NATIONAL DISABILITY INSURANCE SCHEME QUALITY AND SAFEGUARDING FRAMEWORK

Acknowledgments

ARTD CONSULTANTS
strategy & evaluation

ARTD Pty Ltd   **Level 4, 352 Kent St Sydney**
ABN 75 003 701 764   **PO Box 1167**
Tel 02 9373 9900   **Queen Victoria Building**
Fax 02 9373 9998   **NSW 1230 Australia**

Contents

ARTD CONSULTANTS
strategy & evaluation

ARTD**CONSULTANTS**
strategy & evaluation

ARTD CONSULTANTS
strategy & evaluation

Executive summary

Consultation on quality and safeguarding in the NDIS

The NDIS represents a major change to how services are funded and delivered. It requires a new national approach to quality and safeguarding to ensure consistency across states and territories and replace quality and safeguarding measures currently managed through state-based legislation and funding agreements between providers and government agencies.

Commonwealth, State and Territory Governments are developing a national approach to quality and safeguarding for the NDIS. Because this represents a significant regulatory policy, with the potential to impact on businesses, community organisations and individuals, they needed to prepare a Regulation Impact Statement. This process requires governments to consider a range of options and assess their associated benefits, impacts and costs through consultation and a cost-benefit analysis.

This report presents the findings from the consultation process, which included 16 public meetings in capital cities and regional locations in each state and territory, 7 provider meetings in locations around Australia, 6 workshops with specific stakeholder groups, 220 submissions, 585 questionnaire responses and an online discussion forum.

Key findings

Overall, there was a high-level of agreement among stakeholders about the quality and safeguarding measures that should be adopted for the NDIS. While stakeholders emphasised the need to focus on developmental safeguards, they also generally suggested a need for high-level regulation. Many were sceptical of the assumption that the development of a competitive market for disability care and support would empower people to make choices, particularly in the short-term, and they were concerned about any reduction in current quality and safeguarding measures given that cases of abuse and neglect have occurred even with these protections.

There were differing views about particular details, such as the type of services that should be required to meet particular quality assurance requirements in order to be registered with the NDIA and the safeguards that should apply if restrictive practices are required to keep a person safe. There was also one element that stakeholders had very different views about—the question of what, if any, quality and safeguarding measures should apply in circumstances where people are managing their own supports.

ARTD**CONSULTANTS**
strategy & evaluation

What are the overarching considerations for the Framework?

As well as views on particular elements of the NDIS Quality and Safeguarding Framework, the consultation identified a range of overarching considerations. These include emphasising the human rights basis for the Framework; clarifying the links with other relevant policies and legislation; recognising differing levels of individual risk and risks for particular groups of people with disability; achieving the right balance between enabling choice and safeguarding and between the different elements of the Framework; reflecting the costs of quality; addressing potential gaps in the market; streamlining measures, such as provider approval processes, across relevant sectors; and recognising approaches across sectors.

What information do people require and how can we make sure it is accessible?

Stakeholders stressed the need for information about a range of topics to enable people with disability to effectively exercise choice and control. This included information about navigating the system, their rights and responsibilities, complaints mechanisms, available providers, and independent information about provider quality. This information is needed in a range of formats—including easy English, pictorial, community languages, Auslan, braille, audio, video, large print and screen-reader accessible—and through multiple channels. The consultation identified information from peers as important, but that there would be both pros and cons in establishing an online forum for sharing information about provider quality. It also identified that some people will need support to interpret information and that targeted information strategies will be needed to reach people who might not otherwise come into contact with the NDIS.

What is required to build capacity?

The importance of building individual capacity—to enable choice and control, and to support effective safeguarding—was a significant theme in the consultation. Individuals with disability will come to the NDIS with varying levels of experience and capacity to make informed choices and take control of their supports. Some will be ready to develop their plan and manage their own supports, while others will need time and supports to understand their rights, develop their goals, and make choices. People with intellectual disability, complex communication needs and few natural supports will need particular supports.

Stakeholders identified an opportunity to build people's decision-making skills and support exploration of opportunities, risks and safeguards through the NDIA planning process. However, to enable this, some people may need pre-planning supports, decision-making supports and more time for planning.

ARTD CONSULTANTS
strategy & evaluation

While families often play an important support role, many stakeholders (including people with disability and their families, as well as advocates) said that independent advocacy services and peer support networks also have important functions. They can help people to understand their rights, make choices, navigate service systems, make complaints and raise issues if something goes wrong. Self-advocacy supports can empower people to make choices and advocate for their rights, and systemic advocacy can identify trends and issues at the system level.

The consultation identified building community capacity for inclusion as a key quality and safeguarding measure. How this is done is tied to the *NDIS Framework for Information, Linkages and Capacity Building* (formerly Tier 2), but suggestions from the consultation included funding community awareness-raising campaigns, building community connections, building the capacity of community and mainstream services, and supporting coordination across sectors.

While stakeholders recognised the significant transformation and growth required in the sector, the consultation was less focused on building sector capacity than other elements of the NDIS Quality and Safeguarding Framework. Work has already commenced in outlining the future structure of the market, the sector and its workforce under the NDIS. The *NDIS Integrated Market, Sector and Workforce Strategy* provides a vision of what the future market would look like, and how it would function. The Strategy aims to provide guidance to the NDIA and governments in implementing the NDIS for the development of a sustainable and efficient future market. Some projects that will help build sector capacity under the Strategy will be funded through the Sector Developmental Fund.

The consultation noted the importance of building positive organisational cultures and training in a range of areas to support organisations and staff to transition to the NDIS. As were general concerns about the difficulties of attracting and maintaining a skilled workforce, and particular concerns about building the market in regional and remote areas, ensuring appropriate services for Aboriginal communities and culturally and linguistically diverse communities, and ensuring supports are available to people with complex needs.

What requirements should apply to registered providers?

Support was strongest for Option 4 (mandated participation in an external quality assurance system for providers of supports considered higher risk), that is, the continuation of existing requirements for many government-funded specialist disability services. However, there were different views about what requirements should apply to different service types.

ARTD CONSULTANTS
strategy & evaluation

The consultation emphasised the benefit of nationally consistent requirements, recognition of providers' compliance with other relevant quality standards and professional registration to reduce red tape; input from people with disability in assessing provider quality; and a strong focus on assessing outcomes for people with disability.

Some stakeholders suggested that there should also be registration requirements at the individual staff level for professionals that do not already have to meet registration requirements, while others stressed the importance of staff attitudes and values over qualifications.

What staff screening arrangements should be required?

The majority of stakeholders supported Option 3 (working with vulnerable persons clearance for staff delivering supports considered to pose a higher risk) and were keen to ensure this drew on live information and more than just information about convictions. There was also support for Option 4 (a barred persons list), but somewhat less than for Option 3. This is probably in part because people have had very limited experience with this model (it has only been in place for accommodation services in Victoria for a short time), but some had particular concerns about the implications it would have for employers and employees. Stakeholders often suggested combining the options because they wanted to see the highest level of safeguarding possible. As with provider registration, there were differing views about which services screening requirements should apply to.

There was strong support for a nationally consistent approach to staff screening to prevent people with a history of criminal and/or exploitative behaviour from moving interstate to take up a new position and for consistency across sectors. Some questions were raised about who would manage staff screening or a barred persons list and who would decide whether a person is safe.

Stakeholders also noted that screening processes are not all that is required to ensure that people with disability are protected from abuse, neglect, exploitation and inappropriate staff practice. There were references to the need for effective recruitment practices; the development of organisational cultures that do not tolerate abuse, neglect and exploitation; ongoing staff training and supervision; and the involvement of people with disability in selecting the staff that they work with.

How should complaints be handled?

There was overwhelming support among stakeholders for Option 3b (an independent statutory complaints body) to address complaints that cannot be effectively resolved

between participants and providers. They argued that an independent body was necessary to give people confidence in the system; internal complaints systems would be inadequate; and the NDIA could not manage complaints as this would conflict with their regulatory role. There were, however, different views about whether there should be a new national body or existing state-based bodies should be used, and whether the complaints body should cover all NDIS funded services, all specialist disability services or all specialist disability services funded by the NDIS.

The significant barriers that people with disability can face in accessing complaints systems was a strong theme in the consultation. Stakeholders noted the important roles that advocates, community visitors and natural support people play in supporting people to make complaints. Others noted the importance of providers developing positive complaints cultures and recognising the value of feedback.

What oversight functions are required?

There was a high level of support for an independent oversight body among the various stakeholder groups. Many stakeholders identified an oversight body as an extension of the independent complaints body discussed above.

While not all stakeholders were aware of or had experience with community visitors, there was a substantial amount of support for some form of community visitor type function, including among providers, statutory bodies, people with disability and their families. However, questions were raised about how a community visitors scheme would work in the NDIS environment.

There was less discussion of serious incident reporting than other elements of the Framework. This may be because some stakeholders assumed that serious incident reporting would be required as it is currently in most states and territories. Among those who expressly supported serious incident reporting were statutory bodies, advocates, peak bodies, professional associations, providers and academics. The consultation also identified some specific considerations in establishing serious incident reporting requirements for the NDIS, including the need for agreed definitions of what is to be reported, identification of which providers would be required to report, and clarification of how this process would complement police investigations.

What quality and safeguarding measures should apply to self-managed supports?

Views were divided on the best option for self-managed supports. Some, particularly people with disability and their families, argued for Option 1 (allow self-managing participants to choose any provider other than close family members while building their capacity to manage their own risks), indicating that additional measures could

curtail choice and control, and dignity of risk. Others argued that some regulation was necessary because of the risks staff and providers could pose to self-managing participants. Some of these argued for some form of minimum screening (Options 2b or 3c) to protect people from staff that have a history that suggests they may pose a risk. While others—particularly providers, professional associations and unions, but also some people with disability and their families—argued that all providers should have to meet NDIA registration requirements. A few of these argued for Option 3a (limited registration requirements) to provide flexibility while reducing potential risks to people with disability, but more argued for Option 3b (full registration) to best ensure people with disability receive high quality services and are safe from harm.

Stakeholders from all groups identified the importance of providing self-managing participants with information, advice, training, support and/or skills building in a range of areas, including recruiting, managing and training staff; budgeting and managing finances; and negotiation. Some also identified the need for consideration of particular safeguards around the use of nominees and plan managers, and employment of friends or extended family.

What should be the authorisation and reporting requirements for restrictive practices?

Regulation of restrictive practices was discussed less than other elements of the Framework. This may be because their use concerns a smaller group of people. Among those who did comment, there was strong support for government oversight to protect the rights of people with disability and contribute to the reduction of these practices (in line with the *UN Convention on the Rights of Persons with Disabilities*). Stakeholders also stressed the importance of positive behaviour support plans and the involvement of people with disability, their family members and other relevant professionals.

Of the options for authorisation, support was strongest for Option 4 (requiring that an independent decision maker authorise the use of restrictive practices). There were, however, differing views about the most appropriate model for authorisation—whether a Senior Practitioner, tribunal or panel—and some suggestions for a tiered approach.

Reporting on the use of restrictive practices was also supported as necessary for reducing the use of these practices and understanding the impact of any actions intended to reduce their use. However, stakeholders did not always specify which level of reporting they supported. At public and provider meetings, stakeholders said that reporting was important, but that processes should not be too onerous. Among submissions and questionnaire respondents, there was support for both Option 2 (mandatory reporting on emergency use and one-off reporting on positive behaviour

ARTD CONSULTANTS
strategy & evaluation

support plans that include a restrictive practice) and Option 3 (all elements of Option 2, plus routine reporting on each occasion when certain restrictive practices are used). The argument for the higher level of reporting was that it is necessary to monitor patterns and trends to support reduced use of restrictive practices. Whichever level of reporting is chosen, stakeholders noted that there would be a need for an easy-to-use data system. Providers in some jurisdictions also suggested that processes around developing behaviour support plans could be simplified.

The consultation also identified a range of other considerations in supporting the commitment to reduce and eliminate the use of restrictive practices. Chief among these were the need for clarification of definitions and guidelines, education and advice around restrictive practices and positive behaviour support, and building the behavioural support workforce.

How will your views be considered?

The findings of the consultation, the cost-benefit analysis, inquiries into abuse in the disability sector, and other relevant policy work will help inform decisions about the best options for the NDIS Quality and Safeguarding Framework. Based on this information, Commonwealth, State and Territory Governments will work together to prepare a Decision Regulation Impact Statement for consideration by Ministers in early 2016.

ARTDCONSULTANTS
strategy & evaluation

1.   The consultation project

1.1 The context

1.1.1 The National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) provides individualised funding for reasonable and necessary supports for people with a permanent and significant disability that affects their ability to take part in everyday activities. It also provides information, referrals and support for people with disability, their families and carers through Information, Linkages and Capacity Building (formerly known as Tier 2).

The NDIS is administered by the National Disability Insurance Agency (NDIA). It is currently being trialled in the Hunter (New South Wales), Barwon (Victoria), Perth Hills (Western Australia), Barkly (Northern Territory), the Australian Capital Territory, South Australia (for children birth to 14 years old), and Tasmania (for 15–24 year olds), and will progressively replace existing disability support arrangements in all states and territories (except Western Australia) between July 2016 and 2019.[1]

The NDIS represents a major change to how services are funded and delivered. It gives participants more choice and control about the services and supports that they access through individualised planning and funding, including the ability to manage their own funding or use a nominee or a plan manager to manage their funding (unless the NDIA deems this an 'unreasonable risk' for the participant). It requires providers to position themselves within a competitive service market to attract clients rather than apply for block funding from government agencies. It is also attracting new entrants to the market, including private organisations and providers of general services, such as transport and household assistance.

1.1.2 Developing an NDIS Quality and Safeguarding Framework

Existing state and territory quality and safeguarding systems and the *NDIA Terms of Business for Registered Support Providers* are being used in the NDIS trial. However, once the NDIS is fully rolled out, a new approach to quality and safeguarding will be needed to ensure consistency across states and territories and to replace quality and safeguarding measures currently managed through state-based legislation and funding contracts between providers and government agencies.

---

[1] Western Australia has made no commitment to the full rollout of the NDIS.

Commonwealth, State and Territory Governments are developing a national approach to quality and safeguarding for the NDIS.

The development of an NDIS Quality and Safeguarding Framework has the potential to have a significant regulatory impact on businesses, community organisations and individuals. Any new policy work of this nature being developed for Ministerial Councils must meet the requirements of the Council of Australian Governments' (COAG) guide to best practice regulation. As a result, a Regulation Impact Statement needs to be developed. This process requires governments to consider a range of options (including, as appropriate, non-regulatory, self-regulatory, quasi-regulatory, co-regulatory and regulatory approaches) and assess their associated benefits, impacts and costs through consultation and a cost-benefit analysis.

ARTD was contracted to facilitate the public and provider consultation meetings and write a summary report on all consultation activities. Nous Group was contracted to conduct the cost-benefit analysis.

Decision-making about the design of the NDIS Quality and Safeguarding Framework coincides with and will also be informed by current inquiries into abuse in the disability sector (the Australian Senate inquiry into violence, abuse and neglect of people with disability in institutional and residential settings, the Victorian Parliamentary Inquiry into Abuse in Disability Services, and the Victorian Ombudsman's Inquiry into the handling of abuse allegations in the disability sector), and other relevant policy work, including the design of the *NDIS Framework for Information, Linkages and Capacity Building*, the *NDIS Integrated Market, Sector and Workforce Strategy* and the review of the *National Disability Advocacy Framework*.

1.2   The consultation

1.2.1   Focus of the consultation

Governments developed a Consultation Paper to seek stakeholder views about a national approach to quality and safeguarding. The paper drew on information about existing quality and safeguarding systems in the disability and other relevant sectors in Australia and internationally, and the research literature. It identified the need for an NDIS Quality and Safeguarding Framework to include a range of elements in three domains: developmental, preventative and corrective (see Figure 1).

ARTD CONSULTANTS
strategy & evaluation

Figure 1.   **Proposed structure of the NDIS Quality and Safeguarding Framework**

Developmental	Preventative	Corrective
Focus: Building individuals' natural safeguards	**Focus**: Preventing harm and promoting quality	**Focus**: Responding if things go wrong
Information for participants Accessible information on how the system works, support types and service quality	**Formal individual safeguards** Risk management through individual plans, reducing the use of restrictive practices	**Universal safeguards** Protections outside the NDIS such as consumer law
Building natural safeguards Supporting individual capacity building, families and community support networks	**Service level safeguards** Capacity building for providers of supports and ensuring staff are safe to work with participants	**Systems for handling complaints** Responding to complaints
	System level safeguards NDIS legislation and policy including registration arrangements for providers of supports	**Serious incident reporting** Gathering information on dangerous situations
		Oversight functions Monitoring quality and safeguarding across the NDIS

Safeguards for participants who are self-managing
Strengthening support for self-managing participants

Five of these elements were identified as having a potentially significant impact on businesses, community organisations and individuals, depending on the approach adopted. These are:

- NDIA provider registration
- ensuring staff are safe to work with participants
- systems for handling complaints
- safeguards for participants who manage their own plans
- reducing and eliminating restrictive practices in NDIS funded supports.[2]

---

[2]A restrictive practice is any intervention which restricts the rights or freedom of movement of a person with disability who displays challenging behaviours, where the primary purpose of that intervention is to protect that person or others from harm. The Commonwealth, State and Territory Governments have all committed to reducing and eliminating the use of restrictive practices.

