

Consultation paper

Proposal for a National Disability Insurance Scheme Quality and Safeguarding framework

February 2015

This consultation paper was prepared by the NDIS Senior Officials Working Group for the Disability Reform Council.

Contents

Glossary of Key Terms.....	vii
Introduction	1
Background to the NDIS.....	1
Changes to the Disability Sector.....	1
Need for a Quality and Safeguarding framework.....	3
Principles to guide the development of a Quality and Safeguarding framework for the NDIS.....	4
How the Consultation Paper is organised.....	4
Consultation plans	6
Part 1: Proposed Quality and Safeguarding framework for the NDIS	8
A quality and safeguarding framework for the NDIS — what it means	8
Objectives and scope of a national quality and safeguarding framework	9
Structure of a national quality and safeguarding framework.....	9
Developmental.....	9
Preventative.....	10
Corrective	10
Developmental domain.....	10
Providing information for participants	10
Building natural safeguards.....	13
Preventative domain.....	16
Formal individual safeguards	16
Service level safeguards — support for service level capacity building	17
System level safeguards — quality measures.....	18
Corrective domain	19
Universal safeguards	19
Complaints handling	19
Serious incident reporting	20
Oversight functions	21
Oversight of the NDIA	23
Safeguards for participants who manage their own plans	23
Part 2: Detail of key regulatory elements of the Quality and Safeguarding framework.....	25
NDIA provider registration.....	26
Arrangements under state and territory systems	26

Current arrangements under the NDIS	27
Our aims.....	27
Possible approaches	27
Option 1: Basic registration requirements.....	28
Option 2: Additional registration conditions	30
Option 3: Mandated independent quality evaluation requirements	32
Option 4: Mandated participation in an external quality assurance system.....	34
Summary.....	37
Systems for handling complaints.....	39
What is a complaint?	39
Why is an NDIS complaints mechanism needed?	39
Current arrangements for complaints about providers	41
Our aim	43
Possible approaches	44
Option 1: Self-regulation	44
Option 2: Internal and external complaints handling requirements	45
Considerations	46
Option 3: Independent statutory complaints function.....	46
Option 3a: Complaints office in the NDIA	47
Option 3b: Disability complaints office.....	47
Ensuring staff are safe to work with participants.....	48
How severe is the risk?	48
Identifying perpetrators.....	48
Current controls.....	49
Our aim	51
Possible approaches	52
Option 1: Risk management by employers.....	52
Option 2: Requirement for referee checks for all roles and police checks for certain employee roles	52
Option 3: Working with vulnerable people clearances	53
Option 4: Create a barred persons list.....	56
Safeguards for participants who manage their own plans	58
What is in place now?.....	59
Possible approaches	59
Option 1: Building the capacity of participants to manage their own risks.....	59
Option 2: Prohibiting certain providers from offering supports	61

Option 2a: Negative licensing scheme	61
Option 2b: Creation of an excluded persons or barred persons scheme	61
Option 3: participants required to use a provider who has been approved or screened by the NDIA	62
Option 3a: Separate registration process with limited conditions.....	63
Option 3b: Registration	63
Option 3c: Individuals to be employed have been screened.....	63
Reducing and eliminating restrictive practices in NDIS funded supports	65
Current arrangements in states and territories.....	66
Our aim	68
Possible approaches	68
Authorisation	69
Option 1: A voluntary code of practice.....	69
Option 2: Substitute decision makers must be formally appointed guardians	70
Option 3: Providers would be authorised to make decisions under specific conditions.	70
Option 4: Restrictive practices could only be authorised by an independent decision maker.....	71
Monitoring and reporting.....	72
Option 1: Reporting would be mandatory for emergency use only	73
Option 2: All positive behaviour plans which include a restrictive practice must be reported	73
Option 3: Providers must report on each occasion where a restrictive practice is used	74
Appendices: Background information.....	76
A. Profile of disability service users and providers in Australia	77
Users of disability services	77
Providers of disability services	77
B. The NDIS Pathway.....	81
Participant pathway in the NDIS.....	81
People in the participant pathway who can help.....	82
Options for plan management.....	83
C. NDIA Terms of Business for Registered Support Providers	84
Service Delivery	84
Business Practices.....	84
Interactions with National Disability Insurance Agency	86
Identification as an NDIS Provider and Use of the NDIS Logo	86
Confidentiality	87

Complaints.....	87
References	87
D. Process for providing feedback or making a complaint about the NDIA	88
Raising Concerns About the NDIS	88
Providing Feedback	88
Making a Complaint	88
NDIA Action on a Compliant.....	88
Service Standards.....	89
If the Complaint is About a Decision by the Agency	89
More Information.....	90
E. Codes of Conduct	91
Purpose of Codes of Conduct	91
Content of Codes of Conduct.....	91
F. Restrictive Practices.....	93
The National Framework and the National Disability Insurance Scheme (NDIS)	94
High-level Definitions	95

Glossary of Key Terms

Agency	The National Disability Insurance Agency — see NDIA
Capacity	Understanding, skills and knowledge to support and enable individuals to exercise choice and control, and to participate in the community.
Challenging behaviours	Behaviours of such intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit the use of, or result in, the person being denied access to ordinary community facilities. ¹
Complaint	A complaint is a statement that a decision, service or product is not acceptable.
Corrective actions	Actions under the quality and safeguarding framework that participants and governments need to take to respond to incidents after they have occurred.
Developmental actions	Actions which enable people to capitalise on their own judgement and resources and contribute to building credible, robust information and exchange systems that allow NDIS participants to seek and share knowledge.
Disability-aware communities	Communities that accept, value and support the participation of people with disability.
Disability Reform Council	The Council of Australian Governments Disability Reform Council oversees the trial and implementation of the NDIS. The Council consists of Commonwealth, State and Territory Ministers with responsibility for disability policy and supports.
Individual support plan	An individual support plan documents a participant’s goals and aspirations, the supports needed to meet those goals and the way the plan will be managed. The individual support plan is developed through a planning conversation involving an NDIA planner and participant.
Local Area Coordinators (LACs)	A specialist worker who works with participants to help connect people with mainstream services and local community-based supports and build disability-aware communities.
Mainstream services	Services available to all people in Australia, including, for example, hospitals, doctors, schools, housing, transport and aged-care services.

¹ E Emerson, *Challenging behaviour: analysis and intervention in people with learning difficulties*, Cambridge University Press, Cambridge, 1995.

NDIA	The National Disability Insurance Agency (NDIA) is an independent statutory agency whose role is to implement the National Disability Insurance Scheme.
NDIS	National Disability Insurance Scheme.
Participant	A person with a disability who meets eligibility criteria and has been accepted into the NDIS.
Planner	Someone employed by the NDIA to assist a person with disability through the planning process and in the development of an individual support plan.
Positive behaviour support plan (BSP)	A positive behaviour support plan for an adult with an intellectual or cognitive disability is a plan that describes the strategies to be used to: <ul style="list-style-type: none"> (a) meet an adult's needs (b) support an adult's development of skills (c) maximise opportunities through which an adult can improve their quality of life (d) reduce the intensity, frequency and duration of behaviour that causes harm to the adult or others. The plan should also specify the conditions under which restrictive practices (if required) may be used.
Preventative actions	Actions under the quality and safeguarding framework designed to prevent harm being caused to people with disability.
Proportionate	In the context of the quality and safeguarding framework, proportionate means any regulatory arrangements that are appropriate based on the risk to participants associated with the service or support type.
Provider	See registered provider.
Quality	The extent to which a support is able to meet a participant's requirements.
Registered provider	A person or organisation registered with the NDIA to provide supports to participants or to manage the funding for supports for participants.
Registration	Providers of supports need to apply and be approved by the Chief Executive Officer of the NDIA to be registered with the NDIA.
Restrictive practices	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 them or others from harm.
Risk to participants	Risk to participants is principally about the potential of supports to cause harm or be unsafe in some way.

Safeguarding	Actions designed to protect the rights of people to be safe from the risk of harm, abuse and neglect, while maximising the choice and control they have over their lives.
Scheme	The National Disability Insurance Scheme — see NDIS.
Self-managing	Refers to a participant who is responsible for finding and arranging their own supports, making payments to their chosen providers and managing their plan expenditure.
Serious incident	Any event which threatens the safety of people or property. Some jurisdictions use the term ‘client incident’ or ‘critical incident’.
Supports	Different forms of assistance offered to a person with disability to enhance their quality of life and assist them to meet their goals. Supports can include, for example, personal care or transport, as well as activities of the NDIA provided in relation to a participant such as local coordination and referral.
We	For the purpose of this paper, ‘we’ means Australian governments.

Introduction

The National Disability Insurance Scheme (NDIS) is currently being trialled in most states and territories and will be implemented in all jurisdictions (except Western Australia) between July 2016 and July 2019.

Australian governments are looking at ways to make sure the national scheme will provide good quality supports and will maximise the choice and control of participants. It will also be important that the rights of people are protected and participants are safe from harm. These matters make up the quality and safeguarding framework for the NDIS.

This paper describes options that have been developed for the quality and safeguarding framework and will be used in discussions to find out what people think about governments' plans.

Background to the NDIS

The NDIS is a new way of providing individualised support for eligible people with permanent and significant disability, their families and carers. It will progressively replace the existing disability arrangements in the states and territories participating in the NDIS² and the Commonwealth.

The Productivity Commission's report, *Disability Care and Support*, was released in August 2011. The Commission found that existing systems for people with disability were not working and recommended an NDIS be created to provide all Australians with insurance for the cost of support if they or a family member acquired a disability.

In April 2012, Australian governments agreed to fund the NDIS. Legislation for the scheme, the *NDIS Act 2013* (the NDIS Act), covers eligibility criteria, age requirements and what reasonable and necessary support means. The NDIS Act makes it clear that people with disability will be able to receive care and supports based on their needs. The scheme is designed to give people real choice and control over these supports, including the ability to manage their own funding, if that is approved by the National Disability Insurance Agency (NDIA). It will offer early intervention therapies and supports, where they will improve a person's functioning, or slow or prevent the progression of their disability over their lifetime. The NDIS Act also establishes the NDIA to administer the NDIS.

The first stage of the NDIS began in July 2013 in the Hunter region in New South Wales, the Barwon region of Victoria, South Australia (for children aged 0–5) and Tasmania (for young people aged 15–24). There are now trials in all states and territories except Queensland.

Changes to the Disability Sector

There will be significant changes for both people with disability and disability support providers under the NDIS.

In 2012–13 there were 2,151 disability support providers funded by state, territory or Australian governments throughout Australia, managing 15,659 service-type outlets.³ These providers offer

² Western Australia has made no commitment to the full rollout of the NDIS. The final framework will be consistent across the states and territories that participate in the full NDIS.

supports such as accommodation support, community support, community access, respite, employment and advocacy.

The existing disability sector is made up of mainly not-for-profit providers. The sector does have some private for-profit providers (mostly in healthcare and nursing), however these are a minority. Historically, many providers developed from charitable beginnings, often focused on supporting specific disability groups. In most states and territories the government also delivers disability supports and in some jurisdictions the government is the dominant provider for some market segments. Governments have traditionally delivered supports where there are few or no alternative providers; where it is more efficient or effective to do so; or to act as the provider of last resort in thin market segments.

Currently, disability services predominantly rely on funding via 'block contracts' from state and territory governments. This funding arrangement means that government, as the main purchaser of disability support, determines the products, quality and price of support provided to people with disability, while government regulation provides for safety and quality standards.⁴ Further information about the current disability services sector is at Appendix A.

Under the NDIS, funding for disability supports is allocated to each eligible individual, not to a provider of supports. The NDIS pathway for a person with disability starts by contacting the NDIA to find out if they are eligible. Once this has been decided, eligible people will talk to a planner about their goals and what supports they need to meet their goals. An individual support plan will be drawn up and the person with disability, their guardian or nominee then chooses who will provide their supports and how, when and where they get delivered. Changes can be made to their goals and plan, what supports they need and how supports are provided. More information about the NDIS pathway and assistance provided by the NDIA is in the *Appendices*.

As the NDIS is implemented, providers will need to diversify and adjust their operations in order to remain competitive under the participant choice model.

The transition to the NDIS raises a number of other risks and challenges to providers of supports:

- The need for new business models (and staffing) to operate in an environment where payments are retrospective and contracts for support are individualised
- Less predictability and certainty about demand and funding
- Competing on price, quality and customer experience
- Multiple intermediaries to interact with, in addition to the participant
- Potentially several degrees of separation between the provider and the participant, in contrast to situations pre-NDIS where some providers were funded to 'case manage', resulting in situations where customers stayed with the same provider over long periods of time
- Having to earn the trust and loyalty of clients so they become repeat customers.⁵

It is likely that different kinds of support providers will enter the market, including mainstream providers that offer transport or household assistance. Early evidence from the first stage of the

³ Australian Institute of Health and Welfare (AIHW), *Disability support services: services provided under the National Disability Agreement 2012–13*, p. 11.

⁴ PricewaterhouseCoopers (PwC), *Planning for a sustainable disability sector*, 2012, p. 14.

⁵ Ernst and Young (EY), *Analysis of issues affecting viability of government service providers and NGOs operating in contestable environments*, February 2014, p. 3.

NDIS is that more registered health professionals and providers of transport, household cleaning and gardening services have entered the market.

Workforce will also be a key issue for the disability sector. It is anticipated that the disability sector workforce will likely need to double in size between now and full implementation in 2019–20 as a result of the NDIS. The workforce will need to increase from around 70,000 full-time equivalent (FTE) workers to an approximate estimate of 160,000 FTE workers.⁶ This growth will be across all jurisdictions.

Issues facing the disability market will be intensified in regional and remote areas, where the market may not provide sufficient level of range or competition in support services because of insufficient demand in the area, limitations to the diversity of supports, workforce shortages and lack of infrastructure.

Need for a Quality and Safeguarding framework

In this context of rapid change, governments need to reconsider protections for people with disability and arrangements to ensure supports are of a high quality. There are four main reasons to have a new national quality and safeguarding framework:

1. **Greater choice and control.** Existing arrangements for quality and safeguarding are based on funding agreements between governments and providers of supports. These funding agreements set quality expectations for participants and providers and aim to protect people with disability from harm. The NDIS, in contrast, provides the funding to individual participants who then make choices about their supports. This creates the need for a new quality and safeguarding framework because it is the person with disability, not government, who is able to make judgements and decisions about the quality of providers. It also means a different mix of providers will enter the market, requiring a new approach to quality and safeguarding.
2. **Governments will no longer be purchasing specialist disability services.** In the NDIS, the primary funding relationships will be between the person with disability and the provider of supports. This means the Commonwealth, states and territories will not continue to have funding agreements with providers. The current quality assurance arrangements, and some of the current safeguards, will therefore no longer apply.
3. **An opportunity exists to streamline requirements, reduce red tape and promote the market for supports.** The development of a new quality and safeguarding framework is an opportunity to simplify the rules and make them the same across all states and territories. This should facilitate the start-up of new national providers and offer greater choice to people with disability in the scheme.
4. **There is a greater need for National consistency.** The NDIS is a national scheme and as such needs a consistent quality and safeguarding framework for all jurisdictions that it operates across.

⁶ PwC, *Planning for a sustainable disability workforce report*, 2012, additional material.

Principles to guide the development of a Quality and Safeguarding framework for the NDIS

The United Nations Convention on the Rights of Persons with Disabilities promotes the rights and dignity of people with disability. Australia is a signatory and is expected to actively pursue the objectives of the UN Convention.

The NDIS Act also contains a number of statements about the rights of persons with disability, including that they have ‘the same right as other members of Australian society to respect for their worth and dignity and to live free from abuse, neglect and exploitation’.⁷ It also states that ‘people with disability should be supported to exercise choice, including in relation to taking reasonable risks in pursuit of their goals and the planning and delivery of their supports’.

The quality and safeguarding framework in this paper has been shaped by the following principles, reflecting the aims of the scheme:

- **Choice and control.** The NDIS should maximise opportunities for people with disability to make decisions about their supports.
- **Risk-based and person-centred approach.** Safeguards under the NDIS should relate to the actual level of risk faced by a person.
- **Presumption of capacity.** The NDIS should presume that all people with disability have the capacity to make decisions and exercise choice and control.
- **National consistency.** The quality and safeguarding framework should provide the same protection to people, regardless of where they live in Australia.
- **Reducing/minimising regulation.** The quality and safeguarding framework should create the least burden possible on individuals and providers of supports while still achieving the agreed quality and safeguarding aims of the framework.
- **Administrative efficiency.** A national quality and safeguarding system should be well organised.

How the Consultation Paper is organised

The Consultation Paper has been organised into two parts.

Part 1 describes the quality and safeguarding framework being proposed for the NDIS. This part of the paper provides readers with a general understanding of what is being proposed for the framework without having to go to more detailed discussion in Part 2 and the Appendices if they choose not to.

Part 2 of the paper details five specific elements of the proposed quality and safeguarding framework. These are challenging issues; a number of options have been developed for them which warrant more detailed discussion than is provided in Part 1.

These five elements also potentially have a significant regulatory impact for participants, other family members, the not-for-profit sector and businesses. Any new policy work of this nature being developed for Ministerial Councils must meet the requirements of the Council of Australian

⁷ *National Disability Insurance Scheme Act 2013* (Cth), section 4(6).

Governments' guide to best practice regulation.⁸ These elements are therefore presented in a way that meets these requirements. The elements in Part 2 are:

- NDIA provider registration
- Systems for handling complaints
- Ensuring staff are safe to work with participants
- Safeguards for participants who manage their own plans.
- Reducing and eliminating restrictive practices in NDIS funded supports

Appendix A describes how the scheme will work — that is, what happens from a participant's first contact with the NDIA through to implementation and review of their individual support plan. It identifies the key supports available through this time and describes their roles.

⁸ The Council of Australian Governments Disability Reform Council oversees the trial and implementation of the NDIS.

Consultation plans

The Consultation Paper is intended to reach a broad audience and feedback is welcome from all interested parties. The Consultation Paper will be published online and available in paper form on request. Easy English and audio versions will also be available on the website. It will be promoted in major newspapers and on the NDIA website.

Parts 1 and 2 of the Consultation Paper include questions people may choose to comment on. Feedback on all areas of the paper is welcome.

Governments want to make sure that the things people think are most important about quality and safeguarding in the NDIS are heard. People may have concerns that have not been addressed in this Consultation Paper, or ideas about better ways of achieving outcomes than those that have been suggested and discussed in the paper. New and different ideas are welcome.

Interested parties are encouraged to submit their comments by email, in writing or online (see the box on this page).

The closing date for submissions and other contributions is 30 April 2015. This aims to give people time to consider and provide their input. The consultation process will include active engagement through meetings with peak organisations as well as small group discussions involving people with disability.

Once the time for consultations closes, we will create a new version of this paper that takes into account people's comments. We will also collect data and information from the consultation process that will help governments understand the impact of different options on participants, providers and other organisations which will interact with the NDIS. This includes what the impacts for people could be if there was a major failure by a provider to ensure the safety of participants. The updated paper will also consider financial impacts, including the internal administrative costs for providers to become registered with the NDIA.

This new version will be a Decision Paper. It will be provided to the Council of Australian Governments Disability Reform Council to assist Ministers make decisions about quality and safeguarding in the NDIS.

Consultation arrangements

Visit engage.dss.gov.au to:

- download the **Consultation Paper**
- download or order an **Easy English** or large print version of the Consultation Paper
- download consultation **fact sheets**
- enter or upload a **written submission**
- find out where and when **public meetings** will be held
- contribute to the **online forum**.

Alternately, hard copy submissions can be sent to:

NDIS Quality and Safeguards
PO Box 7576
Canberra Business Centre ACT 2610

If you upload your submission online, including via the online template, you will be asked to specify whether you would like your submission to be published on the DSS website. If you send a submission via email or standard post, please specify whether you would like your submission to be published online. Questions about the consultation process can be directed to ndisqualitysafeguards@dss.gov.au

The closing date for submissions and other contributions is 30 April 2015.

Part 1: Proposed Quality and Safeguarding framework for the NDIS

A quality and safeguarding framework for the NDIS — what it means

The NDIS quality and safeguarding framework will replace existing state-based arrangements and is designed to give participants choice and control over their supports and allow people to take reasonable risks to achieve their goals. This is consistent with the overall approach of the NDIS.

Central to the framework are developmental safeguards designed to make sure participants have the capabilities and supports to be able to choose quality supports and to build good and safe lives. Traditional regulatory controls of the kind canvassed in Part 2 of this paper are intended to supplement the safeguards which people have developed naturally. These may include, for example, the capacity to advocate for themselves, or having family, friends and links with their community which help to ensure they are safe and their rights are protected.

The framework is intended to be risk based. There are two key types of risk that need to be considered. There is a risk that people with disability could receive poor quality supports that do not help them achieve their goals. There is also a risk that people with disability could be harmed in some way.

Some risks can be managed by individuals and through strategies agreed between the NDIA and participants as they develop and monitor individual plans. Other types of risk may require regulatory approaches in order to ensure the rights of people with disability to be free of harm, abuse, exploitation or violence are upheld.

The aim of a risk-based framework is to target those areas where the dangers are greatest and the consequences of harm the most severe. This means that providers of support types where there is potentially a greater risk to participants will have to comply with a stronger regulatory framework than providers in low-risk areas like home handyperson services.

Finally, the proposed framework is intended to be nationally consistent. While current systems are state based and differ between states and territories, the NDIS quality and safeguarding framework aims to be consistent across the country.⁹ The *National Standards for Disability Services*, which were revised in 2013, provide a guide to the development of the national quality and safeguards framework.

⁹ Western Australia has made no commitment to the full rollout of the NDIS. The final Framework will be consistent across the states and territories that participate in the full NDIS.

Objectives and scope of a national quality and safeguarding framework

The objectives of the quality and safeguarding framework are to advance the rights of people with disability and minimise the risk of harm, while maximising the choice and control they have over their lives.

The quality and safeguarding framework set out in this paper will apply to all supports funded through the NDIS. Arrangements might differ between supports managed by the NDIA and those purchased directly by people managing their own plans, as discussed in the section on 'Safeguards for participants who manage their own plans' later in Part 1. Arrangements may also differ between providers offering supports that could potentially pose a higher risk of harm to participants and those providers offering supports with a reduced risk of harm.

Many of the suggested approaches and options for quality and safeguarding are also relevant to supports that the NDIA might purchase directly from a provider (sometimes referred to as block funding). Supports purchased in this way could include general information and referral, capacity building, and local area coordination.

The way quality and safeguarding objectives are achieved for providers under block funding arrangements could differ from arrangements proposed for providers of supports registering with the NDIA. Because block-funded organisations have a direct contractual relationship with the NDIA, it is expected that these contracts will continue to specify minimum quality and accountability requirements.

Structure of a national quality and safeguarding framework

The structure of the proposed quality and safeguarding framework starts with the individual, as described earlier. There are three broad areas as follows.¹⁰

Developmental

This domain aims to build individuals' own natural safeguards. People with sound knowledge of their rights who understand how the system works and people who have support from others in their lives will always be better protected by these natural safeguards than they could be by any safety net built by governments. Governments should enable people to capitalise on their own judgement and resources. Governments should also contribute to building credible, robust information and exchange systems that allow NDIS participants to seek and share knowledge. We need to recognise that every person is at a different stage along the way to independent decision making and there are special responsibilities for the NDIA, governments and people in our communities to help build confidence and capacity.

¹⁰ Adapted from the schema developed by the NDIS Safeguards and Quality Assurance Expert Group in *A personalised approach to safeguards in the NDIS*, Marita Walker, Kate Fulton and Bruce Bonyhady, March 2013.

Preventative

The preventative domain includes risk management strategies developed between individuals and the NDIA, as well as measures that encourage providers of supports to deliver safe, high-quality supports. This can involve support for providers to build their capacity, including training of frontline staff. It also includes the requirements that providers need to meet to be registered with the NDIA.

Corrective

The corrective domain covers the actions that participants and governments need to be able to take to respond to incidents after they have occurred. An independent complaints system, oversight and compliance are examples.

These three areas cover the quality and safeguarding framework as a whole. The diagram at **Attachment 1** shows all the parts of the framework and how they fit together. A greater investment in the developmental and preventative domains will, over time, reduce the need for extensive measures in the corrective domain. A Glossary of Key Terms is provided at the beginning of this paper. There are some specific elements of the framework that have particular implications for people with disability and providers, on which your views are being sought. These are covered in Part 2.

Developmental domain

Without access to high-quality, meaningful and credible information about support options and providers, it will continue to be difficult for people with disability to exercise choice and control. Information is therefore an important safeguard. Similarly, the support of family, carers and community will be essential in enabling people with disability to make informed choices as consumers.

Likewise, actively supporting participants to develop their self-advocacy and decision-making skills and understand their rights will be vital to ensuring their ability to use the information that is available to them to make well-informed choices.

Providing information for participants

The NDIS aims to position participants as active consumers with choice and control over the supports they need to live the life they want.

This means participants need access to high-quality information that can:

- give them the tools to choose the best providers of their supports
- ensure participants know what they are entitled to expect and what they can do if these expectations are not met
- drive quality improvement in the system, including building knowledge of what participants should reasonably expect from the delivery of their supports and enabling participants to influence the design and delivery of their supports through real-time feedback
- harness, but not depend on, the internet or social media to build empowered communities.

In designing the NDIS, people with disability had a number of opportunities to talk about the kinds of information they thought they would value and how they should get it. Various forums, including

one facilitated by the Purple Orange project (see box below), provided some early advice on what people identified as important features of an information platform.

