**National Disability Services (NDS)**

# Submission to the Royal Commission on the group homes issues paper

Group homes have been a core component of the suite of disability services funded by state and territory governments over the past 40 or so years. At some stage, most governments have been significant providers of these group home supports, gradually decreasing in most jurisdictions due to the transfer of properties to the non-government sector (primarily not-for-profit organisations) to manage. With the introduction of the National Disability Insurance Scheme (NDIS) the Commonwealth is also contributing funding to people with disability living in shared arrangements.

During this time, a significant proportion of government funding for disability services has been directed to group homes, primarily due to the high level of support provided over the course of a week. As group home providers assist people with significant disability with their in-home supports needs (such as personal care, behaviour and medication management, relationship matters and meals) and often with some social participation, they can be a relatively complex and high-risk support to provide.

This submission provides a brief picture of group homes and quality and safeguarding systems prior to the introduction of the NDIS, highlighting significant differences across jurisdictions. It then considers the current operating environment for group homes (though that is a term no longer used) and challenges experienced, before addressing some of the questions posed in the issues paper. This history is important as it demonstrates group homes across Australia have operated with quite different resources and under different regulatory frameworks. This would have impacted on levels of supports and how they were provided.

The submission also provides links to resources NDS has produced and promoted to providers in an effort to encourage and guide them to improve the quality of their services—A Guide to Good Group Homes and the Zero Tolerance Initiative. Each is referred to in more detail later in this submission.

## Group homes pre-NDIS

The story of accommodation for people with disability in Australia is one of transition. With the closure of most large-scale institutions in the 1980s and early 1990s, many residents moved into group homes, whereby they would receive both supports and accommodation alongside three to five other people with disability. The history of this transition is succinctly outlined in ‘A brief history of the disability services sector in Australia: 1992–present day’. For a description of the history of accommodation support, see Life Without Barriers, 2019, ‘A brief history of the disability services sector in Australia: 1992-present day’

Following the closure of institutions, the landscape of group homes varied across jurisdictions, in how they were managed, the prevalence of their use, and their resourcing.

The Report of Government Services 2015 provides information about users of accommodation services (all types) as a proportion of the total estimated potential population for accommodation services in 2012–13 (which is just prior to the beginning of the introduction of the NDIS). South Australia and Tasmania had the highest proportions of users (at 13.6 and 10.5 percent respectively). Victoria and the ACT had the lowest at 5.3 per cent each (the Australian average was 6.5 per cent). See the [Productivity Commission’s Report on Government Services](https://www.pc.gov.au/research/ongoing/report-on-government-services/2015/community-services/services-for-people-with-disability) 2015, Tables 14A.15, 14A.18, 14A.59 and 14A.87

Governments funded the group homes they managed at substantially higher rates than they funded non-government group homes. For example, the cost per user in government group homes in Queensland was $268,052 but only $135,303 for non-government providers. In Victoria, the cost was $141,543 for government-run group homes but only $84,937 for non-government run group homes. On average, the Queensland government was funding users of its own group homes at more than three times what the Victorian Government was funding users of non-government group homes. The disparities in funding were substantial.

Across Australia, 31.7 per cent of users of accommodation services in 2012–13 lived in accommodation that was run by government, with this being as high as 48.7 per cent in Victoria.

In the absence of data that separates group home users from all accommodation users, the following table helps paints a picture of a jurisdiction’s commitment to community living. ‘Access to community accommodation and care services’ is an indicator of governments’ objective to assist people with disability to live as valued and participating members of the community. Governments provide or fund accommodation support services to people with disability in institutional/residential settings and through community accommodation and care services. Institutional or residential accommodation support services are provided in both institutions and hostels. Community accommodation and care services are provided in group homes and other community settings. The services provided in other community settings are attendant care/personal care, in home accommodation support, alternative family placement and other accommodation support.

At this time, Tasmania and NSW still had a significant proportion of accommodation users living in institutions, as did Queensland and South Australia. The other states had reached proportions of less than 5 per cent (the Australian average was 9.9 per cent of accommodation users lived in/used services other than community accommodation or care services). Victoria closed its last institution in late 2019.