ARTDCONSULTANTS
strategy & evaluation

For each of these, a range of options were identified and views were sought on other potential options.

The key question for the consultation was: What is the right balance between, on the one hand, governments' duty of care and, on the other, ensuring there is genuine choice and control for people with disability and streamlined regulation for providers?

1.2.2 Consultation methods

The consultation involved the following activities between February and May 2015:

- 16 public meetings in capital cities and regional locations in each state and territory
- 7 provider meetings in locations around Australia
- 6 workshops with specific stakeholder groups
- 220 submissions
- 585 questionnaire responses about particular elements of the NDIS Quality and Safeguarding Framework
- an online discussion forum.

Officials from different jurisdictions also engaged in specific stakeholder consultations, which are not dealt with in this report.

The consultation report draws on all data from the activities listed above (see Table 1).

Table 1.   Consultation methods

Method	Numbers	Timing	Comments
Public meetings	- Canberra (n=75) - Adelaide (n=102) - Whyalla (n=14) - Launceston (n=28) - Hobart (n=26) - Darwin (n=26) - Alice Springs (n=16) - Brisbane (n=61) - Townsville (n=34) - Bunbury (n=11) - Perth (n=48) - Sydney (n=35) - Newcastle (n=60) - Melbourne (n=92) - Geelong (n=48) - Mildura (n=24)	19 March – 23 April	**Registration process:** DSS advertised the meetings in each location through <u>DSS Engage website</u> and relevant media. ARTD managed an online registration process. **Attendee numbers and characteristics**: The number of attendees for each meeting is an estimate because not all attendees at each meeting signed in; some people who registered did not attend; and some who did not register attended. The proportion of people from each stakeholder group varied between meetings. All meetings were in accessible locations; supports to enable people with disability to participate were available; and where a high proportion of providers registered for a public meeting in a location with a provider meeting, registrants were informed of the option to attend the provider meeting. However, across the meetings, a higher proportion of providers attended than people with disability and their families. Advocates were also generally well represented across the meetings. **Data**: ARTD senior staff presented the <u>Consultation Paper</u> and facilitated the meetings. Meetings lasted from 2–3 hours depending on the number of attendees and the amount of discussion. Not all meetings covered all elements of the Framework, and the depth of discussion on each element varied according to the interests of attendees. The meeting in Canberra included small discussion groups on particular aspects of the Framework at the request of ACT government agencies. **Analysis**: ARTD summarised meeting data into key elements of the Framework and other considerations and analysed this to identify levels of support for the options for each element of the Framework, the reasons given in support of particular options, suggestions about the implementation of particular options, and other key themes.
Provider meetings	- Adelaide (n=100) - Hobart (n=26) - Brisbane (n=55) - Perth (n=23) - Sydney (n=51)	25 March – 16 April	**Registration process:** DSS advertised the meetings in each location through <u>DSS Engage website</u> and local newspapers. National Disability Services managed promotion of the meetings and an online registration process. **Attendee numbers and characteristics**: The number of attendees for each meeting is an estimate because not all attendees at each meeting signed in; some people who registered did not attend; and

ARTD CONSULTANTS
strategy & evaluation

Method	Numbers	Timing	Comments
	▪ Melbourne (n=67) ▪ Geelong (n=80)		some who did not register attended. National Disability Services encouraged senior managers to attend the provider meetings. Additionally, where a high proportion of providers registered for a public meeting in a location with a provider meeting, ARTD informed registrants of the option to attend the provider meeting. Registrants were from a mix of organisations providing different service types, including supported accommodation, early childhood intervention, respite, mental health services, independent living, home care and youth services. There were also registrants from organisations supporting people with particular disabilities, including cerebral palsy, spinal injury, deafness, visual impairments and blindness, epilepsy, autism, and motor neuron disease. **Data**: ARTD senior staff presented the <u>Consultation Paper</u> and facilitated the meetings. Meetings lasted from 2–3 hours depending on the number of attendees and the amount of discussion. **Analysis**: ARTD summarised meeting data into key elements of the Framework and other considerations and analysed this to identify levels of support for the options for each element of the Framework, the reasons given in support of particular options, suggestions about the implementation of particular options, and other key themes.
Workshops	▪ Culturally and linguistically diverse (CALD), Perth (n=6) ▪ Women with Disability, Melbourne (n=10) ▪ Aboriginal and Torres Strait Islander, Newcastle (n=12) ▪ Mental health, Canberra (n=17) ▪ Acquired Brain Injuries (ABI), Newcastle (n=13) ▪ Carers, Canberra (n=20)	8 April – 10 June	**Registration process:** DSS worked with peak bodies and advocacy services to invite participants to workshops. **Attendee numbers and characteristics**: ▪ *Culturally and linguistically diverse*: 5 representatives from WA-based advocacy organisations (of these, 2 had lived experience of disability and 1 was a parent of a person with disability) and 1 representative from the National Ethnic Disability Alliance participated. ▪ *Women with disability:* participants were women with varying disabilities. ▪ *Aboriginal and Torres Strait Islander*: participants were people with disability, advocates, volunteers, and representatives from the NDIA and providers. ▪ *Mental health:* participants were mental health consumers and carers. ▪ *Acquired Brain Injuries*: 6 participants had an ABI, 6 were parents of a person with an ABI and 1 was a support worker. ▪ *Carers*: participants were carers of adults with disability, some of whom were already receiving

ARTD CONSULTANTS
strategy & evaluation

Method	Numbers	Timing	Comments
			services through the NDIS, but most of whom were waiting to be assessed.
			Data: The workshops were designed to capture feedback particular to certain stakeholder groups that may not otherwise have been well-represented in public meetings or submissions. DSS facilitated the Aboriginal and Torres Strait Islander, mental health and carers workshops; a specialist facilitated the women with disability and ABI workshops; and ARTD facilitated the CALD workshop. The workshops varied in length and not all covered each element of the Framework.
			Analysis: ARTD analysed workshop data to identify levels of support for the options for each element of the Framework, the reasons given in support of particular options, suggestions about the implementation of particular options, and other key themes.
Submissions	n=220	April – May	**Submission process**: DSS promoted the opportunity to make a submission through <u>DSS Engage website</u> and the public and provider meetings.
			Submission numbers and characteristics: There were submissions from a range of national organisations and providers and other organisations from all states and territories except the Northern Territory. The number of submissions from NSW and Victoria was higher than from other states and territories. There were submissions from a range of stakeholders, including people with disability, family members and carers, advocacy services, providers, peak bodies, professional associations, statutory bodies, government agencies, unions, universities and academics. About 50 submissions came from advocacy services and 50 from providers.
			Data: Submissions varied in length and detail. Not all submissions covered all elements of the Framework and some did not clearly state support for particular options.
			Analysis: DSS staff analysed the submissions, summarising comments into the relevant elements of the Framework and other key themes using an excel template. ARTD then used an Access database to identify levels of support for the options for each element of the Framework, the reasons given in support of particular options, suggestions about the implementation of particular options, and other key themes.

ARTDCONSULTANTS
strategy & evaluation

Method	Numbers	Timing	Comments
Questionnaires	- Total (n=585) - Capacity (n=108) - Registration (n=72) - Staffing screening (n=156) - Complaints and oversight (n=78) - Self-managing participants (n=119) - Restrictive practices (n=52)	February – 30 April	**Questionnaire process:** DSS developed questionnaires for each Framework element and promoted these through DSS Engage website and the public and provider meetings. **Respondent numbers and characteristics**: The number of respondents to each questionnaire varied, as did the proportion of respondents from each stakeholder group. People with disability submitted questionnaire responses on all elements of the Framework, but they made up a higher proportion of respondents to the questionnaires on capacity, self-management and complaints and oversight. Family members and providers were well-represented across the questionnaires. **Analysis**: DSS staff analysed the questionnaires to identify levels of support for the options for each element of the Framework, the reasons given in support of particular options, and other key themes. A summary of the analysis was provided to ARTD for inclusion in the report.
Online discussion forum	- Total (n=21) - NDIS quality and safeguarding (n=10) Capacity (n= 9) - Registration (n=9) - Staffing screening (n=0) - Complaints (n=1) - Oversight: (11) - Self-managing participants (n=4) - Restrictive practices (n=3)	February – 30 April	**Discussion forum process**: DSS set up a discussion forum with an area for comments on each element of the Framework and an area for the Framework overall. **Participant numbers and characteristics**: The numbers we have reported are participant numbers for each area and overall; some participants made more than one comment. It was not always possible to identify stakeholder characteristics from comments. **Analysis**: ARTD analysed the forum data to identify levels of support for particular options and key themes. Where a comment in one area was relevant to another, we analysed it with other comments from that area.

In addition to this the NDIA posted a question about staff screening on the NDIS Facebook page on April 13 (*Who should decide if staff at NDIS service providers are safe to work with people with a disability?*) In total, 37 people made 48 comments in response. This data was considered with other data on staff screening.

ARTD CONSULTANTS
strategy & evaluation

Limitations and considerations

The purpose of this report is to describe the views expressed in the consultation to inform government decisions about the design of the Framework. In bringing together the feedback collected it has been important to remember that the consultation posed questions that are difficult to answer and which different stakeholder groups see from different angles. Stakeholder views on the elements of the Framework are also shaped by the different quality and safeguarding systems that they have experienced, by their role and position within existing systems, and by their individual experiences. Additionally, some people may have been reluctant to express contrary views to the majority during the public and provider meetings.

Some stakeholder groups were not as well represented as others in the consultation process. People with disability made up a smaller proportion of participants in the public meetings than providers. Also, few of the meetings identified particular concerns for Aboriginal and culturally and linguistically diverse communities. The targeted workshops were designed to address these gaps. This is why the report considers the levels of support for different options from different stakeholder groups, not only the overall levels of support. However, it was not possible to identify which stakeholder groups held which views in all data sources and there was limited feedback from providers of general services.

Lastly, some elements of the Framework were discussed in less detail than others, in particular the authorisation and reporting of restrictive practices, because stakeholders generally had less experience with these or because of time constraints in the meetings.

Concerns related to other aspects of the NDIS

The consultation identified concerns about a number of other aspects of the NDIS that are outside the scope of the NDIS Quality and Safeguarding Framework. These included concerns about:

- assessment, eligibility criteria, and access to the NDIS
- the supports that will be available to people with psychosocial disability through the NDIS and community mental health services
- the ability to access additional supports through the NDIS, including support for siblings
- waiting lists for supports, services, surgery and equipment
- the accessibility of public spaces

ARTDCONSULTANTS
strategy & evaluation

- housing and supported accommodation services, and access to accommodation
- recognition of the importance of health services and nutrition for people with disability
- the outsourcing of service delivery and privatisation.

These will need to be dealt with through other appropriate channels.

ARTDCONSULTANTS
strategy & evaluation

2. Overarching considerations for the Framework

As well as views on particular elements of the NDIS Quality and Safeguarding Framework, the consultation identified a range of overarching considerations. These include emphasising the human rights basis for the Framework; clarifying the links with other relevant policies and legislation; recognising differing levels of individual risk and risks for particular groups of people with disability; achieving the right balance between enabling choice and safeguarding and between the different elements of the Framework; reflecting the costs of quality; addressing potential gaps in the market; streamlining measures, such as provider approval processes, across relevant sectors; and recognising approaches across sectors.

2.1   Achieving the right balance

While the consultation identified the tension between enabling choice and control and ensuring sufficient quality and safeguarding measures, there was generally a high level of agreement among stakeholders about the quality and safeguarding measures that should be adopted for the NDIS. While many stakeholders emphasised the need to focus on developmental safeguards and to enable positive risk taking (or dignity of risk), many also suggested a need for high-level regulation. They were generally sceptical of the assumption that the development of a competitive market for disability care and support would empower people (particularly people with intellectual disability and people with few natural supports) to make choices, particularly in the short term, and they were concerned about any reduction in current quality and safeguarding measures given that cases of abuse and neglect have occurred even with these protections. However, a small proportion of stakeholders advocated a light-touch approach; some were concerned that regulation can give a false sense of security; and some suggested that regulation could potentially be reduced over time as the market matures.

The one element of the Framework that stakeholders had very different views about was the quality and safeguarding measures for participants who manage their own plans. Some argued for the right to choose any provider, while others argued that additional safeguarding and/or quality measures are required.

Views also differed on how different regulatory requirements should be applied across different service types and situations. Some suggested community and general services

ARTD CONSULTANTS
strategy & evaluation

providing funded supports should also have to screen their staff, and/or meet additional requirements, such as completing disability awareness training. Others thought this would limit people's choice and control and their right to access the same supports as other people in the community. Some suggested that these services should be able to voluntarily choose to meet additional requirements to differentiate themselves in the market.

Stakeholders also noted the need to consider the interconnections between different elements of the Framework—for example, how information collected across different elements could inform provider registration. Some also thought that if there was higher regulation in one area there could be lower regulation in another.

A strong theme was the need to learn from experience with current systems—where they have worked and where they have failed—to achieve the right balance.

2.2   Emphasising the human rights basis for the Framework

Various stakeholders suggested that there should be a strong emphasis on the human rights basis for the NDIS Quality and Safeguarding Framework, in particular, the rights flowing from Australia's ratification of the [UN Convention on the Rights of Persons with Disabilities](#). Some Victorian stakeholders also emphasised the need to ensure that the safeguards provided by state-based human rights legislation (Victoria's *Charter of Human Rights and Responsibilities Act 2006* and the ACT's *Human Rights Act 2004*) are not eroded in a national system.

2.3   Clarifying the links with other relevant policies and legislation

Comments from some stakeholders suggested a need to clarify the links with other policies that will contribute to the NDIS Quality and Safeguarding Framework objectives of building individual capacity, strengthening natural safeguards, building the capacity of the community and mainstream services, protecting people with disability from harm, and promoting access to quality supports. Some of these are currently being developed or reviewed.

- The *National Disability Strategy 2010–2020* has actions to support six priority areas (inclusive and accessible communities; the protection of rights; economic security; personal and community support; learning and skills; and health and wellbeing), many of which are relevant to the objectives of the NDIS Quality and Safeguarding Framework.

ARTD CONSULTANTS
strategy & evaluation

- The *NDIS Framework for Information, Linkages and Capacity Building* (formerly Tier 2) was in draft form at the time of the consultation. Its components (the provision of information and referrals; capacity building for mainstream services; community awareness and capacity building; individual capacity building; and Local Area Coordination) are relevant to the developmental objectives of the NDIS Quality and Safeguarding Framework.
- The *NDIS Integrated Market, Sector and Workforce Strategy* will support the workforce growth required to meet the needs of people with disability and sector capacity to adapt to the new service environment.
- The *National Disability Advocacy Framework*, which is currently being reviewed because of the significant changes in the disability environment since it was endorsed in 2012, will also affect the NDIS Quality and Safeguarding Framework. Stakeholders described the importance of advocacy functions including supporting individuals to navigate the system, building capacity, supporting people to make complaints, and identifying and addressing systemic issues.

Evidently, there are also implications for current Commonwealth and state-based legislation. The submission from People with Disability Australia and Women with Disabilities Australia spoke to a need for significant reform to address the Commonwealth, State and Territory laws, policies and practices that, in their view, deny or diminish the right of a person to exercise their legal capacity and for supported decision-making to be integral to the NDIS Quality and Safeguarding Framework. The Australian Guardianship Administration Council submission suggested that substitute decision-making and supported decision-making need to be viewed as key NDIS safeguarding mechanisms for people with significant cognitive impairments or mental ill health; that clarity is needed about the various overlapping powers and different appointment processes for substitute decision-makers under Commonwealth, State and Territory laws; that recommendations 5–1 to 5–5 in the Australian Law Reform Commission's *Equality, Capacity and Disability in Commonwealth Laws Final Report (2014)*, which specifically relate to the NDIS, should be implemented; that substitute decision-making should be restricted to situations of absolute necessity and supported decision-making should be promoted and used wherever possible in the context of NDIS-related decisions; and that the NDIS should fund a small number of innovative supported decision-making initiatives throughout Australia. The Australian Law Reform Commission submission suggested that the Framework should explicitly recognise supported decision-making. It should also support the shift to ensuring that the 'will, preferences and rights' of people who may require decision-making support direct the decisions that affect their lives, not another person's assessment of their 'best interests'. The Australian Government is currently preparing a response the Commission's report.

ARTD CONSULTANTS
strategy & evaluation

2.4　Recognising differing levels of risk and associated needs

There was support for the risk-based and person-centred approach to quality and safeguarding proposed in the Consultation Paper, that is, the identification of risks and safeguards through individual planning and higher compliance requirements for staff and providers of supports considered to pose a higher potential risk because they involve more direct contact between staff and participants or unsupervised contact (such as personal care in the home).

Some stakeholders suggested that a risk-based and person-centred approach should also recognise differing levels of individual vulnerability (associated with individual capacity and natural supports) in the setting of compliance requirements.

Many stakeholders also identified the need for particular considerations for specific populations, including measures to:

- ensure access to culturally appropriate information and supports for Aboriginal and Torres Strait Islander and culturally and linguistically diverse populations
- enable people with intellectual disability to exercise choice and control, and provide adequate safeguards that recognise their heightened vulnerability to exploitation, abuse and neglect
- recognise the particular needs of people with psychosocial disability
- recognise the particular needs of people with progressive neurological conditions
- recognise the particular needs of children with disability and their families, including requirements that providers comply with child safe principles and deliver evidence-based and best practice early childhood intervention
- recognise gender-based violence and the heightened vulnerability of women and girls with disability to exploitation, violence and abuse, and provide adequate safeguards
- recognise the particular needs of lesbian, gay, bisexual, transgender, and intersex people.