Purple Orange project

The Purple Orange project¹¹ developed a blueprint of the features people living with disability, their families, support agencies and other suppliers said they would value in an online platform specifically focused on disability supports. The blueprint describes the following key functions:

- **Find it** — participants want a central ‘go to’ site that provides a trusted default entry point at the start of their journey, directing them to information and services available elsewhere online
- **Share it** — participants want the capacity to share their experiences and draw on the experiences of others who might be in similar circumstances, as well as the ability to interact online with providers and other players in the system
- **Buy it** — participants want to be able to buy supports directly online, either through a central e-market site (ebay/Amazon-style ‘supermarkets’), or by being directed to provider websites
- **Manage it** — participants want to be able to set up an account, ideally tied to their plan, which enables them to access information targeted at them, as well as assisting in managing their ongoing interactions with the NDIA and with providers.

One of the most important features of an information system for people with disability identified by the Purple Orange project was that it should be accessible to them. This means that information will be available in a range of accessible formats such as the National Relay Service, Auslan and Braille. Applications and webpages will need to be designed with accessibility in mind, including compatibility with mobile devices such as phones and tablets.

In addition, online systems could also be developed in a way that allows family, friends, advocates, trusted professionals and NDIA staff to access information suited to the needs of particular groups and individuals, and to download it in a variety of formats (print, audio, etc.). The NDIS will also ensure that information is accessible and culturally appropriate for Indigenous people with disability and those from culturally and linguistically diverse backgrounds. This could include availability of information in a number of community languages.

A variety of other strategies could be used to ensure all people, including any people with disability, family members and carers who are not regular internet users, have access to information. Some trial sites, for example, are using approaches like support ‘expos’ to make consumers aware of the variety of providers and products, and provide education on their rights and responsibilities. If these prove successful, they could be useful for the broader implementation phase of the NDIS. Another possibility would be to set up a phone helpline service.

¹¹ Julia Farr Association Inc Purple Orange, *NDIS eMarket: User-defined features for an eMarket to assist National Disability Insurance Scheme participants and others to connect to support agencies and other suppliers*, 17 May 2013, available at: <http://www.ndis.gov.au/document/410>.

It will also be important to actively promote the availability and use of information through trusted professionals such as doctors and other health professionals (particularly for people with newly acquired or diagnosed disabilities and people with disability who will not be eligible for NDIS funded supports), advocacy groups and forums, and more generally.

The information and technical capabilities needed by people with disability — and the resources available — are likely to change as the market develops. Information and communications technology is an area that will constantly change and business and governments will need to be nimble and innovative to keep up with the rapid pace of change. Accordingly, it is proposed we design a system which builds on what is already available, promotes peer support and focuses on identifying the best available information to meet user needs. If necessary, this could involve commissioning content and delivering it directly to users in ways that make it readily accessible.

Under this approach, there might be a dedicated website that would provide a starting point for those looking for disability-related information. The key emphasis, however, would be on ensuring consumers are aware of the information that is available by proactively informing them of ‘what they need to know when they need to know it’. This could involve supporting users to subscribe to information feeds through social media sites such as Twitter and Facebook, as well as email newsletters.

Where users agree, they could be provided with individually targeted, timely information, for example, alerting them to the opening of a new provider in their locality, evidence on what type of supports are proving most effective, changes in the registration or accreditation status of a provider, or resources to help them prepare for plan reviews. In addition, the website could provide a platform for online communities and user blogs.

Initially, the key focus would be on working with users, including through social media, to identify information gaps, and commissioning appropriate content to address these. Over time, as more commercial and other products from the sector emerge, the emphasis could shift to directing consumers to them. The system could also help consumers assess the usefulness of the resources available, for example, through fact-checking resources and making available ratings by other consumers.¹²

Key types of information that have been identified as important for people with disability include the following:

- **Information on navigating the system and knowing your rights.** This includes information on how the system works, your rights, how to exercise them, what a quality service looks like, and what to do when you are unhappy with the quality of your supports.
- **Information about support types and availability.** This includes information about what supports are available so you can choose which supports will help you achieve your goals. The NDIA will gather a large amount of information on what supports participants with particular disabilities are accessing and, potentially, how effective these are.

¹² OECD, *A good life in old age*, OECD/European Commission, June 2013 makes the point that consumer awareness of quality information tends to be low, limiting its potential impact on the market.

- **Information about service quality and choosing a provider.** This includes detailed information on providers of supports, including price, effectiveness, safety, and the quality of the experience for people with disability. Quality checks on providers proposed in the section ‘Systems level safeguards — quality measures’ and under ‘NDIA Provider Registration’ in Part 2 would lead to the creation of reports about the quality of their supports. Making this information about service quality publicly available could encourage providers to improve their service.

QUESTIONS

- What are the most important features of an NDIS information system for participants?
- How can the information system be designed to ensure accessibility?
- What would be the benefits and risks of enabling participants to share information, for example, through online forums, consumer ratings of providers and other means?

Building natural safeguards

The second key developmental safeguard will be to strengthen natural supports for people with disability, who often rely on the support of those they trust (such as families and carers) to make important decisions about their lives. This is a natural safeguard for these individuals. However, many adult participants in NDIS trial sites are not well connected with family and other informal supports when first engaging with the NDIA. Many have had little experience in identifying their own goals and aspirations and exercising choice and control.

It will therefore be critical to develop and build the capacity of participants for self-direction and self-advocacy, to focus on building personal support networks and help people connect with mainstream and community-based supports, particularly people who may be isolated and have no natural supports. For example, for people who may be particularly isolated, a goal to establish and maintain personal friendships with others in their local community may be a really important step towards establishing natural safeguards.

Building capacity through plan development

The plan development process will be a new experience for many people. However, the process will help participants to learn the skills necessary to make choices about the supports they need. Participants will be assisted by an NDIA planner who will be available to respond to questions and assist participants to develop and make changes to their plans. More detail about the plan development process and the role of NDIA staff is included in the ‘Appendices’ section of this paper.

If people with disability need more assistance to exercise choice and control, the NDIA could also provide access (within an individual’s plan) to specific supports (for example, decision-making supports) to provide individuals with the knowledge and skills to make choices, understand their plan and exercise their rights when required.

The NDIA may also play a role building the capacity of individuals by funding or delivering training courses and mentoring programmes, and by facilitating local support networks so people can learn from the experiences of others.

Families and carers also play an important role supporting individuals to make choices about their needs. During the plan development, consideration will be given to the participant's family context, living arrangements and informal supports. Discussions will take place with participants and their family and carers, and will take account of carers' circumstances and future plans.

The intention is to put in place arrangements through the plan that support carers and provide certainty for carers and people with disability that support will continue even if the caring relationship changes. For people who have limited or no friends or family, their plan might include supports to assist them to establish and maintain personal relationships with others in their local community, to help them develop more natural safeguards.

Building capacity through Local Area Coordinators

The NDIA has a role in developing individuals' natural safeguards through its Local Area Coordinators (LACs). LACs will help people with disability connect to providers, including providers of mainstream supports such as community and health services.

LACs will also work to build 'disability aware' communities that can help safeguard vulnerable or isolated individuals. They will be able to provide general information about the NDIS, the types of supports available through the NDIS, and other supports available in the broader community to others who are likely to play a key role in the lives of people with disability. LACs will have greater involvement with scheme participants, but they will also be an important resource for people with disability who may not require an individual package if they are able to access a little support. The NDIA will also have a broader role in the community.

Many people with disability are able to gain the supports they need through mainstream systems. They may not need individualised supports. Under the *National Disability Strategy 2010–2020*, mainstream systems have a responsibility to ensure that supports meet the needs of people with disability. However, the NDIA may have a role in building capacity of mainstream providers to improve the ability of those providers to meet the needs of the whole community, including people with disability.

Building capacity in the community and targeted funding of community organisations

While the NDIA has an important role to play in supporting people with disability, there will be others contributing to building natural safeguards, including not-for-profit and community organisations. These organisations and programmes could provide supports to people before and during (or in place of) formal engagement with the NDIS. People with disability might access advocacy or peer support services through these organisations. The NDIA has provided grants for community organisations to use a community development approach to reach out and support people with disability and their families in their communities. These organisations aim to increase the capacity of people with disability and their families to exercise choice and control, engage with the NDIA and other community supports, as well as actively participate economically and socially.

The NDIA will also enhance the natural safeguards of people with disability by building partnerships with community organisations.

Examples from the trial sites are provided on the next page.

The Mentor Project in New South Wales and Tasmania

Five people with disabilities with experience using assistive technology are currently undergoing training to work as 'Assistive Technology Mentors'. They will be engaged by the NDIA to provide individual support to participants to make better choices about equipment and technologies. This model of individualised peer support is used extensively and successfully in mental health services. Part of this project also includes an assessment of the competencies required to undertake this role, with a view to establishing a nationally recognised training programme at the Certificate IV level.

Mental Health Council of Australia Project

The Mental Health Council has been funded to engage with people with severe and persistent mental illness and their families and carers. This consultation will lead to strategies to help people with mental illness understand the choices available to them through the NDIS, and to build their capacity to participate in goal-based planning and to direct their own support packages.

NPY Women's Council and Tullawon Health Services Project in South Australia

The First People's Disability Network is working with urban, regional and remote communities to raise awareness of the NDIS and assist Indigenous people with disability, and their families and carers, to understand and use individual packages effectively. The NDIS is working with the NPY Women's Council and Kakarrara Wilurrara Health Alliance to trial new service delivery models for remote Indigenous communities on the APY Lands and around Ceduna and Yalata in South Australia. This includes engaging community leaders as scheme champions to support communication.

Building capacity through education and employment

The NDIS role is to provide reasonable and necessary supports where they are related to disability. However, the needs of people with disability extend beyond disability-related supports. For example, access to education can have a profound impact on natural safeguards. Education can improve employment prospects and earning capacity, as well as support better health and increased civic and social engagement.¹³

In the same way, employment is described as 'the route out of disadvantage for most people of working age'. Under the *National Disability Strategy 2010–2020*, mainstream systems have a responsibility to ensure that providers meet the needs of people with disability. However, the NDIA may have a role in building capacity of mainstream providers to improve the ability of those providers to meet the needs of the whole community, including people with disability. The NDIS will also support people with disability to access mainstream education and employment if this is consistent with their goals, aspirations and capacity.

¹³ R McLachlan, G Gilfillan and J Gordon, *Deep and persistent disadvantage in Australia*, rev. edn, Productivity Commission Staff Working Paper, Canberra, 2013.

Work and training in the Barwon Region Trial

'Karingal' offers Work Education Courses for people of all abilities in the Barwon region. For example, there is a Certificate I in Work Education which is aimed at providing people with specific learning needs an opportunity to improve their employability and work readiness in a supportive environment. Karingal's EdLinks Programme supports adult students with a disability to focus on the development and maintenance of basic literacy and numeracy skills, and Karingal's Living Skills Programme is a practical, hands-on course that aims to increase independence with a focus on cooking, looking after money, being healthy, getting around, meeting new people and living independently.

QUESTIONS

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

Preventative domain

While the NDIS quality and safeguarding framework will focus on building individual capacity and natural safeguards, some measures will also be required to prevent harm to people with disability. Preventative measures fall into three groups defined briefly here and described in further detail below:

1. **Formal individual safeguards.** These are supports provided by the NDIA which are tailored to the individual. They might involve agreeing risk assessment and management strategies as individual plans are developed and monitored.
2. **Service level safeguards.** Providers of supports have a responsibility to ensure that their support provision is safe and that they are providing a high-quality product to participants. This might be achieved through good management practices, staff training and development, and formal background checks for staff who are employed by the provider.
3. **System level quality measures.** The NDIA also has a role to play in this domain. The primary role of the NDIA will be to ensure that providers are suitable to provide supports in the NDIS.

Formal individual safeguards

During the planning process, NDIA staff will work together with participants to identify risks and safeguards. Participants will be supported to determine the level of risk they wish to take on, with some participants choosing to take on a higher level of risk than others. The NDIA will also work with participants to put in place supports to reduce these risks, including plan review points. Safeguards should be proportionate to the actual level of risk people face, based on their capacity, natural support network and the supports available to them — as well as the level of risk they choose to take on.

Reducing and eliminating restrictive practices

An important question for the NDIS is what, if any, role it should assume in relation to the regulation of restrictive practices where these occur in NDIS funded supports. Restrictive practices are practices or interventions that restrict the rights or freedom of movement of a person with disability with the

primary purpose of protecting the person, provider staff or others from harm.. An estimated 8,000 to 9,000 people across Australia are currently subject to restrictive practices. Restrictive practices carry risks to individuals and all Australian governments have committed to the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*.¹⁴

Consistent with a commitment to reduce and eliminate restrictive practices, it is important that there are clear rules about when a restrictive practice can be used and what data is collected about the use of these practices. This is so we can understand how and when they are used and measure progress in their reduction.

There are significant differences between current state and territory approaches to the use of restrictive practices in their funded disability services. These include voluntary codes of practice, government policy which is enforced through contracting arrangements, and legislation schemes requiring providers to be approved to use such practices and to adopt specific authorisation procedures.

Options for a nationally consistent approach to restrictive practices for NDIS funded supports require detailed consideration and are discussed in more depth in Part 2. Questions are also raised there in relation to these options.

Service level safeguards — support for service level capacity building

In the NDIS, the most important relationship will be between participants and providers. The capacity of providers is therefore a critical safeguard.

A quality provider will usually have strong governance, policies and procedures, and a corporate culture that fosters respect and openness. They will respect and value feedback from their clients and others and use this feedback to improve and innovate. They will have appropriate procedures for managing serious incidents, including reporting, as required.

Quality providers will also have effective practices for hiring and supervising staff. They provide staff with training and invest in continuous education and improvement. The NDIS service model is very different from former arrangements in most states and territories and the Commonwealth. Therefore, frontline staff in provider organisations may benefit from training that increases their understanding of the NDIS and builds capacity to be responsive to individual needs and to respect the rights of participants.

Commonwealth, state and territory governments currently work with providers to help them improve quality and use best practice. In the future, the NDIA, industry bodies and non-government organisations, including academic institutions and centres of best practice, could all play a role in this respect. For example, a capacity-building strategy for frontline staff could be one element of the support for improved service quality.

¹⁴ [National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector](#), accessed 8 December 2014.

QUESTIONS

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

Ensuring staff are safe to work with participants

A particularly important issue to be considered at the provider level concerns the risk of criminal or exploitative behaviour by employees, something that is a known risk in the disability services sector. As the demand for workers in the NDIS grows, the risks associated with poor or hurried recruitment processes will increase.

A number of options for improved employee vetting are considered in detail in Part 2. One approach would be to encourage providers of supports to have a risk management framework for prevention of harm. For those providers of supports that are a higher risk to participants due to increased personal contact (such as personal care support, respite or accommodation support), a requirement to vet their staff could be a condition for registration with the NDIA. Employee vetting could require staff to undergo police and referee checks, be subject to working with vulnerable people checks that assess their broader history or be checked against a list of persons barred from working in the sector.

System level safeguards — quality measures

System level measures include the range of legislation, regulation and policy that mandates the rights of people with disability and establishes the rules for the provision of disability support.

NDIA provider registration

At present, quality and safeguarding arrangements are managed in contractual arrangements between providers and state and territory government agencies that provide their funding. This will be replaced in the NDIS by a system of provider registration.

The intention is to set national registration requirements that allow only suitable providers to participate in the scheme, while at the same time not creating unnecessary barriers for providers to enter or remain part of the scheme. The number and diversity of providers will be crucial to give participants more choice, which itself may be a natural safeguard against poor quality and unsafe support provision because people will choose to move from providers they feel offer poor-quality supports. In areas where markets are less developed, such as rural and regional areas, additional consideration may be required to achieve a balance between ensuring quality support provision and minimising unnecessary barriers.

An important mechanism in achieving this balance will be to apply the registration requirements in a proportionate way. This means that providers delivering supports that have a low risk for participants (such as a group recreation activity) will have fewer requirements, while those providing supports of a type likely to create a greater risk (that is, supports that involve more direct staff–participant contact or lack supervision such as personal care, respite or accommodation supports) will have more requirements to address.

Options and questions relating to provider registration are in Part 2 of this paper. A basic option is for providers to be required to meet essential legal requirements and to agree to operate according to a code of practice. Other options introduce additional conditions, with providers needing to

demonstrate they have in place a number of good practice arrangements such as staff vetting procedures, a complaints mechanism and privacy protections.

The nature of these additional conditions would be proportionate to the risk level of particular types of supports and, under some of the options, would include a requirement for providers to participate in a regular cycle of quality checks designed to gauge the quality of supports being provided.

Corrective domain

While the measures in the developmental and preventative domains are designed to prevent serious incidents, some measures will also be required to respond to incidents when they do occur and to deal with issues that cannot be resolved between people with disabilities and providers.

Universal safeguards

For the purposes of NDIS quality and safeguarding, 'universal safeguards' are defined as the legal protections that exist for all citizens when they interact with business, non-government organisations or governments. They include consumer protection law on products and services, state and territory public health legislation, building codes and criminal legislation. Participants of the NDIS will have access to these universal safeguards, as well as separate statutory and other arrangements that are specific to safeguarding the rights and wellbeing of people using disability supports. This means that people purchasing NDIS supports will have the same protections as everyone else in the community. Safeguards which operate outside of the NDIS but have specific applications for people with disability include anti-discrimination, human rights legislation, services provided by Public Advocates, disability advocacy, guardianship tribunals and complaints commissioners or Ombudsmen. The *National Disability Strategy 2010–2020* includes a strong rights protection and justice component.

States and territories also have a range of professional and other industry bodies involved in ensuring standards within their industries are met (some voluntary and some subject to formal regulation). These bodies may also be responsible for responding to complaints about their members. However, not all supports are covered by industry regulation or self-regulation. This is particularly true of supports (such as personal supports) which are currently the subject of state and territory funding arrangements and associated quality management processes.

Where universal safeguards are available, their effectiveness is still dependent on whether they are accessible to people with disability. Some of the universal systems are better adapted to meeting the needs of people with disability than others. The effective implementation of an NDIS quality and safeguarding framework will require that universal systems in all jurisdictions ensure their practices are accessible to NDIS participants to the extent their legislative responsibilities allow.

Complaints handling

A key issue for the quality and safeguarding framework is how to handle complaints about supports that are paid for under the NDIS.

The Commonwealth and the states and territories currently have a variety of ways of handling complaints about providers, whether made by consumers themselves, family and friends, or third parties. Many providers have also worked hard to make sure that they have good systems to respond to feedback – positive and negative. A best practice complaints resolution process typically involves timely resolution of complaints, independent investigation, seamless referral to other complaints bodies where appropriate, and an emphasis on continuous improvement for providers based on the complaints received.¹⁵

Options for complaints handling under the NDIS (and specific questions for consideration) are described in detail in Part 2. One approach is simply to encourage providers to establish effective internal complaints processes and agree to refer complaints to an external disputes resolution mechanism if they are not resolved at the provider level. A second option would be to require providers to demonstrate, for registration purposes, that they have internal complaints processes in place and that they agree to abide by the decisions of an approved external disputes resolution agency. A third option would involve establishing a formal external complaints handling body which would assist providers to manage complaints and support participants in having their complaints resolved quickly and effectively.

Serious incident reporting

Serious incidents, also called ‘critical incidents’ in some jurisdictions, are events which threaten the safety of people or property. A serious incident could be:

- the death of, or serious injury to, a participant
- allegations of, or actual, sexual or physical assault of a participant
- significant damage to property or serious injury to another person by a participant
- an event that has the potential to subject a participant or the NDIS to high levels of adverse public scrutiny.¹⁶

Planning for and managing serious incidents is an important element of the effective management of any service, but even more so where providers are offering supports to people with disability where such incidents could injure or harm participants, staff, family, carers, community or the provider.

It is important to gather information about these events so that providers can make improvements. For this reason most states and territories currently require reporting of serious incidents. However, serious incidents do not necessarily mean there is a concern about provider quality. Sometimes they occur due to the complex circumstances of particular participants, accidents and external events

¹⁵ See, for example, Calluna Consulting, *External dispute resolution schemes and systemic issues*, December 2010; Department of Health, *Review of the aged care complaints investigation scheme*, October 2009; Auditor-General, *Performance audit managing aged care complaints* (and the references therein), Audit Report No. 10 2012–13, Department of Health and Ageing; Australian Law Reform Commission, *For your information: Australian privacy law and practice*, ALRC Report 108, 2008; Minister for Customs and Consumer Affairs, *Benchmarks for industry-based customer dispute resolution schemes*, 1997.

¹⁶ *Terms of Business for Registered Support Providers*, published on the NDIA website and accessed on 17 October 2014 at: [Terms of business for Registered Support Providers](#). The *National Disability Insurance Scheme (Registered Providers of Support) Rules* state that registered providers must agree to the National Disability Insurance Agency Terms of Business.

outside the provider's control. In many cases, the important information is not that a serious incident occurred, but how well it was managed. Reporting therefore needs to focus on systemic problems and how serious events can be avoided in the future.

Notification requirements and the analysis of the data obtained currently differ substantially between jurisdictions. In most states and territories, serious incidents in funded disability services are required to be reported to the funding agency. However, in some cases there are requirements to report some or all incidents to independent agencies such as police or complaints commissioners.

In the NDIS we will need to decide how serious incidents will be handled. One approach would be to require that all providers have effective internal systems in place to deal with serious incidents. It would not, however, provide a mechanism for external monitoring of the effectiveness with which incidents are managed, or provide early warning of systematic issues with a provider or support. Incidents involving allegations of assault, theft or any other crime must of course always be reported to the police.

Another option would be a requirement, as there is now under the NDIA's terms of business (detailed in Appendix C), for registered providers to report serious incidents to the NDIA. These incidents could also be reported to an independent oversight body.

Oversight functions

The NDIA will oversee operation of the NDIS. It will be responsible for monitoring whether the goals in individual plans have been achieved and will gather information about which supports are most effective. It will also need to have its own complaints system for participants who are not happy with the NDIA's service. The existing NDIS complaints handling arrangements are described in Appendix D.

In addition, there are potential roles for industry and, consistent with their responsibilities, for universal safeguarding bodies such as consumer protection agencies.

A key issue for the scheme is whether there is also a case for establishing a body with an independent oversight function to provide an additional level of assurance for the NDIS. Such a body would provide a leadership role across the NDIS to ensure that registered organisations hear and respond to complaints and other feedback in positive ways. It could, as many Disability Service Commissioners do now, have a strong educational role.

Depending on what other infrastructure is created to assist people with a complaint, a body with an oversight function might have authorisation by law to investigate and resolve individual complaints that cannot be resolved with the provider in the first instance. This might include powers to make directions in some circumstances. Typically, such a role would also involve identifying systemic concerns (on referral or on their own initiative). The oversight body could also offer advice to the NDIA in relation to providers or individuals who breach conditions of registration with the NDIA, including the Code of Conduct. An independent oversight body could provide information, education, training and advice about matters relating to complaints and complaints handling and monitor and report publicly on the effectiveness of complaints handling in the sector.

An oversight body might even have powers to make binding decisions which providers would be legally obliged to implement and award compensation up to a specified dollar value. This is the model that is used by the Telecommunications Industry Ombudsman.

A further oversight function could involve independent monitoring and assessment of the NDIS market. This would assist participants to better understand and take advantage of the choices on offer, and inform governments on how the market is developing.

A market-based model for support provision depends on competition in that market and ongoing user confidence. This function might sit with the NDIA Board, given its responsibility for the financial integrity of the scheme and the importance of an effective market for achieving this, or it could operate independently from the NDIA.

Market oversight functions could include proactively monitoring, reviewing and reporting on the effectiveness of the NDIS market. This could include, for example, trends, levels of competition and, where required, identifying and making recommendations about market growth. This function could also include the identification and review of matters such as anti-competitive pricing, thin markets and market failure.

In the interests of NDIS participants, a market oversight function could include referrals to universal consumer protection functions where there was evidence of anti-competitive behaviour by providers (and potentially employers), including:

- predatory practices (including inappropriate marketing to people with disability) and pricing by providers
- collusion amongst providers (and potentially employers)
- manipulative or exploitative behaviour by providers towards participants, families and their carers.

There could also be an educative role, working with providers (wherever possible) to translate learnings into improved organisational performance and also wider market practice. This work could be informed by a range of data including (though not limited to):

- participant and industry stakeholder feedback mechanisms
- trends in demands for supports in plans
- trends in complaints.

The UK Government will introduce a market oversight regulatory function with similar roles in 2015.¹⁷

¹⁷ The UK Government is introducing a market oversight regulatory function of adult social care from 5 April 2015. In response to significant provider failure, the market oversight function will initially focus on market failure, in particular monitoring financial sustainability and assessing the likelihood of business failure of difficult-to-replace adult social care provider organisations. However, recommendations from the report, *Stability of the care market and market oversight in England* (2014), noted the importance of establishing a wider market intelligence role: ‘... if the wider market intelligence activity is functioning well then that should allow for the regime to be better informed and hence less of a burden on both the regulator and the market’. (Institute of Public Care, *Stability of the care market and market oversight in England*, Oxford Brookes University, UK, 2014).

QUESTIONS

- Should there be an independent oversight body for the NDIS?
- What functions and powers should an oversight body have?

Oversight of the NDIA

NDIS legislation establishes external oversight structures including the Board of the NDIA, the NDIS Independent Advisory Council, the Disability Reform Council comprised of Commonwealth, State and Territory Ministers, and the scheme actuary. In addition, bodies such as the Administrative Appeals Tribunal, the Commonwealth Privacy Commissioner and the Commonwealth Ombudsman will oversee the NDIA's work.

The Commonwealth Ombudsman can investigate complaints about the actions and decisions of Australian Government agencies to see if they are **wrong, unjust, unlawful, discriminatory or unfair**. He or she can also investigate complaints about goods and services delivered by contractors for and on behalf of the Australian Government. The Commonwealth Ombudsman would be able to deal with complaints about the NDIA, but there is no legislatively mandated external mechanism to deal with complaints about providers.

