**National Disability Services**

Submission to the Royal Commission on the Violence in the home issues paper

Whatever words we choose to use when we talk about housing and support for people with significant disability it should be home we have in mind.

Home is a rich and evocative word. It’s where you reside, but it’s more than that. Home is where you can express yourself, remove your armour, relax, feel safe, entertain friends, be accepted for who you are. In our collective imagination home is a haven from the outside world. Home is cosy and familiar; it’s where you have a sense of dominion.

A person’s home should be their refuge but this is not a reality for some people with disability. Accommodation services are fundamental to many people with disability achieving their goals. Still, personal, service-based and organisational/cultural factors interact in unique ways in accommodation settings – in some cases increasing risk of abuse. Long-term disability accommodation is often characterised by a higher proportion of people with intellectual disability, people who use personal care services, and people who live together for extended periods of time. Supports provided in accommodation services are often fundamental to a person’s daily functioning, which may mean fewer people report abuse when it does occur. For those who experience abuse, ‘opting out’ of their accommodation is often not simple.

This submission will focus on risks and strategies associated with disability service provision in the home (including private homes, dedicated disability service settings and other home settings where disability providers operate). NDS has previously addressed a significant part of accommodation service provision (and history) in our response to the Royal Commission’s Group homes issues paper (see NDS 2020, [Submission to the Royal Commission on the group homes issues paper](https://www.nds.org.au/policy-library/nds-disability-royal-commission-submission-group-homes), February); the current submission will focus on new material, guided by questions outlined in the issues paper.

# What drives violence and abuse in the home? What increases risk, and how do risk factors vary among people with disability?

## Academic research

Literature on preventing abuse in accommodation services has suggested that policy responses tend to focus on individual instances of harm rather than the ‘big picture’— such as culture, environment and the impact of funding rules and regimes (see Robinson, S and Chenoweth, L 2010, ‘Preventing abuse in accommodation services: From procedural response to protective cultures’, Journal of Intellectual Disabilities, vol. 15, no. 1 p.64). A 2010 literature review suggests that resources are often allocated to compliance, complaints and managerial service approaches – instead of on decreasing the likelihood of abuse by addressing the oppression, isolation and dehumanising of people with disability (see Ibid, p64).

Note: Devaluing people with disability being a root cause of abuse was considered by the Senate Community References Affairs Committee, reporting in November 2015 (see [Violence, abuse and neglect against people with disability in institutional and residential settings](http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Violence_abuse_neglect)).

The NDIS is a significant reform, which we hope will help drive cultural and environmental change in how people with disability are supported and therefore in their lives. However there is a question as to how quickly it can happen. NDS’s Zero Tolerance initiative begins with human rights, which underpin a subsequent focus on understanding and preventing abuse. NDS has been driving the use of these resources by providers across Australia.

The literature is consistent in stating that effective approaches to accommodation and support for people with disability (the literature primarily focuses on people with intellectual disability, who are the most likely to be in settings like group homes (see Bigby, C and Bould, E 2017 ‘Guide to Good Group Homes: Evidence about what makes the most difference to the quality of group homes’, p. 2, Centre for Applied Disability Research)) include positive individual support and supporting the person to foster a range of relationships in a range of communities of their choosing (see Robinson, S & Chenoweth, L 2010, ‘Preventing abuse in accommodation services: From procedural response to protective cultures’,Journal of Intellectual Disabilities*,* vol. 15, no. 1, p. 66). There is a recognition of a tension which emerges between policymakers attempting to promote service user choice and independence while simultaneously protecting them – and of the dangers at either end of the spectrum (see Ibid., p. 68). The majority of literature highlights a need for training which goes beyond procedural responses to ‘a deeper understanding of the factors which increase the risk of abuse occurring, strategies to minimize its occurrence and protective approaches’ (see Ibid., p. 69).

Studies note how cultures of abuse can flourish in spite of exemplary paperwork, policies and procedures to prevent them (see Burstow, P 2013,’Care and corporate neglect: the case for action’, Journal of Adult Protection, vol. 15, no. 4, pp. 203-214). Conversely, features of organisational cultures where restrictive practices and abuse are reduced include:

* A human-rights approach
* Positive risk taking
* The promotion of (practice) leadership
* The adoption of reflective practice
* A culture of low arousal (see McDonnell, A, Breen, E, Deveau, R, Goulding, E and Smyth, J 2014, ‘How nurses and carers can avoid the slippery slope to abuse’, Learning Disability Practice, vol. 17, no. 5, pp. 36-39; and NDS has developed Zero Tolerance videos on [Being Aware of Sensory Needs and Preferences](https://www.youtube.com/watch?v=Z89uAqiFQS0))

Some authors highlight power as a key factor in abuse (see Robinson, S and Chenoweth, L 2012, ‘Understanding emotional and psychological harm of people with intellectual disability: an evolving framework’, Journal of Adult Protection, vol. 14, no. 3, pp. 100-121; and see Woodlock, D, Western, D and Bailey, P 2014, ‘Voices Against Violence: Paper 6: Raising Our Voices - Hearing from with Women with Disabilities’ Women with Disabilities Victoria, Office of the Public Advocate and Domestic Violence Resource Centre), noting that emotional and psychological abuse can be harder to identify, potentially cumulative and sometimes unintentional. They suggest mechanisms such as person-centred circles of support, positive behaviour support plans, service evaluation and monitoring, and training and education (see Robinson, S and Chenoweth, L 2012, ‘Understanding emotional and psychological harm of people with intellectual disability: an evolving framework’, Journal of Adult Protection, vol. 14, no. 3, p. 112). Power can be particularly important in home settings – especially where people with disability have limited control, and perpetrators (such as parents and doctors) may be considered more believable by authorities and society.