2.5　Reflecting the costs of quality

Stakeholders, particularly providers, noted the need for the Framework to consider the costs of providing high-quality services. Some suggested a need to support providers with the costs of compliance associated with registration conditions. Some said that if registration requirements differ, pricing structures need to reflect this; while others said requirements should not differ so as to ensure a level playing field and quality services. More broadly, some were concerned about the sufficiency of the NDIS 'efficient price' to ensure quality services.

At the Framework level, some suggested a need to consider the cost of different elements and select options that would be effective and cost-efficient, while there was another view that costs should not determine decision-making.

2.6   Addressing potential gaps in the market

The consultation recognised the significant growth required in the sector for the transition to the NDIS. There were particular concerns about market development in regional and remote areas, ensuring appropriate services for Aboriginal and Torres Strait Islander communities and culturally and linguistically diverse communities, and ensuring supports are available to people with complex needs.

There were concerns that high requirements for provider registration might limit market growth and access to services in regional and remote communities, but also concerns about ensuring that good quality services are provided in these areas. Some suggested the need for an innovative approach and monitoring of the market.

More specifically, some suggested the need to establish providers of last resort to ensure that people in regional and remote areas and groups of people for whom the market might fail receive the services that they need. There was also reference to the need for options in crisis situations where government services have traditionally provided a response.

2.7   Streamlining measures across relevant sectors

As noted in the Consultation Paper, stakeholders identified the development of the NDIS Quality and Safeguarding Framework as an opportunity to streamline measures across relevant sectors—the aged care and children's services sector in particular. They emphasised the importance of recognition of accreditation against relevant quality standards and of professional registration to reduce red tape for providers. They also identified the value of introducing consistent staff screening arrangements for staff working with children with disability and staff moving between the disability and aged care sectors.

Stakeholders also identified the potential for further complicating system pathways for people with disability, particularly people wanting to escalate a complaint if it could also be made to another existing complaints body. Particular reference was also made to the need for clarification of the interaction between NDIS quality and safeguarding measures with mental health sector quality and safeguarding measures.

ARTD CONSULTANTS
strategy & evaluation

2.8   Recognising approaches across sectors

The consultation noted responsibilities across sectors and areas in which coordination will be required to prevent or respond to abuse, neglect and exploitation. In particular, stakeholders noted interactions with the child protection and the criminal justice systems and to the need for a joint approach to responding to violence against women with disability and links to the *National Plan to Reduce Violence against Women and their Children 2010–2022*. There were particular concerns about the barriers that people with disability (particularly people with intellectual disability, people with complex communication needs and women with disability) can face in accessing the justice system and to the need for coordination between police investigations and the body that receives serious incident reports from providers.

There were also broader references to how the success of the NDIS will depend on the interfaces with other sectors and to the need for coordination across sectors to ensure integrated and holistic supports for people with complex needs.

2.9   Other considerations

Some submissions suggested a need to reconsider some of the language and definitions used in the Framework, for example, use of the words 'consumer', 'vulnerable' and 'serious incidents', and definitions of behavioural support and challenging behaviours.

There were also references to the need to clarify how quality and safeguarding measures for the NDIA are considered within or outside of the Framework. One provider submission suggested a need to articulate responsibilities at different levels of government, providers, and individual people with disability and their families.

Some providers suggested a need to consider protections for staff. Particular references were made to the need to ensure appropriate wages, superannuation, fair working conditions, and insurance and occupational health and safety provisions for staff directly employed by participants who manage their own plans, and to the need to consider staff safety when working with people with challenging behaviours.

More broadly, there were references to the need for iterative development of the Framework, for further consultation, and for evaluation and research to inform developments over time. This would require effective data collection at a national level. Some stakeholders also noted the need for time and supports to transition to the new system.

ARTDCONSULTANTS
strategy & evaluation

3. Information and capacity building

The Consultation Paper identified a range of information and capacity building measures for the NDIS:

- Accessible information on navigating the system, rights, types of support and service quality
- Building individual capacity, including through plan development and Local Area Coordination
- Strengthening natural safeguards
- Identification of risks and safeguards through individual planning
- Building the capacity of the community and mainstream providers
- Building the capacity of providers.

It asked what information people need to exercise choice and control, how we can make sure that information is accessible, and what other capacity building measures need to be considered?

3.1 Information provision and exchange

Stakeholders stressed the importance of accessible information about a range of topics to enable people with disability to effectively exercise choice and control.

3.1.1 The types of information people need

The consultation identified the need for information about a range of topics. These are in line with, and build on, the suggestions collected through consultations about the design of the NDIS and those included in the Consultation Paper.

- **Navigating the system**
  – NDIS eligibility criteria and application process
  – Supports available through the NDIS
  – Options and considerations for participants interested in managing their own plans
- **Rights and responsibilities**
  – Rights in the *UN Convention on the Rights of Persons with Disabilities*
  – What constitutes abuse, neglect and exploitation
  – Principles of choice and control
  – What to expect from a provider
  – The right to complain
  – Responsibilities of providers and participants
- **Planning**
  – Developing goals
  – Selecting supports
  – Identifying opportunities, risks and appropriate safeguards

ARTD CONSULTANTS
strategy & evaluation

- **Different types of supports**
  - Evidence-based interventions and practices
  - What supports the NDIS will fund
  - What different types of services there are, what they do and why you would use them
  - Prices for different service types
- **Registered providers**
  - Who the registered providers are
  - Providers' location, contact details, opening hours, and the types of services they provide
  - Formal information about the quality of providers
  - What other people think about the quality of providers
- **What to do when things go wrong**
  - How to access and navigate complaints systems

The specific information needs of self-managing participants are discussed in Section 7.2.3. Stakeholders also noted the need for information to be tailored to suit the needs of people at different stages of life and of their journey. There was also reference to the need for gender-specific information, recognising the particular needs of women and girls with disability.

The type of formal information about provider quality that is available will depend on the registration requirements introduced (See Chapter 4). National Disability Services, a peak body representing the non-government disability services sector, and some providers expressed support for making the results of formal quality assessments public to support informed decision-making. However, some providers expressed reservations about this for a range of reasons, including that it could take away the focus on supporting continuous quality improvement and encourage providers to cover up areas of weakness; the information could be misinterpreted; the information could be used for vexatious purposes; and providers would often be unable to defend their reputation due to legislated confidentiality and privacy requirements. Some were mostly concerned about the level of information that would be released.

The consultation also identified information from people with disability, their families and carers as important, but that there would be both pros and cons in establishing an online forum for sharing information about provider quality. The pros included that it would:

- enable people to share information about their experiences with providers
- support informed decision-making about which services to access

ARTD CONSULTANTS
strategy & evaluation

- be a trusted source of information as people are more likely to access and trust information from others with similar experiences.

The cons included concerns that it:

- would not provide structured feedback from a representative sample of participants (while independent quality evaluation would)
- could be skewed towards negative comments that do not reflect general experience with a provider
- could be open to providers adding fake positive comments that could not be differentiated from real comments
- would be open to trolling and deliberately destructive comments
- would not protect the privacy of individuals who share through the forum
- could contravene the Australian Health Practitioner Regulation Agency registration requirement that registered professionals not use testimonials and other professional Codes.

Many of those who saw value in an online information sharing forum suggested that it be moderated. Some noted specifically that this should not be the role of government or the NDIA. While others noted that some forums have already been independently established.

3.1.2 Making information accessible

Consistent with previous consultations, stakeholders stressed the importance of making sure information is accessible. They noted difficulties knowing where to start, knowing what to ask for, and finding the information they needed, as well as some particular issues with navigating the NDIS website. They stressed the need for information to be provided in a range of formats and distributed through multiple channels.

As a rule, information should be clear and jargon-free so it is easy to understand. However, there is no one way to provide information because people have varying communication needs and preferences and they absorb information in different ways. Suggestions for necessary information formats included easy English, pictorial, community languages, Auslan, braille, audio, video, large print and screen-reader accessible. There is also a need for information to be culturally appropriate and structured so that people who want, or need, less detailed information can get this and those who want more can access more.

Suggestions for ways to distribute information included through a website, social media platforms, apps and live chat formats, but it was stressed that these would not

be accessible to many people with disability and their families. For this reason, information should also be available in print formats, face-to-face, over the phone, via text message and through face-to-face forums; through traditional and community media (radio, television and newspapers); from peer networks, advocates and Local Area Coordinators; from community and mainstream services (including schools, community centres and general practitioners); and in relevant public places (including libraries and shopping centres).

There was also discussion of the need for strategies to reach communities and people that might not otherwise contact the NDIS and for culturally appropriate information that meets the needs of Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities. Suggestions included engaging and working with communities and Elders and the use of community radio.

Some stakeholders noted that some people will need help to interpret information. Advocates and peer support networks can provide this support.

3.1.3 Other considerations

Stakeholders identified the need for high-quality information. To many people, 'high-quality' meant information from a credible independent source; otherwise those providing information could be trying to influence people to choose a particular service. There were also references to the need for information to be accurate, up-to-date and consistent.

Information requirements

> *People with disability and their natural supports need information available in a range of formats and from sources that suit their individual needs. For example, some people will be comfortable with a centralised website, others will rely on a local, trusted community organisation. [NSW Council for Intellectual Disability, submission]*
>
> *Being socially isolated my opportunities to discuss the good and bad of any given program is limited. Online resources are paramount. [Person with disability, SA, questionnaire]*

ARTDCONSULTANTS
strategy & evaluation

> *I'm a big fan of the TripAdvisor concept. I think there are obviously inherent risks with that, particularly when you're talking about I guess an element of the population who doesn't have access to computers...There's also I guess people who get a bit of a bee in their bonnet and put something that is maybe over the top negative when maybe that's not necessarily the case. So there does need to be some sort of protection in that. Most of those sorts of things tend to be used if someone has a negative experience as opposed to a positive experience. So all of those things need to be taken into account when developing a system like that. [Parent, Newcastle, public meeting]*
>
> *My experience is that within services, the people with disability are not given the same access to information as we are. The onus is on services and on all of us to actually bridge that gap, to give them the information, whether that be in casual get-togethers, in education sessions. [Parent, Brisbane, public meeting]*
>
> *Obtaining knowledge from other people with disability or family members is an important aspect of learning and obtaining knowledge. Peer networks and local support groups such as those being established under the Disability Support Organisation Sector Development funding is providing the building blocks to support and facilitate this. [Queenslanders with Disability Network, submission]*
>
> *You know getting taught about my rights is the best powerful thing I've done. Getting taught by an advocate who knows about rights is the best. They give you confidence, it makes you feel good, like I can do anything in the world. They're always on your side ….Always. [Person with disability, Tasmania, advocacy service submission]*

3.2 Building individual capacity

The importance of building individual capacity—to enable choice and control, and to support effective safeguarding—was a significant theme in the consultation. Individuals with disability will come to the NDIS with varying levels of experience and capacity to make informed choices and take control of their supports. Some people may be ready to develop their plan and manage their own supports, while others will need time and supports to understand their rights, develop their goals, and make choices. People with intellectual disability, complex communication needs and few natural supports will need particular supports.

While families often play an important support role, many stakeholders (including people with disability and their families, as well as advocates) said that independent advocacy services and peer support networks also have important functions. They can help people to understand their rights, make choices, navigate service systems, make complaints and raise issues if something goes wrong.

ARTD CONSULTANTS
strategy & evaluation

3.2.1 Planning and decision-making

Consistent with the [Consultation Paper](#), stakeholders identified an opportunity to build people's decision-making skills and support exploration of opportunities, risks and safeguards through the NDIA planning process. However, many noted that the current process needs to be strengthened to support this. Key concerns included the need for information to prepare for the meeting, the time available for planning, the variability in skills and attitudes of planners, and the matching of participants and planners for suitability.

Stakeholders noted that capacity and risk will vary between individuals and over time, and that they are associated with multiple inter-related factors including disability type, communication needs and skills, available natural supports, the nature of the interaction between a person and provider, and the presence of comorbid physical and mental health issues. Some health professionals suggested that experienced health professionals may need to have a role in assessing capacity and risk in some cases.

Stakeholders also said that some people will need supports to start to identify what is possible, develop goals, and think about supports before they meet with an NDIA planner. Some (including people with intellectual disability, acquired brain injuries and complex communications needs, as well as some parents of newly diagnosed children) are likely to need more time and decision-making supports to take in information, reflect on it and make choices.

Stakeholders suggested that peers with lived experience, independent advocates, people with specialist skills and knowledge of particular disabilities and people from the person's cultural background could have roles in supporting planning and decision-making. While some emphasised the need for parents and carers to be involved in the planning process, others (including advocacy services and people with disability) emphasised the need for people to have the right to choose who they involve in their planning meetings. Some people with intellectual disability and women with disability noted concerns that families can be over-protective.

Additionally, in some cases, people may be subject to abuse, neglect or exploitation by family members. For this reason, planners need to be able to identify the risk of family violence and respond appropriately.

More broadly, stakeholders identified the need for the NDIA planning process to include a thorough exploration of opportunities, risks and safeguards. While some were particularly concerned about risk, various stakeholders emphasised the need to

ARTDCONSULTANTS
strategy & evaluation

include the concept of positive risk taking (or dignity of risk) within the Framework because, in the words of one person with disability 'if you don't take risks you don't learn'.

3.2.2   Someone in my corner

Many stakeholders (including people with disability and their families, as well as advocates) said that while family members will often play an important role in supporting people with disability, independent advocacy services and peer support networks also have important functions. These services were identified as particularly, but not only, important to people with few natural supports and people with cognitive disability. In the workshops, people with disability talked about the need for 'someone in my corner' who is independent of the NDIA and of providers.

Stakeholders identified advocacy services and peer support networks as important to help people to:

- understand their rights
- understand information
- assess the pros and cons of different options and make informed choices
- build decision-making capacity
- build capacity to self-advocate
- navigate service systems
- communicate their concerns and/or make complaints
- raise issues if something goes wrong.

The consultation also identified an important role for self-advocacy supports to empower people to make choices and advocate for their rights, and for systemic advocacy to identify trends and issues at the system level. What advocacy supports look like in the NDIS environment will be informed by the current review of the National Disability Advocacy Framework.

Consultations with Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities identified the importance of community organisations in supporting people with disability, particularly given that these communities often under-utilise services.

ARTDCONSULTANTS
strategy & evaluation

3.2.3 Building natural supports

The consultation identified the importance of natural supports as a safeguard. Broadly, there were references to the need to recognise and support parents and carers in their roles, to support positive relationships, and to support other family members, including siblings.

More specifically, circles of support and peer support networks were identified as useful. A circle of support involves a group of people voluntarily coming together to help formulate, promote and support the goals of a person with disability. Because they involve a number of people they enable people to take time out when needed and provide ongoing and sustainable support.

Stakeholders also referred to community visitors as a useful support for people with few natural supports (see section 6.2.2) and to the need to for supports to build positive community connections and community capacity for inclusion (discussed in the next section). In this context, a submission from a person with autism noted that there is a need to support people with intellectual disability to understand different relationships because they can be susceptible to predators and to recognise that intensive social environments can be incredibly traumatising for people with autism. This person was concerned that professionals had pushed them to make a friend, join a group and make local connections, without considering their individual needs, why they were not making friends, what skills they might need to develop first, and whether they wanted to participate.

Individual capacity building

> *Talk to us and ask us what we want and need. Have more advocates who only work for us to help us. Advocates teach us about our rights and teach us honestly. They are the only ones who tell us everything and don't baby us. [Person with disability, Tasmania, questionnaire]*
>
> *People with disability can learn new skills – it may take longer, and they may learn in a different way, but they can learn – with the right support. Skills around keeping safe, like decision-making and speaking up when things aren't going well are important safeguards for people. But regardless of all the capacity building that might be done, it's still important that independent advocates are there to keep an eye on things and support people to speak up when they need to. Advocates can also help people to learn new skills by showing them a way to approach something and supporting them to do it themselves. I see advocacy as a capacity building thing as well as a preventative thing and someone to help when things go wrong. [Parent, online discussion forum]*

> *The informal supports after a while naturally take over. I was volunteering somewhere, and after a year or so someone realised, "Hang on, when I drive home, I drive past your house. We're friends, I like you, I will take you home." It's having that consistent support there long enough that stuff like that happens… you can't just decide you're going to do something and then say, "Oh, you've been there ten times, you don't need me anymore," because that may not be true. [Person with disability, Newcastle, public meeting]*
>
> *I think peer support groups are really important in activating choice for participants in the scheme, and especially for people who would like to try self-managing funds and might not have the confidence to go about starting to do that. [Provider, Sydney, provider meeting]*
>
> *It's very important to have peer support. It happens by phone and group meetings are important too. Twenty years ago I was a wreck. I had to write notes to shop keepers and I was afraid to speak publicly. Now I can't shut up (because of peer support). [Woman with disability, Victoria, advocacy service submission]*

3.3   Building community and mainstream service capacity

As well as using community and mainstream services to distribute information, the consultation identified building community capacity for inclusion as a key quality and safeguarding measure. There were particular references to the need to build the capacity of community and mainstream services to support and include people with intellectual disability and complex support needs.