Safeguards for participants who manage their own plans

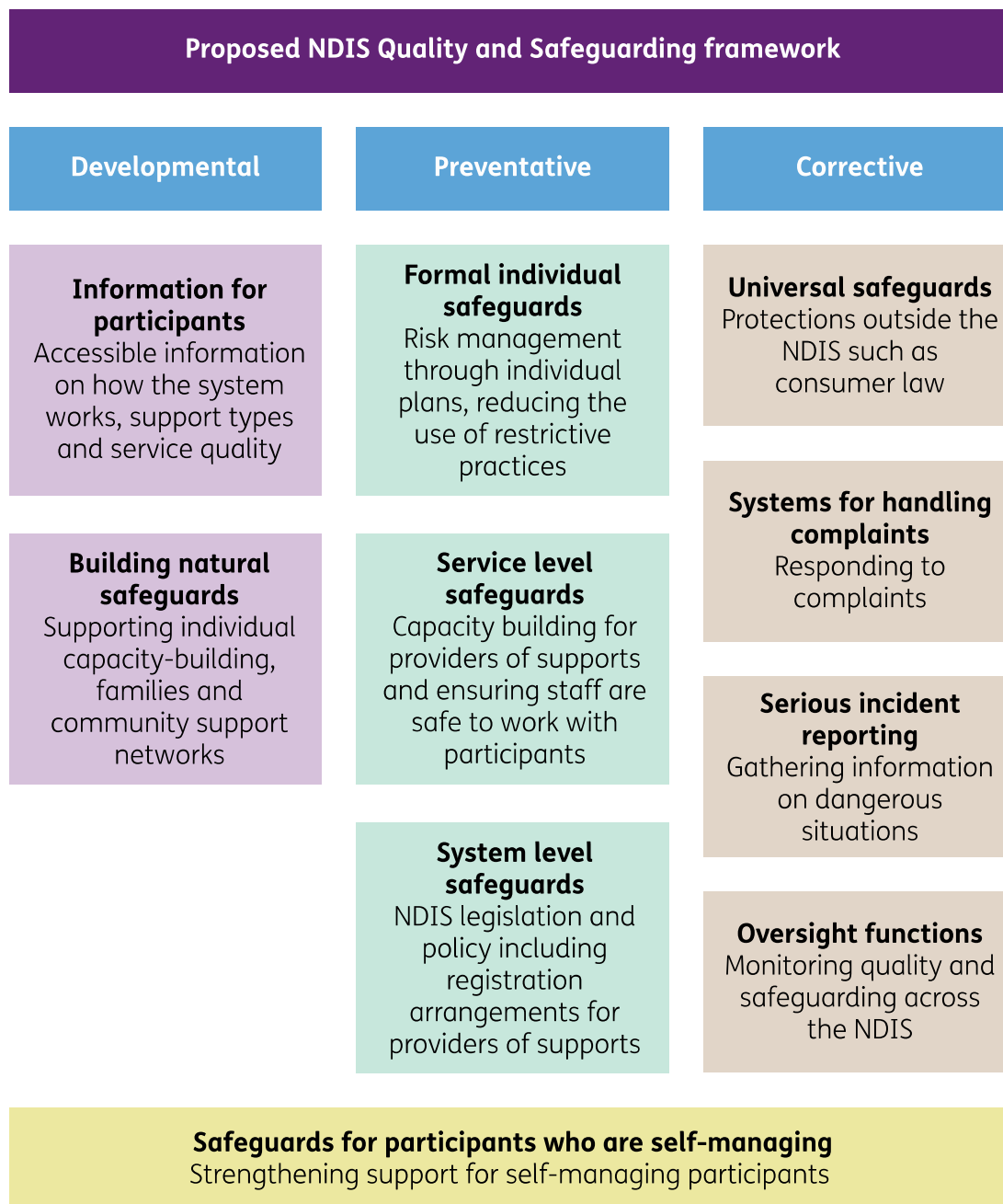
While self-managing their own plan gives participants greater flexibility and control, with this comes some level of risk both to participants and the scheme. The NDIA is responsible for working with self-managing participants at the planning stage to assess their risk and identify strategies to manage risk, and to review this periodically. In other instances, the NDIA and the participant might agree that their particular risks are best mitigated by the NDIA managing the plan, or they might agree that just some parts of the plan should be managed by the NDIA. Alternatively, the participant could ask for a registered plan management provider to be funded.

The biggest potential risk for people managing their own plans is whom they employ. Self-managing participants have a lot of flexibility and for many of them the risks of employing a person who will be a risk to their physical, emotional or financial wellbeing is low. Some will employ a provider they know reasonably well and trust. Others will choose a well-established provider with a good local reputation. Assuming the provider is working more widely with the NDIA, we would expect it has other clients that are not self-managing and so would be a registered provider (which would bring with it a range of safeguards).

Part 2 considers options that could help strengthen protections for self-managing participants while ensuring that they maintain choice and control over whom they pay to provide their supports. One way to do this is to ensure that people who are working with self-managing participants have been subject to some kind of screening.

It is very important to acknowledge that every participant, self-managing or otherwise, is different. NDIS participants have vastly different natural supports and the day-to-day risks they will encounter will vary. Safeguards for self-managing participants are not intended to presume that individuals are not able to make good judgements for themselves or that everyone faces similar risks.

Attachment 1



Part 2: Detail of key regulatory elements of the Quality and Safeguarding framework

NDIA provider registration

This part of the Consultation Paper describes options for registration of providers that governments could use to decide whether a person, business or non-government organisation is suitable to provide supports to participants under the NDIS.

These registration options have been developed because the states and territories and the Commonwealth are not expected to keep their existing quality and safeguarding systems when the NDIS is in full scheme. In addition, the current NDIS legislation does not provide detailed guidance about the requirements a provider must meet to be considered to have the appropriate capacity and experience. A different mix of providers will enter the market during the transition to the NDIS. Alongside traditional disability support providers, there will be greater numbers of registered health professionals and providers of transport, household cleaning and gardening services. In this context, there is an opportunity to consider new ways of ensuring the suitability of providers while not creating unnecessary costs or other barriers for those who want to register with the scheme.

Arrangements under state and territory systems

Quality and safeguarding arrangements for providers of disability supports are currently managed by the 'terms and conditions' in contractual agreements between providers and the government agencies that provide funding. These agreements can also refer to additional requirements in state and territory legislation that providers need to meet. For example, all jurisdictions have either included the National Standards for Disability Services¹⁸ in their disability and other relevant legislation, or mapped these to existing standards to ensure each standard has the same meaning across Australia. To demonstrate they are meeting these standards, most state and territory governments and the Commonwealth currently require providers to submit to an independent quality assessment or quality evaluation process within 12 months of their funding agreement commencing.

During the NDIS trial phase, states and territories and the Commonwealth are continuing to operate their quality and safeguarding systems for providers registering with the NDIS. However, once the NDIS is fully rolled out, the Chief Executive Officer of the NDIA (as the registrar of providers) will have primary responsibility for deciding whether individuals and organisations proposing to provide supports meet the quality and safeguards standards for the NDIS.

Under the current arrangements, some providers experience significant duplication and have substantial regulatory costs associated with having to meet multiple requirements across different systems, such as disability and aged care. If the organisation operates in more than one state or territory, it will also likely be subject to more than one jurisdiction's quality assurance and compliance arrangements. A national quality and safeguards system for the NDIS presents an

¹⁸ At the 18 December 2013 meeting of Disability Reform Council Ministers from all states and territories, the revised National Standards for Disability Services were endorsed. A copy of the new standards can be found at: www.dss.gov.au/our-responsibilities/disability-and-carers/standards-and-quality-assurance/new-national-standards-for-disability-services.

opportunity to minimise duplication and costs by recognising where providers have already demonstrated that they have met equivalent standards or requirements through their interactions with other service systems.

Current arrangements under the NDIS

In designing the NDIS, governments heard from many people that having choice and control over the supports in their plans means that there needs to be a lot of flexibility about who can provide supports. For example, people said they did not think that training and qualifications were necessarily so important for support workers. Instead, they wanted to choose their workers because they had the right attitude for the job.

Governments have also been mindful of the need not to create red tape or other obstacles that would make it difficult or costly for individuals or organisations to provide supports in the NDIS. While these are important objectives, some people also said that there should be enough safeguards in the system so participants can make their choices knowing that any provider who is registered by the NDIS will offer high-quality and safe supports.

In keeping with these objectives, the NDIS Act was written in a way that creates a lot of flexibility about who can be a registered provider. Except where a person is providing a support for which they must by law have certain qualifications (such as a psychologist or speech therapist), anyone can register if they can prove to the NDIA that they have the capacity and experience to provide the supports.

Once a person or organisation has been registered by the NDIA, they must then meet certain rules that the NDIA requires of all registered providers. The NDIA calls these the 'terms of business'. The terms of business say, for example, that providers must protect participants' privacy. Providers are not allowed to discriminate between people because of gender, marital status, pregnancy, age, ethnic or national origin, disability, sexual preference, religious or political belief. They also say that providers must have a complaints system. Requirements that providers report serious incidents such as the death or serious injury of a participant or an allegation of sexual assault or violence are also covered in the terms of business. The current terms of business for NDIA registration are provided at Appendix B.

Our aims

A registration system for the NDIS should:

- support the goal of choice and control for participants, including confidence that the providers they choose are safe and competent
- minimise the red tape burden on providers, including the elimination of unnecessary duplication of quality, compliance and reporting systems.

Possible approaches

Four options have been developed for provider registration, starting with a basic option in which providers would be required to meet all legal requirements and agree to operate according to a Code of Conduct. Other options introduce additional conditions, with providers needing to

demonstrate they have in place good practice arrangements such as staff screening procedures, a complaints mechanism and privacy protections. To the greatest extent possible, there would be recognition of other quality management systems the provider uses, such as third party assessment.

These options are not mutually exclusive; rather they build on one another. The extent to which they would be applied would also vary based on the level of risk associated with the types of support provided. The most regulatory options would therefore apply to a smaller number of providers. Basic options may still be applied to lower risk providers.

The options are described below and are summarised in Table 1.

Table 1: Summary of options for registration

Options	Basic legal requirements	Code of Conduct	Additional conditions	Quality evaluation	Quality assurance/industry certification
Option 1	Required	Required	Voluntary	Not required	Voluntary
Option 2	Required	Required	Required	Voluntary	Voluntary
Option 3	Required	Required	Required	Required	Voluntary
Option 4	Required	Required	Required	Required	Required

Option 1: Basic registration requirements

This is the ‘light touch’ option which, in most jurisdictions, will be a significant reduction from what individuals and organisations wanting to provide disability services must currently do to obtain funding. Under this option, individuals and organisations or businesses who want to offer NDIS supports would confirm in their applications that they comply with any Commonwealth, state or territory legislation, including legislation that is relevant to their profession or business. This could involve legislation that would apply to most support types, for example, Australian Consumer Law. Depending on the activity, it might involve legislation relating to qualifications for professionals or licensing for some tradespeople.

Providers would be encouraged to use good practice and the NDIA might provide general advice to providers about what they can do to make sure their service is of good quality. This would include directing providers to the National Standards for Disability Services so they can understand what people with disability are looking for in a quality provider, but such guidance would not be mandated.

Providers who wish to obtain independent validation that they offer high-quality supports could have their service assessed against relevant standards, such as the National Standards for Disability Services, or others, such as the National Mental Health Standards. They could also do this by participating in an industry-based quality program. As part of that program, the provider would undergo a formal assessment process and would receive a certificate if they met the standards. This would be entirely voluntary under this option.

Continuing registration of a provider would be subject to the provider behaving safely and ethically. There would be an 'NDIS Code of Conduct', setting out what the expectations are for safe and ethical behaviour (see box below). It is proposed that if the NDIA has received information that a provider has behaved unsafely, or in a way that is unethical or caused harm, there would be an investigation by the NDIA or an independent authority (depending on the complaints and oversight options selected). This could lead to the provider's registration being suspended or cancelled, or other conditions imposed.

An NDIS Code of Conduct

Under all options, registered providers must obey state, territory and Commonwealth law. Where a law is breached by an employee or a provider, the agency administering that legislation is responsible for investigation and action.

There are also behaviours that may not technically breach a law but should never be acceptable in the NDIS, such as neglect, financial or sexual exploitation, harsh or rough treatment, depriving a person of food, sleep or basic needs, bullying, or intimidation or vengeful behaviour in response to a complaint. There are also basic professional standards that would be expected, for example, that a person comes to work in a fit state, unaffected by drugs or alcohol.

An option that is used in some sectors is a 'Code of Conduct', which sets out the values and expectations for the industry, often by specifying behaviours or actions that would be a breach of those values and expectations. The NDIS Code of Conduct (the Code) would be consistent with the National Standards for Disability Services. The Code would operate as a basis for determining whether a complaint or concern about a provider or an individual's behaviour requires some form of penalty. Providers would not be expected to prove their ongoing compliance with the Code unless a specific concern has been raised with the provider about a possible breach. The Code might also sanction providers who make false or misleading claims, or who offer a support that is outside of their approved scope of practice. This could include providing a support for which there is no basis of evidence that it is effective.

In serious cases, a breach of the Code could lead to a person being banned from working with NDIS participants but there could be a range of other responses, for example, a suspension, additional conditions imposed or a warning. A provider who has breached the Code could have their registration taken away (in a very serious case) or have conditions imposed.

Registered providers would be required to agree to comply with the Code when registering to be a provider and to ensure that any individuals they employ or volunteers they engage are aware of the Code and what could happen if they act in breach of the Code.

Considerations

The most significant benefits of this option are that it would enable providers to register and enter the market quickly and would maximise choice and decision making for participants. However, this option involves establishing low barriers to entry and could have the adverse effect of creating rapid turnover of providers in the market because providers who were not serious entrants would be able to easily move in and out, potentially leaving participants without essential supports. Providers that may have been previously dissuaded from seeking funding because they thought they may not

satisfy standards for an independent quality assessment would be potentially able to enter the market. And those with a questionable history could find it relatively easy to re-establish themselves in a new setting.

In order to assess the quality of providers beyond compliance with basic legal requirements, participants would also have to rely on informal information and reviews that might be available on the internet, or by word of mouth from others who have used the provider. On the other hand, providers would be required to comply with an NDIS Code of Conduct and serious failures by providers to operate ethically and safely would mean that the NDIA could de-register them.

All providers seeking payments for supports from the NDIA would be required to meet the requirements under this option. The impact of this option on providers would be limited — essentially the internal administrative cost of completing and submitting an ‘application to register’, which is already required in some form under current arrangements. This option would be a reduction in requirements for providers in all jurisdictions currently delivering specialist disability services.

Option 2: Additional registration conditions

This option builds on Option 1 by requiring additional conditions for registration. The purpose of these additional conditions would be to enable the CEO of the NDIA to check that a registering organisation or individual has the systems in place to limit risks to participants.

Additional conditions could include a requirement to demonstrate that a provider uses safe practices when recruiting staff, tell the NDIA or notify the police if there is a serious incident, and have a complaints handling system and a system of privacy protection in place.

The conditions required for registration would vary according to the potential risk related to the types of supports the provider offers. While there are a number of factors that determine the risk to any single individual, there are some types of supports where risk is always greater because of the circumstances in which the support is typically offered, for example, when supports are provided in a person’s home. The NDIA would decide what specific conditions a provider should be required to meet based on an assessment of the potential risk for a particular provider type. An example of a condition that could be required for a subset of providers is that housing providers could be required to meet specific conditions regarding the rights of participants in relation to security of tenure (and grounds for termination) and the right to privacy within a supported residential service.

All providers, including those considered to be low risk, would be required to meet the conditions outlined under Option 1. As under Option 1, the NDIS Code of Conduct would apply to registered providers and their employees. Providers would also be encouraged to participate in an independent industry-based quality program which would enable them to gain certification and formal recognition. Alternatively, they could adopt a less formal approach by providing customer testimonials and other information from clients on their website.

The NDIA could set a review date to go back to a provider to check that it continues to meet its additional registration conditions, or it might conduct a review following complaints or other information it receives that suggest there may be a concern.

Considerations

The most significant benefit of Option 2 is that, like Option 1, it will allow providers to register and enter the market quickly. However, it will provide a greater level of assurance than Option 1.

There would be different impacts on different providers. For organisations currently delivering specialist disability services, requirements are likely to already be embedded in their business practices and funding agreements, so additional costs would be low. While this option may involve financial costs for new entrants, particularly for smaller providers who may need to invest in establishing new systems to meet conditions, these are expected to be relatively low. A limitation of this option is that it does not provide independent information on quality to assist participant choice in the market.

Case study: Help@Home

Help@Home is a small business operating in suburban Brisbane offering a combination of personal care and other supports in the home. They offer support with meal preparation, shopping and helping their clients with domestic chores. They also offer personal care for people who need support with daily living tasks like showering or dressing. Their team consists of three experienced but not formally qualified support workers.

What Option 2 would mean for Help@Home

The NDIA would look at the kind of supports Help@Home provides. Because their staff will be working alone with participants in their homes, the NDIA will require evidence that staff have been through referee checks and police checks.

What this would mean for participants

Fiona has a spinal cord injury that means she is unable to shower or dress herself. She has a full-time job and needs a local provider who will turn up on time every work day. She lives on her own and needs someone to help her shower and change clothes before and after work.

Fiona has seen ads for Help@Home which say all their staff have police checks. Fiona talks to her planner at the NDIA who confirms that Help@Home has registered as a provider and has provided evidence that their staff have police checks. Fiona decides to call Help@Home and confirms that staff will be available at the times she requires.

Option 3: Mandated independent quality evaluation requirements

This option is an extension of Option 2. The additional element proposed under this option would be a requirement for certain providers to participate in an independent evaluation to evaluate their quality and how they contribute to meeting planned outcomes for participants.

The focus would be on the participants' experiences of the supports they receive. The assessment would be independent of both the NDIA and the organisation. If a provider is required to meet additional conditions (for example, ensuring staff are safe to work with people with disability), the evidence that these are met would be checked as part of the quality evaluation, so there would only be one process.

What does a quality evaluation mean? Quality evaluations would be undertaken by an independent evaluator who would assess against indicators of effectiveness through observation and in-depth interviews with individuals and families who use the supports. The evaluator would be looking for views on the culture of the organisation, in particular whether participants are supported to realise their goals, enabled to make choices, treated with respect and supported to participate. Other indicators could be assessed by reviewing systems and records. This approach is similar to the Independent Quality Evaluation Western Australia uses for its quality system (see box below).

The assessments would provide information based on participants' experiences of the organisation in assisting them to access supports and meet their individual needs and goals. The evaluation assessments would be descriptive and made public. The assessment would also consider other aspects of a provider's business, such as safety, staff management, timeliness and responsiveness to user feedback. The aim of doing this would be to inform future and current participants about the relative strengths and areas of improvement of providers. A provider would not be excluded from registration on the basis of a below average assessment, provided they continued to meet all other registration conditions. New entrants to the market would have 12 months to establish themselves before they would be expected to begin participating in a process of periodic quality evaluation. However, prior to registration, they would still be required to demonstrate that they had met any additional conditions prescribed under Option 2.

How would the NDIA decide if a provider is required to undertake a quality assessment? The majority of businesses operating in the general marketplace, for example, general gardening or household supports, taxi services, and suppliers of aids and equipment, would be exempt. These types of supports are used widely across the population and information on people's experience of these supports is becoming increasingly available online. Any of these exempted providers could still choose to participate in an NDIS independent quality evaluation process if it made good business sense for them to do so.

Only providers delivering supports of a type likely to create a greater risk to participants (that is, supports that involve more direct staff-participant contact or which lack supervision such as personal care support, respite or supported residential services) would be required to participate in a quality assessment under this option. Providers offering lower risk supports would be asked to meet the basic requirements under Option 1 or additional requirements as described under Option 2.

Experience from NDIS trial sites shows that the majority of providers are either specialist disability service providers or registered/accredited health professionals. Both of these groups are likely to be included under this option, although many providers described as ‘registered/accredited health professionals’ could be subject to existing quality checks through their own professional bodies.

Disability Services Commission Western Australia — Quality System

In 2013–14, the Western Australia Disability Services Commission conducted a review of its Quality Management Framework processes for evaluating the quality of services in the disability sector. It found strong support in the sector for the continued use of independent quality evaluation. The review resulted in the development of a new quality system which continues to independently evaluate the quality of WA government funded and operated disability services. This involves assessing compliance with the National Standards for Disability Services and the achievement of individual outcomes from the perspective of people with disability, whose feedback is central to the evaluation process.

The evaluation is based on an evaluator’s observations, discussions with people with disability and their families and carers, staff and management, and a review of documentation, systems and processes. This is then assessed for compliance with the National Standards for Disability Services.

The evaluation can include required actions, which are recorded when a National Standard has not been met and has significant implications for the rights, duty of care, safety and/or wellbeing of people with disability. The evaluation may also include suggestions for service improvements, which are designed to better meet National Standards or individual outcomes.

Considerations

The most significant benefit of this option is that participants will be provided with independent outcomes-based quality information to help them make choices about providers. This means that the quality evaluation will describe a range of attributes of a particular provider and participants will be able to make their own decisions based on what is most important to them and choose from a potentially wider range of providers. See case study on the following page.

The regulatory impact of this option would be the same as for Option 2 but for some there may be additional costs associated with having to participate in a quality evaluation. However, providers in jurisdictions where a quality evaluation is already a requirement are likely to experience no impact and may in fact have a reduced burden because the NDIA will be able to recognise other quality certifications or evaluations. As with the additional conditions under Option 2, the extent of the quality evaluation would be proportionate to the risk profile of the provider type.

Case study: Cecilia

Cecilia has multiple sclerosis. She lives alone and goes to work each day, but needs support in the mornings with showering, dressing and toileting. She also needs help with some tasks around the house such as cooking and cleaning. Cecilia and her NDIA planner identify a budget for personal care in her plan and the NDIA gives her a list of registered providers in her area.

Cecilia wants to be certain that she can trust the people coming into her home. She is particularly concerned that her provider is respectful and is also keen to know whether the provider's existing clients are happy with their service. Cecilia reads the independent quality evaluations of several providers in her area, including information about the experiences of former clients. After reading and comparing these reviews she feels satisfied that one provider, South District Care, will best meet her needs even though they did not do so well on some indicators. She informs the NDIA of her decision to purchase support from this provider.

Option 4: Mandated participation in an external quality assurance system

This option is an extension to Option 3. It would require providers of certain kinds of supports to undertake a more rigorous quality assurance and improvement process to meet recognised industry governance and management standards and achieve certification with a recognised certification/accreditation body. The outcomes-based quality information provided under Option 3 could be built into this option to help participants make decisions about what is most important to them. Whereas Option 3 focuses on the participants' experiences of the organisation and other key elements such as staffing and timeliness, Option 4 considers this, and also the governance and operational systems of the organisation to ensure viable, safe and effective organisations.

Quality assurance is any systematic process of checking to see whether a product or service being developed is meeting specified requirements. Industries and governments develop quality assurance systems that reflect the standards they believe their customers expect. The process for checking that these standards are being achieved is meant to be very robust. Specially trained and accredited auditors are employed to work closely with their client businesses over a period of time until the business is able to meet the standards. Once the auditor agrees that the business conforms to the standards, a certificate can be issued for a period of time, for example, three years. Quality assurance standards therefore require continuous quality improvement processes. The bar is raised each time the standards have to be 'met' to achieve certification/accreditation.

For businesses in many industries, gaining a quality assurance certification is commercially essential for the business. Increasingly, quality assurance is also being used by providers in the health and human services sectors as a way of assuring people that they offer safe and quality supports.

Quality assurance systems can and do engage with clients of the service to get their perspective and information about individual outcomes can be built into this approach, but this type of quality assurance system has a more rigorous focus on the processes and policies which organisations must use in order to conform to the standards.

Currently, the reports of quality assurance auditors are typically not publicly available. This means that other than knowing an organisation has been certified as meeting the standards, there would be limited information available to potential consumers from these assessments. If this option were adopted for the NDIS, a provider might choose to make their assessment public or this could be a requirement. A further option could be to ensure the outcomes section is available publicly as in Option 3, but certification reports would not be required to be made publicly available.

In some cases, providers will be unable to meet the standards for certification within the required time frame and under this option would not be able to be registered with the NDIA.

There could be a range of certification bodies recognised. The purpose of 'recognising' a certification body would be to ensure that only legitimate certifications are made and participants are not misled. Providers who have an existing certification required by a system outside of the NDIS would have all or parts of that certification recognised, which would reduce the impost and cost to the provider.

New entrants to the market would have 12 months to establish themselves before they would be expected to begin a process to obtain an independent certification. However, they would still be required to demonstrate that they had met any additional conditions prescribed under Option 2 prior to registration.

Like Option 3, this option would be applied proportionally to providers delivering supports of a type likely to create a greater risk to participants and would therefore not apply to all providers. Providers who belong to a professional body that has its own registration requirements could also have all or part of that registration process recognised. This could reduce duplication, depending on the extent to which they are required currently to participate in quality assurance accreditation/certification processes for different systems, and how those processes map to the requirements for registration with the NDIA.

Considerations

Under Option 4, participants could be provided with independent outcomes-based quality information to help them make choices about providers, along with the additional assurance that the provider has met a form of recognised industry standards.

The report on which the certification was based could be made publicly available and could include information on individual outcomes to help participants judge whether a provider is the right fit for them.

This option may result in some providers being excluded from registration because they are unable to meet standards which may be applicable to some kinds of support. However, this impact is likely to show no net change in jurisdictions where this option is already a current requirement.

Costs are likely to be of a similar scale to an accreditation assessment based on the *National Standards for Disability Services* currently required in states and territories and the Commonwealth. This has been estimated to be in the order of \$4,000 for small to medium providers and \$5,000 for large providers.

Providers in jurisdictions where the quality certification process does not currently focus on participant outcomes may experience an increase in costs, while the effect would be smaller on providers in jurisdictions where the quality assessment already includes a focus on participant outcomes. Similar numbers of providers would be affected by this option as by Option 3; however, the process for this option would be more detailed and intensive and there could be costs for providers associated with licensing.