## Risk factors

The Australian Institute of Health and Welfare has noted the more severe a person’s disability, the more likely they are to be living in ‘cared accommodation’ (defined as three months or longer) (see [AIHW 2019, ‘People with disability in Australia 2019: In brief’, Australian Government](https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia-in-brief/contents/about-people-with-disability-in-australia-in-brief), p. 12). The evidence regarding the types and extent of abuse experienced by people with disability is disturbingly weak, however some factors which may increase risks in accommodation settings are considered below.

### Accommodation setting

* Lack of privacy or gender-appropriate care opportunities (see Marsland, D, Oakes, P and White, C 2007, ‘Abuse in care? The identification of early indicators of the abuse of people with learning disabilities in residential settings’, Journal of Adult Protection, vol. 9, no. 4, pp. 6-20)
* Institutional practices which isolate people from local communities and long-term support relationships (see Ibid)
* ‘Grooming’ is likely to be more prevalent in what have been described as ‘closed’ services (see Healey, L 2015, Briefing paper on violence against women with disabilities in disability care, Women with Disabilities Victoria)
* Services being provided in private homes create unique opportunities for abuse (due to limited oversight of worker practice, for example)
* Studies report high levels of sexual abuse in residential homes, with other residents and staff being identified as primary perpetrators (see Office of the Public Advocate (Victoria) 2019, [“I’m too scared to come out of my room”: Preventing and responding to violence and abuse between co-residents in group homes, Office of the Public Advocate, November](https://www.publicadvocate.vic.gov.au/opa-s-work/research/142-i-m-too-scared-to-come-out-of-my-room))

Features of residential settings which may increase risk of abuse include:

* People having limited or no control over daily routines and activities
* Relying on others for personal care (particularly where there is little/no choice of provider (see consideration of ‘thin markets’ in [NDS’s response](https://www.nds.org.au/pdf-file/a7e7b6e1-e864-eb11-80f1-005056ac7853) to the Royal Commission’s Safeguards and quality issues paper)
* Residential settings where there is above-optimum number of residents (see Bigby, C and Bould, E 2017 ‘Guide to Good Group Homes: Evidence about what makes the most difference to the quality of group homes’, Centre for Applied Disability Research, p. 2), or where invasive behaviours among residents can contribute to a culture of abuse between residents (see Marsland, D, Oakes, P and White, C 2007, ‘Abuse in care? The identification of early indicators of the abuse of people with learning disabilities in residential settings’, Journal of Adult Protection, vol. 9, no. 4, pp. 6-20)

### Personal factors

* People particularly reliant on service providers – for personal care, transport or mealtime support, for example – may be less likely to speak up for fear of losing essential supports.
* People supported by only one service provider (recently highlighted by the death of Ann Marie Smith) (see Robertson, A 2020, Independent review of the adequacy of the regulation of the supports and services provided to Ms Ann-Marie Smith, an NDIS participant, who died on 6 April 2020: Report to the Commissioner of the NDIS Quality and Safeguards Commission, NDIS Commission, 31 August)
* People with limited access to advocates, medical support or other external support
* People who are not aware of the existence of supports (including advocacy), or are unable to access them (due to lack of transport or support, for example)
* People who are not educated on the many (subtle and overt) forms of abuse and exploitation. Something is unlikely to be reported if not seen as abusive.
* Lack of economic resources or sufficient income (particularly where people experience domestic violence)
* Complaints-based systems, while vital, rely on ‘articulate, assertive and empowered complainants’ (see Robinson, S and Chenoweth, L 2010, ‘Preventing abuse in accommodation services: From procedural response to protective cultures’,Journal of Intellectual Disabilities*,* vol. 15, no. 1, p. 71.). More should be done to build service users’ capacity to complain, but also to uncover abuse without relying on complaints – such as via a national Community Visitors scheme.

### Organisational/cultural

* Failure of adequate supervision in residential settings
* Poor support cultures can encourage well-intentioned staff practices to deteriorate or allow intentional abuse to remain hidden
* How abuse is dealt with can impact upon future risk (‘normalisation’). If abuse is not acted on appropriately, this can increase the risk of further abuse and decrease the likelihood of reporting.
* Poor workplace culture. Hierarchical organisational structures, punitive approaches and autocratic management styles trickle down to direct service provision.
* Environments that readily accept excuses for abuse, have low accountability, a closed culture or neutralise ‘normal moral concerns’ (see Wardhaugh, J and Wilding P 1993, ‘Towards an explanation of the corruption of care’, Critical Social Policy, vol. 13, no. 37, pp. 4-31.) will allow abuse to flourish.