**Users of NDA community accommodation and care services as a proportion of all accommodation support service users**

New South Wales: 87.2 percent

Victoria: 95.3 percent

Queensland: 89.3 percent

Western Australia: 95.7 percent

South Australia: 90.5 percent

Tasmania: 86.8 percent

Australian Capital Territory: 100 percent

Northern Territory: 100 percent

Australia: 91 percent

Under the NDIS, payments flowing to group homes take two forms: one for the bricks and mortar which supplements the rent paid by participant (a Specialist Disability Accommodation or SDA payment) and support funding (Supported Independent Living or SIL). Data on the enrolment of properties for SDA helps to flesh out the picture of group homes prior to the NDIS. In Quarterly Reports, the NDIA provides information about SDA properties. ‘Existing’ and ‘legacy’ categories can be used as a proxy for the group homes that existed prior to the NDIS (noting that some properties that were being used as group homes will not have been enrolled as SDA dwellings but the numbers should be relatively small). [[NDIA, 2020 Report to the COAG Disability Reform Council for Q2 of Y7](https://www.ndis.gov.au/media/2146/download) Appendices, pp.431-444]. ‘Existing’ dwellings must accommodate five or fewer residents while legacy dwellings accommodate six or more (this will include some remaining institutions).

**Numbers of existing and legacy properties enrolled for SDA**

New South Wales: Existing – 1298; Legacy – 58

Victoria: Existing – 363; Legacy – 86

Queensland: Existing – 355; Legacy – 37

Western Australia: Existing – 7; Legacy – 0

South Australia: Existing – 877; Legacy – 12

Tasmania: Existing – 26; Legacy – 3

Australian Capital Territory: Existing – 8; Legacy – 0

Northern Territory: Existing – 18; Legacy – 3

Australia: Existing – 2745; Legacy – 196

Note these numbers exclude new builds enrolled as SDA dwellings and do not include accommodation being provided under in-kind arrangements by state or territory governments. While we do not know where vacancies exist, it should be safe to assume that at least 2000 people with significant disability remain living in large dwellings or institutions. Deinstitutionalisation is not yet complete.

Policy under the NDIS will help drive the demise of dwellings accommodating six or more people as SDA payments for these are being phased out. However, how long this will take is unknown as dwellings can continue to operate without SDA payments.

As sketched briefly here, there has been substantial variation in the provision of group homes across Australia. Substantial differences remains even as the NDIS nears full implementation.

It is difficult to get a picture of the quality of existing houses being used as group homes but it is safe to assume that a sizable proportion is old and not well-suited to the purpose it is being used for. SDA funding will generate much-needed new housing stock but is not without risks, to be detailed later in this submission.

## Quality and safeguarding pre-NDIS

The development and refinement of quality systems across states and territories has followed a similar broad pattern over the last two decades. It has generally begun with regulation of the sector by state or territory-based legislation in the first instance, accompanied by some initial measures to safeguard service users by screening workers (sometimes only requiring a declaration of suitability by the applicant).

An extensive revision of legislation was common in the early 2000s with a trend towards: increasing the scrutiny of provider service quality standards (generally mandated state-based standards which were later aligned with the National Standards for Disability Services); the formalisation of procedures for governments to receive reports of critical incidents and to investigate these; promotion of the importance of a ‘complaints culture’; and an increasing awareness of the human rights implications of the unregulated use of restrictive practices.

In investigating the need for a national disability scheme, the Productivity Commission noted (Productivity Commission 2015, ‘Disability Care and Support’, pp. 494–495):

Service providers are subject to various (Commonwealth, state and territory) regulatory and statutory provisions in areas such as home and community care, occupational health and safety and building codes. However, state and territory governments mainly regulate service delivery through their respective disability laws (with the exception of disability employment services, which are subject to the Commonwealth *Disability Services Act 1986*). The scope of legislation varies widely, with some Acts as short as seven pages (South Australia) and others over 200 (Victoria). Most include requirements for dealing with complaints. Some have more detailed prescriptions relating to the provision of services, such as:

* requirements for criminal history screening (Queensland)
* enactment of certain monitoring bodies (such as community visitors and the office of the senior practitioner in Victoria)
* specific laws relating to service provision (such as the provisions for residential disability services in Victoria).

Since this time, additional requirements were introduced in some jurisdictions. A summary of approaches used in recent years across Australia is provided in the Appendix.

The above general description obscures the great variation in how quality and safeguarding measures were actually implemented and how effective they were.

Prior to regulation by the NDIS Commission, jurisdictions had vastly different approaches to: accreditation (including whether it was undertaken by an independent auditor); use of restrictive practices (definitions and understandings of what constituted a restrictive practice, approval of their use, reporting and use of positive behaviour supports); the culture of complaints (and the encouragement and support available to make a complaint); incident reporting and management; and the investment by governments in training and development for organisations and their staff on improving practice.