The *NDIS Framework for Information, Linkages and Capacity Building* was in draft form at the time of the consultation and stakeholders noted that the supports it funds will be important to the NDIS Quality and Safeguarding Framework. Suggestions made for building community capacity included:

- funding community awareness raising campaigns
- developing and strengthening the Local Area Coordination role
- building capacity in community organisations and mainstream services to support people with disability
- working with Aboriginal and Torres Strait Islander and cultural organisations
- building community connections
- providing disability awareness training for staff in mainstream services
- supporting coordination across disability, mainstream and community services
- supporting community organisations with the transition to the NDIS
- supporting community organisations to deliver information and training sessions.

ARTDCONSULTANTS
strategy & evaluation

More broadly, there were also references to the need to increase the accessibility of community venues and infrastructure, including housing, transport, employment and education, including in rural areas.

Building community capacity

I think sometimes we start terrifying people of the community. The community has kept my son safe on numerous occasions and they haven't gone through any of these procedures and processes to check them off. So I think we've got to start valuing that. [Parent, Canberra, public meeting]

If we try to keep some of these safeguards purely within the scheme, that's going to be one of the failings. If we don't go to that broader community and have mechanisms in there, community building… that helps cover some of this then the implications will be that the system will be probably wound up tighter than it needs to be. So I think that needs to be another consideration in this, that we actually need to make some of this much bigger than the sector [Stakeholder, Canberra, public meeting]

3.4   Building sector capacity

While stakeholders recognised the significant transformation and growth required in the sector, the consultation was less focused on building sector capacity than other elements of the NDIS Quality and Safeguarding Framework. Work has already commenced in outlining the future structure of the market, the sector and its workforce under the NDIS. The *NDIS Integrated Market, Sector and Workforce Strategy* provides a vision of what the future market would look like, and how it would function. The Strategy aims to provide guidance to the NDIA and governments in implementing the NDIS for the development of a sustainable and efficient future market. Some projects that will help build sector capacity under the Strategy will be funded through the Sector Developmental Fund.

The consultation noted the importance of building positive organisational cultures and training in a range of areas to support organisations and staff to transition to the NDIS.

3.4.1   Building organisational and staff capacity

At the organisational level, stakeholders noted the importance of supporting the development of positive organisational cultures—cultures that value, respect, seek input from, and involve people with disability; are accountable and transparent; and do not tolerate abuse, neglect and exploitation. There were various suggestions for training covering areas such as:

ARTDCONSULTANTS
strategy & evaluation

- the rights of people with disability, including *the UN Convention on the Rights of Persons with Disabilities*
- the NDIS principles
- preventing, recognising and responding to abuse, neglect and exploitation (with particular references to National Disability Services' Zero Tolerance project)
- prevention and responding the particular needs of women and girls with disability
- specialist violence prevention (developed in consultation with and delivered by women with disability, family violence, sexual assault, justice, police, mental health, aged care and disability organisations)
- person-centred and family-centred approaches
- thinking from a safeguarding perspective rather than a risk-management perspective
- supported decision-making
- positive behaviour support
- understanding of different types of disability
- evidence-based practices
- cultural competency
- working with lesbian, gay, bisexual, transgender and intersex people
- the gendered nature of violence and abuse.

There were concerns about maintaining the educative and advisory functions provided by statutory bodies in current systems, for example, around complaints handling and reducing the use of restrictive practices. There were also references to the benefits of establishing ways for providers to share learnings.

3.4.2 Building workforce capacity

The consultation identified broad concerns about the sector growth required to deliver the NDIS and the difficulties of attracting and maintaining a skilled workforce. Some providers were concerned about the sufficiency of the NDIS 'efficient price' to support the recruitment and maintenance of a skilled workforce and the provision of ongoing professional development. There were also some concerns related to the increasing focus on a casual workforce and what this might mean for worker skills and competence.

Some stakeholders noted difficulties accessing relevant training courses in some areas. Additionally, one provider suggested a need to review the Australian Quality Training Framework for disability-related training to ensure it has a greater focus on capacity building, person-centred service delivery and understanding the NDIS.

ARTD CONSULTANTS
strategy & evaluation

More particular concerns were about building the market in regional and remote areas, and for Aboriginal and Torres Strait Islander and culturally and linguistically diverse communities and people with complex needs. Some stakeholders suggested the need to establish providers of last resort to ensure people receive the services they need.

The difficulty of accessing services in remote and outer-regional communities came through in the Aboriginal and Torres Strait Islander workshop and public meetings in Darwin, Alice Springs and Mildura. The Aboriginal and Torres Strait Islander workshop identified the need to ensure a strong place for Aboriginal organisations in the NDIS and to build the capacity of people in local communities to provide supports. One participant suggested that larger providers should mentor local Aboriginal organisations. This would ensure that local Aboriginal organisations not only survive but thrive in the new system. Building cultural competence among providers was also seen as key to quality service provision, with attendees agreeing that Aboriginal non-government organisations should be able to provide this training. They also suggested the need for NDIA planners to be culturally competent and emphasised the benefits of employing people with disability in the NDIA.

Participants in the culturally and linguistically diverse workshop strongly supported the need to build the capacity of providers to ensure cultural competency, including requiring some level of qualifications in cultural competency. However, they were not supportive of a peak body, such as the National Ethnic Disability Alliance, being responsible for a register of culturally competent staff.

Building sector capacity

> *The current price structure for supports does not create incentives for organisations to exceed expectations and continuously improve safeguarding systems and [we] see this as a concerning problem. [Provider, submission]*
>
> *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. [National Disability Services, submission]*

ARTD CONSULTANTS
strategy & evaluation

4. Registered providers

The Consultation Paper identified four options for provider registration:

- Option 1: Requirement to comply with the law and an NDIS Code of Conduct and safe practice

- Option 2: Additional registration conditions, including staff screening and complaints handling systems for providers of supports considered higher risk

- Option 3: Mandated independent quality evaluation for providers of supports considered higher risk

- Option 4: Mandated participation in an external quality assurance system for providers of supports considered higher risk.

Note: These options are not mutually exclusive; rather they build on one another.

4.1 Views on the options

Support was strongest for Option 4 (mandated participation in an external quality assurance system for providers of supports considered higher risk), that is, the continuation of existing requirements for many government-funded specialist disability services.

4.1.1 Support for Option 4

Support was highest for Option 4. Stakeholders from a range of groups, including people with disability and their families, providers, peak bodies, professional associations, statutory bodies and academics, supported this approach. Many of the providers that supported Option 4 had participated in external quality assurance and found it valuable. However, not all providers with experience of external quality assurance were convined of their value.

The arguments for Option 4 were that:

- lower-level requirements would not provide sufficient assurance of quality, for example, a Code of Conduct alone would be insufficient without auditing
- it would provide an independent, objective and professional assessment of quality
- it would provide the best assurance of quality supports
- it has supported and would continue to support continuous service improvement
- communities expect some level of quality assurance for government-funded services
- it should ensure that services have appropriate risk-management processes and governance
- it would help to ensure that services are sustainable

ARTDCONSULTANTS
strategy & evaluation

- it would build on developments in quality management in the disability sector and not reduce current requirements.

There were different views about which kinds of providers should be required to participate in an external quality assurance system (see Section 4.3.1).

Support for Option 4

> *The only way to truly assess providers and make sure they are [the] best they can be. A large number of participants are incredibly vulnerable and do not have the skills and abilities, nor the supports around them to work it out alone. [Person with disability, Victoria, questionnaire]*
>
> *...probably in the last ten years I think there's been improvement in the sector and that's because we've had legislation which has had a strong human rights framework and we've also had external quality accreditation, so I think that has pushed people to actually review what they do and to have transparency. I think in terms of our quality auditing there's a big focus on talking to our consumers and looking at our consumer feedback. So it's about how that quality process is done. But I think we've made really important gains in the last 10 years and there is a risk that we're actually going to lose that. [Provider, Geelong, provider meeting]*

4.1.2　Support for Option 3

There was some support for Option 3 (mandated independent quality evaluation for providers of supports considered higher risk) among different stakeholder groups and from National Disability Services. The reasons given for this were that:

- the focus of quality assessment should be on the perspectives of people with disability and the outcomes for people with disability, not processes
- quality assurance systems are not a guarantee of quality and they are costly
- it would provide the right balance.

Support for Option 3

> *As the Productivity Commission found – the disability services system is broken. They have not been good self-regulators in the past so there's no reason to think this will suddenly change – so a Code of Conduct is nice but ineffective. Paper-based quality assurance is too easy for organisations to fudge so they look good on paper when it may be very different to participants' experiences day to day. This has certainly been our experience over years of using disability services – the paper explanations of meeting standards and rhetoric means nothing as it is how they interact with our family member that matters to us. The paper-based quality assurance systems also tend to advantage the bigger organisations over the little local ones. An independent evaluator talking with people would see how things really are on the ground in practice. [Carer, NSW, questionnaire]*
>
> *Just looking at that fourth option, which has us looking at quality assurance measures and systems, I guess I'd be interested as to whether or not there has been any research about the actual outcome achieved through quality assurance systems. As we know currently most of us will be subject to one or more of these as a condition of funding arrangements and there are obviously crossovers and I think others might disagree, but in my experience they often come as quite costly, quite time consuming. I'm not actually sure how much they actually provide a level of assurance of quality. [Provider, Brisbane, provider meeting]*

4.1.3 Support for Options 1 or 2

There was only limited support for either Option 1 (requirement to comply with the law and an NDIS Code of Conduct and safe practice) or Option 2 (additional registration conditions, including staff screening and complaints handling systems, for providers of supports considered higher risk). The arguments for Option 2 included that it would provide a balance between choice and assurance and that quality assessments are not a guarantee of quality.

Support for Options 1 or 2

> *Currently we have quality assurance systems and evaluations which are ineffective for 2 main reasons: 1. the assessor informs the provider when they are coming; 2. the provider pays for the assessment and therefore the evaluator has an invested interest in remaining employed. If there was a Code of Conduct that all high-risk providers have to sign and abide by, which consists of practical implementations of weighed risks this could be adhered to in a helpful way rather than a restrictive way. [Person with disability, Queensland, questionnaire]*
>
> *...in a market driven environment I think having something that is minimum, that has the safeguards probably at the second level. And then your point of difference in your marketing and the way you attract clients, participants, is going to be "We are a provider that is registered with the NDIS, but we're taking these measures also" and that becomes your point of difference. [Provider, Hobart, provider meeting]*

4.1.4   Other suggested approaches

There were various suggestions for tiering of the requirements in different ways to those proposed in the Consultation Paper (discussed below). Additionally, a couple of submissions suggested the options could be simplified and a two- or three-tiered system could be introduced.

There were also a very small number of suggestions that all participants should have the right to choose any provider, not only self-managing participants, for some or all of their funding.

4.2   Design issues

4.2.1   Considering how the requirements should be tiered

There was support for a risk-based approach to registration requirements (that is requiring services considered to pose a higher potential risk to comply with additional requirements), but there was also some support for broader application of requirements, and some for a tiered approach to registration to take account of individual vulnerability or other factors. This was also the case for staff screening (see Section 5.2.1).

There was also some discussion about encouraging providers to seek a higher standard of accreditation than the minimum required for their service type because this would

ARTD**CONSULTANTS**
strategy & evaluation

provide higher levels of confidence for people who are at higher risk and enable people who wish to choose a provider based on their assessment by an external body.

In considering the various views, it is important to note that providers of services that are already required to participate in external quality assurance systems had a strong voice in the consultation and there was limited feedback from providers of general services.

Service type

Stakeholders generally identified services such as personal care, accommodation and respite, as well as other supports critical to wellbeing and daily living, as higher risk. Some also put children's services and services using restrictive practices in this category. However, others noted that situations in which a person is alone with a staff member are also potentially risky.

Some stakeholders wanted assurance that general services—other than those which are already regulated—funded through the NDIS were good quality because some people with disability (particularly those with intellectual disability, complex communication needs and few natural supports) might otherwise be at risk of exploitation by unscrupulous individuals or receive a poor quality service that does not meet their needs. Some of these stakeholders suggested that providers of general services should have to undergo some form of quality assurance, while others suggested that they could be required to meet minimum standards, such as undertaking disability awareness training. Some thought requirements in line with Option 2 should be the minimum for all registered providers.

On the other hand, there were stakeholders who were concerned that additional requirements would limit access to general services and the choice and control of people with disability. Some suggested that providers of general services could voluntarily meet additional requirements to differentiate themselves from other providers, and that this could be reflected by something like a Heart Foundation Tick or the UK's [Disability Confidence Quality Mark](). There was a lack of feedback from general services about how requirements would affect their provision of services to NDIS participants.

> *[What would be a low risk situation?] Taking someone to the gym, because you're in the community, there are people there. Particularly if you don't have really severe disabilities, it's not like you're going to be there on your own. However, if you were providing personal care to someone or you are a specialised driving instructor and you*

ARTD**CONSULTANTS**
strategy & evaluation

are on your own, then there should be a higher level of regulation and stuff involved because there is that higher level of risk. I also think that police checks and stuff should be mandatory, particularly if you're going to be on your own, just to provide that safety net. [Person with disability, Newcastle, public meeting]

If you're providing a service for the most vulnerable in our community, then you have to have the highest quality assurance that these people will be safe. My daughter wouldn't know if the lawn was mowed properly or not, but she would cheerfully pay the man if he came and knocked on the door and said, "I need that amount of money". She would cheerfully sign the piece of paper and say yes, it was done. It wouldn't take long for a person of less scruples to know, "I don't have to provide this service" or "I can add on to this service for the guy next door and she's paying for it." [Parent, Geelong public meeting]

Individual risk

Some stakeholders said that service type was not the only or not the main factor by which risk should be defined. Risk varies between individuals and relates to individual capacity, communication needs, and natural supports. Children, people with intellectual disability, people with complex communication needs and women with disability were identified as being at higher risk. The Attendant Care Industry Association proposed an approach to tiering registration requirements by service and individual risk factors.

You're looking at a whole lot of different services and different supports that are being provided— from someone just providing one-on-one verbal support to go out in the community and go shopping, through to personal care, through to feeding or whatever the case may be—and that for all of those you've also got that interaction between the participants and the participants' capacity. So I don't think there is a one-size-fits-all solution when it comes to the registration because when you're trying to protect I guess one of the high-risk participants in a high-risk situation, you obviously need a certain level of safeguards, but that's pretty much overkill for someone who has a vision impairment who is going out once a week shopping. I'd be I guess comfortable seeing something along the lines of [what] a lot of sporting organisations are introducing— sort of a silver, bronze, gold sort of star rating… then let the market sort of determine, with that information being provided I guess indicating where you might be best suited. So if you're having a lot of intimate personal care, we'd suggest that the gold level is probably what you're looking for when it comes to a service provider. However, it's your choice to go somewhere else if you feel that's the case. [Parent, Newcastle, public meeting]

Service size

There was some concern that small providers would not be able to meet the same requirements as large providers, but also a counter view that if small providers do not have to meet the same requirements they will be able to deliver services more cheaply, thus creating an uneven playing field.

Service location

There were concerns that high requirements might limit market growth and access to services in regional and remote communities, but also concerns about ensuring that good quality services are provided in these areas.

> *I think when we're talking about quality, it almost sets local providers at significant disadvantage because if you're talking about the information that people need, you're comparing I guess the sell of a really large organisation that has the benefits of economies of scale across the country versus a local organisation, so you're kind of comparing small versus large and information and expectations across remote – there's discussions of it being national, so therefore we need a one-size-fits-all, where in actual fact we probably need a one-size-fits-the-right-situation. [Provider, Alice Springs public meeting]*

4.2.2 Recognising other quality systems

Providers noted concerns that in the current system they are required to comply with various quality standards as well as the National Standards for Disability Services when working in different states and territories or in multiple sectors. They identified the need for nationally consistent requirements and recognition of compliance with other relevant quality standards to avoid the cost of duplication. There was particular reference to recognition of compliance with the National Standards for Mental Health Services for providers supporting NDIS participants with psychosocial disability and to the use of the Attendant Care Industry Standard for home care supports. Some noted that there are existing online systems that help providers to match standards they have met with other standards, making the process quicker and cheaper.

There was a strong argument for recognition of registered professionals, particularly those registered with the Australian Health Practitioner Regulation Agency. There were also some suggestions that these professionals could meet some additional requirements to ensure that they provide appropriate and evidence-based supports, particularly when providing early childhood intervention services. On the other hand,

ARTD CONSULTANTS
strategy & evaluation

some allied health professionals argued that too much additional regulation would drive professionals away from the NDIS, especially in markets where they are already managing high levels of demand.

> *I think we learnt a lot from the Better Start initiative because many families received funded support for a certain period of time, but many families, especially regionally, and not too far out of Brisbane, really struggled to expend their package because many of the therapists who may have had their own businesses found the registration process to register to be a provider under Better Start way too onerous and they just had too many other customers that they were wanting to provide service to … you might have a provider out there that could be offering an excellent service, they're a one-person operation, and if you make the registration way too onerous, they're actually not even going to be open to providing supports to participants under the NDIS. [Provider, Brisbane, provider meeting]*

There were a couple of comments that prosthetics providers should not be required to participate in a quality assurance system because they do not have direct contact with clients and they have their own industry regulation.