Case study: Hamish St George Care

Hamish St George Care is a large multi-site provider which is seeking registration with the NDIA to provide a range of supports, including help with domestic chores, personal care and community access. They have been providing home care supports for people in the St George area for 10 years under the Home and Community Care (HACC) program.

What this option would mean for Hamish St George Care

Because Hamish St George Care provides personal care and community access type supports, the NDIA would decide that their registration should be conditional on their obtaining an independent assessment and certification to ensure that they meet the National Standards for Disability Services, or their equivalent. As they have just started extending their services to NDIS participants, the NDIA will require them to enrol in a quality assurance scheme, but they will have 12 months before they will need to demonstrate that they have met the quality assurance standards.

Hamish St George is also an approved HACC provider. There is a substantial overlap between the Home Care Standards which the Aged Care Quality Agency uses to assess HACC providers and the National Standards for Disability Services. The quality assessor hired by Hamish St George Care will take into account the standards that have already been met and may not ask for additional evidence for those. This would reduce the cost and impost on the provider and speed up the process.

Markus

Markus, who has an intellectual disability, lives on his own and is able to travel independently but requires some assistance with household tasks and activities of daily living such as meal preparation and personal hygiene. He is new to the St George area and doesn't know who the good support providers are. His planner at the NDIA suggests that he look online at the reports that cover the certification of providers. Markus searches online and finds two businesses near him who say they have been independently certified as providing a quality service, each having met the National Standards for Disability Services. The Hamish St George Care website has a report attached to it which includes what the accreditation reviewers said about how the provider rated against the standards, including information about the experience of former clients. Markus thought, on balance, Hamish St George Care looked quite good, so agreed to try them.

QUESTIONS

- Considering the options described above, which option would provide the best assurance for:
Providers?
Participants?
- Should the approach to registration depend on the nature of the service?
- How can the right balance be reached between providing assurance and letting people make their own choices?

Summary

Of the options described above, Option 1 implemented on its own would constitute a significant reduction in regulatory burden for providers currently funded by state and territory governments. It also has the advantage of allowing new providers to enter the market without additional barriers being imposed, and has the potential to widen the choice for participants. However, this option also exposes participants to a greater risk of unsafe providers operating in the NDIS and may not provide the level of assurance and information needed to facilitate choice and drive continuous improvement in the market.

The requirement under Option 1 (and subsequent options) to adhere to an NDIS Code of Conduct establishes a set of behavioural requirements for providers and creates a baseline for assessing and responding to complaints made against providers.

Option 2 introduces additional conditions that strengthen the requirements on providers who register with the NDIS and therefore seeks to address the risks identified in Option 1. These additional conditions will apply in a proportionate way according to the risk to participants associated with specific support types. In most jurisdictions, this would still be a reduction in regulatory burden for many providers currently funded by government. For established and large organisations, any additional conditions are likely to be already embedded in their business practices.

Option 3 builds on Option 2 by adding a further quality check for higher risk providers. This would be an additional cost to these providers, although it may be offset by providers no longer having to participate in a state or territory accreditation system in those jurisdictions that currently require this. It would also be applied proportionately by support type. This option would provide information about quality that would be publicly available to existing and future participants. It would not exclude poorer quality providers (who had met the requirements set out in Option 2) – this would be a choice made by participants.

Option 4 is similar to Option 3, but in addition to the outcomes-based quality evaluation, this option would involve a quality assurance/industry-based certification which indicates that a provider has met certain standards in order to gain certification. Like Option 3, Option 4 could include outcomes-based quality information, but this option would have an additional focus on governance, operations and the quality system to ensure a viable and well-functioning organisation. Providers who do not meet standards would be directed to make improvements, and if they fail to do so, they may be

excluded, reducing the choice available to participants. The costs of Option 4 would most likely be higher than Option 3 as the evaluation process would be more rigorous.

The case study below shows the impact of the different options on a provider of supports.

Case study: YourCare

YourCare is a medium-sized provider that offers in-home supports, including assistance with personal hygiene, domestic assistance and other daily tasks such as dressing.

Under Option 1, YourCare would provide evidence to the NDIA that it complies with all general Commonwealth, state and territory legislation (for example, consumer rights law). Once YourCare is registered, it would also have to comply with the NDIS Code of Conduct, which would mean ensuring safe and ethical conduct of its staff through staff training and supervision, and by setting up internal processes to resolve any problems. YourCare might decide to seek an independent quality assessment through an industry association as this would enable them to prove to participants that they meet industry standards, but this would not be compulsory.

Under Option 2, all of the same requirements would apply as for Option 1, but YourCare would be subject to some additional conditions of registration. As YourCare delivers supports to people in their home in an unsupervised environment, the NDIA might require YourCare to prove that all staff in direct support roles have obtained a police check.

Under Option 3, YourCare would need to meet the same registration requirements as for Option 2. However, there would also be a requirement for YourCare to undertake an independent quality evaluation within 12 months of registration. YourCare would engage a quality evaluator that has been approved by the NDIA. This evaluator would write a report which focuses on the experiences of participants and their families. This report would be made public and future participants could consider it before purchasing supports from YourCare.

Under Option 4, YourCare would need to meet the requirements under Options 2 and 3 and would need to participate in an industry-approved quality assurance process within 12 months of registration. A certification body would assess whether YourCare had met the required standard in areas such as feedback and complaints, access and management. This quality process would also assess the experiences of participants. If YourCare did not meet certain standards, it may be directed to make certain improvements or it could even be excluded from providing NDIS supports.

Systems for handling complaints

Under the NDIS, the disability sector will transition to a more market-based model and complaints are an important part of any consumer-driven system. A complaint can be an opportunity to tell a provider about something it needs to fix, or it can be much more serious. Some complaints are about safety, which might mean that other clients receiving supports from the same provider are exposed to a similar risk of harm. In these instances, a complaint would trigger an immediate response to take protective action and commence an investigation.

For organisations and individuals who sell their products or services, complaints can provide invaluable information on what they need to do to improve their service. For those who are responsible for ensuring the safety and consumer rights of citizens, for example, a funding agency, some complaints are a red flag and will prompt action by the relevant regulator or body responsible for regulation of that activity.

What is a complaint?

A complaint is the expression of dissatisfaction with a decision, service or product. Complaints can take a variety of forms, including:

- dissatisfaction about the service or product and how it is being delivered that may be resolved through the provision of further information
- disagreement with a decision made by the provider of the disability support, product or service that may require explanation and/or investigation
- a claim that a situation or decision should never have happened or been made, or an issue that requires explanation and/or resolution.

A complaint is not the same as a serious incident, which is an event which threatens the safety of people and property and must always be reported. Serious incident reporting is discussed separately in Part 1.

Serious incidents, such as a criminal offence or safety issue, could be reported initially through a complaints system, but these matters would require investigation and/or other action by police and/or other authorities.

Why is an NDIS complaints mechanism needed?

Under the NDIS, participants are customers and purchasers of products. Usually, customers who are not happy with the provision of their supports raise their concern with the provider with an expectation that an appropriate remedy will be agreed. Whether a provider will respond appropriately will depend on the extent to which consumers are empowered to negotiate their needs with providers and the strength of the regulatory framework to compel providers to act appropriately.

A lot of new issues are likely to arise as the NDIS and the disability sector transitions to a more market-based system, particularly as providers adapt to the new environment. The market will also be more fluid, with many new providers expected to enter and with some providers possibly exiting the market or merging with other providers.

In addition, NDIS participants will face some particular challenges exercising their rights without help from others. This is particularly so for participants with significant cognitive impairment or limited verbal capacity. Others may be fearful that a complaint may cause further problems, including retribution from their provider. In some circumstances, the effect of this power imbalance may result in injustice and intolerable harm and suffering unless specific proactive measures are taken.

Certain formal protections exist when there is a direct relationship between the buyer and the seller of a product or service. For example, both parties have certain responsibilities under the Australian Consumer Law (ACL). The ACL sets out rights and obligations and there are legal avenues for redress if the consumer does not agree that the provider has complied with the law.

However, not everything a participant might buy in their plan will be covered by the existing consumer legislation. This has been a challenge in many service sectors, for example, banking, superannuation, telephone, gas and electricity services. To give consumers in these sectors a fairer say when expectations are not met, governments have set up independent bodies with enforcement powers that are able to assess complaints.

Feedback, including both complaints and compliments from participants, can also be a helpful tool for businesses committed to competing on the basis of service quality. Complaints can be a useful barometer of businesses' health and give providers an opportunity to learn what the market expects and get ahead of their competition.

In addition, most jurisdictions already have significant requirements in place for the specialist disability sector and many providers have responded positively. The Victorian Disability Services Complaints Commissioner, for example, has a mandate to promote best practice in this area, and all providers have submitted audits of their own systems as part of this process.

Case study: Amy

Amy lives in a group house in Melbourne with three other women. The women are supported by a local non-government organisation which provides a leader who lives on site.

Amy has cerebral palsy and she has recently bought a new electronic wheelchair with NDIS support. She bought it from a mobility aids shop in Melbourne. Her chair worked for a few months and then the batteries stopped charging properly.

Amy is also experiencing some issues at home. A new house leader has moved in and made new rules banning overnight guests. Amy has an old school friend who visits her regularly from a country town about three hours' drive away. Her friend stays for a couple of days and sleeps in Amy's room on the trundle bed her parents bought for her so her friends could stay. The other housemates are fine with Amy's friend staying for a couple of days.

Amy's wheelchair is covered by a consumer guarantee. The manufacturer is responsible for ensuring that it works and the shop who sold it to her has agreed to send it back to the manufacturer for a replacement battery. In a week she has her new chair back and it is working well. If the shop owner and manufacturer had not been so helpful, Amy would have been able to take the matter further by writing a formal letter of complaint. If this was still unsuccessful she could contact a consumer affairs body in Victoria.

The issue with the new house leader is more difficult. Amy has asked the house leader to reverse the new rule and she has refused, arguing that Amy's friend impedes the rights of the others in the house when she stays overnight. Amy disagrees and so she calls the house leader's manager to complain. The manager agrees with the house leader and Amy thinks they are both wrong so she rings the Disability Complaints Office. The Disability Complaints Office gets in touch with the manager in the organisation and reminds them of Amy's right to have her friends visit her in her own home. They agree that the house leader has been unreasonable and the overnight guest rule is revoked.

Current arrangements for complaints about providers

Over time governments have introduced a number of measures to strengthen the capacity of their systems to respond to concerns about providers in their state or territory. Arrangements vary between states and territories and can include:

- requirements in funding contracts that providers have effective internal complaints handling mechanisms in place — some also require that providers report on the number and nature of complaints they receive
- establishment of complaints systems administered by departments that fund disability providers
- mandatory notification and reporting requirements for certain events (which can trigger investigations)
- telephone hotlines for reporting abuse
- independent complaints-handling bodies such as Ombudsmen or Disability Commissioners

- community visitor schemes that can make in-person visits either in response to particular complaints or with a view to identifying problems through a schedule of random visits.

Table 2 summarises the arrangements that are currently in place by jurisdiction.

Table 2: Complaints handling agencies by jurisdiction

Jurisdiction	Requirements for providers	Funding/management agency for complaints handling	External complaints investigation/dispute resolution bodies (for disability services)
Commonwealth	Funding agreements	Complaints Resolution and Referral Service (outsourced by the Department of Social Services (DSS))	Unresolved complaints can be escalated to the DSS complaints system or the Ombudsman if the complainant is not satisfied with the action of the Department
New South Wales	Legislative requirements	The Department of Family and Community Services — able to request copies of a provider's complaints register and copies of all correspondence and other materials	Official Visitors Ombudsman
Victoria	Legislative requirements and service agreements	Complaints policy	Public Advocate Community Visitors Disability Services Commissioner Ombudsman Department of Education and Early Childhood Development (statutory regulator for <i>Children's Services Act 1996</i>) Some Early Childhood Intervention Services (ECIS) providers
Queensland	Certification requirements, legislative requirements and funding agreements	Central Complaints and Review Unit for government and government-funded NGO services	Community Visitors Scheme Office of the Public Guardian Office of the Queensland Ombudsman
Western Australia	Legislative requirements under s. 48 of the WA Disability Services Act and service agreements	Review during independent quality evaluation and reporting through annual organisational self-assessment	Council of Official Visitors (mental health) Health and Disability Services Complaints Office

South Australia	Funding agreements and legislative requirements	Complaints/Incident Unit (with responsibility for quality compliance) and Care Concern Investigation unit in the Department for Communities and Social Inclusion (for government run services and government-funded NGO providers)	Community Visitor Scheme (mental health and disability, residential facilities) Ombudsman Health and Community Services Complaints Commissioner
Tasmania	Funding agreements	Allegations of Abuse reporting only Other complaints dealt with on an informal advocacy basis only	Ombudsman Health Complaints Commissioner Anti-Discrimination Commissioner
Northern Territory			Community Visitors (mental health) Health and Community Services Complaints Commissioner
Australian Capital Territory			Official Visitors Public Advocate Disability and Community Services Commissioner Human Rights and Discrimination Commissioner

Table 2 illustrates that those complaints mechanisms in place for disability support providers are state and territory based and involve a range of different legislative and operational policy responses. Most, though not all, of the current schemes are tied to the state or territory's funding of disability service providers. As a minimum, current funding conditions in jurisdictions specify that providers must indicate they have a complaints handling process that is accessible to the people using their services.

In the NDIS, having an effective complaints system will be more advantageous to providers because they will be operating in a competitive market. The ability to demonstrate flexibility and to resolve complex issues to meet participants' needs will help them improve their service offer and their reputation.

Our aim

An effective and nationally consistent complaints mechanism could be a key safeguard under the NDIS.¹⁹ It should ensure:

- providers of supports have adequate internal complaints handling mechanisms in place
- effective, fast and accessible external dispute resolution mechanisms are available to consumers
- serious and systematic concerns are able to be identified and addressed.

¹⁹ Western Australia has not committed to the full roll-out of the NDIS and is currently trialling the NDIS and My Way.

The complaints system we are discussing here is not about decisions or actions by the NDIA. There are special arrangements in the NDIS legislation for complaining about an NDIA decision. The NDIA has also created its own internal system to enable people to make complaints about NDIA staff or its services. Information about how complaints about the NDIA services or decisions are handled is provided at Appendix C.

Possible approaches

The NDIS has a much wider range of supports and providers than are offered in the existing systems and many of these support providers already participate in various industry complaints schemes. In other cases, rights under consumer law may be adequate.

There are three broad options for the scope of a complaints scheme:

- The scheme could apply to all funded supports — on the basis that the NDIS may create some particular pressures on providers that need to be addressed in a consistent way, and that many people with disability will need extra help to assert their rights.
- The scheme could be restricted to a subset of supports funded by the NDIA, meaning it would generally encompass what are now referred to as specialist disability services and similar supports that fall outside the scope of other complaints regimes.
- The scheme could apply to all supports specifically targeting people with disability, irrespective of whether the support is funded by the NDIS, for example, supports in the education sector.

A further issue is the role of community visitor schemes in the NDIS. Currently, these schemes are used in some states and territories to provide general oversight of some types of funded supports. They can also assist in raising concerns on behalf of participants who might otherwise be unable or unwilling to make a complaint on their own behalf. There is a range of legislative powers given to Community Visitors, for example, the right to enter a facility and look at records. A question for the future is whether these functions will be required in the NDIS or whether the functions that the NDIA will have in relation to participants, together with other safeguards in the NDIS, will mean that these functions are no longer necessary, or should be redesigned.

Options for an NDIS complaints scheme are as follows.

Option 1: Self-regulation

Under this option, providers would develop and operate their own complaints management and feedback systems. They would be encouraged and assisted to establish best practice internal complaints processes and for many this would be a sensible and commercially beneficial part of their business model. Providers could also be encouraged to subscribe to an external disputes resolution service where an independent perspective would help to resolve concerns. However, there would be no formal requirement to do so.

Participants would also have recourse to state or territory fair trading departments, the health complaints system, or professional registration bodies. The NDIA would not have a role in individual complaints resolution. However, it could be expected to take action where there were serious issues

that could cause the NDIA to review a provider's registration status. Participants would need to be made aware of the circumstances in which it would be appropriate to bring such concerns to the NDIA's attention.

It is also possible that participants will raise matters with their plan manager in the NDIA when they are not able to sort out issues with their provider. The plan manager will need to have some discretion about whether such matters should be managed through a person's individual support plan and the extent to which they should get involved in resolving concerns a participant has with a provider.

Providers could use their approach to complaints management as a source of competitive advantage. Those choosing to subscribe to an external disputes resolution mechanism would face costs in doing so.

Considerations

This option places additional responsibility for action on the consumer because of reliance on the provider to resolve issues and the lack of a clear back-up should participants not be satisfied with a provider's response. This could be problematic in a sector where traditionally many people with disability have had little or no market power. It may take some time for them to become more confident and skilled consumers in the market, but still some participants may have little or no capacity, or could be intimidated by the provider or have limited support networks.

The key risks under this approach are that consumers would not be sufficiently empowered to be able to drive cultural change, and that the lack of independent, low-cost mechanisms to enable consumers to enforce their rights would lead to a loss of confidence in the system.

Option 2: Internal and external complaints handling requirements

Under this option, the NDIA registration conditions would prescribe a set of minimum standards for provider level complaints handling. This could include assurance that the participants who receive supports have access to information about how to complain, what to expect and what to do if they are not happy with the response. The provider should be able to demonstrate they have systems in place to ensure that participants who make a complaint are protected from retribution or other adverse consequences.

The objective would be to ensure that most complaints are resolved by the provider and the complainant themselves, without external aid, by requiring providers to have best practice internal systems in place to receive and respond to feedback.

In addition, there would be an independent complaint review process under this option. This could take the form of an industry-initiated complaints body. For professionals registered with the NDIA, their relevant national professional board would perform this function.

If an industry-initiated complaints body was not feasible at this early stage of development in the sector, an alternative model could be the contracting by government of a third party to perform

these functions. An example of this is the Complaints Resolution and Referral Service, which the Commonwealth Government funds to handle complaints about providers in its Disability Employment Services and Australian Disability Enterprises programmes. The complaints body would be able to assist participants and providers achieve a mutually agreed outcome but it would not be able to make enforceable decisions.

As under Option 1, the NDIA would not have a formal role in individual complaints resolution. Providers and the external disputes resolution body (however constituted) would be required to notify the NDIA registration authority in cases where action may be required. This would include all allegations of abuse, harm, neglect or violence against a participant.

Considerations

Requiring providers to use both an internal and external complaints handling mechanism could increase the credibility of the sector by ensuring that participants have a means of obtaining help to resolve problems when they need to. At the same time, the flexibility around the choice of an external complaints resolution body would give providers some scope to choose a body that is appropriate to the supports they offer.

However, this approach may not be seen as providing sufficient support for vulnerable participants. Questions could remain for participants about the credibility and independence of a provider level system supported by an industry-initiated review body. Furthermore, in weak markets (for example, regional or rural areas) there is no guarantee that feedback will create any incentive for the provider to address deficits. Unless a complaint is serious enough to warrant reporting to the complaints resolution body, systemic problems in the quality of the service may go unresolved.

Option 3: Independent statutory complaints function

Under this option, as under Option 2, providers would be required, as a condition of registration, to demonstrate that they have effective internal complaints handling processes. Government would establish a formal external complaints body which would assist providers to manage complaints effectively and support participants in having their complaints resolved quickly and effectively.

Functions for an independent complaints function could include the following:

- provide information, education, training and advice about matters relating to complaints and complaints handling
- receive, investigate and resolve individual complaints that escalate beyond the provider level, with discretion to refer cases to other appropriate authorities, or not to investigate further in certain circumstances
- review the pattern and causes of complaints, identify systemic issues for service improvement and make recommendations for the improved handling and resolution of complaints
- instigate inquiries and investigations where it considers they are warranted
- monitor and report publicly on the effectiveness of complaints handling in the sector.

Complaints that should be managed by other bodies, for example, a health matter or a consumer product issue, would be referred to the responsible complaints bodies.

There are two possible ways in which these functions could be implemented: through a complaints office within the NDIA; or through a separate complaints body, such as the Complaints Commissioner models currently operating in several states and territories.

Option 3a: Complaints office in the NDIA

Under this approach, government would introduce legislation to allow the NDIA to respond to complaints about providers.

Considerations

The benefit of this approach is that it would enable the NDIA (in its role as the registrar of providers) to know quickly if there are significant issues affecting the safety and wellbeing of participants. The NDIA would also be in a position to evaluate the local market environment and the extent to which a participant is able to exercise choice. A risk, however, is that provider cooperation with the complaints scheme may be undermined by fear of consequences such as de-registration.

Option 3b: Disability complaints office

Alternatively, a disability complaints office independent of the NDIA could be established to deal with those complaints that cannot be resolved between the provider and the participant without assistance.

Where the disability complaints office considered further action was needed on a particular complaint, they would refer the matter to the NDIA for action. For example, where there was a possible breach of the NDIS Code of Conduct (described in the 'NDIA provider registration' section of this paper), or where the complaint originated from a location where the market was weak and the participant was therefore unable to simply change providers.

Considerations

This option would provide a greater degree of independence and external scrutiny. This could, however, be a higher cost option.

QUESTIONS

- How important is it to have an NDIS complaints system that is independent from providers of supports?
- Should an NDIS complaints system apply only to disability-related supports funded by the NDIS, to all funded supports, or to all disability services regardless of whether they are funded by the NDIS?
- What powers should a complaints body have?
- Should there be community visitor schemes in the NDIS and, if so, what should their role be?

Ensuring staff are safe to work with participants

People with disability have the right to feel safe and be safe when accessing supports under the NDIS. An essential element in achieving this is to minimise the risk that those who work or volunteer with people with disability pose a threat to their wellbeing and safety. Employee recruitment practices, including criminal history screening, are regarded as an important first step in preventing abuse.

There are currently different requirements for employee recruitment in each state and territory. Most states and territories require checks for those who are working with children and some have specific requirements for those who are working with vulnerable people. Employee recruitment requirements are also a part of many funding agreements between state and territory governments and providers of supports.

Risk in the disability sector is likely to increase as the demand for workers grows and competition for staff with the aged care and other community services sectors increases. In addition, some self-managing participants will take on responsibility for employing their own workers and the number of self-employed and casual workers is likely to grow.

How severe is the risk?

People with disability are at an increased risk of abuse, harm, exploitation and neglect due to a range of factors, including reliance on others for support, social isolation, fear of retribution and difficulties with communication. Research suggests that the most vulnerable groups, such as those with intellectual disabilities and women, face greater risks.²⁰

Abuse can often go undetected, as victims may not report a problem because they are afraid of retribution, have difficulties communicating or are experiencing trauma. Moreover, even where abuse is reported, it may not be prosecuted due to police perceptions of witness reliability, evidentiary issues and reluctance on behalf of victims (or those with a vested interest in their wellbeing) to engage in criminal proceedings.²¹

Identifying perpetrators

Research by the current Royal Commission into Institutional Responses to Child Sexual Abuse has suggested that perpetrators can be categorised in three ways: serial offenders who deliberately target sectors where they can gain access to vulnerable people; opportunistic occasional offenders; and offenders who react to particular situational factors. It is important that an NDIS quality and safeguarding framework is able to recognise people in these categories to reduce the risk they pose to people with disability.

²⁰ See J Chesterman, *Responding to violence, abuse, exploitation and neglect: improving our protection of at-risk adults*, Report for the Winston Churchill Memorial Trust of Australia, July 2013.

²¹ See, for example, the review of the literature contained in the recent report by the Victorian Equal Opportunity Commission, *Beyond doubt: the experiences of people with disabilities reporting crime — Research findings*, July 2014.

Current controls

The current regulatory framework around disability employment is summarised in Table 3. All states and territories require those working with children (including children with disability) to undergo risk-based assessments by a government screening agency. In addition, most current funding agreements include requirements that staff undergo police and referee checks at specified intervals. However, the information taken into account and ongoing monitoring arrangements differ substantially between jurisdictions. This is problematic given that workers may move interstate.

Table 3: Current arrangements for employee checking by Commonwealth, state and territory

Jurisdiction	Working with children (including children with disability) checks	Disability funding agreement related requirements	Broader requirements for those working with people with disability
New South Wales	The NSW Working with Children Check (WWCC) is a central probity check for child-related positions. All people working in positions or applicants for positions that involve child-related work must have a WWCC clearance. Employers are required to check a person's WWCC number in relation to potential employees (and others in significant roles, including volunteers) if they are employed in certain kinds of child-related employment.	As of 3 December 2014, the new NSW <i>Disability Inclusion Act</i> 2014 and the NSW <i>Disability Inclusion Regulation</i> 2014 requires government operated and funded services to undertake at least one referee check and a criminal record check prior to employment and then subsequent criminal record checks at least once every four years, and conduct these checks for all people who work directly with people with disability (including Board members of funded organisations) in a way that involves face to face or physical contact.	No

Victoria	Employees must apply for risk-based clearance with ongoing monitoring	Referee and police checks Working with Children Checks for some service types	Disability Worker Exclusion Scheme (barring) for accommodation services
Queensland	Blue card system (includes disqualifying offences and orders, and daily monitoring to identify changes to criminal history of blue card holders), risk-based assessment	Criminal history check (including spent convictions) under <i>Disability Services Act 2006</i>	Yellow card — barring based on criminal convictions and related triggers (disqualification framework)
Western Australia	Working with Children Check as relevant, including broad-based assessment	National Police Check and Working with Children Check as relevant	No
South Australia	Anyone working with children, as defined in the <i>Children's Protection Act 1993</i> , must undergo a child-related screening assessment	All organisations providing services under the <i>Disability Services Act 1993 (SA)</i> are required to ensure that employees and volunteers in prescribed positions undergo screening by the authorised screening unit, with a minimum renewal period of every three years	Risk-based assessment
Tasmania	Working with Children Check being phased in	Fit and proper person test including referees and police check	Legislation makes provision for risk assessments
Northern Territory	Risk-based assessment	Police check	No
Australian Capital Territory	Clearance based on risk-based assessment	Police check	Risk-based assessment
Commonwealth	As per relevant state system	Police check	No

A series of recent official reports, as well as a number of other studies, have highlighted inadequacies in the current staff recruitment requirements for those working with people with disability, including:

- Report of the NSW Ombudsman, *More than board and lodging: the need for boarding house reform — Special report to Parliament*, October 2011.
- Disability Services Commissioner (Vic), *Safeguarding people's right to be free from abuse: key considerations for preventing and responding to alleged staff to client abuse in disability services*, Learning from Complaints Occasional Paper No. 1, June 2012.
- Victorian Equal Opportunity and Human Rights Commission, *Beyond doubt: the experience of people with disabilities reporting crime — Research findings*, July 2014.
- SA Health and Community Complaints Commissioner, *Report on HCSCC's role in contributing to improving the safety and quality of disability services provided to vulnerable people*, March 2013.
- The Royal Commission into Institutional Responses to Child Sexual Abuse, Interim report, July 2014.

