They talk to residents/patients to ensure they are being cared for with dignity and respect, and to identify issues of concern. They can liaise with staff and management to seek to resolve issues, or refer more serious issues are referred to Victorian Office of the Public Advocate. Scope supports this scheme for shared supported accommodation.

  This scheme is not suitable to extend to family homes, where the largest number of Australians with disabilities reside, however Scope proposes that having advocates and support workers being comfortable asking questions and noticing any changes in behaviours that might indicate that it is possible that abuse is occurring in family homes is essential.

ENSURING STAFF ARE SAFE TO WORK WITH PARTICIPANTS

- **General comments regarding the risk of Harm and Neglect**

  Scope supports the view that people with disability are at increased risk of abuse, harm, exploitation and neglect due to their reliance on others.

  Scope supports the proposals in the proposed framework in relation to protection from abuse and exploitation.

  Scope is concerned that the proposed framework does NOT address important issues relating to risk of harm and neglect.

  Scope provides support to many people who have complex and multiple disabilities. Some also have particular needs in relation to:

  - health management, including administering of medication, monitoring of health conditions and specialised care such as PEG feeding
  - behaviours of concern and other specialised situations such as Community Treatment Orders
  - safe physical care, including specialised safe meal preparation, safe manual handling and safe positioning in bed

  Scheme Participants with any of these needs are at significant risk of harm unless the staff member providing support has appropriate training and practice skills.

  Pre-service training, on-the-job training and professional supervision are required to ensure that staff members are safe to work with Scheme Participants who have these specific needs.

There are significant costs associated with this training and with the required professional supervision. If these critical supports are to be provided, the cost must be recognised within the price paid or be funded through a separate mechanism. Staff who have specialised skills may also expect to receive a higher salary. This will also need to be recognised within the price paid to ensure that there is an incentive for staff to gain the skills required for safe support.

- **Specific Comments in relation to the Cost of an Effective Protection System to reduce the risk of abuse and exploitation**

  Service monitoring
  The establishment of effective complaint reporting and external review mechanisms is important in ensuring safety. But, this needs to be complimented by an effective internal monitoring capacity within service providers. As services are increasingly being provided on an individual basis, in a person's own home or in the community, effective internal monitoring is even more crucial.

  Pro-active phone contact will work for some Scheme Participants, but for those with significant disabilities, physical visits by supervisors are essential. The cost of this must be built into the price paid for NDIS services.

  Investigation of allegations
  When there is an allegation of inappropriate conduct by a staff member, employers must have the capacity to undertake an initial investigation and, if required, commission a more formal external investigation.

  - The cost of both internal and external investigations must be borne by the NDIS so that lack of resources is never an impediment to investigation
  - Service providers also need to be able to access the appropriate expertise to conduct investigations. Large providers may have the scale to employ a person with the required experience and skills, but small organisations will need to be able to access this as needed. Accredited external investigators will also need to be available and the cost to service providers fully covered by the scheme.

  Stand-downs during investigations
  Employers need to have the financial capacity to stand down a staff member, on full pay, when there is an allegation of inappropriate conduct by a staff member. Natural justice requires the presumption of the innocence of the person accused, but the need to ensure the safety of people with disability means that the employee must be withdrawn from the work situation while the allegation is investigated.

  Service providers must have the capacity to apply for funds from the NDIS to cover the costs of wages and on costs for the period during which a staff member is stood down. Including this cost in the NDIS price will not work because the timing and frequency of such costs are unpredictable. Small providers could be particularly hard hit.

- **Of the options described above, which option, or combination of options, do you prefer?**

  Scope supports the implementation of Option 3: Working with vulnerable people. This should be in combination with a clear expectation on employers to undertake appropriate risk management, including effective referee checks Options 1 & 2.

Scope also believes that Option 4 (Creation of a barred persons list) is worthy of consideration.

Scope is concerned that the costs to employers of implementing an effective system to reduce the risk of abuse and exploitation need to be recognised and covered.

Specific comment in relation to Option 3

The current approach to obtaining and maintaining clearances in relation to working with vulnerable people is not working effectively. Scope supports the establishment of a central clearance system to ensure that the process is consistent, efficient, comprehensive and reliable.