As quality is shaped by the regulatory framework, it is to be expected that the quality of supports received by people living in group homes did vary between jurisdictions as well as within them.

The publication of the NDIS Quality and Safeguarding Framework in 2016 and its subsequent implementation through the new NDIS Commission—through mechanisms such as the NDIS Practice Standards and NDIS Commission Rules and Guidelines—is introducing national consistency (if not uniformity in all aspects) to what has been a patchwork of regulation and practice across the jurisdictions.

## National Disability Insurance Scheme

The introduction of the NDIS has driven a new approach to providing group home funding by making available two payments. In its simplest description (and there are complexities). [A range of documents explaining SDA are available on the [NDIS website](https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/housing/specialist-disability-accommodation)]. SDA funding is made available in the plans of eligible participants and can be claimed by the registered provider who owns the property where an eligible participant lives. In addition, funding is provided to participants (generally SIL but can be through Assistance with Daily Life funding) to purchase support for activities of daily living. On the NDIS website, SDA and SIL are described as:

Specialist Disability Accommodation (SDA) refers to accommodation for people who require specialist housing solutions, including to assist with the delivery of supports that cater for their extreme functional impairment or very high support needs.

Funding is only provided to a small proportion of NDIS participants with extreme functional impairment or very high support needs who meet specific eligibility criteria.

SDA funding under the NDIS will stimulate investment in the development of new high quality dwellings for use by eligible NDIS participants. SDA funding is not support services, but is instead for the homes in which these services are delivered.

Supported Independent Living (SIL) is help with and/or supervision of daily tasks to develop the skills of an individual to live as independently as possible. These are the supports provided to a participant in their home, regardless of property ownership, and can be in a shared or individual arrangement.

Assistance provided to a participant will be included as part of their plan depending on the level of support they require to live independently in the housing option of their choice. [NDIS (Jan, 2020), [SDA Pricing and Payments](https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/housing/specialist-disability-accommodation/sda-pricing-and-payments)]

Prior to the NDIS, most properties used as group homes were owned by governments or not-for-profit providers. SDA payments have been structured to encourage developers into the market, to drive construction of new properties and to replace old stock. SDA payments are expected to increase the supply of dwellings to accommodate about 28,000 participants.

Conversations about SDA cannot be had without referring to the chronic affordable housing shortage in Australia. The supply of accessible, affordable and well-located housing supply falls well short of what is required to meet the needs of people with disability including NDIS participants (most of whom will not be eligible for SDA funding). It is estimated that the percentage of people living in unaffordable housing is substantially higher if they have a disability (11.2 per cent) than if they don’t (7.6 per cent). [The Mandarin (2019) [Why housing is a major public health issue for Australians with disability](https://www.themandarin.com.au/108375-why-housing-is-a-major-public-health-issue-for-australians-with-disability/%29)].The NDIS is not the means to resolving the housing shortage of many people with disability.

SIL is a high-cost support, accounting for 32 per cent of annualised committed supports in current NDIS plans [NDIA, 2020 Report to the [COAG Disability Reform Council for Q2 of Y7](file:///C%3A%5CUsers%5Calisa.maxted%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5C6ODMWTVS%5C%2C%20https%3A%5Cwww.ndis.gov.au%5Cmedia%5C2146%5Cdownload%2C%20pp.431-444) Appendices ] (ranging from 27 per cent in VIC to 48 per cent in NT, excluding WA which is still in transition).

Excluding WA, the table below highlights the large variance in the proportion of participants with SIL funding (from 5.5 per cent in VIC to 10.7 per cent in TAS and 11.8 per cent in NT). Using NDIS data from the latest Quarterly Report it is possible to calculate the average funding per SIL participant. This indicates the average funding per SIL participant varies greatly across the jurisdictions. Excluding NT and WA, VIC has the lowest average SIL funding of $289,661, compared with $344,629 in TAS (and $332,091 in QLD and $327,689 in ACT).

The Quarterly Report does not give reasons as to why there is such a large variation in the proportion of participants who receive SIL across the country, and in the average funding they receive. Possible reasons for the differences include: reflect historical factors; differences in the disability profile across the country; different approaches to developing SIL quotes; differing cost structures of providers; or inconsistent quote approval practices of the NDIA.