In particular, the interim report of the Royal Commission into Institutional Responses to Child Sexual Abuse signalled that there is a case for staff screening requirements to be strengthened further.²²

As Table 3 illustrates, four jurisdictions have now put in place requirements for the centralised screening of adult disability workers:

- Victoria has introduced a register of barred people for state-funded disability accommodation services, based on convictions and/or past work history.
- Queensland's yellow card system excludes some persons from the sector on the basis of their criminal and other history.
- South Australian assessments now take into account criminal history, criminal charges, spent convictions and workplace records, and other categories of information deemed 'relevant history' by regulation.
- ACT has recently adopted a risk assessment based Working with Vulnerable People check.

These recent changes provide options for consideration under the NDIS.

Our aim

Our aim is to:

- reduce the potential for people who pose a risk to participants being employed in supports funded through the NDIS
- remove those proven to pose a risk to participants
- send a strong signal about the priority placed on the right of people with disability to be safe.

²² Royal Commission into Institutional Responses to Child Sexual Abuse, Interim report, Volume 1, Chapter 4, June 2014, p. 135.

Possible approaches

Four options to ensure staff are safe to work with participants are proposed for consideration. These options could each be adopted individually, or a combination of options could be considered. They should be read in conjunction with options for registration arrangements for providers of supports. This is because some of the options for provider registration would impose requirements that providers must meet in relation to how they ensure their staff are safe to work with people with disability.

Option 1: Risk management by employers

Under this option, providers of supports would be encouraged rather than required to have appropriate staff recruitment practices in place, which include systems that would reduce the likelihood of employing individuals who may pose a risk to participants.

Considerations

This option would be a reduction in requirements for providers in all jurisdictions currently delivering specialist disability services.

Building an organisational culture that encourages and supports clients and staff to report problems is a critical factor in preventing abuse. Accordingly, a comprehensive risk management framework is generally regarded as essential for client safety. However, this approach has its limits. Because it is employer based, it would not provide for consistency across the sector. In addition, employers cannot always access all the information relevant to the assessment of employee risk if it is not voluntarily disclosed. They might also lack the experience to identify risk factors. This may mean people with disability are inadequately protected.

Finally, a self-regulation approach could lead to persons who pose a risk entering the sector as self-employed providers of supports.

Option 2: Requirement for referee checks for all roles and police checks for certain employee roles

Under Option 2, in addition to the use of a risk management framework as described in Option 1, employers providing certain types of supports (e.g. personal care) could be required to assess potential employees' previous work history, request police checks²³ and undertake referee checks. Employers could also be expected to update these clearances at intervals.

Considerations

Police checks disclose any current criminal convictions recorded against a person's name and can be obtained for a fee through commercially accredited agencies, provided the potential employee gives his or her permission. Because police checks would not automatically bar someone with recorded convictions from operating in the sector, the employer will still need to make a decision about the

²³ This scaling of regulatory requirements in a way that is proportionate to the risk to participants is discussed in more detail in the section on 'Provider registration' in the section on NDIA Provider registration earlier in Part 2 of this paper. .

relevance of the conviction to the requirements of the job. This may be difficult for employers as they could face claims of discrimination. It could also lead to inconsistency, with some employers hiring employees with criminal histories that other employers have refused to hire. Police checks will only disclose convictions. Information such as spent convictions, charges not proceeded with and Apprehended Violence Orders (AVOs) will not be available.

A system of mandatory bars could provide an additional layer of protection against poor or compromised decision making by employers. A conviction for sexual assault, for example, would result in an automatic bar on employment in disability supports.

Health professionals who are required to be nationally registered with the Australian Health Practitioner Regulation Agency would be excluded from requirements under this option because the professional boards responsible for their registration are required to consider criminal history in their registration process.

For those jurisdictions that have moved beyond basic police check requirements, this option would represent a significant reduction in screening practices.

Option 3: Working with vulnerable people clearances

A more comprehensive strategy would look at a wider range of information about a person's history and put in place a system of centralised checks. Under this approach, a screening agency would be established, either nationally or in each jurisdiction, to assess the risk a person poses. Employees or potential employees working with particularly vulnerable people would be required to obtain a clearance through this screening agency. This would be similar to the Working with Vulnerable People central clearances systems used in several jurisdictions. This approach would enable clearances to capture a wider range of information than police checks do, including spent convictions and non-conviction information such as civil cases, AVOs and child protection information and orders, and work history.

The NDIS would need to make judgements about when a clearance is reasonable. Possible exemptions include those whose roles do not include direct support provision to people with disability and where contact is likely only to be intermittent and minimal, such as gardening services, and registered professionals subject to other similar requirements. There is also scope to align with other systems, for example, working with children checks and aged care vetting processes, so that people need only hold one clearance.

The police could also provide information to the screening agency when there is a change in the criminal history of a person who has received a Working with Vulnerable Persons Check.²⁴

²⁴ Queensland, for example, has a daily monitoring system in place whereby the Queensland Police Service notifies the Department of Communities, Child Safety and Disability Services if a person who holds a yellow card has had a change in their criminal history. The Queensland *Disability Services Act 2006* also requires the individual to report the change in criminal history to the Department.

Understanding the difference between police checks and ‘working with’ checks

Common practice is that employers conduct police checks on potential employees. A police check is essentially a list of any criminal convictions the person may have. Rules on what convictions are included differ between jurisdictions. In general, a police check does NOT include ‘spent’ convictions, where an individual has not reoffended for a specified period, even for crimes that may be relevant to a particular job. It will also not include charges that didn’t proceed (either due to insufficient evidence or because a victim was unwilling to give evidence), AVOs, child protection orders and other information held by police or the courts. A requirement to undertake a police check does not mean that a person with a conviction cannot be employed — the decision on whether or not the conviction is relevant to the job is normally a matter for the employer.

‘Working with’ checks (such as working with vulnerable people) differ from police checks because approved government vetting agencies are able to access and assess the relevance of a wider range of information, including ‘enhanced police records’. This includes, with the exception of Victoria, ‘non-conviction information’, as well as unrelated minor offences that lead to a warning or other action, but not a formal conviction.

While nationally there is a high degree of consistency in the approaches taken by jurisdictions when screening people working with children, there are some notable differences in what each is able to consider. For example, in addition to taking into account criminal history information including all pending charges, convictions or findings of guilt in relation to serious sexual offences, serious violent offences and serious drug-related offences, some jurisdictions also take into account relevant findings from prescribed professional disciplinary bodies and child protection information.

This information can be a strong indicator of risk, but for privacy, security and anti-discrimination reasons it cannot generally be made available to employers. Working with children and vulnerable people checks involve the screening agency, and not the employer, making a judgement about the risk a person poses based on assessment of the relevance and importance of their past history.

Screening in South Australia

In South Australia, it is a legal requirement for funded disability providers of disability services to ensure that staff undergo a screening assessment before commencing in a role and then every three years. This requirement applies to both paid employees and volunteers wishing to work in a ‘prescribed position’. A prescribed position is defined as:

- close and regular contact with or working in close proximity to people with disability
- supervision of people working in close or regular contact with or close proximity to people with disability
- those with access to records of people with disability.

Additional functions can be included in the scope of a ‘prescribed position’ by regulation. Regulations currently include anyone providing overnight care, and this could expand in the future to cover more roles as necessary.

Disability screening was introduced in South Australia to provide for the safety and wellbeing of people with disability when accessing services, by ensuring that those who pose a risk of harm are prevented from gaining positions within the disability sector. The screening goes beyond a consideration of criminal history in order to deter and detect inappropriate and unsafe people. It includes conviction information, police charges regardless of outcome and information about spent convictions, child protection and workplace records, as well as records held by a range of organisations prescribed by regulation.

Considerations

An advantage of the Option 3 approach is that it uses evidence about risk factors that predict the likelihood of offending to identify those who pose an unacceptable risk to participants and ensure they do not work in the sector. This option might also have a deterrence effect, including to prevent those excluded from working with other vulnerable groups (for example, children) from moving into this sector. Anecdotal evidence in states and territories where centralised checks have been implemented indicates that many have chosen to leave the sector rather than go through a clearance process where more information about their background will become known.

A nationally consistent approach could also reduce the likelihood of some people slipping through the screening net by moving interstate. This approach would be consistent with the enhanced staff screening practices adopted by some states.

However, this option could also be seen as unduly restricting flexibility for employers and employees. Employers have the most detailed knowledge of the nature of the job they are offering, the level of supervision involved and client vulnerability, yet this option removes their capacity to make a choice. It may also limit the potential workforce at a time when rapid growth in the disability workforce is required. This would be a particular risk in rural and regional areas, where employers may already face challenges recruiting staff.

Introducing working with vulnerable people checks would involve some additional costs and potential delays. For the great majority of applicants, the check would be a simple data-matching exercise that would establish that no relevant information was held about the person, and so clearance could be granted in 10 days or less without the need for further assessment.²⁵ Where a person's past history does suggest the need for a full risk assessment, the assessment process may stretch out for an extended period of time given the need to provide the applicant with opportunities to exercise their right to make submissions on their case and respond to any material of which they may not have been aware.²⁶

Where a clearance is requested directly by an employer to support a particular appointment, it has been found that there are fewer unnecessary applications. Nevertheless, in order to avoid delays, individuals would be able to apply for a clearance in advance of obtaining a job in the sector. Clearances would also be portable between jobs. In addition, consideration could be given to allowing conditional clearances though this would increase the cost of the scheme. This would mean

²⁵ The most recent data on Working with Children Checks in NSW shows that 78 per cent of applications were processed within 2 days and 98 per cent within 10 days.

²⁶ In NSW, 84 per cent of full risk assessments were completed within 16 weeks in 2012–13.

that a person could be cleared for certain roles or organisations only, or there might be certain activities they would be prevented from performing.²⁷

Costs to employees and employers could be reduced by aligning requirements for those working in different community sectors. Where a person has passed a working with vulnerable people check, for example, they could be granted exemptions from separate requirements to undergo a police check in another sector, or from working with children checks (or vice versa), provided the checks were assessing the same content.

Finally, there is some risk that requiring centralised checks may encourage employers to rely unduly on clearances at the expense of appropriate interview screening, supervision, referee checks and other measures.

Option 4: Create a barred persons list

An approach with more limited scope than Option 3 would be to create an excluded or barred persons list and require, as a condition of registration for certain types of providers, that they:

- notify the holder of the list of certain types of events involving an employee or volunteer where the worker has placed the participant at an unacceptable risk of harm
- consult the excluded persons list prior to any appointment of an employee or engagement of a volunteer in a role where they will undertake defined activities.

This would be similar to the model implemented by Victoria in September 2014 for providers of supported accommodation services. Through agreement, employers in other sectors, such as aged care, could also have access to the list.

Considerations

Under this option, employers would be required to verify, through the NDIA, that a proposed employee was not on the barred list, and to report misconduct. It has the advantage of preventing employees found to have engaged in workplace misconduct from moving to another job in the sector.

However, a barred list focuses on those who have been found to have abused, neglected or assaulted a person with disability. It is corrective only. It would not identify those new to the sector who may pose a risk to participants. This option may also fail to provide appropriate protection given that abuse and neglect of people with disability often goes undetected and unreported. This option would also impose a reporting burden on providers.

This option could be considered for implementation as a component of an overall vetting system that includes screening processes. In Victoria, it was introduced as the first step towards a broader system of employee screening.

²⁷ This is the system that currently operates in the ACT. This is not the case in South Australia, however, where conditional clearances are not provided — an applicant is either cleared or not cleared.

QUESTIONS

- Who should make the decision about whether employees are safe to work with people with disability?
- How much information about a person's history is required to ensure they are safe to work with people with disability?
- Of the options described above, which option, or combination of options, do you prefer?

Safeguards for participants who manage their own plans

A key aim of the NDIS is to ensure that participants are able to determine their own best interests, have choice and control, and be equal partners in decisions that affect their lives, to the full extent of their capacity. This includes taking control of the planning and delivery of supports if they wish.

All NDIS participants will be able to choose which providers they want and how their supports are delivered. Participants also have a choice about whether to manage the supports in their plan for themselves, ask someone else do it for them (a plan nominee) or use a registered plan manager. In the discussion in this paper, any of these plan management choices are regarded as self-management. This contrasts with the situation where the NDIA and the participant have agreed that the NDIA will be responsible for purchasing and managing their supports.²⁸

‘Self-managing’ means the participant is in control and responsible for:

- finding and arranging supports from the providers of their choice
- making payments to the chosen providers, including ensuring that providers receive their payments on time
- making sure that, if they are directly employing a person (as opposed to through an agency), they meet all occupational health, industrial and insurance requirements
- managing their plan expenditure, including submitting purchase forms to the NDIA
- keeping records of all plan purchases and providing these to the NDIA.

A key question for those managing all or some of their own supports is what, if any, quality and safeguard protections should apply.

People who choose to have the NDIA manage their plans for them will have the protection of using registered providers, including any staff vetting requirements, complaints processes, controls on the use of restrictive practices and other measures agreed by governments. Under the NDIS Act, self-managing participants can choose to receive their supports from anyone they wish, whether or not they are a registered provider of NDIS supports.²⁹

The idea of allowing people to choose unregistered providers is to give them greater flexibility, for example, to employ someone they know. There is a risk, however, that the person they employ might not have the skills they need to carry out particular tasks safely, or might have a history of violence or theft or fraud.

²⁸ The NDIA must let participants manage their own plans and supports unless this would mean there is an ‘unreasonable risk’ for the participant. In deciding if there might be an unreasonable risk, the NDIA has to look at the circumstances in the person’s life that might mean there is an increased risk, as well as the supports they might have already that would help manage those risks. Friends and other informal support networks that can help with making decisions are important in reducing the risks for some participants.

²⁹ ‘Unless a provider’s plan is managed by the NDIA, there is no restriction on who may provide supports under the plan’, National Disability Insurance Scheme (Registered Providers of Supports) Rules, 2013, 1.3, p. 3.

There is also a risk that lower quality providers encourage people to self-manage in order to avoid the NDIS registration process. The reputation of the NDIS could also be at risk if there were serious problems with NDIS funded supports, even though the person had knowingly accepted the risks. The potential lack of safety and quality checks could also discourage some people from choosing to manage their plans themselves.

What is in place now?

Currently, people purchasing disability-related supports have access to the same general protections as other citizens. These include consumer protection, privacy, licensing of some professions and tradespeople, public health, and tenancy laws.

In addition, the NDIA already works with participants to support them and build their capacity to manage their plan well. Some participants may not need any help to manage their plans. Others may need to meet with the NDIA more regularly to discuss and review their plan. Those who need a greater level of support could be given funding from the NDIA to learn specific skills, for example, on how to budget.

It is also possible for the NDIA and the participant to agree that a plan should be a mix of some supports that are managed by the NDIA and some that are managed by the participant. For example, a participant might be confident about managing their NDIS money to pay for transport to get to and from work, but they might not want to be responsible for directly employing people to come into their house to help with their personal care needs.

Possible approaches

There are many participants who would be able to manage the administrative and financial aspects of their own plan, but would be more confident if they knew that there were some quality and safeguard measures in place. These could include measures that give participants assurance that their chosen provider meets certain standards. Or participants might just want to be able to assure themselves that a person they intend to place in a position of trust does not have a criminal history that would create potential risks for them.

Three broad options could be considered to assist those managing their own plans.

Option 1: Building the capacity of participants to manage their own risks

Under this option, people would be free to choose the support provider they want, without any restrictions. However, extra support would be given to help people build their capacity to manage potential risks.

Under this approach, it would be up to the participant to choose whether or not to use a provider registered with the NDIA. If a participant chooses to use a provider who is registered with the NDIA, they would have the reassurance that this provider was required to comply with the NDIS Code of Conduct in relation to safe and ethical practice and with any additional requirements which form part of registration.

Self-managing participants or their nominees would also be able to choose a provider who is not registered with the NDIA, in the knowledge that this provider would not have been through the checks associated with NDIS registration.

In the case of a non-registered provider, the NDIA could provide some assistance on how to go about hiring a provider. This could include advice on how to interview for a worker, what they might do to document expectations to avoid disputes and misunderstandings, as well as other aspects of the employment process and responsibilities of being someone's employer. The NDIA could also facilitate access to police checks of potential employees.

Considerations

This option could help ensure the participant is informed of any convictions or other issues, but it would not prevent them from employing the person (subject to any state or territory occupational licensing or other requirements).

Case study: How it would work — choosing a registered or unregistered provider

Mrs Ward wants to hire a personal care worker to help look after her adult son, Ian, for whom she is the plan nominee, and who has cognitive and physical disabilities.

They have a neighbour, Mr Williams, who has done this kind of work before and they would like to hire him.

Mr Williams has registered with the NDIA as a provider, so the agency would have made sure he met the appropriate standards and passed any necessary background checks. After he has been working with them for a month, Mrs Ward notes that Ian has become fearful of Mr Williams and she suspects that he has been rough with him and may be hurting him. Mrs Ward asks the NDIA to investigate and take appropriate action against him.

Alternatively, Mrs Ward could hire Mr Williams without him going through the process of being registered. She could decide, though, to interview him using some questions suggested by the NDIA's information support systems. She could also decide whether to have police and referee checks done. If the arrangement did not work out, it would be up to Mrs Ward to take the necessary action to terminate his employment.

This approach would provide targeted tools to strengthen the capacity of participants (or their nominees) to make good choices about the quality of their supports, and to protect themselves against the things that could go wrong.

However, this approach puts the onus on participants and some people may be uncomfortable in taking on the responsibility of, for example, of having to ask a friend or neighbour to undergo a police check.

It could potentially also expose particularly vulnerable people to a risk of harm, for example, from workers who have previously been dismissed from other jobs in the sector (or other related sectors) or have a record of causing harm to others, even though they have not been convicted of a crime.

Option 2: Prohibiting certain providers from offering supports

This option would provide an additional level of safety for people who choose to purchase supports from non-NDIA registered providers. This would involve establishing a mechanism in which information about unethical or unsafe individuals and organisations could be reported to a central source, assessed, and a decision made as to whether the individuals or organisations should be prevented from providing supports to NDIS participants. The scope of such a scheme would be limited to people and organisations providing support of specific types linked to the potential for harm. It would not duplicate existing schemes such as those which operate in the health sector.

In agreeing on the supports that would be funded in the participant's plan, the NDIA would attach a condition to certain types of supports that the participant must, prior to agreeing to employ any individual, check that the person has not been barred from providing supports to NDIS participants.

Option 2a: Negative licensing scheme

This could be done through a legally binding scheme similar to that being developed for non-registered health practitioners by the Australian Health Ministers Council. Under this option, anyone could be a provider. However, all providers, including unregistered ones, would be subject to the proposed NDIS Code of Conduct. Providers who acted in a way that was inconsistent with the Code could be prohibited from offering further supports. The scheme could apply to all disability-related supports (whether or not they were paid for by NDIS funds), or it could be limited only to those supports purchased with NDIS funds.

Considerations

The benefit of this approach is that it is simple and does not create obligations on providers to prove their suitability. The NDIS Code of Conduct would be a safety net that enabled certain standards of safe and ethical behaviour to be enforced, thus reducing potential future risks of harm. It would be important to ensure that this scheme did not duplicate other systems already designed to regulate providers within specific industries.

Such a scheme would not prevent poor-quality, incompetent or dangerous providers entering the market. It would also rely on a complaint being made about the provider, and people may be reluctant to complain for reasons such as fear of retribution. Each complaint would need to be investigated, which could take a considerable amount of time, and might be hard to prove to the standard necessary to take action to exclude the provider from working in the sector.

Option 2b: Creation of an excluded persons or barred persons scheme

This would be a legally binding version of the administrative scheme being established in Victoria for residential support providers (also discussed in the section on ensuring staff are safe to work with participants earlier in part 2 of this paper). The UK's Disclosure and Barring Service also excludes certain individuals from working with vulnerable groups.

Under this option, employers would be required to report an employee who has behaved in such a way as to endanger participants. The reports would be investigated, and people found to be unsuitable to work in the sector would be placed on an excluded persons list. People intending to

employ individuals in certain roles would have to consult the excluded persons list prior to employment commencing.

A self-managing NDIS participant would be able to check the list, but it would not be mandatory. A person with disability could be an employer by engaging a worker directly, but would not be required to report on employees in the same way.

Considerations

This option is limited if self-managing participants fail to report on the workers they employ. It would also fail to address the risk that could be posed by self-employed providers who could not be expected to report on themselves.

This option may create a burden on providers who would be required to report on their employees. As with Option 2a, an excluded persons scheme would not address the risks posed by those new to the sector, but it could result in more cases being identified, because employers would be required to make a report when things went wrong. Another potential flaw of this option is that it bars people who may not have been found guilty in a court of law.

Case study: How it would work

Mrs Ward wants to employ Mr Williams to provide personal care supports to her adult son with cognitive and physical disabilities. Mr Williams lives nearby and can offer her son the support he needs in the mornings so that he can be ready in time to go to his work.

Under Option 2a, Mrs Ward would need to check the published list of persons who have been excluded from working in the sector in order to make sure that Mr Williams was not on it. It would be up to her whether or not to do any other background checks on him, such as police and referee checks. She would have *the option* of lodging a formal complaint. If her complaint was upheld, Mr Williams might be prohibited from working in the sector in future. This would be voluntary for her because she is acting on behalf of Mr Ward. If she was a business that employed Mr Williams, she would be obligated to tell the agency responsible for the scheme of her actions and reasons.

Under Option 2b, before employing Mr Williams, Mrs Ward would have to check his name with the NDIA, which could advise her whether or not he was on the excluded persons list. If she subsequently dismissed him for misconduct, she could report him to the NDIA, which could take appropriate action, including initiating action to place him on the barred persons list.

Option 3: participants required to use a provider who has been approved or screened by the NDIA

As previously explained, under the NDIS legislation, self-managing participants can choose to receive supports from anyone they wish, regardless of whether they are registered with the NDIA. Under this option, however, participants would still choose whoever they want to provide their supports but that person or provider would have to be registered with the NDIA.

The NDIS rules about providers of supports has already contemplated that there would be circumstances where a participant might not want to self-manage their supports but they would want to select a person as a provider who may not be able to meet the NDIA registration criteria. In

these cases, the CEO of the NDIA can register that provider to provide supports only to that individual on the basis that the participant has confirmed that the person is suitable.

The effect of this option would be that participants who are self-managing would also need to go through a process with their preferred provider to have them registered by the NDIA. As part of its registration process, the NDIA could require that proposed providers are at a minimum police checked so that the participant is aware of any criminal history.

Option 3a: Separate registration process with limited conditions

Under this approach, the NDIA would set up a separate registration process for providers that are not already registered but who self-managing participants wish to engage to deliver their supports. The NDIA would make it a condition of funding for certain types of supports that the providers, if not fully registered, have been approved for this second, more limited, list.

Instead of engaging in the standard registration process, these providers would need to pass a background check based on a screening for criminal history to ensure that their history does not suggest that they pose a risk to NDIS participants. They would also be required to abide by the NDIS Code of Conduct.

Considerations

This would prevent individual workers who have not met screening requirements through the NDIA registration process from being able to offer supports to NDIS participants. Where unacceptable practices occur, the provider could be de-registered. There would be non-financial costs for participants and individuals in order to gain registration.

Option 3b: Registration

A further option would be that all NDIS participants would be required to procure supports from providers registered under the same registration conditions imposed by the NDIA (see the 'NDIA provider registration' section of this paper).

Considerations

Requiring all people to use registered providers has the advantage of simplicity. It would provide the same level of quality and safeguard protection to all participants. It would also ensure that all providers are on a level playing field in terms of complying with minimum standards in the sector. Self-managing participants would still be responsible for the financial management of their supports, including making payments and managing expenditure.

However, the reason for allowing people to manage their own plans is to allow them greater choice and control in line with their capacity. This option might limit choice and control for some participants, although they would still have the option of asking their preferred provider to register under the special provisions in the NDIS rules discussed above under Option 3(a).

Option 3c: Individuals to be employed have been screened

Currently, all providers in each state and territory are required to comply with working with children checks. If a Working with Vulnerable People check system is introduced for registered supports, it

could also apply to providers offering supports to people who are self-managing. Under such a scheme, workers would be required to obtain individual clearances before being allowed to work with people with disability in some support types. It would be against the law for a person to offer certain types of supports without having received a clearance from the relevant authority. It could therefore play both a preventative and a corrective role.

Vulnerable people check requirements would prevent unsuitable people who have not met NDIA screening requirements from gaining access to people with disability who may be managing their own supports.

Vulnerable people checks use risk-based screening, drawing on a range of information that is typically not accessible to a potential employer such as non-conviction information held by police.

Considerations

This option could be a deterrent, discouraging persons who have a record of harming others from seeking to work in the sector and signalling a zero tolerance approach to those already working in the sector.

It also focuses the checks on the individual employee and could therefore prevent multiple offences where disability workers are providing supports to several different clients at a time (or may move between agencies).