- A national clearance system will ensure that police checks cover all jurisdictions and can efficiently obtain information from international jurisdictions. It can also provide periodic proactive updates for all checks for all current and past workers in the field.
- The system must be centred on the individual employee. It should be the employee's responsibility to obtain all the necessary checks (through the central clearance system). The responsibility of employers is then to ensure that any potential and current employee has the necessary clearances.
- Requiring employees to obtain the necessary clearances prior to starting work in the sector also minimises delays in recruitment and avoids duplication of requests from multiple potential employers.
- The cost of the system should be borne by the NDIS overall. Charging potential and current employees anything more than a nominal fee will discourage potential workers in what will be a very competitive market.
- Charging employers will mean that the cost has to be built into the NDIS price. The Scheme is paying either way.

Specific Comments in relation to Option 4

Scope is currently working with the new Victorian Disability Worker Exclusion Scheme. Based on our experience we believe that such a scheme is potentially very valuable in reducing the risk of abuse and exploitation. To be effective, a national scheme:

- Needs to cover a wide range of work roles within the sector. Anyone working regularly with a vulnerable person has the potential to abuse that position. Recent evidence in relation to child abuse in schools and other institutions has identified people in support roles as perpetrators.
- Needs to have adequate provision to ensure natural justice for anyone facing allegations, while ensuring that vulnerable people are not put at ongoing risk
- Must require employers to report concerns and provide appropriate sanctions where this obligation is not met
- Must be integrated with the national clearance system (discussed under Option 3) to ensure that information is current. This must recognise that people will work across different employers at the same time, including being employed directly by Scheme Participants

RESTRICTIVE PRACTICES

- **Who should decide when restrictive practices can be used?**

  We strongly support the NDIS' aim to implement Australian governments commitment to the reduction and elimination of restrictive practices in services for people with a disability'.

  Protecting the rights of people with a disability must be the primary consideration in the use of a restrictive practice. However, the question as to when a restrictive practice can be used acknowledges that there are also times when the use of a restrictive practice may be justified on health and safety grounds. The decision making process therefore needs to reflect the potential legal implications for support workers for improper use of a restrictive practice.

  We support option 3 that 'Providers would be authorized to make decisions under specific conditions' and the decision for when a restrictive practice can be used would be directed by mandatory guidelines within relevant legislation. This is similar to the current practice within Victoria.

  We also support the view that when a restrictive practice is authorised then a behaviour support plan (BSP) that meets contemporary best practice will be mandatory.

  For individual decisions as to when a restrictive practice can be used we support a 'provider initiated panel'. Our experience with the Authorized Program Officer model is that the skills and knowledge required to make this decision is too broad to sit with one person. Quality advice and stakeholder input is essential for making decisions related to restrictive practices. Effective implementation of Positive Behaviour Support also emphasises the importance of collaboration and teamwork. This should occur across all areas of support including decisions around the use of a restrictive practice

- **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?**

  The processes to authorise and use restrictive practices need to be clearly outlined in legislation or regulations. This would include mandatory guidelines for the use of restrictive practices and define mandatory requirements for a Behavioural Support Plan (BSP). We support the view that BSPs should always be required to comply with a minimum standard before the use of any restrictive interventions. The quality of BSPs could be measured using the Behaviour Support Plan Quality Evaluation II (BSP -QEII). The relationship of the legislation or regulations to the existing legal framework needs to be considered.

  The involvement of a person independent of the service provider is needed in order to explain the use of the restrictive practice and the behaviour support plan. The independent person would require a thorough understanding of the BSPs. The independent person would also be empowered to request a review if they were concerned about the restrictive practice or the quality of the BSP.

  The establishment of national and regional networks of Behaviour Support Consultants who have advanced skills in developing and assessing BSPs, communication and behaviour, and ethical decision making is recommended.

- **Are there safeguards that we should consider that have not been proposed in these options?**

  The following are further safeguards to ensure that:

  1. restrictive practices are the least restrictive option available and
  2. behavioural support provided as outlined in a behavioural or person centred support plan meets the needs and wishes of the person and are actioned appropriately:

  Considering that approximately 90% of all reported restrictive interventions in Victoria are for chemical restraint we suggest that it is important to include General Practitioners (GPs) and pharmacists involved in the process of decision making related to the use of chemical restraint. We would recommend training in restrictive interventions and positive behaviour support to GPs that will help to inform GPs when considering prescribing medication whose primary purpose is to change behaviour. Further to this we would suggest the establishment of identified GPs who are competent in this area to have an active input to the decision making process for the use of a chemical restraint.