Supported Independent Living (SIL) is a key service people with disability use in their homes. NDS has provided an overview of SIL in our response to the Royal Commission’s Group homes issues paper (see NDS 2020, [Submission to the Royal Commission on the group homes issues paper, National Disability Services](https://www.nds.org.au/policy-library/nds-disability-royal-commission-submission-group-homes), February). Some of the ways pricing controls may interact with quality and safeguarding in disability services have been considered in NDS’s response to the NDIA’s recent SIL pricing review, which is an appendix to the current submission.

## Different demographics

Women with disability experience higher rates of sexual violence and intimate partner violence than men with disability (see AIHW 2020, [People with disability in Australia, AIHW](https://www.aihw.gov.au/reports/disability/people-with-disability-in-australia-2020-in-brief/contents/about-people-with-disability-in-australia-2020-in-brief), viewed 22 February 2021). Underreporting of violence is more likely when women with disability live in closed or isolated settings, lack a stable home, or face communication barriers (due to disability or speaking a language other than English) (see Krnjacki, L, Emerson, E, Llewellyn, G and Kavanagh, AM 2016, ‘Prevalence and risk of violence against people with and without disabilities: findings from an Australian population-based study’, Australian and New Zealand Journal of Public Health, vol. 40, no. 1, pp. 16-21). Divergences have been noted between the family violence and disability support sectors in their theoretical frameworks, and different understandings of the experience of violence (see Healy, L 2013, Voices Against Violence: Paper 2: Current Issues in Understanding and Responding to Violence Against Women with Disabilities. Women with Disabilities Victoria, Melbourne). Disability providers note some domestic and family violence services have limited understanding of disability – sometimes reflected in limited service accessibility. Further resources are required for cross-sector partnerships, and the reinforcement of links (including referral pathways) between mainstream and specialist services (including disability, mental health, justice, family violence and sexual assault services) (see Ibid).

Recognising the important role service providers can play in the prevention of domestic and family violence, NDS has recently partnered with WorkUP Queensland to deliver free Disability and Domestic and Family Violence Training\* (for more information see [NDS’s events and training webpage](https://www.nds.org.au/events-and-training/all-events-and-training/disability-and-domestic-and-family-violence-training-3662)). The training – to be developed and delivered by people with disability – will provide foundational domestic and family violence knowledge, as well as suggestions for effective organisational responses (delivered over four two-hour modules). At the time of writing, most places in two scheduled series had been filled and a third series was being considered to respond to demand.

\*The project is developed in response to recommendation 10 from ‘[Not Now, Not Ever: Putting an end to domestic and family violence in Queensland](https://www.cyjma.qld.gov.au/resources/campaign/end-violence/about/dfv-report-vol-one.pdf)’, p. 20

In NSW, a new project (developed in response to recommendations from Royal Commission into Institutional Responses to Child Sexual Abuse) aims to support sexual violence services to be more disability-accessible; another led out of the Department of Communities and Justice will support children with disability who have problematic sexualised behaviour.

The provision of personal care raises issues around personal space, privacy, sexuality and sexual expression. For some people, their disability means they need support to take a shower or use the toilet, creating situations where they may be particularly vulnerable. Among people with learning disability, same-gender personal care has been found to largely protect women from the risk of sexual abuse but fail to protect men (see McCarthy, M and Cambridge, P 2006, ‘Chapter 4: Sexuality and intimate and personal care’, in S Carnaby and P Cambridge (eds), Intimate and personal care with people with learning disabilities, Jessica Kingsley, London). Equally, a preference for same-gender personal care may rely on an assumption that the support worker is heterosexual. Service users may have personal and/or cultural beliefs which mean they prefer personal care from a worker of a certain demographic. Same-gender personal care can be difficult to ensure given the disability workforce is comprised of more women than men (see NDS 2020, [NDS Workforce Census Key Findings, National Disability Services, June [Word Accessible]](http://nds.org.au/images/news/NDS-Workforce-Census-Key-Findings-Accessible.docx)).

People with complex communication needs may experience additional risks, ranging from being misunderstood, to disclosure concerns if their interpreter is their abuser, to being considered an unreliable witness in legal proceedings.

# How do disability services work to prevent and respond to abuse in homes? Describe any gaps and promising practices.

NDS has previously provided an overview of its Zero Tolerance initiative to the Royal Commission (the most comprehensive summary can be found in [NDS’s response to the Rights and attitudes issues paper](https://www.nds.org.au/policy-library/nds-disability-royal-commission-submission-rights-and-attitudes)). Part of Zero Tolerance focuses on how to identify good, poor and abusive practice occurring in someone’s home (see NDS 2016, [Understanding Abuse e-learning and resources: Downloadable worksheets, National Disability Services [Word Accessible]](https://www.nds.org.au/images/events/files/zt_worksheets_accessible.docx), pp. 19-20). Some examples have been extracted below.