As discussed in the section on 'Ensuring staff are safe to work with participants', this option may restrict flexibility for employers and employees and may involve additional costs and delays.

QUESTIONS

- Should people who manage their own plans be able to choose unregistered providers of supports on an 'at your own risk' basis (Option 1) or does the NDIS have a duty of care to ensure that all providers are safe and competent?
- What kind of assistance would be most valuable for people wanting to manage their own supports?

Reducing and eliminating restrictive practices in NDIS funded supports

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.³⁰ Restrictive practices include the use of restraint (physical, chemical, mechanical and environmental) and seclusion, as well as other actions which prevent an individual from exercising their rights (refer to Appendix F for definitions). Providers may use restrictive practices to protect the safety of their clients or other people, including families, support workers or other members of the community. Evidence indicates that people with intellectual or cognitive disabilities or autism and people with communication difficulties who also have impaired capacity are at greatest risk of being exposed to restrictive practices.³¹

Current practice does not support the use of restrictive practices as a way of responding to challenging behaviours. Restrictive practices carry risks including death, physical and psychological harm to both individuals and staff, and human rights infringements, and impact negatively on the relationship between individuals and staff, for example, relationships between support workers and people using their supports may become coercive.³² Consistent with the *United Nations Convention on the Rights of Persons with Disabilities*, all Australian governments have committed to reducing and eliminating the use of restrictive practices in services for people with disability.

The *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* (National Framework)³³ establishes a national approach to reducing and eliminating the use of restrictive practices by providers across a range of disability service sector settings.

When the NDIS is fully implemented, replacing current state and territory regulatory arrangements that are tied to funding agreements, there will need to be policies and procedures put in place which meet the Australian Government's commitment to the National Framework.

³⁰ *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector*, Department of Social Services, Commonwealth of Australia, 2014.

³¹ E Emerson, *The prevalence of use of reactive management strategies in community-based services in the UK*, 2002, referenced in Australian Psychological Society, *Evidence-based guidelines to reduce the need for restrictive practices in the disability sector*, 2011.

³² Centre of Excellence for Clinical Innovation and Behaviour Support (Queensland), *Restrictive practices: an approach to safeguarding human rights*, unpublished background paper, p. 6.

³³ The *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* is available at: www.dss.gov.au/our-responsibilities/disability-and-carers/publications-articles/policy-research/national-framework-for-reducing-and-eliminating-the-use-of-restrictive-practices-in-the-disability-service-sector.

Current arrangements in states and territories

Regulation of the use of restrictive practices in relation to people with disability varies significantly across the states and territories.

In Victoria, Queensland, Tasmania and the Northern Territory a system for regulating the use of restrictive practices has been established under disability services legislation. Laws in New South Wales, Western Australia, South Australia and the Australian Capital Territory set out high-level principles and objectives which are relevant to, but do not specifically address the use of restrictive practices in relation to people with disability. In New South Wales this is largely regulated at a policy level, and a voluntary code of practice has been introduced in Western Australia.

The disability services laws in Victoria, Queensland, Tasmania and the Northern Territory apply conditions that must be met before restrictive practices may be used. In these states and territories, the use of restrictive practices in relation to a person with disability must be carried out in accordance with a behaviour support plan prepared for the person. The laws in these states and territories allow for both penalties and immunities for providers and individual workers in relation to their use of restrictive practices.

Victoria, Queensland and Tasmania have established reporting obligations and external review mechanisms. Queensland and Tasmania also generally require the Secretary of the government department or relevant guardianship board to approve the use of restrictive practices in relation to a particular person. Guardianship boards, or guardianship legislation generally, also have a role in states and territories where the use of a restrictive practice may rely on the consent of a guardian, such as New South Wales, Western Australia and South Australia.

Each state and territory has a legislative mechanism for monitoring and investigating funded disability service providers, but not all specifically provide for the oversight of restrictive practices. In Victoria and Tasmania, the position of Senior Practitioner has been established. In both states, the Senior Practitioner has statutory functions such as developing guidelines and investigating and monitoring the use of restrictive practices.

Where the use of a restrictive practice in relation to a person with disability is not regulated by the relevant state or territory disability services legislation, other laws, such as mental health legislation, the criminal law and the common law, may apply in relation to the use of the restrictive practice.

If there are no laws to regulate the use of restrictive practices, it is possible that a person could pursue criminal action against a provider or employee for common assault by use of force. Common assault by the use of force in this context has broad meaning — a light touch or pulling of clothing can be regarded as common assault by use of force. Physical, mechanical and chemical restraints can also constitute common assault.

Where there is no valid consent for the use of a restrictive practice, carers or providers may still be able to rely on a defence to excuse them from criminal liability.

The common law defence of necessity or its statutory equivalent, the defence of sudden or extraordinary emergency, may be available to support workers using restrictive practices.³⁴

For example, the defence of necessity may apply where a support worker uses physical restraint in the reasonable belief that it is necessary to avert an imminent harm to the person or others, and the restraint used is proportional to the harm to be avoided. However, where restrictive practices are used on a long-term basis in circumstances involving threatened harms that are not imminent, unexpected, sudden or extraordinary, the defence would be unlikely to apply.

This has been a significant concern for a number of Australian states and territories which have, in response, enacted laws (described above) to regulate restrictive practices in a way that protects both the person subject to the restrictive practice and the workers who may otherwise be at risk of criminal or civil action in the courts.

In the sections above, we discussed how the law may affect support workers when they use a restrictive practice and what some states and territories have done with their laws to regulate this. However, the most important thing is how these systems work to protect the rights of people with disability to live their lives freely and unharmed.

Generally this means that where jurisdictions have enacted laws, or implemented policies that providers must follow, they must be very clear that restrictive practices are never acceptable unless the person with a disability is at risk of hurting themselves or others and that there is no less restrictive way of preventing that harm. Providers and workers cannot use a restrictive practice because it makes their job easier or allows them to operate with reduced staffing levels. The reverse is true. The challenging behaviours displayed by some people with disability are frequently a response to being forced or coerced, not being listened to, or not being able to have their needs or wants understood. Positive behaviour support plans are the key to reducing challenging behaviours so that the person with disability and others can be safe from harm.

It is also critical that anyone who has a positive behaviour support plan understands what it means for them. They should always have their behaviour support plan explained to them and be allowed to request a review at any time if they do not agree with its contents. Many people may not have the capacity to understand or decide on their own. In some jurisdictions, guardians might be appointed to consent on their behalf. In other states and territories, the laws allow a person with clinical expertise to decide if a behaviour support plan, and any restrictive practices proposed in that plan, should be implemented. These are all safeguards to make sure that decisions on restrictive practices are in the best interests of the person, are always the least restrictive option and are always used as a last resort.

Some states and territories have also introduced systems for monitoring restrictive practices, such as community visitors, who have the powers to enter into funded residential services to observe and

³⁴ The common law defence of necessity is available in NSW, South Australia and Tasmania. For the elements that must be shown for the common law defence: see *R v. Loughnan* (1981) VR 443 at 448. The defence of sudden or extraordinary emergency applies in the ACT, NT, Queensland, Victoria and Western Australia: see Criminal Code (ACT) s. 41; *Criminal Code* (NT) s. 43BC; Criminal Code (Qld) s. 25; *Crimes Act 1958* (Vic.) s. 9AI; Criminal Code (WA) s. 25.

report on people with disability living in community support settings. They may see that restrictive practices are not being used properly or a worker is using practices that are not permitted in accordance with the person's behaviour support plan or that may be dangerous. There are also systems in all states and territories which allow individuals and families to complain about providers and they can be investigated. Clinical advisers, where these have been employed by states and territories, monitor restrictive practices. In addition, in some states and territories, providers are required to report on a regular basis to the funding agency about how and when they are using restrictive practices. This information helps build the national picture, and clinical advisers can look at organisational and individual data to identify where coaching may be necessary for staff or where a behaviour management plan should be reviewed.

Estimate of affected individuals

The use of restrictive practices nationally is difficult to determine because there is a lack of national data. However, in Victoria, where there is standardised reporting on use, the 2012–13 annual report from the Senior Practitioner³⁵ reported that 1,975 individuals in the state were subject to restrictive practices at least once during the year. Different practices for monitoring and reporting in the states and territories makes generalising the Victorian data to all of Australia a rough indication at best. Yet, on this basis, the national figure could be around 8,000 to 9,000 individuals.

Our aim

The approach to restrictive practices in the NDIS will involve continuing to implement Australian governments' commitment to the reduction and elimination of restrictive practices in services for people with disability.

This means that the quality and safeguarding system for the NDIS should ensure:

- any use of restrictive practice in an NDIS funded support is always a last resort and it must be the least restrictive option
- individuals are involved in developing and agreeing their behaviour support plans
- families and others who know the person well should be used to help ensure the person understands and, to the greatest extent possible, agrees with the behaviour support plan
- decisions to include restrictive practices in a behaviour support plan are well informed and decision makers are accountable and authorised to make such decisions
- there are effective systems in place for monitoring the use of restrictive practices in NDIS funded supports, at both the individual and system levels
- appropriate linkages are made for individuals, where appropriate and necessary, with other systems, including the mental health system.

Possible approaches

The options below set out different ways in which these aims could be achieved. The options are divided into two groups: how decisions to include a restrictive practice in a behaviour support plan are made (*authorisation*) and when and how providers should report that they have used restrictive practices (*monitoring*).

³⁵ *Senior Practitioner report 2012–13*, Department of Human Services, Victoria.

Authorisation

When an individual with disability and impaired capacity presents with a challenging behaviour that places the individual or others at risk of harm, a decision must be made about how providers should respond. The majority of people with disability who display challenging behaviours are likely to have limited capacity to provide informed consent or to fully understand the implications of what a behaviour support plan with provision for a restrictive practice might mean for them. This means that there may be significant legal issues for providers and their employees who use a restrictive practice where there has been no explicit authorisation via informed consent by the person or someone legally authorised to provide consent on their behalf.

A feature which could be applicable to any of the options below would be recognition of a role for an 'Independent Person'. This person would be independent of the support provider who is proposing to use restrictive practices. They could be a family member, friend or other trusted person. Their primary function would be to explain to the person with impaired capacity what is being proposed in their behaviour support plan and their rights to seek a review if they wish. Where the Independent Person considers that the person with a disability is not able to understand the behaviour support plan or that the plan or its implementation does not reflect best practice, he or she can report this to the Public Advocate in their state or territory.

The four options described here are about the requirements which could be set for providers who support participants who display challenging behaviours where those behaviours pose a risk of harm to the person or others.

Under all options, behaviour support plans which meet contemporary best practice would be mandatory. These options relate to the process for obtaining consent or other forms of authorisation to include a restrictive practice in an individual's plan.

It is recognised that good practice in developing and implementing plans requires access to resources and supports from experts, as well as tools to assist with developing plans. Over the years most states and territories have invested significantly in education, research and other resources for providers to support them to implement best practice. Under the NDIS providers will continue to be supported to use best practice.

Option 1: A voluntary code of practice

Under this approach, there would be a voluntary code of practice and guidelines. Good practice under the code would guide providers to include participants and their families when developing behaviour support. Providers would be advised to ensure that staff developing these plans were appropriately skilled to do so. There would not be a formal consent or authorisation requirement, although providers would work closely with families or legal guardians, if one has been appointed, to ensure as far as possible that all parties are in agreement with the strategies in the behaviour support plan.

Considerations

This option would encourage, though not require, the sector to invest in building organisational capability to assess the appropriateness of restrictive practices relative to each situation for individual participants. As noted above, providers are solely accountable for their actions. There

would be no legislative protections for the provider or staff from criminal or civil action. Nor would there be legislative protection of people with disability to ensure decisions about restrictive practices are consistent with their human rights.

There is also a risk that workers may be exposed to competing influences associated with the business and operational priorities of the provider. Since many people who are subject to restrictive practices are likely to have reduced capacity to raise concerns about their use, complaints processes are unlikely to provide adequate protection.

Option 2: Substitute decision makers must be formally appointed guardians

Under this option, consent to use restrictive practices in a given situation must be obtained from a person formally appointed as the participant's legal guardian under relevant state or territory law. This prevents family members or carers being able to agree to a behaviour support plan with a restrictive practice for an adult, unless they had been legally appointed as the person's guardian. This requirement could be implemented either through legislation, or by including it as a condition of registration.

Considerations

Option 2 would remove any ambiguity as to whether a person has given informed consent to a restrictive practice. Guardianship or administrative tribunals would have to assess the situation carefully and agree that the person (or persons) seeking to make such a decision on behalf of a person with disability with impaired capacity is the best person to do that.

This option would increase case volume for guardianship tribunals or their equivalents. In Victoria, a recent Victorian Law Reform Commission concluded that 'appointing guardians for all the people [in residential care] who lack capacity to consent to these practices would probably place an unsustainable demand on the Victorian Civil and Administrative Tribunal and the Public Advocate'.³⁶

Option 3: Providers would be authorised to make decisions under specific conditions

Under this option, a specific person or panel of qualified people who work for the provider would be permitted to authorise a positive behaviour support plan which may include use of restrictive practices. They would be assessed for competence and experience and approved for this purpose. Legislation specifying their roles and responsibilities and the requirements that they must ensure are met before they can approve a restrictive practice would be specified in the legislation.

Examples currently in use in states and territories are:

- **Provider initiated panels**, comprised of professionals appointed by the provider to carefully consider the best interests of the participant. There should also be at least one member who is independent of the provider. This is required in New South Wales as a condition of funding agreements.
- **An authorised program officer** who would be selected by the provider from within their organisation to assume responsibility for authorising the use of restrictive practices. The capacity of that person to be an authorising officer would be independently verified. This model is currently being used in Victoria.

³⁶ Victorian Law Reform Commission, *Guardianship*, 2012, s. 15.4, p. 318.

There is evidence to suggest that certain types of restrictive practices (for example, physical restraint) result in serious harm.³⁷ An additional safeguard under this option could be to require authorisation of physical restraint to be obtained from an independent body. This authorising body would be external to the provider and would have the technical expertise to authorise the inclusion of physical restraint in a behaviour support plan.

A further safeguard could be to require the support provider, at either the organisational or outlet level, to be approved to use restrictive practices. The provider would be required to give evidence that they have appropriate policies and procedures that reflect best practice and that staff are well trained in behaviour support. As with Option 2, the provider would also be expected to ensure the person with disability has an independent person (a trusted family member/friend or legally appointed guardian) who is available to assist them with understanding their behaviour support plan and who can refer decisions for independent review where there are concerns.

Considerations

Each of these sub-options enables a greater level of professional expertise than under Option 2. The inclusion of mandatory guidelines (either in legislation or policy) would provide a higher level of accountability than under options 1 or 2. However, decisions are made by employees of the providers and as such are not independent. There is potential that the balance of priorities may favour the provider or there may be a perception that this is the case. A safeguard for this option could be that these behaviour support plans are independently 'audited' on a sample basis.

The net cost impact of this option may not be significant given that a number of states and territories are already operating in this way. The kind of training and resources required to support this option could be expected of providers regardless of the model adopted. There is a risk with this option that the authorisation officer or panel members may be exposed to competing influences associated with the business and operational priorities of the provider.

Option 4: Restrictive practices could only be authorised by an independent decision maker

This option would require that providers obtain authorisation to use restrictive practices from a decision maker that is independent of the provider. This could be implemented through extending the role of guardianship tribunals (or equivalent administrative tribunals) or by establishing an independent office holder, such as a Senior Practitioner. Both of these implementation options would require legislation, particularly the Senior Practitioner who, like the guardianship or administrative tribunals, would need to be provided with the legal authority to authorise use.

Considerations

The benefit of this option is that it establishes a clear separation between the provider and the decision maker and creates clear pathways of accountability. The Senior Practitioner function, in particular, would provide a higher level of technical expertise and greater capacity for the role to contribute to oversight and implementation of best practice in reduction strategies.

³⁷ P Cambridge, 'The risks of getting it wrong: systems failure and the impact of abuse', in D Allen (ed.), *Ethical approaches to physical interventions, Volume 1: Responding to changing behaviour in people with intellectual disabilities*, BILD Publications, Kidderminster, 2002.

However, while providers would be required to prepare proposals concerning restrictive practices for authorisation under Option 3, submitting applications to an external body is likely to be a more formal and time-consuming task (though experience in Victoria suggests that the burden may be reduced by using an electronic process). Compared with Option 3, relying on the formal processes of guardianship tribunals or Senior Practitioners for all authorisation decisions could be costly and may create a delay in authorisation decisions.

Guardianship legislation in each state and territory would need to be reviewed to ensure that it is fit for these purposes given the potential for conflict between decisions about authorisation of restrictive practices and the role of guardianship tribunals.

The capacity of guardianship tribunals or similar bodies to make the best decisions for individuals in these cases is a further consideration. Tribunal members would need expertise in behaviour support best practice and have access to enough information about the individual to be confident that their decisions are right. It would increase the overall workload on tribunals and delay decisions.

QUESTIONS

- Who should decide when restrictive practices can be used?
- What processes or systems might be needed to ensure decisions to use restrictive practices in a behaviour support plan are right for the person concerned?
- Are there safeguards that we should consider that have not been proposed in these options?
- For providers, what kinds of support are you receiving now from state and territory departments that you think would be helpful if it was available under the NDIS?

Monitoring and reporting

Consultations undertaken during the development of the National Framework identified a need for accountability and transparency in the use of restrictive practices. While legislation alone will not reduce the use of restrictive practices³⁸, evidence suggests that monitoring and reporting on the use of restrictive practices is an essential component of a reduction and elimination strategy because it makes decision makers (or providers of supports) more accountable.³⁹

It has been suggested that ‘unauthorised’ practices are more likely to be implemented by staff and under-reporting is more likely to occur in organisations where there is no active monitoring of use at the individual level.⁴⁰ Monitoring and reporting on the individual use of restrictive practices means that cases of inappropriate use or abuse can be identified and responded to appropriately.

Monitoring the use of restrictive practices currently occurs in some form in most states and territories by specialists in their disability departments. In general terms, this includes review of decisions and of behaviour support plans, as well as auditing by Senior Practitioners and/or community visitors.

³⁸ A Keski-Valkama et al., ‘A 15-year national follow-up: legislation is not enough to reduce the use of seclusion and restraint’, *Social Psychiatry and Psychiatric Epidemiology*, vol. 42, no. 9, 2007, pp. 747–52.

³⁹ J Scanlan, ‘Interventions to reduce the use of seclusion and restraint in inpatient psychiatric settings: what we know so far — a review of the literature’, *International Journal of Social Psychiatry*, vol. 56, no. 4, 2010, pp. 412–23.

⁴⁰ *ibid.*

Some states and territories also require providers to report on the use of restrictive practices, to allow for individual and provider level monitoring of certain events such as:

- incidents which did result, or could have resulted, in harm
- occasions where the restrictive practice used was not approved in a person's behaviour support plan, and/or
- each occasion where a restrictive practice has been used in a given situation (including those which have been approved as part of a behaviour support plan).

The options described below are intended to meet the objective of reducing and eliminating restrictive practices through increased scrutiny and accountability of authorisation decisions, as well as each decision made by a provider to use a restrictive practice in a given situation.

Option 1: Reporting would be mandatory for emergency use only

This would involve reporting where a restrictive practice has been used in an emergency and where the restraint or seclusion has not been approved in an individual's behaviour support plan and would also include reporting of serious incidents (for example, where use could have or did result in injury or death).

Considerations

This option has the least impact for providers as information on emergency use and serious incidents is already collected in some form in each state and territory. However, it would not provide accountability and transparency around whether each use of a restrictive practice was appropriate in the situation. It would also not allow for identification of systemic trends and individual cases where use is exceptionally high or continues over a long period of time. It would not produce enough information to enable governments to assess the effects of implementation of the National Framework.

Option 2: All positive behaviour plans which include a restrictive practice must be reported

In addition to reporting of emergency use of restrictive practices and cases where use could have resulted or did result in injury (as described under Option 1), this option would also involve monitoring of decisions made to include restrictive practices as part of a participant's behaviour support plan. It would enable some oversight of such decisions and contribute high-level data which may be of some value in monitoring the implementation of the National Framework. Aside from situations involving emergency use and potential or actual harm, providers would not be required to report on particular occurrences where restrictive practices are used.

Considerations

Option 2 allows government to maintain a record of the individuals who have had restrictive practices authorised as part of their behaviour support plan. This would create reporting requirements for providers in states and territories who are not currently subject to requirements to report authorisation decisions. It would also require a more substantive oversight function, requiring additional resources and systems support.

As with Option 1, this approach to monitoring and reporting would not allow for identification of systemic trends and cases where use is exceptionally high or continues over a prolonged period of time. It would offer very limited information to enable monitoring of the implementation of the National Framework.

Option 3: Providers must report on each occasion where a restrictive practice is used

In addition to the reporting requirements set out in Option 2, this option would require providers of supports to regularly report on each use of chemical, physical and mechanical restraint and seclusion (as per agreed definitions in the National Framework). This information could be reported by providers via an electronic online system which could be automated as much as possible to reduce the administrative burden on providers. This approach could be similar to the Restrictive Intervention Data System currently used in Victoria to enable providers to report on restrictive practices (see box below).

Restrictive Intervention Data System (RIDS) – Victoria

Victoria introduced mandatory reporting on restrictive practices in 2007, which led to the development of an electronic online reporting system called the Restrictive Intervention Data System (RIDS). Providers in Victoria were involved in the design of the RIDS during its development and have continued to be involved in making improvements.

The RIDS has a number of functions, including:

- development, approval and reporting of behaviour support plans — the RIDS steps the decision maker through the process so that all required fields are completed
- automated prompts for providers, including prompting providers to review behaviour support plans within the data system annually
- authorising restrictive interventions — contains an authorisation checking tool which providers must step through before a restrictive intervention can be approved
- end-of-month reporting on the use of restrictive practices for each individual who has restrictive practices authorised as part of their behaviour support plan.

The system also records the details of the provider's Authorised Program Officers, as approved by the Department.

Importantly, the RIDS saves the individual's approved behaviour support plan, which reduces the amount of information providers need to enter for each event. Also, providers are often able to report events where restrictive practices have been used by selecting from options from a set of drop-down boxes. This prompts the provider to provide all relevant information while reducing the amount of time taken for providers to report each event. The RIDS is also used as a checking tool, so that providers are prompted to ensure they are adopting best practice policies and procedures set out by the Senior Practitioner in the Department.

Considerations

Only Victoria and Tasmania currently require providers to report on the use of restrictive practices at the individual level in this way. This option would therefore create additional reporting responsibilities for all relevant providers in other states and territories. A national standardised reporting system would need to be in place and there would need to be a substantial commitment to ensuring that all data is being used to improve practice at both the systemic and provider levels.

However, this option provides protections for individuals through enhanced accountability and transparency of decisions and would provide accountability and transparency around whether each use of a restrictive practice was appropriate in the situation. It would also allow for identification of systemic trends and individual cases where use is exceptionally high or continues over a prolonged period of time. This option would provide sufficient data to enable governments to monitor implementation of the National Framework.

The National Framework outlines that all jurisdictions are encouraged to implement a data monitoring system that integrates with existing service delivery management systems by 2018. However, the National Framework does not require that such a data monitoring system be mandatory.

QUESTIONS

- Would you support mandatory reporting on the use of restrictive practices? Why/Why not?
- If you support mandatory reporting on the use of restrictive practices, what level of reporting do you believe should occur (**based on one, or a combination of, the options above**)?

Appendices: Background information

A. Profile of disability service users and providers in Australia

Users of disability services

According to the Australian Institute of Health and Welfare (AIHW), around 317,616 people received disability support services in 2011–12.⁴¹ Intellectual disability is the most common disability among people who use disability services (33 per cent), followed closely by physical disability.⁴²

The majority of service users needed assistance with independent living (61 per cent), activities of daily living (52 per cent) and with work, education and community living (57 per cent).⁴³ This was followed closely by community access, accommodation support and respite (each at about 10–20 per cent respectively). There is some overlap since some people may use more than one type of support. Table 5.1 taken from the 2010-11 AIHW report⁴⁴, provides a summary of the users of disability support services provided under the National Disability Agreement by service group in each state and territory.

Table 5.1: Service users, service group, by state and territory, 2011–12

Service group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Accommodation support	10,182	13,649	6,799	3,609	5,150	1,301	465	283	41,421
Community support	36,893	44,744	16,253	13,649	14,337	4,772	4,095	1,962	136,236
Community access	15,312	24,740	9,505	4,831	6,624	1,533	455	292	63,247
Respite	9,912	15,723	5,203	3,609	1,735	426	353	125	37,015
<i>Total state/territory services</i>	<i>52,617</i>	<i>76,170</i>	<i>25,477</i>	<i>16,783</i>	<i>19,561</i>	<i>6,463</i>	<i>4,593</i>	<i>2,471</i>	<i>203,371</i>
Employment	43,482	33,370	27,808	11,345	11,591	3,207	1,605	676	132,949
Total (number)	91,313	104,718	50,406	25,265	28,980	9,243	5,949	3,059	317,616

Source: AIHW, *Disability support services: services provided under the National Disability Agreement 2011–12*, p. 1.

Notes

1. Service user data are estimates after use of a statistical linkage key to account for individuals who received services from more than one service type outlet during the 12-month period.
2. Totals for Australia may not be the sum of service components because individuals may have used services in more than one state or territory during the 12-month period.
3. Total service users may not be the sum of service group components because individuals may have used more than one service group over the 12-month period.
4. See AIHW 2013a: Appendix B, Table B59 for a breakdown by state and territory of the service types that comprise the service groups.

Providers of disability services

Today, the Australian disability services provider market is dominated by not-for-profit organisations. Their primary objective is to support improvement in the lives of people with a disability, rather than commercial objectives. Government providers also play a significant role.

The majority of providers rely on ‘block funding’ payments from state and territory governments as their major source of income to continue their day-to-day operations. As the main purchaser, governments determine the products, quantity and price of services provided to people with a disability and government regulation provides for safety and quality standards. Services are

⁴¹ AIHW, *Disability support services: services provided under the National Disability Agreement 2011–12*, p. 1.