  Staffing attitudes, values and skills have a significant impact on any decision to use a restrictive practice and are a crucial mediator for the successful implementation of Positive Behaviour Support and changing restrictive practices. We recommend mandatory training in Positive Behaviour Support for staff supporting people who are on a restrictive practice. It would be preferable for all requirements related to restrictive practices to be addressed in legislation or regulations.

  Education for families and carers regarding what constitutes a restrictive practice. For example using a child's equipment for restraint purposes rather than therapeutic outcomes, holding a child on the mat at group time to increase the length of time they stay with the other children, etc. Families, carers and educators may not be aware of alternative strategies or the impact and consequences that restrictive practices may have.

  Not considered in the options are actions stemming from the failure to report restrictive practices. One way to address this would be to allow spot visits of disability services by registered NDIS visitors who are empowered to report on any unauthorized restrictive practices.

  The need for safeguards to treat the risk to community members from participants will also need to be considered. The disability population includes people who have displayed offending behaviours e.g. people subject to Community Treatment Orders.

- **For providers, what kinds of support are you receiving now from state and territory departments that you think would be helpful if it was available under the NDIS**?

  In Victoria, providers currently receive support from the Office of Professional Practice (OPP) in the areas of legal and reporting requirements. Similar support would be necessary in the future if the sector moved towards a set of National mandatory guidelines.

  Providers also receive information and practice advice from the OPP for supporting someone with behaviours of concern. It would be helpful to receive evidence based practice advice under the NDIS. We recommend that practice advice is separated from advice related to legal and reporting requirements.

Scope would endorse the establishment of a centre of excellence in behaviour support for people with behaviours of concern. The centre would have the role of providing disability services with advice, information and training related to reducing restrictive practices. It would also provide guidance and advice to individuals on restrictive interventions and their supports.

A separate body would provide advice and guidance related to legal requirements for reporting and implementing restrictive practices.

Seeing children in their natural environments and working within their everyday routines assists in establishing when families, carers and educators are having difficulties. It also assists in providing expert support to establish alternative strategies to restraint. Working in the child's natural environment provides an opportunity to observe and identify practices that may not be considered restrictive practices by the care giver.

MONITORING & REPORTING

- **Would you support mandatory reporting on the use of restrictive practices? Why/Why not?**

  Scope supports mandatory reporting of restrictive practices. We strongly support the progress that has occurred in Victoria with reporting and monitoring the use of restrictive interventions and wish to see this continued and strengthened.

  Without monitoring the use of restrictive practices there is a significant risk of under reporting and therefore an increased risk of violating the rights of people with a disability. Mandatory reporting acts as a significant safeguard in protecting the rights of people with a disability.

  Mandatory reporting can also be seen as an important part of the process to educate staff in restrictive practices and how they impact on the rights of people with a disability. Having an evidence base related to the circumstances in which restrictive practices are being used will also contribute to understanding how to eliminate and reduce restrictive practices.

- **If you support mandatory reporting on the use of restrictive practices, what level of reporting do you believe should occur (based on one, or a combination of, the options above)?**

  Scope endorses option 3 'Providers must report on each occasion where a restrictive practice is used (for physical, chemical, mechanical restraint and seclusion). This would be for both emergency and routine use of restrictive practices.

  This could also be extended to GPs who would report on each occasion they have prescribed medication for the primary purpose of reducing a behaviour of concern.

  Scope supports the use of an integrated online electronic system to authorise restrictive interventions, record all instances of restrictive practices and the development, approval and reporting of behaviours support plans. However, we do not endorse the current Restrictive Intervention Data System (RIDS) in use in Victoria. RIDS would require significant improvements to its functionality. These improvements would include:

  - Removing timeouts that result in loss of data
  - Improvements in speed and functionality
  - Accessing data via the person and not a service site
  - Printing of BSPs to more closely represent the electronic version rather than doubling up information.