## Good practice

* People choose where they live and who with
* People have access to their own things when they want
* People have their home respected as their space
* People feel good about, and have keys to, their home
* People choose when and where to eat
* People have privacy respected

## Poor practice

* People not respecting private/personal spaces
* Workers treating things like part of a workplace rather than people’s home
* Physical environments not maintained
* Not facilitating requests to explore other accommodation options

## Abusive practice

* Destroying or disposing of personal property
* Theft
* Locking people in and out of rooms
* False imprisonment
* Denying someone access to their things

A series of films on family violence and disability (developed by Women with Disability Victoria in collaboration with NDS) considers:

* [Preventing and responding to family violence film](https://vimeo.com/350231549/db87976600)
* [Prevention of domestic and family violence film](https://vimeo.com/350231706/93e56e86d6)
* [Early intervention in domestic and family violence film](https://vimeo.com/350231092/926ecec0d1)
* [Responding to domestic and family violence film](https://vimeo.com/350232205/d7429e884d)

NDS has referred to our ‘Guide to Good Group Homes’ in a previous submission (see [NDS’s response to the Group homes issues paper](https://www.nds.org.au/policy-library/nds-disability-royal-commission-submission-group-homes)).

## Natural safeguards

For people in accommodation settings, lack of informal support networks can create risk. For people living in residential support, or alone in a private home, not having positive family support or other ‘natural’ supports may mean they become reliant on their disability support provider to look out for their day-to-day wellbeing and rights.

Many people with disability need support to speak up about their concerns. Service provision should not be considered an adequate replacement for features of informal support such as long-term commitment and effective support, but may be able to foster the development of informal relationships which provide this. It has been suggested that social connectivity and guarding against isolation from the community are the most effective systemic ‘natural’ safeguards for people with disability (see Disability Services Commissioner (Victoria) 2014, [Learning from Complaints: occasional paper no. 2 (Families and service providers working together), Disability Services Commissioner, Victoria](https://www.odsc.vic.gov.au/wp-content/uploads/OccasionalPaper2.pdf), January [PDF]).

## Abuse in private homes

It is not always the case that a person’s family provides positive and appropriate support. In some cases, disability service providers become aware of inappropriate or abusive relationships in a private home, involving a person they support. Particular care and tact is required in managing these complex situations. Based on recent reports, non-government providers and paid workers were the primary source of reports to NSW safeguarding bodies (see [Ombudsman NSW 2018, Abuse and neglect of vulnerable adults in NSW – the need for action](https://www.ombo.nsw.gov.au/news-and-publications/publications/reports/community-and-disability-services/abuse-and-neglect-of-vulnerable-adults-in-nsw-the-need-for-action-2-november-2018), State of New South Wales, November, p. 1; and see [Ageing and Disability Commission NSW 2020, Ageing and Disability Commission Annual Report 2019-20](https://www.ageingdisabilitycommission.nsw.gov.au/download?file=793591), p. 32). Providers report difficulty in responding, noting: the abuse can sometimes be subtle; the limited jurisdiction of the NDIS Commission; workers’ fears of repercussions for themselves and the service user; or the service user not understanding that what they are experiencing is abuse. Service providers report encountering families who use restrictive practices, and who withhold items or care as a form of punishment for behaviours of concern. Especially where the behaviour is a form of communication, this can lead to a cycle of further punishment and behaviours of concern.

NDS has previously noted the issue of the behaviour of a service user being experienced as abuse by another service user, citing statistics from the Victorian Office of the Public Advocate (see [NDS’s response to the Group homes issues paper](https://www.nds.org.au/pdf-file/395ed8f6-4d5c-ea11-80e5-005056ac7853)). While behaviours of concern should be viewed as at least potentially a form of communication, this does not necessarily diminish their impact on the recipient of the behaviour – including workers and particularly other residents.

# Have any government policies, plans or programs reduced risk of violence in the home?

The transition to a single, national regulator under the NDIS Commission has been a welcome development. NDS has relayed opportunities for further strengthening this role in our response to the Royal Commission’s issues paper on Safeguards and quality (see NDS 2021, [Submission to the Royal Commission on the Safeguards and quality issues paper [PDF]](https://www.nds.org.au/pdf-file/a7e7b6e1-e864-eb11-80f1-005056ac7853), National Disability Services, February). Still, providers report that staff engaged in reporting processes can be left with sub-optimal responses (from the NDIS Commission, and other bodies such as child protection agencies). These responses can include advice to ‘maintain your relationship with the service user and monitor’.

Concerns have been raised about the jurisdiction of the NDIS Commission, which accepts complaints of incidents which occur ‘arising out of, or in connection with’ NDIS-funded service provision (see National Disability Insurance Scheme (Complaint Management and Resolution) Rules 2018, p. 8). Much consternation continues about this phrase and what it means for an individual incident. In effect, there is the potential that an NDIS-funded support worker could observe abuse in a family setting, but have no obligation to report it to the NDIS Commission. The potential impact of this distinction is illustrated through two hypothetical scenarios below.

Scenario one: The NDIS Commission may respond appropriately to a Reportable Incident of a case of violence in a home, perpetrated by a paid support worker. The organisation acts swiftly: filing a Reportable Incident to the Commission in 24 hours; standing down the worker immediately; completing incident reports, reporting to family and Police; disciplinary action and potential termination of employment.