⁴² *ibid.*, p. 2.

⁴³ *ibid.*, p. 15.

⁴⁴ AIHW, *Disability support services: services provided under the National Disability Agreement 2010–11*.

provided according to the amount of block funding provided instead of the actual price of support for an individual. In addition to block funding, the sector has relied on 'charitable' structures and contributions from the Australian public.⁴⁵

In 2012–13 there were 2,151 disability support providers funded by state and territory and Commonwealth governments throughout Australia, managing 15,659 service-type outlets.⁴⁶ Available supports included:

- accommodation support — large residential institutions (more than 20 people) offering 24-hour care, hostels, group homes, attendant/personal care, in-home accommodation support, alternative family placements, and other accommodation support
- community support — therapy for individuals, early childhood intervention, behaviour intervention, counselling, regional support and support teams, case management and coordination, and other community support
- community access — learning and life-skills development and recreation/holiday programs
- respite — in own home, centre based, host family respite and other flexible arrangements
- employment — open employment, supported employment or a combination of both
- advocacy, information/referral services, mutual support or self-help groups, and alternative formats of communication

Other support services provided by the sector include research and evaluation, training and development, support by peak bodies and other support services (such as one-off funding for promotional activities or buying aids and equipment).

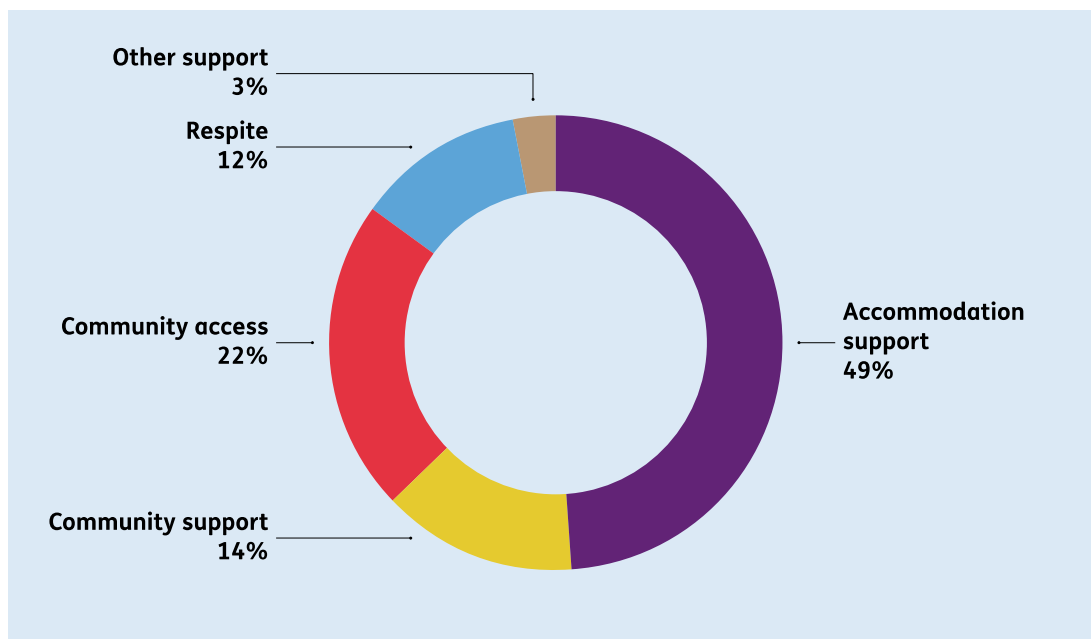
The majority of service-type outlets (60.9 per cent) are located in major cities and a small number (3.2 per cent) in remote or very remote areas. The remainder of service-type outlets (36.6 per cent) are located in inner (26 per cent) and outer (10.6 per cent) regional areas.⁴⁷

⁴⁵ PwC, *Draft Final report: Planning for a sustainable disability sector*, p. 14, for the Department of Families, Housing, Community Services and Indigenous Affairs.

⁴⁶ AIHW, *Disability support services: services provided under the National Disability Agreement 2012–13*, p. 11. Includes Commonwealth funded open employment outlets (1,958 outlets) as open employment which is not funded through the NDIS.

⁴⁷ *ibid.*, p. 18. Note: Four service-type outlets listed their remoteness area as unknown.

Figure 1: State/territory-funded disability supports 2012–2013

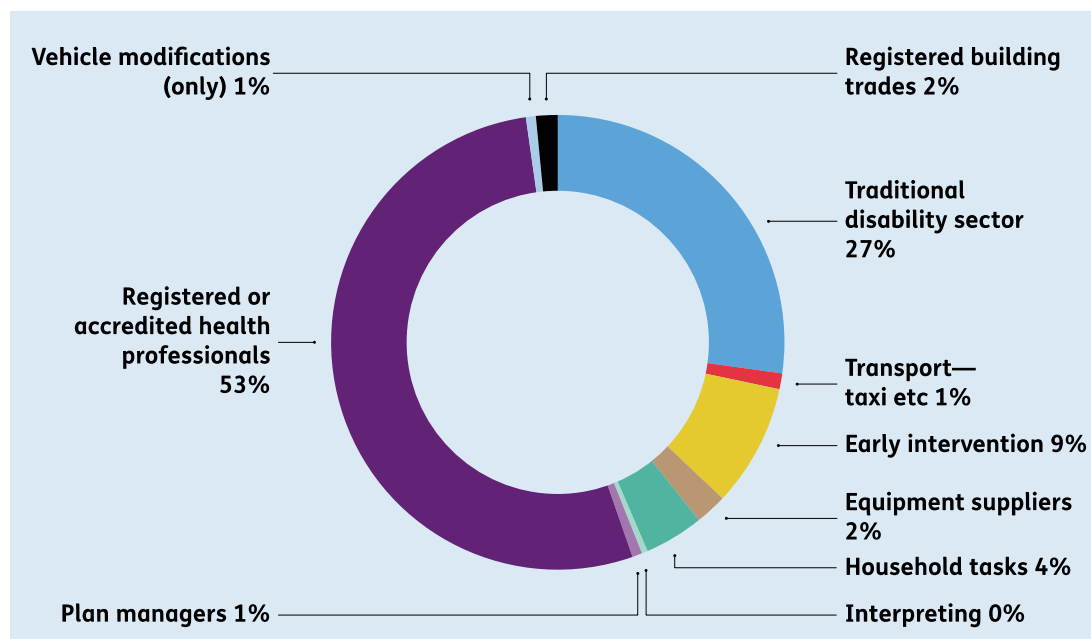


Source: AIHW, *Disability support services*, Appendix, 2012–13, p. 18.

NDIS trial-site registered providers by industry type

Figure 2 and Table 2 show the number and types of providers registered with the NDIA as at August 2014. It is possible that this profile may change over time as the market matures.

Figure 2: Active registered providers by industry type



Source: National Disability Insurance Agency, 2014.

Table 5.2: Active providers registered with the NDIA (August 2014)

Provider category	Number of providers
Traditional disability sector	193
Transport — taxis, etc.	8
Equipment suppliers	62
Early intervention	16
Household tasks – cleaning, gardening	30
Interpreting	3
Plan managers	5
Registered or accredited health professionals	377
Vehicle modifications (only)	5
Registered building trades	11
Total	710

B. The NDIS Pathway

Participant pathway in the NDIS

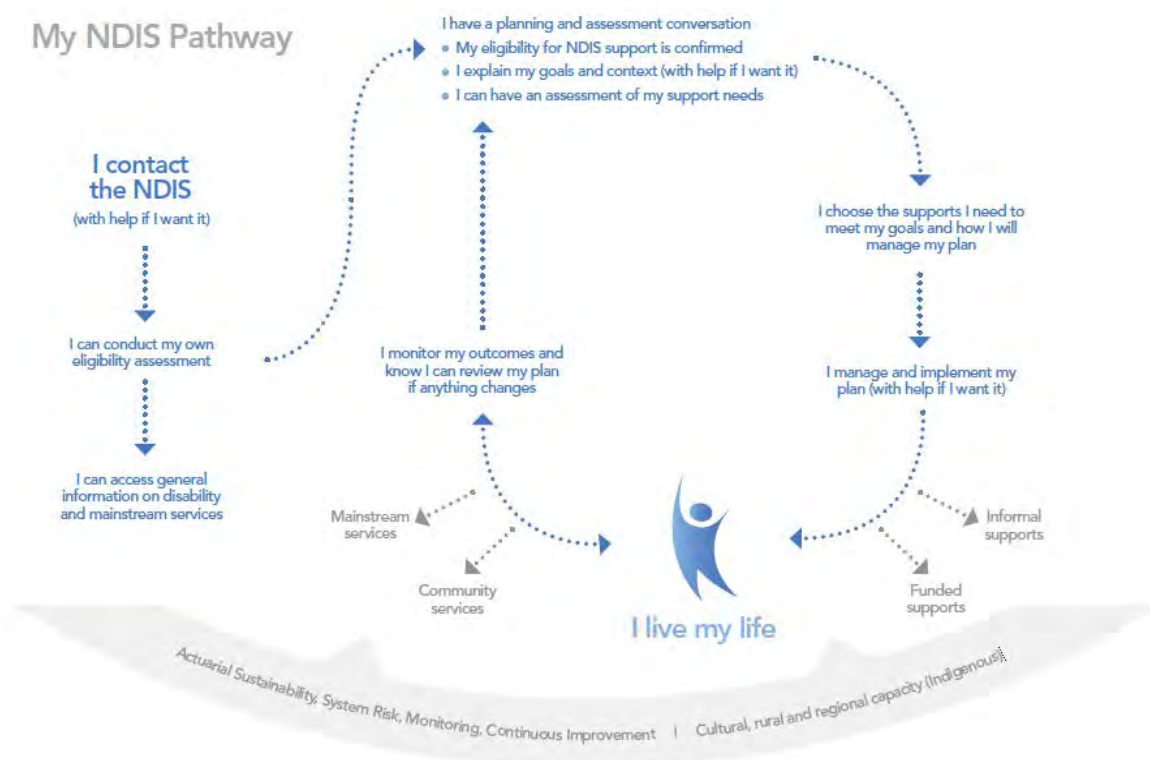
The NDIS process starts with a person with disability contacting the NDIA to find out if they are eligible for NDIS support. Some people may not need the individualised support available through the NDIS and can be assisted by being linked into a specific service or to a broad community support.

Eligible people meet with a planner to talk about their goals and aspirations, the reasonable and necessary supports needed to meet their goals, what safeguards might be required to maximise choice and control, and how they want to implement and manage their support package. This leads to the development of an individualised support plan.

People with disability then indicate how they would like their plan to be managed – whether they wish to manage it themselves or nominate another person, the NDIA or a combination of these options. Putting individual support plans into action involves people with disability choosing who will provide their supports. This involves control over how, when and where to receive supports and arranging these details directly with the chosen provider. Local Area Coordinators from the NDIA can help put plans into action.

Agreed review dates will mean people with disability can talk about their plans and make changes as necessary. Regardless of scheduled reviews, a person can seek a review at any time to discuss changes to their goals and plan, including what supports they need, how supports are provided, and who provides these supports. The participant pathway is shown in Figure 3.

Figure 3: Participant pathway



People in the participant pathway who can help

The NDIA has key people who can help throughout the participant pathway. These roles have been established for the NDIA trials and are still changing because of what has been learnt in the trials. Also, not every trial site has the same kind of support people. The descriptions below therefore provide only an idea of the kinds of help that will be available when the scheme is fully implemented.

Key roles include planners, Local Area Coordinators and service delivery staff. In some trials during 2014, the roles of planner and Local Area Coordinator have been combined. There is also an option for a participant to engage a registered plan management provider to assist in administering their individualised support plan.

Planners

The primary role of planner is to undertake goal-based planning. This involves supportive conversations with participants and helping identify what current and future supports are required in order to realise a person's goals and aspirations. They are the decision makers for the NDIS for eligibility, funded supports, plan management and review.

Planners will be involved in the planning conversation and, where there is no existing evidence of support, in conducting a Supports Needs Assessment. They will also support participants through that process and need to be able to interpret complex information about functional limitations and how they impact on daily life. Specialist assessments are purchased from external providers where they are required, such as for car modifications. They will also facilitate supported decision making in the planning process and gain an understanding of the needs of families and carers in supporting the participant.

Planners have to be able to handle complex conversations where competing interests sometimes need to be managed (including between participants and families and carers). They also need to be able to make decisions that balance reasonable and necessary support, including supports for sustaining informal care, with scheme sustainability. Planners will comprise around 20 per cent of the NDIS workforce by the third year of the scheme.

Local Area Coordinators

Local Area Coordinators (LACs) will be available to assist participants, with around 50 per cent of participants electing or needing to have LAC support in trial sites. They are expected to build relationships with people with disability and their families and carers; help build and support informal support systems; and connect people with mainstream services and local community-based supports. They will also support participants, their families and carers to build their capacity and to 'imagine what is possible' by helping clarify their aspirations, goals and objectives.

LACs are able to work with participants to prepare for planning discussions and exercising choice and control and, in this role, might attend planning meetings with participants. LACs can also assist participants to implement and self-manage their plans and are likely to build enduring relationships with those who want this support.

LACs will have an ongoing role in local community education and community capacity building and will be an important source of information about the on-the-ground impact of the NDIS.

LACs will be able to assist with identifying individuals who might be eligible for NDIS support, but they will have no role in determining access to the NDIS or in resolving planning or assessment issues within the NDIS. LACs are not case managers — they do not provide counselling services or undertake interventions, but they can connect participants with those services. LACs are expected to comprise around 50 per cent of the NDIS workforce by the third year of the scheme.

Service delivery staff

Service delivery staff represent the first point of contact for people when they come in or ring in to the NDIA. They make sure queries from individuals are responded to and that individuals receive the most appropriate service as soon as possible. This includes identifying where individuals are in crisis and require urgent support, as well as more generally helping to ensure individuals receive the support they require. They make appointments for people to see Local Area Coordinators and planners.

Plan management providers

A registered plan management provider is an individual or organisation that undertakes the management of funds for the supports in a participant's plan. A participant may request the use of a plan management provider to manage some or all of the funding for supports in their plan. A plan management provider is paid with funding provided for in a participant's support plan.

A plan management provider might provide assistance in relation to just financial matters, or financial **and** service matters. It is expected that the plan management provider will also assist participants to increase their skills in these areas.

Financial assistance includes such things as organising providers and their payment, processing expense claims, developing monthly statements for participants, and claiming from the NDIA.

Assistance with service matters involves a range of activities to assist the participant in negotiating and coordinating the provision of support. This could include sourcing providers, negotiating method and timing of delivery of supports, and negotiating individual requirements as part of the support management.

If a plan management provider is also a provider of other supports received by the participant, then the plan management provider will need to have mechanisms in place for managing any conflicts of interest that might arise.

Options for plan management

Participants will be able to choose their provider and manage arrangements such as the timing and frequency of service delivery with their provider. Participants can choose how to manage their funding consistent with their plan. Funding can be managed through one of the following options or a combination of options:

- the individual
- a plan 'nominee' such as a family member
- a registered plan management provider
- the NDIA.

C. NDIA Terms of Business for Registered Support Providers

The following section reproduces the Terms of Business for Registered Support Providers, published on the NDIA website and accessed on 17 October 2014 at: [Terms of business for Registered Support Providers](#).

The *National Disability Insurance Scheme Act 2013* provides for the making of Rules and requirements for registered providers of support.

The Rule – *National Disability Insurance Scheme (Registered Providers of Support) Rules* – states that registered providers must agree to the National Disability Insurance Agency Terms of Business. This document sets out those terms and should be read in conjunction with the Rule.

Service Delivery

Supports are to be delivered in accordance with the Objectives and Principles of the *National Disability Insurance Scheme Act 2013*, all relevant National Disability Insurance Scheme Rules and Guidelines, the provider's own Code of Conduct, Code of Ethics or Service Charter and any legislative or other requirements of the Commonwealth, State or Territory authority that is relevant to the type of support delivered.

Competence: Providers are expected to maintain a high level of competence in providing supports to National Disability Insurance Scheme participants and regularly update their knowledge and skills. A verified complaint about the incompetence of a provider may result in revocation of the provider's registration.

Service agreements: It is expected that providers will work with a participant to establish written or verbal agreement about the nature, quality and price of supports to be provided. All supports delivered will be in accordance with that agreement. Such agreements will accord with the National Disability Insurance Scheme Model Agreement and incorporate input from participants including internal management of complaints and cessation of supports. Service agreements need to be consistent with the National Disability Insurance Scheme's pricing arrangements and guidelines.

Withdrawal or termination of services: If a provider intends to withdraw or terminate the provision of services to a National Disability Insurance Scheme participant, adequate notice must be given to enable the participant, their nominee or the Agency to find a suitable alternative. The time frame for notice will vary according to the nature and frequency of the support and will be included in the agreement with the participant. The Agency is to be advised of an impending termination of services, if there is any risk to continuity of supports to a participant.

Business Practices

Providers are to comply with all applicable Commonwealth, state and territory laws in relation to conducting a business and governance arrangements.

Providers must not accept any offer of money, gifts, services or benefits that would cause them to act in a manner contrary to the interests of the participant.

Conflict of Interest: A conflict of interest, or potential conflict of interest (a situation where a provider could be influenced, or seen to be influenced by a financial or personal interest in carrying out their duties) is to be managed by bringing it to the attention of the agency and participant and providing assurance as to how it will be managed by the provider. A provider must have no financial or other personal interest that could directly or indirectly influence or compromise the choice of provider or provision of supports to a participant.

A plan management provider must disclose any financial interests in providing advice or management supports to a participant.

Subcontracting: Where a registered provider subcontracts the provision of supports, the subcontracted provider must comply with these terms and any employment or any workplace health and safety law that applies to the contractor in that provision or management. The provider must have mechanisms in place to ensure the subcontractor is compliant with workplace health and safety and employment laws.

Where a registered provider engages an individual as an independent contractor for the provision of supports or the management of supports, it will pay the independent contractor at least the amount payable as if the individual were employed in accordance with the *Fair Work Act 2009*.

Where a registered provider engages an entity as a contractor for the provision of supports or the management of supports, it will pay the entity an amount that accords with the applicable industrial instrument in relation to the work performed in fulfilment of that contract by each partner or member of the entity, including the *Fair Work Act 2009* where that is applicable.

The participant must be informed of, and understand, the subcontracting arrangements.

Anti-discrimination: When providing supports, a provider must provide supports consistent with the Objectives and Principles of the *National Disability Insurance Scheme Act 2013* and comply with anti-discrimination legislation and not discriminate on grounds of gender, marital status, pregnancy, age, ethnic or national origin, disability, sexual preference, religious or political belief.

Insurances: A provider must maintain an adequate level of relevant insurances including professional indemnity, public liability and workers compensation insurance when employing workers.

Records management: A provider is to keep proper and accessible records of the supports delivered to National Disability Insurance Scheme participants including financial records that are fit for audit. Adequate records must be maintained as evidence of the provision and payment for a support. Financial records are to be retained for at least 5 years. All other records are to be retained for a length of time in accordance with the relevant state or territory laws.

Pricing and Payment conditions: Providers can charge for supports delivered in accordance with the National Disability Insurance Scheme pricing arrangements and guidelines, after the support has been provided. Prepayment is not generally permitted for supports.

A claim for payment is to be submitted within a reasonable time (30 days) after the date of providing the support.

For a self-managing participant, a provider must clearly set out for the participant the costs to be paid, timing of delivery and the payment method. No charges are to be added to the price of the support, including credit card surcharges, or requested from the participant.

No fee additional to the agreed price for the support is to be levied upon a participant for reasonable and necessary supports set out in a participant's plan.

Serious incident reporting: Providers are required to report serious incidents to the National Disability Insurance Scheme State Manager and to the relevant statutory authority in the local jurisdiction. A serious incident is:

- the death of, or serious injury to, a participant;
- allegations of, or actual sexual or physical assault of a participant;
- significant damage to property or serious injury to another person by a participant; and
- an event that has the potential to subject a participant or National Disability Insurance Scheme to high levels of adverse public scrutiny.

Interactions with National Disability Insurance Agency

Provision of information: Providers must supply any information requested by the National Disability Insurance Agency in relation to the provision of supports within a reasonable time frame or as specified in the request.

Providers may be reviewed by the National Disability Insurance Agency in relation to supports funded for a National Disability Insurance Scheme participant. Providers must cooperate fully with National Disability Insurance Agency officers who are undertaking review activities.

Where a decision by the National Disability Insurance Agency is the subject of a merits review or complaint, or a request for information is made under the *Freedom of Information Act 1982*, the provider is required to cooperate in providing any documents or other information requested.

Provider information updates will be provided via the National Disability Insurance Scheme website and/or provider portal. Providers will be responsible for updating their knowledge and information about any changes to the National Disability Insurance Scheme’s requirements published on the website or portal. The Scheme will provide alerts when new information is available.

False declarations: A provider must not make false or misleading declarations in their dealings with the National Disability Insurance Agency or during the delivery of their supports. A declaration may be misleading if information is omitted or presented in a manner that enables a misleading view of a situation to be formed.

Providers must not collude with other parties with the intention of providing false or misleading information. Providers must take all measures to maintain the integrity of the supports they provide and their records.

Notification: It is the responsibility of the provider to maintain accurate contact details with the National Disability Insurance Agency. A registered provider must advise the National Disability Insurance Agency of any changes to the information contained within the application for registration as soon as is practicable. Paragraph 4.1 of the *National Disability Insurance Scheme Rule – Registered Providers* contains further detail about the requirement for providers to notify the National Disability Insurance Agency about changes in their compliance with the criteria for registration.

Identification as an NDIS Provider and Use of the NDIS Logo

Registered providers may identify their National Disability Insurance Scheme registration by stating “<Organization/person’s name> is registered to provide supports for National Disability Insurance Scheme participants.”

The National Disability Insurance Scheme logo is not to be used by a provider in any publicity material.

Public comments: As members of the community, all providers have the right to take part in public debate on issues of public concern. However, providers must be careful that public comments made as a private individual cannot be construed as an official comment on behalf of the National Disability Insurance Agency or the Government.

The provider must not represent themselves as spokespersons for the National Disability Insurance Scheme.

If elected or nominated as a spokesperson for a professional or community association, providers are entitled to make public comments about relevant issues. In making such statements, providers must clearly acknowledge that comments are made on behalf of that association and cannot be attributed to the National Disability Insurance Scheme.

Confidentiality

Providers must treat all information obtained as a National Disability Insurance Scheme provider as confidential.

All information related to participants must be stored in a secure manner. Providers must have a secure storage system for their records.

Participant information may be disclosed if the law requires the disclosure or when there is reason to believe that the use or disclosure is reasonably necessary for:

- reducing or preventing a serious or imminent threat to an individual's life, health or safety, or preventing a serious threat to public health or safety;
- preventing, detecting, investigating, prosecuting or punishing of criminal offences and other breaches of the law that attract a penalty;
- preventing, detecting, investigating or remedying of seriously improper conduct or proscribed conduct; and
- the preparation or conduct of proceedings before any court or tribunal.

With the exception of an imminent threat to life, health or safety, all requests for disclosure must be referred to the National Disability Insurance Scheme Privacy Contact Officer for consideration prior to release.

Complaints

Providers are to have clear and accessible complaints handling and dispute resolution processes. Records related to complaints are to be maintained for at least 5 years or as required by any other law.

All complaints to the National Disability Insurance Agency about a provider will be resolved in accordance with the Complaints Procedure of the National Disability Insurance Agency, or the State authority, whichever applies.

References

National Disability Insurance Scheme Act 2013
Freedom of Information Act 1982

D. Process for providing feedback or making a complaint about the NDIA

The following section reproduces the process for making a complaint about the NDIA, published on the NDIA website and accessed on 20 October 2014 at: [Feedback, complaints and reviews](#).

Raising Concerns About the NDIS

The National Disability Insurance Agency (NDIA) genuinely welcomes feedback, including complaints. We believe people have a right to speak up as it helps us to see what works, what doesn't and where we can make improvements.

It doesn't cost anything to give us feedback or make a complaint. You can:

- provide feedback or lodge a complaint in person at a local NDIS office, by telephone, by email or in writing
- use our website
- download a form and email or post it to us.

Alternatively we can send you a form to fill out and send back.

Providing Feedback

We believe our front-line staff are the best people to assist you. If you want information about our services or you are unsure about something, we encourage you to contact your local NDIS office.

Alternatively you can go to our website, send an email to feedback@ndis.gov.au or call us for more information on 1800 800 110. If we can't help you, we will try to refer you to someone who can.

Making a Complaint

A complaint can be made to any one of our local offices in-person, by telephone, email or in writing. You can also lodge your complaint on-line via our website: ndis.gov.au/feedback

Forms are available but you do not have to fill out a form to make a complaint. You can make a complaint in your preferred language. Our local staff can help you lodge your complaint.

If we cannot deal with your complaint, we will explain why.

NDIA Action on a Complaint

We will contact you to talk about your complaint and may ask you to provide more information to help us understand the nature of your complaint.

We will contact the person or organisation you are complaining about, provide them with details and ask for their comments and relevant information. We will let you know what they say in response to your complaint.

Complaints can be resolved in many different ways and the officer who is handling the complaint can provide you with information about how other complaints have been resolved.

If you are dissatisfied with the outcome of your complaint you can ask for a supervisor or manager to review your complaint and how it was handled.

If you are not satisfied about the way your complaint was then managed, you may seek assistance

from the Commonwealth Ombudsman. You can:

- call: 1300 362 072
- visit the website: ombudsman.gov.au/pages/making-a-complaint/

Service Standards

We will resolve your complaint as quickly as possible at the local level.

Our complaints procedures require that we:

- take immediate action where there appears to be a high risk of harm, neglect or abuse
- acknowledge complaints within 24 hours of receipt
- call you within 48 hours of acknowledgement
- resolve complaints within 21 calendar days
- publish information on our performance.