4.2.3 Defining the quality assessments

Stakeholders emphasised the need for much more than a 'tick-a-box' approach—for an assessment of provider quality that is truly independent and reflective or people's day-to-day experience with a service. They noted the need for input from a range people with disability (not only the people put forward by the provider whose views may not reflect general experiences with the provider) and a strong focus on outcomes for people with disability. Some stakeholders noted that this would require assessors with the necessary skills to undertake this work. The NSW Ombudsman suggested community visitors and Local Area Coordinators could feed into quality monitoring.

Additionally, the consultation identified the need for consideration of how frequently assessments should be undertaken and concern about the potential for conflict of interest in a model in which providers select and pay the organisation that conducts their quality assessment.

4.2.4 Developing the Code of Conduct

Stakeholders noted the need for organisations to have effective recruitment, training and supervision processes, effective complaints and serious incident management processes, and accountability and governance arrangements. There were also

references to the importance of services understanding and respecting different cultures.

What a Code of Conduct for registered providers would include was not a major focus of the consultation. Suggestions that were made were generally in line with the National Standards for Disability Services, which the Consultation Paper proposed as a basis for a Code of Conduct. These included prohibiting behaviours that may cause harm, respecting people with disability, listening to and being guided by what a person wants, and respecting people's right to privacy. There was reference to the need to recognise other codes of conduct that providers may be subject to, for example, the Code of Conduct for various allied health professionals.

4.2.5   Factoring in the compliance costs

Providers identified the need for assistance with the costs of compliance with quality requirements.

4.3   Other considerations

4.3.1   Considering requirements at the individual level

To support flexibility and choice and control, the *NDIS Act 2013* allows anyone to register if they can prove that they have the required capacity and experience, except where they are providing a support for which they must by law have certain qualifications (such as psychology or occupational therapy). The consultation raised the question of whether there should be specific registration requirements at the individual level, such as minimum qualifications, continuing professional development or registration with a professional association for other support workers.

There were different views about whether these sorts of minimum requirements would be appropriate where they are not already required. Some stakeholders emphasised the importance of employee attitudes over qualifications, as they did in consultations around the development of the NDIS. Others (including people with disability and providers) advocated for training, qualifications or accreditation in particular areas.

There were references to work done on a model for a registration and accreditation scheme for the disability support workforce through the NDIS Practical Design Fund and to the need to reconcile differences between current minimum qualification requirements for particular sectors across states and territories. A submission from a

ARTD CONSULTANTS
strategy & evaluation

consultant involved in developing advice to DSS on a national workforce strategy for the NDIS noted that a Code of Conduct at the individual level would have the advantage of applying to all contractors and employees, including those engaged directly by participants, and that stakeholders consulted about the workforce strategy had argued for broad application of the Code because of cases of recent abuse involving indirect workers, such as bus drivers. Another submission supported a national role-based registration and accreditation scheme modelled on the Australian Health Practitioner Regulation Agency.

There were also specific references to the need for:

- interpreters to be qualified and accredited by the National Accreditation Authority for Translators and Interpreters to ensure that people receive correct and appropriate information[3]
- staff working with people with complex communication needs or particular disabilities (such as acquired brain injury, multiple sclerosis and autism) to have appropriate training
- staff working with people with complex communication needs to understand how to effectively support people with these needs
- behavioural support staff to meet certain standards (see Section 8.3.3).

There were also some suggestions for basic requirements to include things such as a First Aid Certificate and training in working with people with disability.

4.3.2   Considering requirements for particular services

Various stakeholders suggested the need for specific considerations for particular sectors.

- Stakeholders identified the need for particular considerations for children's services, including the need for these to provide evidence-based early childhood intervention and to work with and through families, and the need for providers to be child safe.
- Some suggested there should be particular requirements for accommodation services to prevent forced co-tenancies and other undesirable practices.
- There were references to the need for specific standards for guide dog services to ensure these are good quality.
- Mental health organisations suggested minimum qualification requirements, such as a Certificate IV in Mental Health or Mental Health Peer Work.

---

[3] The Auslan Interpreting Industry suggested that Auslan interpreters should also be attached to an agency that can assume responsibility for monitoring quality and managing complaints.

ARTD CONSULTANTS
strategy & evaluation

- Occupational Therapy Australia noted the need to consider requirements for assistive technology and related supports in light of work being progressed on this for the NDIS. The Australian Rehabilitation and Assistive Technology Association noted that its review of national and international systems to inform an approach to establishing a national accreditation system for the sector identified the need for regulation commensurate with risk. Similarly, Assistive Technology Suppliers Australasia suggested that there should be differentiated requirements for assistive technology services because some are complex and high risk and some low risk.
- Home Modifications Australia said that delivering home modification services for particular groups requires specific skills, so there should be a register of approved home modifications providers to support participants to make informed choices about providers, ensure that work is carried out to a high standard, and afford a level of protection against work that does not meet standards or expectations.
- The NSW Agency for Clinical Innovation suggested specific requirements for home enteral nutrition (tube feeding).

ARTD CONSULTANTS
strategy & evaluation

5. Staff screening

The Consultation Paper identified four options for ensuring staff are safe to work with participants:

▪ Option 1: Risk management by employers

▪ Option 2: Referee checks for all staff and police checks for staff delivering supports considered to pose a higher risk

▪ Option 3: Working with vulnerable persons clearance for staff delivering supports considered to pose a higher risk

▪ Options 4: A barred persons list.

5.1 Views on the options

The majority of stakeholders supported Option 3 (working with vulnerable persons clearance for staff delivering supports considered to pose a higher risk). There was also support for Option 4 (a barred persons list), but somewhat less than for Option 3. Stakeholders often suggested combining the options because they wanted the highest level of safeguarding possible.

5.1.1 Support for Option 3

The majority of stakeholders supported Option 3. The reasons given for this included that:

▪ government has a duty of care to protect NDIS participants from people with a history of criminal, predatory and/or exploitative behaviour
▪ self-regulation and referee checks would be inadequate as they may not be carried out properly or the staff member may provide an incomplete employment history
▪ police checks would be inadequate because not everyone who has committed abuse receives a conviction (in part because of the criminal standard of evidence requirement)
▪ there may be a range of issues with establishing a barred persons list, including the potential for vindictive reporting by other workers and employers and implications for employers required to report staff for inclusion on the list
▪ these clearances will prevent the need for multiple screening processes if they draw on real-time information and move with the worker.

However, some were concerned about what information the check would include and the basis on which a decision would be made (see section 5.2.3).

ARTD**CONSULTANTS**
strategy & evaluation

Support for Option 3

I have some concerns about a barred persons' list… Who would have the authority to put someone on the list and what misdemeanours would put someone on the list? This could be quite subjective. Also, how long would someone stay on the list? It could be a human rights issue. At the same time, some screening is necessary to protect vulnerable people. [Family member, Queensland, questionnaire]

Employers should be required to obtain referee and police checks for all staff who will have client contact. However, these are minimal safeguards in view of the vulnerability of people with intellectual disability and the various reasons why mistreatment of people with intellectual disability seldom lead to criminal convictions. We support a requirement for working with vulnerable people clearances at least in relation to staff who have client contact. [Peak, NSW, submission]

5.1.2 Support for Option 4

There was somewhat less support for Option 4 (a barred persons list). This is probably in part because people have had very limited experience with this model (it has only been in place for Victorian accommodation services for a short time), but some had particular concerns about the implications it would have for employers and employees (as discussed above).

Those who supported Option 4 gave similar reasons to those who supported Option 3. Additional arguments for Option 4 included that this would be a systematic approach to information sharing that currently occurs informally between providers and that self-managing participants could access the list.

Many stakeholders supported Option 4 combined with Option 3 because they wanted the most safeguards possible, but others said that one would exclude the need for the other. National Disability Services recommended Option 4 combined with Option 2 (referee and police checks). They did not support Option 3 because they did not feel this would give employers sufficient information to manage any risks that may be indicated in a criminal history check.

ARTDCONSULTANTS
strategy & evaluation

Support for Option 4

> *A national register of barred persons would enable any provider to check the register prior to employing a prospective worker. [ACT Disability and Community Services Commission, submission]*

5.1.3 Support for Options 1 or 2

Few stakeholders (mostly providers) thought Option 1 (risk management by employers) or Option 2 (referee checks for all staff and police checks for staff delivering supports considered to pose a higher risk) would be sufficient on their own. However, stakeholders did describe employer risk management and supervision practices, and referee checks as important to use alongside other measures.

Reasons for supporting these options alone included that screening gives a false sense of security and that a zero tolerance organisational culture is more effective in discouraging high-risk individuals from seeking employment.

5.2 Design issues

5.2.1 Considering how the requirements should be tiered

Stakeholders did not always specify which staff should be screened. Among those who did, there were differing views, as was the case with provider registration (see Section 4.2.1). There was support for a risk-based approach to screening, but there was also some support for broader application of screening requirements (particularly from parents and women with disability), and some for the tiering of screening requirements to take account of individual vulnerability. Some stakeholders thought that referee and police checks should be the minimum level of information required because staff in general services, such as gardening and transportation, can pose a risk. While others thought introducing these requirements could limit access to general services. Again, there was a lack of feedback from general services about how requirements would affect their provision of services to NDIS participants.

ARTD**CONSULTANTS**
strategy & evaluation

The following quotes illustrate the different perspectives.

> *Home cleaning or gardening aren't seen as traditional disability services, but as someone with a disability I need to know that, for example, Jim's gardening services have undertaken police checks. [Woman with Disability, Victoria, advocacy service submission]*

> *I think it really depends on the service type. You mentioned before about a gardener or somebody who isn't necessarily having intimate contact with the person. I would be wary of something that was restrictive of a service that doesn't necessarily require very much hands-on activity. However, if there is a very intimate personal involvement between the participant and the person working with them, then I certainly would support even going as far as a barred persons list. [Provider, Hobart, provider meeting]*

Questions were also raised about the requirements for casual staff and for volunteers, for example, whether family and other natural support people would require clearance if volunteering.

5.2.2 Establishing a nationally consistent model for relevant sectors

There was strong support for a nationally consistent approach to staff screening, which could prevent people with a history of criminal and/or exploitative behaviour from moving interstate to take up a new position.

There was also strong support for establishing a consistent approach across relevant sectors because the same type of information would be important for deciding who is safe to work in these sectors. Most references were to the need for consistency with aged care and children's services because staff often work in positions that have contact with these groups at the same time or move between these sectors. But there was also reference to the benefit of consistency across the broader community services sector.

5.2.3 Defining what information is considered in the check and the basis on which a is decision made

The consultation identified concerns about ensuring both protection for people with disability and natural justice for staff.

Stakeholders identified the need for clearance to be based on real-time information. There was limited discussion of the particular information to be included in the check, but there were multiple references to the need for screening to include international

police checks for people that have lived or worked overseas. However, there were some questions raised about the administrative feasibility of this and the Federation of Ethnic Communities' Councils of Australia suggested a need to consider how this would affect humanitarian entrants who may not be able to obtain police checks from previous countries of residence. Others suggestions for information to be considered in staff screening included convictions; historical, current or pending charges; allegations of workplace misconduct; professional disciplinary proceedings; records of domestic violence, child abuse and child sex offences; and supporting information provided by the applicant.

Stakeholders wanted to ensure that the process would identify and exclude staff who have committed an offence but do not have a conviction record (because of the barriers people with disability face in accessing the justice system) or a record of formal workplace proceedings (because they left their role before their employer could start or finish an investigation). For this reason, some expressly supported mandatory reporting requirements for providers and decision-making on the balance of probabilities. Some stressed that if there were reporting requirements for providers (associated with a barred persons list) there would be a need for protection from litigation by former employees, protection for whistle blowers and resourcing of investigations.

Some stakeholders, including National Disability Services, the ACT Disability and Community Services Commissioner and the Victorian Mental Health Complaints Commissioner, suggested that a national negative licensing scheme of the kind developed by the Australian Health Ministers' Advisory Council be replicated for the disability services sector.

Stakeholders were equally concerned that people not be excluded from working in the sector on the basis of an offence that they committed many years ago and which has no bearing on their ability to safely support a person with disability. This was noted as a particular concern in regional and remote Aboriginal communities and for people that have come into contact with the justice system because of mental health issues or previous issues with drug and alcohol. There was also concern that people with lived experience are not excluded from roles where that experience is valuable to others.

ARTD CONSULTANTS
strategy & evaluation

5.3 Other considerations

Stakeholders noted that screening processes are not all that is required to ensure people with disability are protected from abuse, neglect, exploitation and inappropriate staff practice. Many referred to the need for other actions, including:

- support and guidance for employers about staff selection
- guidance on instances where staff require specific skills to undertake support roles
- ensuring staff recruited have the right values and attitudes
- a focus on building organisational cultures that recognise the rights of people with disability and do not tolerate abuse, neglect and exploitation
- management accountability
- effective and ongoing staff training, including training on the rights of people with disability
- effective supervision practices.

Stakeholders also noted that staff quality is important. Some suggested that having registration requirements at the individual staff level and making available information about registered professionals would support this, while others stressed the importance of staff qualities and the relationship between the staff member and person with disability (as discussed in Section 4.3.1). The submission from the Speak Out Association of Tasmania (an advocacy service for people with intellectual disability) suggested there could also be a voluntary good worker passport that lists complaints and positive comments about a worker. Some other stakeholders, including people with disability and advocates, said that involving people with disability in selecting support workers, and providing them with the opportunity to choose or refuse a support worker was an important quality and safeguarding measure.

> *[I have] gone through the interviews with new staff in a service provider who provides support to me and that was very interesting because I could quite easily see during the interview those who would be good for people may not necessarily be for me but for others, and a person who just didn't sit well and really who should not have been in the industry ... I think that should be more prevalent ... because we're the ones who have to live with them, therefore we have a right as a group of people to say well, that person is not going to be okay, but I can see that will work with them. Or I love that person, they will work with them very well, because that in itself is a level of safeguarding that no one has been talking about. [Person with disability, Newcastle, public meeting]*

ARTDCONSULTANTS
strategy & evaluation

One of the things that I would like to see... is a process for each participant to be able to be able to say, "I don't want to work with that staff member" and that that is one of the things that is reported on. That way you can see whether there are trends in an organisation not matching people up well, trends with a person who, "Actually, I'm getting a lot of complaints around this particular worker" and they're just shuffling around the industry, or whatever the case may be. [Parent, Newcastle, public meeting]

ARTD CONSULTANTS
strategy & evaluation

6.　Complaints handling and oversight

The Consultation Paper identified four options for complaints handling:

- Option 1: Self-regulation

- Option 2: Requirements for internal complaints handling processes and an industry complaints body

- Option 3: Independent statutory complaints function for complaints that cannot be resolved with providers

    – a: Complaints office in the NDIA

    – b: Disability Complaints Office.

The Consultation Paper also asked which of the following oversight systems are required:

- an oversight body

- community visitors

- serious incident reporting.

Note: These options are not mutually exclusive; rather they build on one another.

6.1　Complaints handling

6.1.1　Views on the options

The majority of stakeholders identified a need for an independent complaints body. Support for other options was very limited.

Support for Option 3b

There was overwhelming support for Option 3b to address complaints that cannot be effectively resolved between participants and providers. The reasons given for this included that:

- providers' internal complaints systems alone can be inadequate because
    – there is a power imbalance between providers and people with disability
    – people are often reluctant to complain because of fear of retribution or negative past experiences with providers' internal complaints processes
    – in 'thin markets' people would be reluctant to complain to their provider because of a lack of alternatives
    – there is a history of people feeling 'grateful' for any supports received
    – there would be potential for providers to make biased decisions and ignore or dismiss complaints

ARTD CONSULTANTS
strategy & evaluation

- the NDIA should not manage complaints because
  - this could be a conflict of interest
  - there is a need to separate the complaints system from the body responsible for funding and registering providers, in particular to support the development of a positive complaints culture among providers
  - some complaints may be about both the NDIA and a provider/s
  - the NDIA should be focused on other priorities
- an industry body would not have the same credibility as an independent body
- independence would
  - give people confidence in the system
  - provide assurance of unbiased assessment
  - support transparency and accountability
  - provide an avenue for whistleblowing
- a system-level complaints body would
  - enable identification of patterns and systemic trends to be addressed
  - prevent complaints slipping through the cracks.

Support for Option 3b

Having an independent body will mean that this body is unlikely to be accused of protecting workers from within the NDIA, service providers etc. People with disabilities, their families/ advocates will be more likely to come forward and complain if they feel that their support will not be threatened. [Provider, SA, questionnaire]

It's structurally unsound to expect a provider to monitor themselves. If it's a free market system, one would not envisage a provider being critical of its services: more likely to make people keep quiet. [Person with disability, NSW, questionnaire]

It is essential for there to be a fully independent complaints body from both the NDIA and providers of support. Hence a Disability Complaints Office needs to be totally separate. We cannot trust providers to operate on the basis of a voluntary Code of Conduct and nor can we just tell families to shop around and find something else. Many people have very limited choices, and even the choices they do have, they are scared and feel powerless to say anything. Even if they do speak to the providers, not all of them are going to voluntarily change something, as history already tells us. If they have no reason to change, and it is easier to pretend nothing ever happened then they will do just that. [Person with disability, submission]

There is a perception when you have an ABI [acquired brain injury] – that the ABI accounts for everything – it's the ABI's fault that you have made these things up... We would need an independent specialist service to be believed [Woman with disability, Victoria, advocacy service submission]

ARTD CONSULTANTS
strategy & evaluation

Support for Options 1, 2 or 3a

While stakeholders recognised the importance of complaints being handled at the service level, very few thought that this alone would be sufficient. They were also wary of conflict of interest were the industry to be responsible. Most people thought a complaints function should be separate from the NDIA, also because of the perceived conflict of interest.