Scenario two: The NDIS Commission may respond to a case of violence in a home by a co-tenant by advising it is not a Reportable Incident within its jurisdiction, but provide some direction regarding behaviour support for the person whose behaviour resulted in abuse. Decision-makers may be reluctant to approach Police and press charges against their family member’s co-tenant. If Police are approached, they are not responsible for resolving immediate issues (such as accommodation alternatives) and so the victim may remain in the co-tenancy, exposed to further violence. Rarely is the same level of urgency described in the first scenario associated with cases of client-to-client abuse. Service providers may have little other option other than to use restrictive practices while seeking more sustainable responses.

## Out-of-home-care

Out-of-home care, by definition, may involve children who have been exposed to abuse – including in their family home. Children are particularly vulnerable, susceptible to environmental factors, and are constantly undergoing transition as they age. Children in out-of-home care often sit at the intersection of a number of different service systems and interact with multiple agencies – from the NDIA and NDIS Commission, to child protection, children’s guardians, Police and other parts of the justice system, and others. The result is a complex service provision environment.

Disability service providers report fragmentation of responsibility. Risks emerge when providers are required to report to multiple different entities – each of which has its own emphasis and jurisdiction. It is likely that some incidents fall through the gaps. Even with the system working optimally, no one agency has full visibility. Providers report the absence of case management for these children within the NDIS as stark – particularly for supporting families – and that Support Coordination is an insufficient proxy. For these children, clearer guidelines between the NDIS and other services is urgently needed, in combination with a commitment by state and territory governments to fund required case management. Opportunities for a more joined-up approach include, for example, linking a child’s case plan (a requirement in NSW voluntary out-of-home care) with their behaviour support plan under the NDIS.

# Conclusion

This submission has considered some of the key factors which may interact in home settings to increase the risk of abuse; as well as some means for reducing this risk. Disability service providers play multiple roles – from providing accommodation services to supporting someone in their private home. This paper has considered how providers at each of these points can work to reduce the risk of abuse for people with disability, to ensure they can feel and be safe in their homes.

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National Disability Services is the peak industry body for non-government disability services. It represents service providers across Australia in their work to deliver high-quality supports and life opportunities for people with disability. Its Australia-wide membership includes more than 1100 non-government organisations which support people with all forms of disability. Its members collectively provide the full range of disability services—from accommodation support, respite and therapy to community access and employment. NDS provides information and networking opportunities to its members and policy advice to State, Territory and Federal governments.

# Appendix A: NDS submission to the NDIA’s review of SIL Price Controls

## Review of Supported Independent Living Price Controls

NDS made a submission to the inquiry into outcomes for participants living in Supported Independent Living (SIL). It should be read in conjunction with this one as the issues discussed overlap.

The consultation paper on SIL price controls directs many questions at individual providers. The Agency will have received this information. NDS will provide comment on the substantive matters that impact SIL prices and funding allocations.

* In its current form, the Disability Support Worker Cost Model does not adequately cover all the costs associated with the provision of SIL
* If the current Cost Model is used to price SIL, it needs to be amended by the following:
  + Workers’ compensation levies paid by providers are higher than 1.7% (the NSW rate for residential services, for example, is 4.07%)
  + Overheads are far too low, particularly as SIL providers bear significant costs associated with clinical governance and the management of risk and requirements for quality and safeguarding
  + Span of control which doesn’t reflect good practice in supervision, practice leadership and de-briefing
  + Inadequate leave provisions as many SIL workers are shift workers and therefore entitled to an additional week of annual leave (including the need to pay penalties when these staff are on leave)
  + High use of casual staff at times when penalty rates apply
  + The absence of an allowance for handovers
  + Inadequate prices for participants who have very complex support needs or circumstances
  + No allowance for the on-call services operated by SIL providers (to assist with emergencies)
* As the turnover of staff in the sector is high, the real costs of recruiting, inducting, training and supervising the high proportion of the workforce being constantly replaced are not currently reflected in the Cost Model
* Practice leaders are widely used by the sector to drive improved practice; the cost of these workers is not included in the Cost Model
* The pricing model does not reflect the infrastructure, oversight, capacity and capability required by SIL providers to respond to emergencies and/or act as the provider of last resort

A vacancy should immediately trigger a top-up of the funding for shared support in the plans of participants who remain in the property

## SIL is much more than attendant care support

SIL is a multi-faceted support; it is not equivalent to providing attendant care (Assistance with Daily Living, otherwise known as ADL). SIL supports encompass a vast array of tasks, including assisting with: activities of daily living; management of health and wellbeing; behaviour management; friendships; family relationships; transport; changes to other support arrangements; and community participation. Some of these activities are done by disability support workers but many are undertaken by the house supervisor or manager. Some activities are undertaken face-to-face; some are not.

The NDIA’s approach to pricing and claiming for supports delivered in SIL does not reflect the diversity/variety of supports provided. This is exacerbated by the recent changes to claiming. In addition, many tasks that had been the responsibility of SIL providers when delivered under state and territory government contracts continue to be provided but are now no longer funded under the NDIS.

NDS assumes the Agency believes support coordinators undertake a bigger role in the lives of SIL participants than they actually do. Support coordinators do not assist a participant to manage their everyday life; providing this assistance falls to SIL providers. These activities are generally not funded.