If the Complaint is About a Decision by the Agency

If your complaint is about a decision made by or for the Chief Executive Officer (CEO) of the NDIA you can lodge an application for a Review. These are known as Reviewable Decisions and any person directly affected by a decision of the Agency can request such a review.

Before an internal review you are encouraged to request reconsideration by the original decision maker about your concerns, especially if you think an important matter was overlooked or new information has come to light.

When a decision is reviewed by the CEO, or the Administrative Appeals Tribunal, it could confirm the decision or it may change the decision.

A list of reviewable decisions is in the legislation. These relate to things like being accepted as a participant, the provision of reasonable and necessary supports, a decision to become a registered provider of supports and many other decisions. When informed of a NDIS decision you will be told how to request a review.

A request for a review must be made within 3 months of receiving notice of the reviewable decision from the CEO. The CEO will ask a NDIA staff member to review the decision.

The staff member responsible for the review will not have been involved in the earlier decision. They may want to talk to you directly as part of this process.

A request for a review can be made by:

- sending or delivering a written request to the CEO at:
NDIS
GPO Box 700
Canberra ACT 2601
- making a request orally at the NDIS office
- calling 1800 800 110
- sending an email to feedback@ndis.gov.au

At the time of asking for a review, you should explain why you think the decision is incorrect. A form requesting a review is also available from ndis.gov.au/document/394

You do not have to use this form but it can help you to describe why you want a review.

If you are still unhappy after the first review by the CEO, you have two choices:

1. you may seek a further review by the NDIS, or
2. you can ask for a review by the Administrative Appeals Tribunal.

More Information

- Visit: [ndis.gov.au](https://www.ndis.gov.au)
- Email: enquiries@ndis.gov.au
- Call 1800 800 110* Monday to Friday, 9.00am to 5.00pm EST.

For people with hearing or speech loss:

- TTY: 1800 555 677
- Speak and Listen: 1800 555 727
- For people who need help with English TIS: 131 450

*1800 calls are free from fixed lines; however calls from mobiles may be charged.

E. Codes of Conduct

This section includes examples of codes of conduct used in other sectors to show, in general terms, what a Code of Conduct might contain. The examples drawn on are the *Code of Conduct for unregistered health practitioners* in New South Wales⁴⁸ and the *Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England*.⁴⁹

Purpose of Codes of Conduct

The *Code of Conduct for unregistered health practitioners* states that it ‘sets out what you can expect from your provider’. The *Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England* states that it is ‘based on the principles of protecting the public by promoting best practice’. It addresses healthcare support workers in saying that ‘it will ensure that you are “working to standard”, providing high quality, compassionate healthcare, care and support’. It also addresses consumers of health care by saying that it ‘describes the standards of conduct, behaviour and attitude that the public and people who use health and care services should expect’.

Content of Codes of Conduct

The *Code of Conduct for unregistered health practitioners* is made up of a number of key points under which there are specific details of expected behaviours. The key points are as follows:

- Health practitioners to provide services in a safe and ethical manner
- Health practitioners diagnosed with infectious medical condition
- Health practitioners to adopt standard precautions for infection control
- Appropriate conduct in relation to treatment advice
- Health practitioners not to practise under influence of alcohol or drugs
- Health practitioners not to practise with certain physical or mental conditions
- Health practitioners not to financially exploit clients
- Health practitioners required to have clinical basis to treatments
- Health practitioners not to misinform their clients
- Health practitioners not to engage in sexual or improper personal relationship with client
- Health practitioners to comply with relevant privacy laws
- Health practitioners to keep appropriate records
- Health practitioners to keep appropriate insurance
- Certain health practitioners to display code and other information
- Sale and supply of optical appliances.

The *Code of Conduct for Healthcare Support Workers and Adult Social Care Workers in England* has a set of high-level statements of expected behaviour. Under each is a set of more specific ‘guidance statements’. The high-level statements of expected behaviour are:

- Be accountable by making sure you can answer for your actions or omissions.
- Promote and uphold the privacy, dignity, rights, health and wellbeing of people who use health and care services and their carers at all times.

⁴⁸ www.health.nsw.gov.au/phact/Pages/code-of-conduct.aspx

⁴⁹ www.skillsforhealth.org.uk/about-us/news/code-of-conduct-and-national-minimum-training-standards-for-healthcare-support-workers/

- Work in collaboration with your colleagues to ensure the delivery of high quality, safe and compassionate healthcare, care and support.
 - Communicate in an open and effective way to promote the health, safety and wellbeing of people who use health and care services and their carers.
 - Respect a person's right to confidentiality.
 - Strive to improve the quality of healthcare, care and support through continuing professional development.
 - Uphold and promote equality, diversity and inclusion.
-

F. Restrictive Practices

National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector

(the 'National Framework')

Introduction: Reducing and Eliminating the Use of Restrictive Practices

Reducing and eliminating the use of restrictive practices is consistent with the United Nations Convention on the Rights of Persons with Disabilities (CRPD)⁵⁰ and its intent to protect the rights, freedoms and inherent dignity of people with disability. Australia has ratified and agreed to be bound by the terms of the CRPD under international law.

People with disability who are supported by disability service providers and engage in challenging behaviours that are perceived to be harmful to themselves or others are at risk of being subjected to restrictive practices.

The National Framework focuses on the reduction of the use of restrictive practices in disability services that involve restraint (including physical, mechanical or chemical) or seclusion. It aims to contribute to the promotion and full realisation of all human rights for people with disability, including liberty and security of the person and freedom from exploitation, violence and abuse, in accordance with Articles 14 and 16 of the CRPD. Restrictive practices should only be used where they are proportionate and justified in order to protect the rights or safety of the person or others.

The National Framework establishes a national approach to addressing the use and reduction of restrictive practices by disability service providers across a range of disability service sector settings, including institutional and community based care. Whilst some jurisdictions have legislation or policy that regulate the use of restrictive practices, minimum requirements in relation to restrictive practices, including reviews and monitoring, are not explicitly identified in every state and territory.

Restrictive practices used in disability services in Australia have been reviewed by the Commonwealth, states and territories in relation to the National Disability Agreement, and recommendations have been made for the National Framework to guide jurisdictions' individual arrangements. Some jurisdictions already have in place or are implementing advanced, comprehensive strategies that address the use of restrictive practices in disability services. These strategies are increasing the level of awareness and understanding of restrictive practices within the sector and are contributing to a reduction in the use of restrictive practices.

⁵⁰ Australia has agreed to be bound by the International Covenant of Civil and Political Rights (ICCPR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) as well as other major human rights instruments, including Convention on the Rights of Persons with Disabilities; Convention against Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment; Convention on the Rights of the Child; and Convention on the Elimination of all forms of Discrimination against Women. Australia also supports the United Nations Declaration on the Rights of Indigenous Peoples (Source: Australian Human Rights Commission).

Consistent with the CRPD, people with disability accessing disability services should be active participants in decisions about their lives, support and care. Maximum respect for a person's autonomy and recognition of an individual's rights is paramount. There are many relevant stakeholders in the use, reduction and elimination of restrictive practices: the person with disability and his or her family, carers, guardians or advocates, staff at all levels in the disability service sector and relevant government agencies.

Disability services are sometimes challenged to provide safe and therapeutic services for clients who have complex high support needs, as well as providing the safest possible work environment for staff. It has been recognised internationally and domestically that restrictive practices can be significantly reduced and in many cases eliminated. The National Framework outlines change processes which require leadership and commitment from officials and staff at all levels of organisations and provides the opportunity to demonstrate excellence in delivering safer, quality disability services throughout Australia that are based on evidence-based best practice.

The National Framework outlines high-level principles to guide work in this area and core strategies to reduce the use of restrictive practices in the disability service sector. The National Framework represents a commitment from the Commonwealth, states and territories to the high-level guiding principles and implementation of the core strategies to reduce the use of restrictive practices in the disability service sector. It also outlines a commitment to collaborative development of a national reporting model (including where voluntary reporting occurs).

The National Framework and the National Disability Insurance Scheme (NDIS)

The commencement of the National Disability Insurance Scheme (the NDIS) on 1 July 2013 significantly changes the way disability support is funded and accessed. As part of the NDIS, a quality assurance and safeguards system will be implemented and will include responsibilities for oversight of and reporting on the use of restrictive practices by services providing supports to participants. In the interim, NDIS host jurisdictions have agreed that existing state and territory quality assurance and safeguards frameworks will be used. This will include that appropriate restrictive practice laws and policies applying in that jurisdiction are observed.⁵¹ The future development of an NDIS quality assurance and safeguards system will be assisted and informed by this National Framework.

⁵¹ The NDIS legislation and rules recognise that there will be circumstances where the National Disability Insurance Agency (the NDIA) should make a decision that a support must be provided by a qualified person or organisation that meets certain quality and practice standards. This will be the case where any restrictive practices are thought to be necessary to supporting the participant. This means that in developing the participant statement of supports, NDIS planners will include appropriate supports for the development or implementation of a behaviour support plan in the NDIS participant plan of supports.

The National Framework is an interim step that delivers leadership toward reduction of the use of restrictive practices, which will then be taken forward into the NDIS quality assurance and safeguards framework to be implemented in the longer term. In the interim, the National Disability Insurance Agency (NDIA) will take on funding responsibility for supports for some participants where those supports may involve some use of restrictive practices. By agreements between the Commonwealth and host jurisdictions, current state and territory quality assurance arrangements, including safeguards in respect of restrictive practices by providers, will apply until such time as an NDIS quality and assurance framework has been agreed, regardless of whether the funding for the support is from the NDIS.

The NDIA will work with jurisdictions and the service provider in preparation for transition of these individuals to the NDIS. This will ensure supports in the person's plan will be aligned with this Framework.

Commonwealth, state and territory parties who will continue to be responsible for quality assurance systems in the interim may also explore the possibility of amending their regulatory frameworks to accompany this initiative. Further consideration will also be given to options regarding a national or nationally consistent regulatory framework.

High-level Definitions

A nationally agreed set of high-level definitions will guide legislation and policy development, and will facilitate greater inter-jurisdictional collaboration. The following definitions will be used by jurisdictions for implementation, reporting and evaluating progress against the National Framework.

The definitions are intended as high-level definitions only, under which restrictive practices should be categorised. It is anticipated that definitions in the National Framework will guide and support the development of detailed operational guidelines and mechanisms as appropriate in jurisdictional settings.

People With Disability

Within the National Framework, "people with disability" refers to persons in receipt of disability support services under the National Disability Agreement and the NDIS.

Individualised/behaviour support

The National Framework articulates principles and strategies for maximising individualised behaviour support for people with disability, with the overall objective of reducing the occurrence and impact of challenging behaviour and the use of restrictive practices. This may include the provision of positive behaviour support and development of an individual/behaviour support plan.

Positive Behaviour Support is the term used to describe the integration of the contemporary ideology of disability service provision with the clinical framework of applied behaviour analysis. Positive Behaviour Supports are supported by evidence encompass strategies and methods that aim to increase the person's quality of life and reduce challenging behaviour (Source Note: Carr et al., 2002; Singer & Wang, 2009).

An individual/behaviour support plan is a plan developed for a person with disability which specifies a range of strategies to be used in supporting the person's behaviour, including proactive strategies to build on the person's strengths and increase their life skills.

Restrictive practice

A “restrictive practice” is defined as any practice or intervention that has the effect of restricting the rights or freedom of movement of a person with disability, with the primary purpose of protecting the person or others from harm.

Seclusion

“Seclusion” means the sole confinement of a person with disability in a room or physical space at any hour of the day or night where voluntary exit is prevented, implied, or not facilitated.

Chemical restraint

A “chemical restraint” means the use of medication or chemical substance for the primary purpose of influencing a person’s behaviour or movement. It does not include the use of medication prescribed by a medical practitioner for the treatment of, or to enable treatment of, a diagnosed mental disorder, a physical illness or physical condition.

Mechanical restraint

A “mechanical restraint” means the use of a device⁵² to prevent, restrict or subdue a person’s movement for the primary purpose of influencing a person’s behaviour but does not include the use of devices for therapeutic or non-behavioural purposes. For example, purposes may include the use of a device to assist a person with functional activities, as part of occupational therapy, or to allow for safe transportation.

Physical restraint

A “physical restraint” means the sustained or prolonged⁵³ use or action of physical force to prevent, restrict or subdue movement of a person’s body, or part of their body, for the primary purpose of influencing a person’s behaviour. Physical restraint is distinct from the use of a hands-on technique in a reflexive⁵⁴ way to guide or redirect a person away from potential harm/injury, consistent with what could reasonably be considered the exercise of care towards a person.

Additional restrictive practices

This Framework aims to reduce the use of restrictive practices that comply with applicable jurisdictional regulatory, policy and work practice requirements.

Some jurisdictions may have arrangements that authorise the use of additional restrictive practices to those defined above, including those broadly termed as:

- psycho-social restraints, usually involving the use of ‘power-control’ strategies;
- environmental restraints, which restrict a person’s free access to all parts of their environment; and
- consequence driven practices, usually involving the withdrawal of activities or items.

Qualification

Existing Commonwealth, state and territory legislation sets out their own respective practices that are unlawful and constitute criminal offences and civil wrongs that may lead to legal action, including assault, abuse, neglect or wrongful imprisonment. The National

⁵² A device may include any mechanical material, appliance or equipment.

⁵³ For example, a physical force or action lasting longer than approximately 30 seconds, that is not a reflexive manual restraint (McVilly, 2008).

⁵⁴ For example, momentary contact to guide or redirect a person, lasting for no more than approximately 30 seconds (McVilly, 2008).

Framework intends to work within existing legislative arrangements, to set out minimum requirements in relation to restrictive practices and guide jurisdictions' individual arrangements.

High-level Guiding Principles

The following high-level guiding principles should underpin planning, implementation and evaluation of the National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector.

1. Human rights:

- a. Full and equal enjoyment of all human rights and fundamental freedoms by people with disability without discrimination of any kind, as outlined in the United Nations Convention on Rights of Persons with Disabilities.⁵⁵ People with disability have equal rights to those of all members of society, including but not limited to the right to:
 - i. Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons (Article 3);
 - ii. Equality before the law and to equal protection under the law, without discrimination (Article 5);
 - iii. Liberty and security of the person (Article 14);
 - iv. Freedom from torture or cruel, inhuman or degrading treatment or punishment (Article 15);
 - v. Freedom from exploitation, violence and abuse (Article 16);
 - vi. Respect for his or her physical and mental integrity on an equal basis with others (Article 17);
 - vii. Personal mobility with the greatest possible independence (Article 20);
 - viii. Freedom of expression and opinion and access to information (Article 21);
 - ix. The highest attainable standard of health without discrimination on the basis of disability (Article 25);
 - x. Attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life (Article 26); and
 - xi. An adequate standard of living for themselves and their families, and to social protection without discrimination on the basis of disability (Article 28).
- b. Recognising an individual's rights is paramount. Restrictive practices should occur only in very limited and specific circumstances, as a last resort and utilising the least restrictive practice and for the shortest period of time possible under the circumstances. Restrictive practices should only be used where they are proportionate and justified in order to protect the rights or safety of the person or others.

⁵⁵ Article 1, United Nations Convention on the Rights of Persons with Disabilities

2. Person-centred focus:

- a. People with disability (with the support of their guardians or advocates where required) are the natural authorities for their own lives and processes that recognise this authority in decision making, choice and control should guide the design and provision of services.
- b. Approaches, including behaviour support planning, will be individualised and involve personalised supports that are informed by evidence-based best practices.
- c. Disability service providers should seek to understand the nature and function of a person's behaviour and to respond appropriately to that behaviour, ensuring the use of restrictive practices in very limited and specific circumstances and only as a last resort.
- d. An emphasis on prevention including proactive skills building and environmental design to produce desirable behaviour change.
- e. Provision of decision support to assist people with disability and their guardians or advocates to identify needs and goals, plan their service requirements, access services, and maximise participation in decision making.
- f. Maximum respect for a person's autonomy, including:
 - i. Recognising the presumption of capacity for decision making;
 - ii. Seeking a person's consent and participation in decision making (with support if necessary) prior to making a substitute decision on their behalf; and
 - iii. Engaging the appropriate decision maker and seeking consent where appropriate, where a decision must be made on behalf of a person.
- g. People with disability and their guardians or advocates are informed restrictive practices may be used in the service(s) that they access, noting that restrictive practices are implemented on an individual basis.

3. A national approach:

- a. The principles of the National Framework should apply across Australia to ensure people have access to the same protections, in regard to restrictive practices, regardless of where they live.
- b. All jurisdictions and levels of government should ensure that disability services meet agreed standards focusing on protecting and promoting the human rights of people with disability.
- c. Disability service providers and their staff understand and comply with relevant Commonwealth, state and/or territory legislative and policy frameworks around use and reduction of restrictive practices.
- d. An integrated response between all governments to practices, outcomes and reporting in order to build a representative picture of the use and reduction in restrictive practices, without changing core governance arrangements.

4. Delivering quality outcomes and safe work places:

- a. Policies, procedures and tools should protect the rights of people with disability, focusing on improving clients' quality of life, and reducing and monitoring the use of restrictive practices.
- b. Disability service providers should ensure that people with disability have protection against inhuman or degrading treatment and attention is provided to personal dignity, privacy and self-respect as well as individual needs.
- c. Staff have the right to work in a safe environment and disability service providers may have legal obligations with respect to the observance of work health and safety.
- d. Review mechanisms are developed, maintained and utilised for client and staff de-briefing, review of restrictive practices used (incident reporting), assessment of appropriateness and alternatives, and for aggregated reporting on an organisational and service provider basis.

5. Accountability through documentation, benchmarking and evaluation — working towards transparent and consistent reporting:

- a. Formal assessment, planning, approval and review processes that are based on valid and evidence-based risk assessments undertaken by appropriate professionals should be required to authorise and monitor the use of restrictive practices.
- b. Transparent reporting mechanisms to:
 - i. Ensure accountability and that the person with disability and their guardian or advocate are involved as far as possible; and
 - ii. Detail independent monitoring and access to independent processes for complaints, or review and appeal of decisions to use restrictive practices; and
 - iii. Allow for the analysis of trends to evaluate the effectiveness of the strategies and recognise where there may be an increased reliance on the use of restrictive practices.
- c. Measure success through a national picture (or stocktake) of the use and reduction of restrictive practices.

6. Collaboration between service providers:

- a. A commitment to developing and maintaining stronger relationships across the health, allied health, aged care and disability sectors, including between physicians, nurses, mental and other health professionals, and disability services staff to ensure a multidisciplinary approach to the monitoring, use and reduction of restrictive practices.
- b. Collaborative approaches across sectors for client assessment, planning and review should be encouraged by all service providers involved with implementing a person's individual/behaviour support plan. Collaboration should enable a solid basis for individualised, person-centred approaches aimed at reducing the use of restrictive practices.

7. Raising awareness, providing education and facilitating accessible information about restrictive practices:

- a. A commitment to raising awareness of issues relating to the use of restrictive practices, including amongst people with disability and their guardians or advocates as key stakeholders in decision making, and in the implementation of behaviour support strategies and plans.
- b. People with disability and their guardians or advocates should be made aware of the relevant rights within jurisdictions to complain or seek a review of the use of restrictive practices and to participate fully in formal complaint resolution or review processes.
- c. A commitment to building capacity and reducing barriers amongst people with disability and their guardians or advocates to utilise complaint or review mechanisms about restrictive practices.
- d. People with disability and their guardians or advocates are informed that restrictive practices may be used in the service(s) that they access, noting that restrictive practices are implemented on an individual basis.

Core Strategies for a National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector

Jurisdictions agree that, by 2018, all disability service providers for which they or the NDIA have funding responsibilities should implement the following set of key core strategies to reduce the use of restrictive practices in disability services.

A comprehensive review of the research literature found evidence for six core strategies for reducing the use of restrictive practise (Rimland, 2011). The six core strategies are:

1. Person-centred focus

Including the perspectives and experiences of people with disability and their families, carers, guardians and advocates during restrictive practice incident de-briefing, individualised behaviour support planning, staff education and training, and policy and practice development is a key element of restraint minimisation across sectors (Azeem et al., 2011).

Key implementation areas are:

- a. Development and regular review of individual/behaviour support plans (including strategies for de-escalation and ensuring the safety of the person, staff and others) that are based on valid and evidence-based risk assessments, in conjunction with people with disability, and their guardians or advocates where appropriate, as active participants in decisions about their lives, support and care.
- b. Development and use of appropriate individualised behavioural and environmental risk assessment tools by disability service providers, which are in line with human rights and person-centred approaches.
- c. Development of individualised and evidence-based practices such as teaching the use of replacement skills (skills the person can use to replace the challenging behaviours), based on the principles of positive behaviour support.
- d. Availability of tools to assist people with disability and their guardians or advocates (where appropriate) to participate in decision making.

2. Leadership towards organisational change

Leaders play an important role in facilitating processes, structures and resources for supporting change. While acknowledging that whole of organisation approaches are required, the senior

management of disability services must create a goal of reducing restrictive practices and make it a high priority. Leaders must also support their staff through workforce development opportunities, the development of restraint and seclusion reduction tools, and implementation of rigorous evidence-based debriefing techniques to move away from the use of restrictive practices (Williams and Grossett, 2011).

Key implementation areas are:

- a. Leaders at all levels, across government and the non-government sector, commit to implement reduction in the use of restrictive practices.
- b. Governments provide strategic direction to disability service providers.
- c. Disability service providers form relevant governance structures and groups to provide organisational support mechanisms aimed at reducing restrictive practices.
- d. Clear and transparent mechanisms for disability representatives and stakeholders to inform policy makers on practices and guidelines.

3. Use of data to inform practice

Mechanisms to trigger periodic review of restraint authorisations, client assessments and individual/behaviour support plans are necessary to continuously assess the necessity of restrictive practices and possible alternative restrictive practices. Data is also important to determine what factors are effective in reducing or eliminating the use of restrictive practices (Webber et al., 2012).

Key implementation areas are:

- a. Collection of data at a service unit and/or organisational level to inform and improve future practice and to contribute to national data collection.
- b. Identification of baseline data to be collected, ability to set improvement and performance targets and to evidence how these will be used to reduce reliance on restrictive practices.
- c. Development and maintenance of an auditing tool to evaluate the use of restrictive practices, including the frequency with which they are used. The tool should have capacity to feed back into the support of people with disability, including into risk assessments and service reviews — preferably integrated with disability service provider staffing and management systems.
- d. Collection of and measuring outcomes through feedback from people with disability and staff about their experiences with restrictive practices within disability services.
- e. Making use of data on formal complaints or reviews about the use of restrictive practices in disability services, made through existing complaint or review mechanisms, such as an Ombudsman or Tribunal, or through new mechanisms that may become available through the NDIS, where appropriate.

4. Workforce development

There is good evidence to show that disability support staff who understand positive behaviour support, functional behaviour assessment as well as a focus on skills for trauma informed care, risk assessment, de-escalation, and restrictive practice alternatives are able to provide good support and reduce their use of restrictive practices to people who have complex needs.

Key implementation areas are:

- a. Promoting the use of interdisciplinary approaches toward assessment, intervention and individual/behaviour support plans.
- b. Competency assessment, individually tailored training and education for staff and managers, including on restraint reduction, valid and evidence-based risk assessment, positive behaviour support and relevant Commonwealth, state and territory legislative frameworks including human rights legislation in the *Disability Discrimination Act 1992* (Cth) and equivalents and international human rights treaties.
- c. Disability service providers implementing guidelines, processes and protocols for staff and managers that are informed by evidence-based best practice.
- d. Debriefing and support — continuous improvement for staff at all levels.

5. Use within disability services of restraint and seclusion reduction tools

Restrictive practices reduction tools need to be based on core assessment and prevention approaches, the results of which need to be integrated into each individual's support plan (Huckshorn, 2005).

These approaches would include:

- Evidence-based assessment tools which screen for increased risk of violence and physical and emotional issues which counter-indicate restrictive practices.
- Emergency management plans.
- Changes to the therapeutic environment.
- Meaningful activities aimed at lifestyle improvement and increased engagement.

Key implementation areas are:

- a. Practice guides and reference material on reduction tools and processes for staff and managers.
- b. Integration with service provider staffing and management systems.

6. Debriefing and practice review

Disability service providers should undertake regular review processes of their use of restrictive practices in order to identify areas for practice and systemic improvement.

Following the unanticipated or emergency use of a restrictive practice, an immediate “post event” debriefing should be completed on site led by the appropriate senior staff member on duty. The goal of this immediate debriefing is to ensure that everyone is safe, that satisfactory information is available to inform the later structured debriefing process and that the person subject to the restraint is safe and being appropriately monitored. Formal debriefing should occur within days after the event and include all involved, the treatment team and relevant administrative staff (Huckshorn, 2005).

People with disability and their guardians or advocates should be involved in debriefing and review processes to ensure their perspectives and experiences are understood.

Key implementation areas include:

- a. Practice guides and reference material for staff at all levels.

Measuring Performance/Effectiveness

Jurisdictional reporting on progress of the implementation of the National Framework will occur on a biennial basis. Monitoring of the *National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector* will provide enhanced

accountability, public transparency and a national picture and measurement of effectiveness aimed at improving practice. By 2018, all jurisdictions or the NDIA, where it is the funder of a support that involves restrictive practices, are encouraged to implement a data monitoring system that integrates with existing service delivery management systems.

Work will initially focus on seeking agreement to achieve standardised data collection and reporting (including for voluntary reporting where commitments occur) in order to establish benchmarks and performance indicators that measure effectiveness in reducing restrictive practices over time. Milestones will be developed which take an incremental approach toward reaching data reporting capacity on the use of restrictive practices by disability services.

Future opportunities may arise through the evaluation of the National Framework for expansion of these six core strategies to be integrated into other mainstream service sectors that support people with disability such as health, education and criminal justice.