One argument for the complaints function to sit with the NDIA was that it would make the system seamless for families. Arguments for an industry body were that it would enable more efficient processing of complaints and a feedback loop to improve overall quality.

Other suggested approaches

There were some suggestions for a tiered approach to complaints handling to support efficient and timely processing of complaints. National Disability Services proposed a variation on Option 2: an industry body to manage complaints that cannot be resolved at the provider level, and an external statutory oversight body to which complainants and providers could appeal if they did not feel that the complaint had been satisfactorily resolved by the industry body. An alternative suggestion—proposed by a few different stakeholders—was for the NDIA to be the middle tier in this type of approach.

There were also a few suggestions to strengthen the role of advocacy services as a complaints resolution mechanism.

6.1.2   Design issues

Selecting a model

Some stakeholders, including existing statutory bodies, suggested that rather than establishing a new independent body, existing state-based bodies should be used or that these bodies should at least be used during the transition to the NDIS. Arguments for this included that it would be more efficient, would provide clarity for people with disability in a time of uncertainty and that state-based bodies have the necessary local knowledge and would be able to cover disability services not funded through the NDIS.

ARTDCONSULTANTS
strategy & evaluation

> *The COAG National Health Care Agreement 2012 provides a model for establishing a network of local Health Complaints Commissioners who manage complaints in a similar fashion, have a regional presence, and have knowledge and understanding of local providers and legislative frameworks. A similar approach is worthy of consideration – using and expanding on existing state and territory infrastructure. Some minimum standards could be set requiring consistency in powers, reporting etc. In this way, service providers, whether they are national or locally based, will have the same experience in dealing with complaint authorities. [ACT Community and Disability Services Complaints Commissioner, submission]*

Others argued for a single national body, potentially building on an existing complaints body in the Commonwealth, with a local presence.

Defining which supports a complaints body should cover

Many stakeholders noted that the independent complaints body should cover both the NDIS and providers. Some also emphasised the need to cover self-managed supports. However, there were mixed views about the types of services that the independent complaints body should cover, including:

- all NDIS funded services
- all specialist disability services, whether or not they are funded by the NDIS
- all specialist disability services funded by the NDIS.

There are tensions here because of the potential for an independent complaints body to cover some of the same services that existing complaints bodies cover, for gaps in the system, or confusion for people trying to navigate complex systems. Those who advocated for the system to include specialist disability services not funded by the NDIS said that this would ensure a complaints system that is accessible to the significant number of people with disability who will not receive NDIS funded supports, provide a holistic perspective on complaints about specialist disability services and enable targeted improvement strategies. In terms of whether the independent complaints body should cover more than specialist disability services, some thought it should not because mainstream complaints systems should be inclusive of people with disability. However, others thought that it should because it is difficult for people with disability to access mainstream complaints systems and existing complaints bodies lack the skills to work effectively with people with disability. There were also particular questions raised about the clarity of complaints processes for people with psychosocial disability receiving NDIS funded supports, who could also access mental health complaints systems, and people using NDIS funding for allied health professionals, who could also access health complaints systems. Questions were also raised about the

appropriateness of combined complaints functions, for example, between disability and aged care.

Stakeholders stressed the need to ensure that, whatever decision is made about the coverage of the independent complaints body, the system is easy for people with disability to navigate, for example, by establishing a warm referral process. There were also references to the need for effective communication between complaints bodies and supports to make mainstream complaints processes more accessible.

National Disability Services suggested that continuation of the National Disability Abuse and Neglect Hotline would be useful as this has proven a useful entry point for some complainants and advocates.

Defining the functions and powers of a complaints body

Stakeholders suggested a range of functions that a complaints body should have, in line with those identified in the Consultation Paper. These included:

- providing information, education and advice to people with disability and their families around complaints
- supporting people with disability to make complaints
- providing information, education, training and advice to providers about matters relating to complaints and complaints handling
- providing good practice guidelines on complaints handling
- supporting providers to improve their internal complaints systems
- receiving, investigating and responding to individual complaints that cannot be resolved between providers and participants
- referring complaints to other appropriate authorities where relevant
- reviewing complaints data to identify patterns within providers and systemic issues and making recommendations for improving complaints handling
- monitoring and reporting publicly on the effectiveness of complaints handling in the sector
- providing advice to the NDIA and DSS on complaints matters.

Stakeholders noted the need for the complaints body to accept complaints from people with disability, their families, provider staff, and other stakeholders. They also noted that people should be able to make complaints in a range of different formats to ensure that the system is accessible and stressed the need for confidentiality and protection from retribution (for people with disability and staff who report issues).

While stakeholders emphasised the need for providers' internal complaints systems to be the first port of call, the ACT Community and Disability Services Commissioner said

ARTD CONSULTANTS
strategy & evaluation

that the complaints body should also be able to accept complaints that have not been raised with a provider because people with disability may be reluctant to complain to their provider for a range of reasons. Some statutory bodies also suggested the need for alternative dispute resolution.

There was a strong view among stakeholders that the complaints body needs to 'have teeth'. Suggestions included having the powers to:

- start inquiries and investigations where it considers they are warranted
- compel action by the NDIA CEO to review registration and impose sanctions and/or conditions.

Defining provider obligations

Stakeholders stressed the need for providers to have accountable and transparent internal complaints systems and there were many suggestions for this to be a registration requirement.

Some stakeholders, including some statutory bodies, suggested that providers should also be required to provide data on complaints to the independent complaints body because this would support system improvements. They suggested that existing data systems could be enhanced to support this.

Clarifying responsibilities for the associated costs

The costs of the complaints system were not a focus of the consultation, but some questions were raised about who would be responsible for the associated costs— whether the NDIS would be responsible or providers would be expected to contribute.

6.1.3 Other considerations

As noted above, the consultation identified a range of significant barriers that people with disability—particularly people with intellectual disability, complex communications needs or few natural supports—can face in accessing complaints systems, including fear of retribution, negative past experiences with providers' internal complaints systems, and a lack of awareness about their right to complain and the situations that would merit a complaint. Stakeholders described the roles that advocacy services, self-advocacy supports, community visitors and natural supports can play in supporting people through all stages of the complaints process as important. Stakeholders also

ARTDCONSULTANTS
strategy & evaluation

stressed the importance of informing people of their right to complain, how to make a complaint and of the development of a positive complaints culture among providers.

6.2 Oversight

6.2.1 An oversight body

Views on the need for an oversight body

There was a high level of support for an independent oversight body among the various stakeholder groups. The arguments for this included that independent oversight is required to:

- address power imbalances between providers and people with disability
- provide a safeguard for people with few natural supports and people with complex support needs
- ensure accountability and transparency
- support and compel improvements in the sector
- monitor the market, particularly in regional and remote areas and for people with complex support needs
- support positive outcomes for people with disability.

Support for an oversight body

The NDIA and registered providers all need to be accountable to an independent body. This will assure participants that there are fair, transparent and non-biased processes that they will have access too if the need arises. [Provider, Queensland, questionnaire]

The independence of an oversight body is crucial to the trust people complaining can have in the system. [Advocate, Victoria, questionnaire]

Some stakeholders did not identify an independent oversight body as necessary. Some thought this would be 'another layer of bureaucracy' that could create confusion because of overlaps with other statutory bodies.

ARTD CONSULTANTS
strategy & evaluation

Design issues

While it was not a significant focus of the consultation, some stakeholders expressed mixed views about whether there should be a separate national oversight body, the function should be combined with an existing national body (such as the Aged Care Commissioner or Commonwealth Ombudsman) or state-based bodies should have a role. Some suggested a need for state-based offices if there is a national body. The NSW Ombudsman indicated that, if the oversight function was to be part of an existing national body, there is potential to draw on the learnings from how the NSW Community Services Commission was merged with NSW Ombudsman's office in 2002, in particular maintaining a separate disability division headed by a Disability Services Commissioner or equivalent, employing staff to carry out NDIS related functions, and undertaking early work to build capacity to work with people with disability. There were also suggestions for people with disability to have a role in the oversight body or for the oversight body to consult closely and/or be reviewed by people with disability.

Stakeholders identified a range of functions that an independent oversight body should have. These included:

- providing education and advice to people with disability and their families
- providing advice and support to providers
- supporting community education and awareness
- investigating breaches of the Code of Conduct
- managing staff screening or a barred persons list
- managing complaints
- managing serious incident reporting
- managing community visitors
- managing regulation of restrictive practices
- collecting and analysing data to identify and address systemic issues and to build the evidence base about what supports the best outcomes
- monitoring the market and responding to market failures, identifying strategies and stimulating growth
- identifying and taking appropriate action to respond to price gouging, anti-competitive behaviour and fraud
- overseeing the regulatory body
- monitoring the efficacy and efficiency of the NDIS
- monitoring implementation of the National Disability Strategy and compliance with the *UN Convention on the Rights of Persons with Disabilities*
- reporting to Parliament
- advising governments and the NDIA on the NDIS.

ARTD CONSULTANTS
strategy & evaluation

Many stakeholders identified an oversight body as an extension of the independent complaints body (discussed above). However, not all stakeholders identified all of the functions in the list above as belonging to an independent oversight body. Additionally, some stakeholders made a clear distinction between a regulatory function for the NDIS and an oversight body—noting the importance of separating the responsibility for registering providers from external complaints and oversight functions.

Again, stakeholders identified the need for the independent body to 'have teeth'. There were references to the need for the oversight body to have powers to:

- enter and inspect premises
- seize documents
- start inquiries and investigations where it considers they are warranted
- make binding decisions and impose sanctions and fines.

A market oversight function

As noted above, an oversight function could involve independent monitoring and assessment of the NDIS market. Market oversight functions could include proactively monitoring, reviewing and reporting on the effectiveness of the NDIS market. This could include monitoring trends in demand for particular supports and levels of competition. It could also include the identification and review of matters such as anti-competitive pricing, thin markets and market failure. These functions would help to ensure participants can be active and empowered consumers within the NDIS market.

Support for oversight of the market

With disability support provision shifting to a market driven model, there is a real risk that some people with disability will not have their needs met, and they will be left without essential supports. This is particularly the situation for people with disability who may be regarded by providers as 'too difficult', 'too complex' or 'too costly', and where the provider does not have specialist expertise to meet complex requirements, such as providing intensive, long-term support for those leaving the criminal justice system.

The negative impacts of a market driven NDIS are highly likely to limit or deny the human rights of people with disability. In order to ensure a market that provides quality, choice and safeguards in line with human rights, the Q&S Framework needs to include a market regulation function, such as an independent market regulation body. [Advocacy organisation, submission]

ARTD CONSULTANTS
strategy & evaluation

6.2.2 Community visitors

Views on the need for community visitors

While not all stakeholders were aware of or had experience with community visitors, there was a substantial amount of support for some form of community visitor type function. The arguments for such a function included that it can:

- play an important role in promoting and protecting the rights and wellbeing of people who are at higher risk, particularly those with intellectual disability, complex communication needs and few natural supports
- identify issues that people with disability would not otherwise raise and support people to make complaints
- provide an avenue for staff to report issues
- provide an early warning system, helping to prevent abuse and neglect
- escalate serious issues
- identify misuse of restrictive practices.

However, a few stakeholders were not sure whether there would be a long-term role for community visitors in their current form—because of the way disability supports are changing. Some observations were also made about the interaction between advocacy services, peer support, and community visitors.

Support for Community Visitors

The community visitors scheme is an important role, being independent of the service provider to ask important questions about the quality of the service the participants are receiving. For vulnerable and socially isolated people, it is another safeguard where participants would have the opportunity to divulge if anything is going wrong, without fear of retribution. The fact that community visitors have the freedom to come without notice puts the onus on service providers to consistently maintain their quality of service. You can make the environment look good for a day which is anticipated for an audit, but this needs to happen every day. [Provider, SA, questionnaire]

Community visitors are, in the Commissioner's view, more effective than any self-reporting mechanisms e.g. around restrictive practices or complaints, which can fail to pick up real issues of concern that service providers may wish to keep hidden. Disability community visitors in the ACT have provided an invaluable 'eyes and ears on the ground' addition to the disability safeguarding framework. [ACT Community and Disability Services Commissioner, submission]

....when we're going out and we're doing visits and inspections and engaging with a range of residents in disability accommodation, also now in supported residential

ARTD**CONSULTANTS**
strategy & evaluation

> *facilities, there's a whole range of people out there who because they have a disability and because they think there's not a lot of options are constantly making compromises, constantly accepting services that are sometimes not as good as they can be, and just talking to them about what a reasonable, what the standards are and what their entitlements are, what their rights are as residents, it's really helpful. But I think there needs to be a lot more done. In the mental health area, they have statement of rights. Anyone in mental health they get a statement of rights, how they can appeal against their current order, et cetera. In a lot of the houses we see, there's posters up about services saying 'it's okay to complain', 'we encourage you to complain', et cetera. That's really good. But in terms of someone independent going in and supporting them and also listening to staff, because a lot of the issues that get raised with us are from great staff, staff who are concerned about services, lack of resources, et cetera. But feeding that back also to senior management of organisations in that loop and getting changes made has been really important and we've seen some great improvements done. [Community visitor, Adelaide, public meeting]*

Design issues

The consultation identified a number of questions about how a community visitors scheme would work in the NDIS environment. Chief among these was which supports the scheme would cover. Views were particularly divided on whether it would be appropriate for community visitors to enter private accommodation. Those who argued in favour of this spoke of the potential risk of abuse and neglect by family members or other residents. Those who argued against it were concerned about ensuring people's right to privacy. Some suggested that community visitors could visit people in private accommodation on a pre-agreed basis.

> *I'll say something probably controversial, and that is why would community visitors not visit people in their own home? We see a lot of people that use our seniors legal and support service, who are 60, 55, and they live with their family and it is the family that are the abusers. So why would that not happen or that option be available to everybody? [Advocacy service, Brisbane, public meeting]*

> *I would like to say that my home is my home, or is it an industrial workplace that I happen to reside in? I am not sure. I have done this in the community for 25 years and formal supports come into my home, and for the time they are there, it is an industrial workplace that I happen to reside in, apparently. I would pick up the point that the police do have the right to enter your home, as any citizen if they so choose and they have good reason... So there are other services that can enter your home if you are at risk. This idea that people with disabilities may be more vulnerable I think is very much overplayed. I agree that there are people with disabilities that are at risk and they need to be safeguarded, absolutely. That is what we are talking about. But if I am going to*

57

participate in a social and economic way in the community, then my home is my castle and I expect people within my home to be treated with respect, and that includes me, by everybody. So I think we just need to get real. [Person with disability, Brisbane, public meeting]

…we believe that there would be merit in considering the scope for expanding the OCV [official community visitors] scheme to potentially include other kinds of care arrangements that will emerge under the reform agenda. For example, people living in private accommodation and receiving full-time disability support; and people in private living arrangements that may expose them to higher levels of risk. However, any expansion of the scheme to these areas would need to be informed by the wishes of people with disability who live in these settings. [NSW Ombudsman, submission]

There were also mixed views about which of the existing community visitors schemes would provide the most effective model, although there was agreement on the need for effective staff selection, training and debriefing.

One provider suggested that a community visitor scheme could be complemented by a community calling scheme to make contact with participants more regularly than visitors can and provide another safeguard for participants who are able to communicate by phone.

6.2.3   Serious incident reporting

Views on the need for serious incident reporting

There was less discussion of serious incident reporting than other elements of the Framework. This may be because some stakeholders assumed that serious incident reporting would be required as it is currently required in most states and territories. Among those who expressly supported serious incident reporting were statutory bodies, advocates, peak bodies, professional associations, providers and academics. The arguments for requiring serious incident reporting included that:

- there are high risks in some disability service arrangements
- it would support appropriate responses
- it would enable the oversight body to complement justice system processes, which would be useful given the challenges that some people with disability face in accessing the justice system
- data would help to identify trends and enable systemic issues to be addressed.

ARTD CONSULTANTS
strategy & evaluation

Support for serious incident reporting

> *When women report violence their concerns aren't always taken seriously, they aren't believed and it rarely goes to court. We need some kind of balance to ensure that we are safe, without necessarily going to court. [Woman with disability, workshop]*
>
> *I think it's a bit of a long shame of the sector that it hasn't been a mandatory reportable requirement for people with a disability experiencing harm or an incident. So I think it's certainly something which we need to carry forward and strengthen, because I am concerned that a lot of incidents get managed in house and the investigation aspects might be less than perfect or dubious or just internal. So I think having an impartial external body for serious incidents is quite an important aspect. [Provider, Sydney, provider meeting]*

Design issues

The consultation identified a number of considerations in establishing serious incident reporting requirements for the NDIS, including the need to:

- establish clear and agreed definitions of the incidents to be reported
- identify the providers that would be required to report
- define any mandatory reporting requirements for staff
- clarify which body providers will report to (whether the NDIS or an independent oversight body) in light of decisions about other regulatory functions
- clarify how this reporting will inform provider registration and staff screening
- clarify the timing and sequence of reporting requirements, noting that criminal matters must also be reported to police
- provide a data system to support reporting, potentially by enhancing existing online reporting systems
- ensure that the body that receives reports has investigatory powers to ensure appropriate responses to serious incidents
- identify 'red flag' patterns of incident reporting
- analyse data disaggregated by characteristics to inform systemic responses
- monitor the adequacy of providers' responses to serious incidents and use data to inform prevention strategies and support improvements in the way providers and staff handle incidents
- introduce penalties for failing to report
- establish information sharing protocols to enable effective responses to reports, noting that this may include cross-jurisdictional information sharing
- clarify the interaction with police investigations, including how local relationships that support effective responses will be maintained.