Providers need to be reimbursed for all the costs of the supports they undertake for a participant, at a rate that is appropriate for the level of the worker who delivers the support. Ideally, this would not require an organisation to bill for every support/task undertaken (and every instance it was undertaken) but instead would allow for the costs of undertaking support/tasks to be claimed at a regular frequency at an average amount. Records of the supports/tasks could be used for provider assurance.

If the Agency agrees these supports can be claimed but insists they are claimed separately for each time they are delivered, they must be able to be claimed at an appropriate rate and include the provision of non-face-to-face supports/tasks.

NDS urges the NDIA to cease using the Disability Support Worker Cost Model—which was developed for pricing attendant care-type supports—for SIL. If a Cost Model is to be used, it needs to be developed specifically for SIL, which has different cost drivers than community participation or ADL supports. Moreover, and as we note in the following section, if reliance on the DSW Cost Model is to be continued at all, the assumptions underpinning the model need to reflect sector practice and experience.

## Disability Support Worker Cost Model

In 2013, NDS worked with the Agency to undertake an urgent review of some of the price caps that had been released for that financial year. It focused on the price caps for community participation and attendant care-type supports, which the sector believed were far too low. The review and its findings were never developed for SIL.

The review team—comprised of staff from the NDIA and NDS, and an external accountant and external economist—agreed that the best way to approach setting a price for this type of support was to ‘build it up from its components’. The Disability Support Worker Cost Model was constructed.

What NDS, and the external advisers, did not do was to agree with the NDIA as to levels at which the assumptions (such as overheads, the SCHADS levels of workers or the span of control) should be set. At the time, NDS objected to the settings the NDIA made in the Cost Model; they did not reflect sector practices or experiences. It is interesting to note that the assumptions in the initial Cost Model generated a price cap that the Agency thought too high; in response, the Agency announced lower prices caps.

Seven years later, NDS still objects to the assumptions being made by the NDIA in the Cost Model to set Assistance with Daily Living (ADL) prices. They understate the real costs borne by providers.

The introduction last year of the Temporary Transformation Payment (TTP) levy saw the Agency also mandating that the TTP could only be charged by providers who had agreed to participate in the TTP benchmarking survey. How the results of that benchmarking survey are being used is unfair. In particular, NDS objects, for example, to the Agency’s reliance on the 25th percentile for many of the cost assumptions in the Model.

For example, the Annual Price Review 2020–21 report, together with the reports on the Cost Model, indicate the following:

|  | Cost Model 2019 | Cost Model 2020 | 25th percentile | Median |
| --- | --- | --- | --- | --- |
| Workers’ Compensation | 3.0% | 1.7% | 1.7% | 2.3% |
| Utilisation (Level 1) | 92% | 92% | 92% | 85% |
| Overheads | 10.5% | 12% | 19.8% | 28.1% |
| Span of Control | 1:11 | 1:15 | 1:15 | 1:9 |

The use of the 25th percentile for a number of the assumptions is too high, resulting in most providers struggling to be able to deliver supports at these prices. It is hard not to believe that the assumptions used in the 2020 Cost Model have been set at levels that generate very little change in the basic price for one-to-one supports this financial year. The manipulation of the Cost Model, evident in 2013, has not gone away.

NDS urges the NDIA to change this approach; using mean or median values would be fairer and more achievable and would assist providers to operate in this competitive, and still maturing, market. Moreover, for SIL, the assumptions need to reflect the actual costs borne by SIL providers (with additions that reflect the nature of the supports). Relying on survey results from providers of community participation or ADL supports to set SIL prices is a flawed methodology, which should be ceased.

If the current Cost Model continues to be used, of particular concern to SIL providers are the following assumptions and issues:

* Workers’ compensation levies paid by providers are higher than 1.7 per cent (the NSW rate for residential services, for example, is 4.07 per cent )
* Overheads are far too low, particularly as SIL providers bear significant costs associated with clinical governance and the management of risk and requirements for quality and safeguarding
* Span of control which doesn’t reflect good practice in supervision, practice leadership and de-briefing
* inadequate leave provisions as many SIL workers are shift workers and therefore entitled to an additional week of annual leave (including the need to pay penalties when these staff are on leave)
* High use of casual staff at times when penalty rates apply
* The absence of an allowance for handovers
* Inadequate prices for participants who have very complex support needs or circumstances
* No allowance for the on-call services operated by SIL providers (to assist with emergencies)

Many of these are addressed in more detail below.

## Risk management: delivering high quality and safe supports

Shocking stories of the abuse and neglect of NDIS participants have hit the headlines in recent years, along with reports on preventable deaths. The disability support sector—together with mainstream services—can, and must, do better.

The benchmarking being undertaken by the NDIS and used to set price caps is divorced from any consideration of quality and safety. While NDS would not argue that the highest cost providers can be used as a proxy for the highest quality and safest services, we would strongly submit that the NDIA’s approach in setting very tight cost assumptions (such as using the 25th percentile) will drive cost cutting. NDIA price caps which have been set using the current methodology will work against efforts to provide better supports for people with disability. There is a real risk that quality and safety may be compromised.

It is disturbing that quality and safeguarding are not mentioned in the Agency’s pricing documents. Similarly, there is no evidence that adequate pricing is an issue considered by the NDIS Commission.

NDS supports, and always supported, the establishment of the NDIS Commission to replace the patchwork of quality and safeguarding systems around the country. These legacy systems were of varying sophistication and effectiveness, and were onerous for providers operating in more than one state or territory. In our view, NDIS participants should be protected by the same quality and safeguarding system, and be able to expect the same quality of supports, regardless of where they live.

In 2019–20, the allowance in the Cost Model for supervision of disability support workers was based on one supervisor to eleven workers. For this current year, the NDIA has made the unjustifiable decision to reduce the allowance for supervision based on the assumption of there being one supervisor to fifteen workers. This decision should be overturned urgently. Adequate supervision and support of this workforce is essential to the delivery of high quality and safe supports.

Incompatibility of residents of group homes is a significant factor in violence that occurs between residents (see [Violence by Co-residents in group homes | Public Advocate](https://www.publicadvocate.vic.gov.au/media-centre/377-violence-by-co-residents-in-group-homes)). The NDIA plays no role in considering compatibility of people living in SDA (previously this was done by some state and territory governments through their vacancy management processes). Providers of SIL, who are working in the dwellings providing support, may or may not be involved in discussions about the suitability of participants to live together. To believe the market will drive good decisions about who can live together is, in our view, naively optimistic. Similarly, the NDIS Commission has no involvement in living arrangements, but will be receiving the incident reports that indicate violence is occurring.

As noted above, reducing violence against and abuse of participants is a serious concern of providers, the NDIA and the NDIS Commission. Efforts need to be directed at leveraging this shared concern to improve the decisions about who lives together in a shared support arrangement and how we can drive ongoing improvements to the quality and safety of supports received.

Managing the delivery of high quality and safe supports in the high-risk environment of SIL requires strong risk management policies and processes. The costs associated with providing high quality and safe supports in SIL are not adequately reflected in the overheads component of the Cost Model.

## Complexity and clinical governance

The adequacy of funding for people with complex support needs has been a vexed issue since the scheme began. The NDIA still struggles with it.

The NDIA’s current approach to pricing for complexity is too blunt and does not address the costs of supporting participants with complex needs such as:

* challenging behaviours
* complex medical conditions
* require two-person transfers or assistance with tasks such as dressing
* require skilled mealtime assistance
* are from CALD or Deaf communities (including the additional time and cost of organising and using interpreters)
* require skilled communication support
* are Indigenous or from the Torres Strait Islands
* are involved (or have past involvement) with the justice system
* highly sexualised behaviours
* complex family circumstances (including violence)
* misuse of drugs and alcohol
* comorbidity of a mental illness as well as disability.

Some participants have a range of these complexities which interact to make the cost of support provision substantially more than higher intensity prices for SIL. The level two prices need to increase.

Of the support types provided under the NDIS, SIL is one that requires a substantial clinical governance overlay. The need to have good clinical governance in SIL has been highlighted by the COVID-19 pandemic. Protecting the health and well-being of SIL participants, and the staff who support them, has been a priority and has been costly.

It is obviously critical to also have appropriate clinical governance processes in place whenever support is being provided to people with challenging behaviours or who have complex medical needs.

Given the above, NDS is very concerned that the costs of clinical governance are not included in the ADL prices currently used in the SIL environment.

## Workforce

The introduction of the NDIS market drove the use of a more casualised workforce, not least because the operating environment was uncertain and participants wanted greater choice over when they wanted support. After reaching highs of about 40%, it has now dropped somewhat but still sits at over 30% (this decrease is almost certainly related to the Federal Court decision that casual staff must be paid penalty rates as well as the casual loading). Figure 1 below is generated from NDS’s regular workforce census (note: from December 2018, the census has moved to being every six months).