ARTD CONSULTANTS
strategy & evaluation

There were also a few references—including in submissions from the Chair, Intellectual Disability Behaviour Support at the University of NSW and the University of Newcastle—to the need to focus on more than serious incidents, as a series of incidents together can be a 'red flag'. The University of Newcastle submission suggested a similar approach to that used in health care in NSW.

6.2.4 Other considerations for oversight

A very small number of stakeholders noted other considerations for the oversight system, including:

- oversight of fly-in fly-out and drive-in drive-out providers, such as requiring connections with trusted local organisations
- oversight of transport services
- an independent pricing tribunal
- processes for dealing with concerns about people at risk of abuse and neglect in community settings where the source of the risk is not a provider.

The Australian Guardianship and Administration Council submission recommended that there be an independent investigatory body empowered to investigate reports of concern where adults are residing in the community and the harm is suspected of being perpetrated in a family home or other private setting.

Participants in the Aboriginal and Torres Strait Islander workshop identified the need for close oversight of NDIS implementation in Aboriginal and Torres Strait Islander communities. They discussed the need for close engagement between DSS, the NDIA and Aboriginal and Torres Strait Islander communities to ensure ongoing input from communities into the design of the NDIS. There was a suggestion for the development of an Aboriginal and Torres Strait Islander Advisory Council with representation from diverse communities.

ARTD CONSULTANTS
strategy & evaluation

7.   Self-managed supports

The Consultation Paper identified six options for self-managed supports:

- Option 1: Allow self-managing participants to choose any provider other than close family members while building their capacity to manage their own risks

- Option 2: Prohibit certain providers or staff

 – a: Require providers to comply with the NDIS Code of Conduct and prohibit those who breach the Code from providing supports

 – b: Create a barred persons list that participants would check before engaging staff

- Option 3: Require providers to be approved or screened by the NDIA

 – a: Establish a separate registration process with limited conditions (compliance with a Code of Conduct and staff screening) for providers of certain types of support

 – b: Require providers to meet the same registration requirements as for NDIA-managed supports

 – c: Require that individual staff be screened before they can provide certain types of support.

It also asked what supports would be useful to people wanting to manage their own supports?

7.1   Views on the options

Views were divided on the best option for enhancing safeguards for people who manage their own supports.

7.1.1   Support for Option 1

Some—among them people with disability, parents and carers, advocates and some providers—supported Option 1 (allow self-managing participants to choose any provider other than close family members while building their capacity to manage their own risks).[4] The reasons they gave for this approach included that it would:

- best reflect the NDIS principle of choice and control for people with disability
- enable dignity of risk
- enable people with disability to choose supports in the same way that other members of the community would (helping to 'normalise' life with disability)
- enable people with disability to choose the provider that best meets their individual needs and preferences
- maximise access to supports, particularly in regional areas where there may be a shortage of providers, but also to general services and providers whose main client base will not be NDIS participants.

---

[4] In trial sites, self-managing participants are able to choose any provider.

ARTDCONSULTANTS
strategy & evaluation

Support for Option 1

> *The NDIS is based on choice and control and on the premise that there should be the same rights as every other Australian, if they can't choose who they want then the choice and control and rights are void. [Family member, SA, questionnaire]*
>
> *For a number of years [our son] did receive services from providers. The difficulties we had were that there was always someone different turning up and we never knew them intimately. The people who worked with him, the people who came, often did not have enough information about [him] and what was going on. There was no continuity from day to day. If [he] had a seizure on the Tuesday, no-one knew on the Wednesday what to do. It was just impossible. If a worker had an accident on the way... no-one turned up, he'd scream for two hours. If they couldn't come for sickness, they weren't able to provide another worker in time. It just did not work. Therefore, [he] went to individualised funding. [He] selects his own workers. That's important because he then knows who's coming in to support him. They are reliable. He has currently five support workers and if one can't turn up, they'll ring another one who can. It just works perfectly. I would never go back to a system where there's a provider trying to provide staff to our son. It does not work. [Parent, Adelaide, public meeting]*

Some of those who argued for Option 1 noted that there are safeguards for self-managed supports. These include the NDIA's ability to prevent a person from self-managing if they deem this an 'unreasonable risk', use of the planning and review processes to explore risks and management strategies, information and capacity building activities, the role that natural support people play, and professional registration requirements.

> *There is a level of I guess competence and skill that needs to go with self-managing your plan, and that in itself offers a degree of protection when it comes to choosing someone who's right and choosing someone who is quite safe with you. So you're still looking at someone who has their own ABN, has their insurances attached to those sorts of things, so someone who is in a professional capacity. I think there's a lot of inbuilt [safe]guards put into that even if it's not within the disability framework itself. [Parent, Newcastle, public meeting]*
>
> *Registered professions have a Code of Conduct and a board for complaints so will cover this. Maybe more professions need to be registered? Similarly there is licencing for electricians and builders would have standards to uphold, so there are some safeguards in place for this. [Provider, SA, questionnaire]*

Others noted that self-managing participants could choose to use registered providers if they wanted this level of assurance.

ARTD CONSULTANTS
strategy & evaluation

Isn't NDIS all about choice for the client? So shouldn't they have the option to choose whoever? Obviously they would have more protection if they went with someone who was a registered provider, but at the end of the day it's all about choice and freedom of choice. [Provider, Geelong, public meeting]

7.1.2 Support for Option 2

Fewer stakeholders supported Option 2a (requiring providers to comply with an NDIS Code of Conduct) or Option 2b (establishing a barred persons list) than Options 1 or 3. Those who did argued that it would:

- reflect government duty of care
- provide a balance between choice and control and protection from unscrupulous providers and staff that have committed abuse.

National Disability Services suggested that all organisations providing NDIS funded disability support services should have to register with the NDIA and sign up to the Code of Conduct. Self-managing participants that directly employ individual staff should not be required to register as a provider but should be monitored to ensure that they comply with relevant laws and some minimum conditions, including use of criminal history screening and the barred persons list, and an induction process to ensure that workers have the necessary knowledge.

7.1.3 Support for Option 3

Some stakeholders—particularly providers, professional associations and unions, but also some advocates, peak bodies, people with disability and their families—supported either Option 3a (requiring providers to comply with a limited set of registration requirements), 3b (requiring providers to meet the same registration requirements as for NDIA-managed supports) or 3c (requiring staff to be screened). One reason given for all of these options was that it would reflect government duty of care.

Reasons for supporting **Option 3a** included that it would provide flexibility while reducing potential risks to people with disability.

Reasons for supporting **Option 3b** included that it would:

- provide a level playing field for providers of supports (while differential requirements would enable unregistered providers to offer services that do not meet the same quality standards more cheaply than registered providers)
- support better outcomes for participants (through higher quality supports)

ARTDCONSULTANTS
strategy & evaluation

- reflect communities' expectation that government-funded services will be high quality
- ensure appropriate wages, insurance and occupational health and safety provisions for staff.

Reasons for supporting **Option 3c** included that it would provide protection against staff that have committed abuse. When asked, some of the stakeholders who argued for the continued ability to access unregistered providers said it might be reasonable to ask support workers to be screened.

Support for Option 3a, 3b or 3c

I think it is all well and fine to say people should be allowed to take their own risks; problem is much self-management is done by families on behalf of individuals. Many of these families while wanting to protect their loved ones from harm are also looking for ways to get extra hours of support and cutting back on costs of checks can do that. In most cases they honestly believe that they will be able to use their gut feelings to know if something is wrong, but abusers are very good at manipulating those around them to get trust. [Person with disability, submission]

As a safeguard, it would be the best option for people with disabilities to obtain support through registered providers, although it may take away the choice of receiving support through a long-time friend, neighbour etc. It is of course critical that support workers have a DCSI screening and clearance (as in South Australia) in working with children/ vulnerable people. Service providers have worked to provide the best possible support to clients and implement "Duty of Care" and comply with "Staff Professional Conduct". [Provider, SA, questionnaire]

Registered providers have to meet certain standards to be accredited to legally provide selected services. Unregistered providers, such as family and friends, may not have the training to provide services that are safe and reliable. There will be unscrupulous providers looking to make money out of this scheme and also family members may see this as an opportunity to make a quick buck. Who is going to assess the validity of the services provided? Who is going to monitor unregistered providers? [Person with disability, Queensland, questionnaire] Families may be using our services for part of the service and then an unregistered provider who gets paid the same amount who doesn't have to comply with any of the quality... So it's a very un-level playing field at the moment. I suppose we're being asked to do all this extra work at the same price and those kinds of inequities stand out. [Provider, Geelong, provider meeting]

7.2   Other considerations

Stakeholders noted a range of other considerations as important to ensuring that self-managing participants are protected from abuse and neglect and able to access quality services.

7.2.1   Defining when self-management is an 'unacceptable risk'

Some stakeholders noted that the NDIA's ability to prevent a person from self-managing if they deem this an 'unreasonable risk' is a safeguard for self-managed supports. Given this, there was reference to the importance of NDIA planners having the skills and capacity to assess the risks to the participant, and for the assessment to draw on relevant information about the participant's capacity and natural supports.

Carers NSW suggested that carers should be consulted where a participant or planner is considering self-management. But there were also comments from others, including people with disability, noting that not all people with disability want their family involved in planning and that families can be overprotective.

7.2.2   Using the planning process as a safeguard

Some stakeholders noted that the NDIA planning process could provide an important safeguard if used to explore risks and safeguards. As discussed in Chapter 2, some suggested a need to strengthen the existing planning process to allow for this.

> *We argue the planning process should be used as an opportunity for the identification of risk and vulnerability that relates directly to that individual. This would initiate a process that allows discernment of that person's fundamental needs and requirements, to complement the focus on goals and aspirations. It would also support people (alongside trusted others, whether it be family or other) to identify their own vulnerabilities and risks... We find most everyone we work with inherently knows the areas of their lives where they are more vulnerable. What they often lack are processes and supports which enable them to articulate these and then ways to turn those into practical and empowering strategies to minimise that risk. [Provider, submission]*

ARTD**CONSULTANTS**
strategy & evaluation

7.2.3 Providing information and support for participants who self-manage

Stakeholders suggested that in addition to the information that all participants need (discussed in Chapter 2) self-managing participants should have access to specific information and supports. The suggested topics included:

- the benefits and risks of self-management
- the range of self-management options available, including the use of plan managers and other intermediaries
- the pros and cons of choosing registered and unregistered providers
- recruiting, managing and retaining staff
- responsibilities as an employer, including wages, superannuation, occupational health and safety, working conditions, and insurance requirements
- budgeting and managing finances
- negotiation
- what to do if something goes wrong.

There were suggestions for information resources, advice and support, and training or skills building sessions. Stakeholders noted a range of sources for these, particularly peer support groups, mentors with experience of self-management and advocacy services, but also case managers or coordinators, plan managers, natural support people, a telephone helpline, and specialists in Human Resources and Industrial Relations. The importance of self-advocacy was also noted.

There were a few suggestions that training should be mandatory for people who self-manage their funding.

7.2.4 Having safeguards around the use of nominees and plan managers

While the use of nominees and plan managers can be seen as a safeguard, some stakeholders noted that it can also pose risks, in particular the risk of exposure to exploitation or financial abuse.

Suggestions for safeguards around the use of parents or carers as nominees included:

- ensuring that nominees have the required attributes to act as nominees
- enabling people to speak with NDIA planners without parents or carers present
- providing nominees with information and support
- using the plan review process to check on the situation
- developing back-up or succession plans to address situations where things go wrong, where the primary supporter or family member becomes unwell or where their circumstances change

ARTD**CONSULTANTS**
strategy & evaluation

▪ having processes and supports to remove nominees where required.

As one woman with disability said:

> *If I was in situation where a family member was being my administrator and I found out they were misusing my funds I would want support in the process to get them removed as my administrator because their might be backlash (emotional or financial) I need an independent person to make sure my best interest is protected. [Woman with disability, Victoria, advocacy service submission]*

Suggestions for safeguards around the use of plan managers included:

▪ requiring plan managers to comply with registration requirements
▪ preventing plan managers from also providing other supports to NDIS participants
▪ having rules that prevent the kind of 'unscrupulous' behaviour that has arisen in the financial advisory sector.

7.2.5   Restricting employment of family members and friends

Some stakeholders noted concerns about the potential risks involved in employing family members to provide supports. Stakeholders who commented on this subject generally felt that this should not be an option, except in limited circumstances (for example, when cultural or language needs can only be met by family members, in remote Aboriginal communities, and when no local provider is able to meet the person's needs), and that there should be safeguards around it.

Some stakeholders, particularly women with disability, also said that it would be important to establish professional employment relationships if employing friends.

> *I think it's a good idea to have a police check even if you know and get along with your neighbour. I mean we know there are people out there who have abused people... who didn't have checks. [Woman with disability, Victoria, advocacy service submission]*

> *It has happened for hundreds of years where best friends have turned out to be all sorts of, well, nasty people and you don't know—you don't know what someone is like. [Parent, Hobart, public meeting]*

8.   Restrictive practices[5]

To support the commitment to reduce and eliminate the use of restrictive practices (in line with *the UN Convention on the Rights of Persons with Disabilities*), the Consultation Paper identified four options for authorisation of restrictive practices:

- Option 1: Voluntary code of practice

- Option 2: Substitute decision-makers are formally appointed guardians

- Option 3 Providers authorised to approve restrictive practices where certain conditions are met (e.g. provider initiated panels with at least one independent person or authorised program officer)

- Option 4: Restrictive practices can only be authorised by an independent decision maker (e.g. by extending the role of guardianship tribunals or establishing an independent office holder, such as a Senior Practitioner).

Under all options, the development of behaviour support plans that meet contemporary best practice would be mandatory. Alongside each of these options, a role for an independent person (for example, a family member, friend or other trusted person) could also be recognised. Their primary function would be to explain to the person with disability what is being proposed in their behaviour support plan and their rights to seek a review if they wish.

The Consultation Paper also identified three options for reporting requirements:

- Option 1: Mandatory reporting on emergency use only

- Option 2: Mandatory reporting on emergency use and one-off reporting on positive behaviour support plans that include a restrictive practice

- Option 3: All elements of Option 2, plus routine reporting on each occasion when certain restrictive practices (physical, chemical, mechanical restraint and seclusion) are used.

8.1   Authorisation

8.1.1   Views on the options

Regulation of restrictive practices was discussed less than other elements of the Framework. This may be because their use concerns a smaller group of people. Among those who commented on options for authorisation, there was strong support for Option 4 (requiring that an independent decision maker authorise the use of restrictive practices) to best protect the rights of people with disability and reduce use of restrictive practices. Stakeholders also stressed the importance of positive behaviour

---

[5] A restrictive practice is any intervention which restricts the rights or freedom of movement of a person with disability who displays challenging behaviours, where the primary purpose of that intervention is to protect that person or others from harm. The Commonwealth and State and Territory Governments have all committed to reducing and eliminating the use of restrictive practices.

ARTD CONSULTANTS
strategy & evaluation

support plans and the involvement of people with disability, their family members and other relevant professionals.

Some stakeholders expressed concern about the concept of authorisation and the inclusion of restrictive practices in the Framework because they represent an infringement of human rights. However, comments from many others identified regulation as necessary to protecting these rights by ensuring that restrictive practices are used only as a last resort and that the least restrictive option is used.

Support for Option 4

There was strong support for Option 4 among all stakeholder groups, including statutory bodies. Reasons given for this included that it would:

- best protect the rights of people with disability
- provide expert clinical input into decision-making
- ensure separation of decision-making from providers to avoid biased decisions that are not in the best interests of people with disability, and restrictive practices being used as punishment or because they are convenient
- best support the reduction of the use of restrictive practices
- provide protections for providers (from criminal or civil action).

Support for Option 4

I like that its independent so emotions are taken away from the decision and that there wouldn't be a perceived advantage for anyone [including service providers] [Person with disability, Victoria, questionnaire]

It is the only way to ensure integrity and transparency of the decision-making and monitoring processes as restrictive practices are a human rights issue and should be highly regulated. [Provider, NSW, questionnaire]

...it took us a long time to get to that point [having a Senior Practitioner] and there has been so much fantastic work done in reducing that really it should be onwards and forward, not looking backwards. [Provider, Hobart, provider meeting]

In principle, it is highly inappropriate for decisions about restrictive practices to be made by staff of a support provider, including if they have had the input of an independent professional chosen by the provider. There is a conflict of interest here. The only argument we can see against authorisation being required from an independent body or guardian is the extremely large number of people currently subject to restrictive practices in Australia. [Peak, NSW, submission]

ARTD CONSULTANTS
strategy & evaluation

8.1.2 Support for Option 3

There was some support for Option 3 (providers authorised to approve restrictive practices where certain conditions are met), particularly among providers and peak bodies. Reasons given for this included:

- Options 1 and 2 would provide insufficient safeguarding
- Option 4 would be impractical because the volume of approval requests would create delays in authorisations.