### Figure 1 – Type of employment (%)

**Sep 2015:**

Permanent workers: 59%

Fixed workers: 4%

Casual workers: 36%

Number of Organisations (n): 118

**Dec 2015:**

Permanent workers: 59%

Fixed workers: 6%

Casual workers: 35%

Number of Organisations (n): 135

**Mar 2016:**

Permanent workers: 57%

Fixed workers: 7%

Casual workers: 36%

Number of Organisations (n): 159

**Jun 2016:**

Permanent workers: 58%

Fixed workers: 6%

Casual workers: 36%

Number of Organisations (n): 169

**Sep 2016:**

Permanent workers: 56%

Fixed workers: 7%

Casual workers: 38%

Number of Organisations (n): 184

**Dec 2016:**

Permanent workers: 57%

Fixed workers: 5%

Casual workers: 38%

Number of Organisations (n): 187

**Mar 2017:**

Permanent workers: 56%

Fixed workers: 6%

Casual workers: 38%

Number of Organisations (n): 192

**Jun 2017:**

Permanent workers: 54%

Fixed workers: 5%

Casual workers: 41%

Number of Organisations (n): 196

**Sep 2017:**

Permanent workers: 54%

Fixed workers: 7%

Casual workers: 39%

Number of Organisations (n): 175

**Dec 2017:**

Permanent workers: 51%

Fixed workers: 8%

Casual workers: 41%

Number of Organisations (n): 184

**Mar 2018:**

Permanent workers: 52%

Fixed workers: 9%

Casual workers: 39%

Number of Organisations (n): 191

**Jun 2018:**

Permanent workers: 54%

Fixed workers: 6%

Casual workers: 41%

Number of Organisations (n): 175

**Sep 2018:**

Permanent workers: 53%

Fixed workers: 5%

Casual workers: 42%

Number of Organisations (n): 182

**Dec 2018:**

Permanent workers: 57%

Fixed workers: 4%

Casual 40%

Number of Organisations (n): 159

**Jun 2019:**

Permanent workers: 55%

Fixed workers: 4%

Casual workers: 40%

Number of Organisations (n): 118

**Dec 2019:**

Permanent workers: 60%

Fixed workers: 6%

Casual workers: 34%

Number of Organisations (n): 266

**Jun 2020:**

Permanent workers: 64%

Fixed workers: 5%

Casual workers: 31%

Number of Organisations (n): 108

SIL supports must be delivered every day and at hours when penalty rates apply; they are supports that generally can’t be cancelled or deferred. For this reason, the use of casual staff in SIL cannot be avoided. The cost impact of the use of casual staff in SIL—due to the payment of both the causal loading and relevant penalties—is now substantial. The allowance for this in the Cost Model is inadequate, particularly due to the delivery of supports at times that incur penalty rates. The use of temporary or agency staff to cover shifts is also higher in SIL than for other supports.

Similarly, the 24-hour nature of SIL supports results in a significant proportion of SIL workforce being entitled to additional annual leave. This is not factored into the Cost Model but it needs to be.

Turnover rates in the sector are high. There was a small rise, from 10% to 11%, in the turnover of permanent roles in the latest NDS Workforce Census. By contrast, casual turnover which had risen sharply in the previous survey fell back from 28% to a still-high 24%.

The real costs of recruiting, inducting, training and supervising the high proportion of the workforce being constantly replaced are not currently reflected in the Cost Model.

## Supervision

A SIL participant spends more time within the SIL environment than anywhere else. Good SIL supports are critical to their quality of life.

Many SIL providers have embraced active support and practice leadership (see [descriptions of active support and practice leadership](https://www.latrobe.edu.au/lids/research/effective-disability-services/active-support-And-practice-leadership), viewed on 21 October 2020) to help deliver a better quality of life for participants.

The La Trobe University website describes a practice leader as a:

…front-line manager that have a key role in the implementation of person-centred active support and the high quality of support provided by disability support workers. The practice leader role encompasses training of a staff team to understand the needs of the people they work with, ensure the principles of active support are being adopted by the support team and demonstrate effective support through modelling and examples. Effective practice leaders encourage staff to deliver high quality support, provide detailed and consistent feedback, providing opportunities to improve through team discussions and support staff with developing their skills in high quality support.

They work alongside other staff, providing training and advice but also model the way participants should be supported. They improve participants’ quality of life.

A practice leader is a more expensive staff member. The cost of these workers is not covered by the Cost Model.

## Emergency response and/or provider of last resort

The pricing model does not reflect the infrastructure, oversight, capacity and capability required by SIL providers. Capacity to respond to day to day changes in a participant’s life, including incidents, family and health matters is essential. Capability and expertise to provide a truly person centred service model with well trained and skilled roster of staff needs to be maintained and indeed grown.

The overhead component in the Cost Model needs to reflect this.

SIL providers are often the provider of last resort, or the provider who needs to respond to an emergency. New or additional supports need to be provided immediately and without concern about how they will be paid for. There may not be funding in the ‘irregular supports’ allocation in a plan.

Providers need assurance that they will be paid, without having to ‘jump through hoops’, for the unplanned supports they provide in an emergency or critical circumstance. Emergencies happen. Unplanned events happen. Funding needs to be readily available to cover the cost of providing unplanned SIL supports.

Applications to increase allocation of funding to ‘irregular supports’ or ‘changed circumstances’ need to be processed quickly.

## Responding to a vacancy

The provision of SIL when a vacancy emerges has been a fraught issue since the scheme began. In an individualised support scheme it is surprising, and disappointing, that participants living in a house with shared SIL are expected to bear the brunt of a vacancy.

NDS agrees with the NDIA’s pricing team that building a ‘vacancy allowance’ into SIL prices would be difficult and would not direct an appropriate level of funding to where the vacancies existed. A more direct, and immediate, response is therefore required.

NDS urges the Agency to understand and acknowledge the shared support that is going into a SIL property. A vacancy should immediately trigger a top-up of the funding for shared support in the plans of participants who remain in the property. The vacancy is not their responsibility; they should not have to forgo supports because it has arisen.

A substantial proportion of legacy SDA is reaching the end of its life. This older housing stock can be expected to experience higher vacancy rates before a decision is taken to redevelop the property (as SDA or for another use). Unless we address the funding of vacancies, participants will feel the impact of them on their shared supports.

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National Disability Services is the peak industry body for non-government disability services. It represents service providers across Australia in their work to deliver high-quality supports and life opportunities for people with disability. Its Australia-wide membership includes almost 1200 non-government organisations which support people with all forms of disability. Its members collectively provide the full range of disability services—from accommodation support, respite and therapy to community access and employment. NDS provides information and networking opportunities to its members and policy advice to State, Territory and Federal governments.