Support for Option 3

There needs to be a consultative approach with all parties caring for the person with disability in the use of restrictive practices. A panel would provide and be a watchdog, to ensure that the decided restrictive practices are in the best interests of the person with the disability and not being used to deny the person with a disability their rights to live a life to the best of their abilities, along with all the care and assistance they need to achieve their goals. [Family member, WA, questionnaire]

Of the four options presented in the consultation paper, Option 3 would provide the best starting point for a national system. Options 1 and 2 would not provide sufficient safeguards nor ensure the continued reduction of restrictive practices. Option 4 would not be practical to implement, would exceed the capacity of the guardianship system and would create substantial delays in people receiving appropriate support. [Provider, NSW and ACT, submission]

Support for Options 1 or 2

Only a very small number of stakeholders supported Option 1 (voluntary code of practice) or Option 2 (substitute decision-makers must be formally appointed guardians). However, some suggested that legal guardians should have input alongside a panel or independent decision-maker.

Support for Options 1 or 2

A legally appointed guardian should be assessed to be a suitable guardian with obligations and accountability to provide the best for the participant. The guardian shouldn't just be mother or grandmother. The legal guardian should be able to advocate for the participant and family with the service provider. [Provider, Queensland, questionnaire]

ARTDCONSULTANTS
strategy & evaluation

This guardian can be a family member—someone who knows the individual well and has their best interest at the fore. [Family member, Queensland, questionnaire]

Other suggested approaches

While stakeholders generally noted the need for input from various people to inform behaviour support plans and decision-making about restrictive practices, some suggested decisions require sign-off by multiple stakeholders.

> *A broad system is needed that includes consent from a guardian or parent, people with specific experience in restricted practices, positive behaviour support professionals, and a person independent from all of these people. A combined panel and online registration system could work well (Victoria meets NSW). [Provider, NSW and Victoria, questionnaire]*

There were also suggestions for two-tiered approaches (combining Options 3 and 4) to enable efficient and timely processing of applications. The NSW Ombudsman noted that, while they prefer independent decision-making, panels could be used to ensure timely authorisation if: there were legislated requirements around authorisation and panels were required to include one independent person with appropriate knowledge of positive behaviour support, able to raise issues with a designated agency, and monitored by an independent body. There were also some other suggestions from providers for using a panel or provider-based model with access to advice from an independent body with tribunal- or guardianship-level monitoring of panel operations.

National Disability Services proposed an alternative model with expert practice advisors located in an industry body to advise on the authorisation and review process, which would be overseen by civil administrative tribunals.

There were a few comments that family members should be able to authorise the use of restrictive practices, but there were also strong views against this.

8.1.3   Design issues

Selecting the authorisation model

While there was generally agreement in the consultation on the need for independent authorisation, there were varying views about what model would be most appropriate, likely tied to varying experiences with current models, which differ significantly across states and territories.

ARTD CONSULTANTS
strategy & evaluation

Among those who supported Option 4, many referred to using a Senior Practitioner. However, National Disability Services suggested that there is disagreement about the value of advice from Senior Practitioners. There were some references to extending the role of guardianship tribunals, but some questions were raised about their clinical expertise and capacity to take on this role.

Among those who supported Option 3, more referred to using a panel than authorised program officers. This may be because of lower levels of experience with authorised program officers, but there were also arguments that a panel would be preferable because one person should not be responsible for decision-making and a panel would bring an independent professional opinion into the process.

Stakeholders noted particular concerns about ensuring that the model enables timely authorisation. Some of these saw the solution as ensuring sufficient resourcing of the independent decision-maker role to ensure this occurs, while others suggested selecting Option 3 or using a tiered approach (combining Options 3 and 4) to manage this issue.

The Australian Guardianship and Administrative Council suggested a four-year extension of current regulatory models so that these can be evaluated and this can inform the selection of a national model.

Noting who should provide input into decisions

Stakeholders noted the need to ensure that decision-making about the authorisation of a restrictive practice is informed by appropriate expertise and a good understanding of the individual situation, including factors that could be contributing to a person's behaviours, which could be addressed through other means.

Stakeholders described the need to involve the person with disability and people who know them well and understand the factors that may be leading to their behaviours in the development of behaviour support plans. Some stressed the need to gain the informed consent of the person with disability wherever possible. The Australian Law Reform Commission did not have a view on the authorising model where the person concerned does not agree, or whether this should be permitted, but suggested that decision-makers should have obligations consistent with their recommended *Will, Preferences and Rights Guidelines*.

There was also reference to the need for collaboration between professionals and multidisciplinary collaboration in certain complex cases. Some stakeholders referred to

ARTD CONSULTANTS
strategy & evaluation

the need for practitioners with expertise in the area relevant to the particular practice being signed off, for example, psychologists for behavioural constraints, occupational therapists for postural restraints and psychiatrists for chemical restraints. The NSW Council for Intellectual Disability was concerned about ensuring that practitioners prescribing psychotropic medication for people with intellectual disability have expertise in intellectual disability mental health.

Defining how requirements should be tiered

Some stakeholders suggested that the requirements for authorisation might be tiered by the type of practice in question. This reflects the suggestion in the Consultation Paper that a higher level of sign-off could be required for restrictive practices that might result in serious harm (for example, physical restraint).

- The Australian Psychological Society suggested that the most severe practices should require 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 general practitioner, psychologist, and specialist; while the use of physical restraints could require approval from professionals, such as a general practitioner, physiotherapist or occupational therapist, and specialist.
- The NSW Ombudsman suggested that there should be special requirements for authorisation of chemical restraints.
- The Australian General Practice and Quality Innovation Performance submission suggested a two-tiered approach: with internal authorisation for any positive behaviour support plan, authorised by an appropriately skilled senior person in the organisation, dependent on certain conditions, such as capacity of the participant, predicted frequency of use and severity of the restraint; and external authorisation (e.g. by a Senior Practitioner), where the frequency of the application of the restrictive practice, the seriousness of the restriction or the capacity of the participant and the staff enacting the practice might contribute to the requirement for external authorisation.

Additionally, the submission from People with Disability Australia and Women with Disabilities Australia suggested the need for a legislative framework that explicitly prohibits and criminalises the use of restrictive practices, which are cruel, inhumane or degrading or used as a punishment.

ARTD CONSULTANTS
strategy & evaluation

Clarifying emergency and temporary authorisation

The consultation identified the need for clarification of provisions for emergency use and temporary or short-term authorisation. There was a suggestion in the Aboriginal and Torres Strait Islander workshop that the independent decision-making authority could maintain a centralised national database with 24-hour telephone contact, providing temporary approvals for the use of restrictive practices in specific cases. It was thought that this method would alleviate fault on the part of the provider, ensure that qualified staff act as decision-makers, and provide a record of all use of restrictive practices.

Clarifying responsibilities for seeking authorisation

National Disability Services noted a need to clarify responsibility for seeking authorisation when a participant may be using several providers with a restrictive practice in place (such as pharmaceutical restraints).

Establishing a mechanism for appeal

Some stakeholders noted a need for a mechanism to appeal decisions made about the use of restrictive practices where the person with disability and/or their family do not agree.

Including mechanisms to support reduced use of restrictive practices

Stakeholders suggested mechanisms, such as review periods or specification of the time when a practice must stop, to ensure authorisation processes support reduced use of restrictive practices over time. One provider suggested regular reviews to ensure that the least restrictive alternative is being used and independent audits to ensure compliance with best practice.

ARTD CONSULTANTS
strategy & evaluation

8.2   Reporting

8.2.1   Views on the options

Among those who commented, there was support for accountability and reporting on the use of restrictive practices. This was identified as necessary to reducing the use of these practices and to understanding the impact of any actions intended to reduce their use. It is also required by the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*.

However, stakeholders did not always specify which level of reporting they supported. At public and provider meetings, stakeholders said that reporting was important but that processes should not be too onerous. Among submissions and questionnaire respondents, there was support for both Option 2 (mandatory reporting on emergency use and one-off reporting on positive behaviour support plans that include a restrictive practice) and Option 3 (all elements of Option 2 plus routine reporting on each occasion when certain restrictive practices are used). The argument for the higher level of reporting was that it is necessary to monitor patterns and trends to support reduced use of restrictive practices.

Support for Option 3

There was some support for Option 3; this was strongest in submissions. The reasons given for this approach included that it would:

- best protect the rights of people with disability
- provide maximum accountability
- provide the most comprehensive data for identifying patterns and trends in the use of restrictive practices, which could be used to identify and address issues
- provide the necessary information to support evidence-based practice
- best ensure reduced use of restrictive practices
- best enable assessment of what is working to support reduced use of restrictive practices.

Support for Option 3

> *I definitely think each incident should be reported because if you don't have that documentation, then you can't be aware of what's going on, and a lot of the times if a restrictive practice is used on an individual, it could be something that is happening in their environment too. [Provider, Hobart, public meeting]*

ARTDCONSULTANTS
strategy & evaluation

The only way to know if the behavioural support plan is working as required is to know if the use of restrictive practices is being reduced. This can only come through mandatory reporting. In addition, all behaviour plans with restrictive interventions must be registered. This way we can assess whether behavioural support plans are improving, our assessments are improving, our responses are improving, etc. All of those things can be monitored when they are required to be reported. Assuming agencies can do this alone is wrong, they have little incentive to change, it is often easier to just keep the status quo. [Person with disability, Victoria, questionnaire] People will find a solution that does not involve restrictive practice or at least be more expedient in the intervention delivery required to remove the restrictive practice IF they have to fill out paperwork. [Carer, Qld, questionnaire]

Mandatory reporting of all episodes of the use of restrictive practice is not only an essential research function, it provides a principle mechanism for restraint reduction. The consultation paper emphasises the need for practice which is evidence based, and whole of jurisdiction reporting provides a principle data source for the conduct of such research. Importantly, the data is real time and local, ensuring the direct applicability of research findings to NDIS participants. Research conducted by the Office of the Senior Practitioner in Victoria (using the Restrictive Intervention Data System), despite being a limited study, has provided important information on emergent local trends such as the use of chemical restraint and the demographics of people subject to restrictive practices generally (Office of the Senior Practitioner, 2010). This data has been utilised to directly inform policy and practice aimed at improving the lives of people with disability and to reduce the likelihood of abuse occurring. [Provider, submission]

Support for Option 2

There was also some support for Option 2 (mandatory reporting on emergency use and one-off reporting on positive behaviour support plans that include a restrictive practice). The reasons given for this approach included that:

- Option 3 would be too much of a burden on providers
- Option 1 would be insufficient
- reporting is needed to reduce the use of restrictive practices
- this would best support growth of positive behaviour support.

Support for Option 2

> *Developing and implementing a positive behaviour plan is essential wherever restrictive practices are used. NDS [National Disability Services] 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. [National Disability Services, submission]*
>
> *It always makes service providers think twice about taking what appears to be the easy option when managing a person's behaviour. Plan development and notification or registration of the plan is a major step in monitoring the process of implementing and then reducing the use of restrictive practices. [Provider, NSW, questionnaire]*
>
> *I'm not sure whether it would be feasible to report each time a restrictive practice is used, as some may be more than daily, however they should be encouraged to use a recording chart so that if/ when a review is required it is clear what is used, when and to what effect. [Provider, SA, questionnaire]*

Support for Option 1

There was very limited support for Option 1 (mandatory reporting for emergency use only). Reasons for supporting this approach were that it was more realistic or less onerous than the other options, but would still provide a safeguard. In their submission, one Queensland provider argued that the cost and time involved in reporting have, in the past, made some providers reluctant to provide services for participants who require behaviour support plans for restrictive practices.

Support for Option 1

> *It is not realistic to have to report restrictive practices used with positive behaviour support plans. Clients with behaviours of concern may need this for their and others safety. I believe mandatory reporting for emergency use and serious incidents is an essential safeguard. [Provider, NSW, questionnaire]*

ARTDCONSULTANTS
strategy & evaluation

8.2.2   Design issues

Providing a data system to facilitate reporting

Stakeholders noted a need to ensure that reporting is not onerous or burdensome and for a data system to make reporting easy and support providers to meet their obligations. Many who were familiar with it, described the Victorian Restrictive Intervention Data System as useful. However, there were some suggestions for improvement to this system, including improving its speed and functionality and enabling access to data by the individual rather than the service site.

Defining how often should data be provided

There were different suggestions about how often data should be provided. This would need to be further considered in the context of the selected option.

> *Depending on the nature of the restrictive practice being implemented, the frequency of reporting would be determined. Some situations should be reported each time the practice is implemented, in other circumstances for example the use of a locked fridge would not need to be reported all the time but the plan must be reviewed frequently to look at alternatives. [Provider, SA, submission]*

Monitoring and reporting back to relevant stakeholders

Stakeholders identified the need for monitoring and feeding back the data collected to support reduced use of restrictive practices and ensure data is used. This could involve monitoring patterns and trends at an individual, service and system level, identifying concerns and using this to support improved practice. It could also include reporting against benchmarks.

Establishing measures to address non-compliance

A couple of the submissions suggested that non-compliance should result in sanctions. The NSW Ombudsman suggested that the independent authorising body should have legislated powers to direct a service to discontinue or alter a practice.

ARTDCONSULTANTS
strategy & evaluation

Defining the interactions with other quality and safeguarding measures

Some stakeholders noted that other quality and safeguarding measures can also play an important role in monitoring the use of restrictive practices. There was reference to community visitors being able to identify misuse of restrictive practices and monitor compliance with requirements. There was also reference to the role of advocates and to the benefits of linkages between complaints systems and systems for overseeing the use of restrictive practices to protect and promote the rights of people with disability. The Victorian Office of the Public Advocate suggested a need for further consideration of the potential role of community visitors, public advocates, public guardians and tribunals because various statutory bodies currently have a role in relation to restrictive practices in certain states and territories.

Considering oversight of restrictive practices outside of formal service settings

The consultation raised concerns about use of restrictive practices outside of formal service settings and in the context of self-managed supports. There were some particular concerns that parents may expect staff to use restrictive practices because of a lack of awareness about what constitutes a restrictive practice.

8.3   Other considerations

The consultation also identified a range of other considerations in supporting the commitment to reduce and eliminate the use of restrictive practices. Chief among these were the need for clarification of definitions and guidelines, education and advice around restrictive practices and positive behaviour support, and building of the behavioural support workforce.

8.3.1   Clarifying definitions and guidelines

A range of stakeholders noted the need for greater clarity about what constitutes a restrictive practice and the development of nationally consistent and shared definitions and guidelines. The submission from the Chair, Intellectual Disability Behaviour Support at the University of NSW noted the lack of an accepted definition of restrictive practices and of the boundaries around each type of restrictive practice.

There was reference to the need for consistency across sectors and particular consideration of the authorisation and reporting requirements around the use of restrictive practices with people with psychosocial disability who are supported by the NDIS because of the overlaps with mental health legislation.

ARTDCONSULTANTS
strategy & evaluation

There was also reference to the need to clarify particular terms for reporting purposes.

> *The terms "emergency use" and "serious incidents only" can be open to subjective definition. Will there be very specific standard definitions of those two terms which ALL service providers must use when making decisions? What is determined as being an "emergency" or "serious incident" can also vary according to the context/ location in which it is taking place? [Person with disability, WA, questionnaire]*

8.3.2   Providing education and advice

The need for education, advice, support and training about restrictive practices was a strong theme in the consultation. Stakeholders were concerned about a lack of clarity among families and professionals (in the disability and other sectors) about what constitutes a restrictive practice, the factors that might be influencing a person's behaviours, and alternative approaches. There were also some particular concerns about misuse of restrictive practices, non-compliance with existing requirements, over-prescription of medications, and use of over-the-counter medications.

Providers receiving advice and support through current state-based systems wanted to ensure that this is continued, although there were different suggestions about who should take this role in the new system. Suggestions about the type of ongoing support required included:

- information on evidence-based practice
- guidance on positive behaviour support strategies
- clinical advice and input
- support in developing positive behaviour support plans
- advice on how to effectively withdraw the use of a restrictive practice.

There were some suggestions that staff working with people with challenging behaviours should require training in positive behaviour support.

8.3.3   Building the behavioural support workforce

There were some suggestions about building the behavioural support workforce. These included establishing professional standards, defining professional qualifications and competency requirements for behavioural support staff, and supporting the development of the behavioural support workforce.

The submission from the Chair, Intellectual Disability Behaviour Support at the University of NSW suggested a need for commitment to professional training,

ARTD**CONSULTANTS**
strategy & evaluation

accreditation and ongoing monitoring of workforce practice across Australia, as well as accreditation for agencies and individual practitioners to deliver behaviour support. The Australian Association of Developmental Disability Medicine suggested that all organisations providing therapeutic, direct care, residential or respite care, education or intervention to people with disability should employ a professional with expertise in positive behaviour support to develop behaviour management programs with an emphasis on positive practices and skills development.

9.   How will your views be considered?

The findings of the consultation, the cost-benefit analysis, inquiries into abuse in the disability sector, and other relevant policy work will help inform decisions about the best options for the NDIS Quality and Safeguarding Framework. Based on this information, Commonwealth, State and Territory Governments will work together to prepare a Decision Regulation Impact Statement for consideration by Ministers in early 2016.

ARTDCONSULTANTS
strategy & evaluation