Given that inequities in the supports provided to people with disability across Australia were a driver for implementing a national disability scheme, we need to understand whether these differences (or the extent of them) are justified or not.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Number with SIL** | **% with SIL** | **Total committed funds for SIL** | **% committed funds for SIL** | **Ave SIL per participant** |
| **NSW** | 8058 | 7.1 | $2,580,189,545 | 35 | $320,202 |
| **VIC** | 5020 | 5.5 | $1,454,098,545 | 27 | $289,661 |
| **QLD** | 4173 | 6.8 | $1,385,816,722 | 29 | $332,091 |
| **WA** | 1278 | 5.3 | $339,636,625 | 23 | $265,756 |
| **SA** | 2174 | 7.0 | $709,420,554 | 36 | $326,320 |
| **TAS** | 820 | 10.7 | $282,595,810 | 46 | $344,629 |
| **ACT** | 422 | 5.8 | $138,284,931 | 33 | $327,689 |
| **NT** | 332 | 11.8 | $175,993,238 | 48 | $530,100 |
| **Total** | **22,277** | **6.6** | **$7,066,035,970** | **32** | **$317,189** |

Almost all participants who receive SDA funding will also receive SIL. Across Australia, 13,683 people currently receive SDA funding (4.0 per cent), at an average rate of $10,848 per annum. The proportion of people with SDA is expected to increase to about 6.0 per cent when the scheme is fully implemented. [NDIA (Apr, 2018) [Specialist Disability Accommodation Provider and Investor Brief](https://www.ndis.gov.au/media/1137/download), p5.]

Achieving a high quality of life in a group home requires adequate funds for the delivery of SIL supports. Over the past couple of years, payments problems for SIL supports have caused difficulties for providers. Problems largely stem from claiming difficulties linked to the NDIS portal and/or plans, or to difficult negotiations between the NDIA and providers on the value of quotes submitted. Some SIL providers are carrying millions of dollars of debt as a result. In recent months, the NDIA has been raising concerns about the growth in SIL expenditure and has indicated it is seeking to decrease the overall value of committed funds for SIL supports.

* **Separation of housing and support**

The establishment of two payment streams associated with what were known as group homes has propelled a growing separation of the ownership of the building from the supports provided within it. While the portion of NDIS participants who receive SDA and/or SIL is relatively low, for these participants they are critical to their quality of life and ability to achieve their goals (6.9% of NDIS participants have funding for SIL many more receive in-home support. Only 4.4% have funding for SDA — this is estimated to rise to 6% by full rollout).

The NDIA provides some guidance regarding the respective responsibilities of SIL and SDA providers, but there is ambiguity in a number of areas. For example, if there is mould in a residence due to a lack of airflow, is this a result of the construction of the property (the SDA provider’s responsibility) or to lack of cleaning or upkeep (the participant’s or SIL provider’s responsibility)? Ambiguity can result in no one taking responsibility, with negative consequences for the resident’s quality of life.

There is a debate about whether the owner/operator of an SDA property and the provider of SIL supports should be allowed to be the same organisation. There is nothing in the NDIS Act or Rules to enforce complete separation however Practice Standards associated with registration by the NDIS Commission require evidence that this potential conflict of interest is being managed.

* **Operation of the market**

Proponents of the NDIA’s approach of using the market to deliver more properties for use by people who would have previously lived in what was termed group homes are excited by the opportunities it may afford NDIS participants to live in good housing.

While there does need to be investment in the supply of housing this market approach is not without risks. New builds need to fall into one of four main categories:

* Improved Liveability
* Robust
* Fully Accessible
* High Physical Support

The different build types attract different levels of payment; the NDIA determines the payment level to made available to an eligible participant who then seeks a suitable property to live in.

To-date, the requirements for the different builds have been inadequately prescribed and there has been no independent certification process for new SDA properties to check they meet even existing requirements under these categories.

Fortunately, new design standards (see NDIA [Specialist Disability Accommodation design standard](https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/housing/specialist-disability-accommodation/sda-design-standard)) will gradually be introduced which will more clearly define the accessibility and design features of each category. A formal certification of properties will be introduced but information on how it will operate is scant. High-profile mainstream building scandals over the last couple of years have tested the integrity of building approval processes. The independence of the certification process for new SDA properties must be designed to minimise the likelihood of it being compromised.

The quality of fittings in SDA properties has not been prescribed, and is not prescribed under the new design standards. SDA funding should be spent on new properties that are fit-for-purpose (i.e. particularly those built prior to the introduction of new design standards) and have a fit-out of an acceptable quality. Checks on this are not being undertaken.

Information about vacancies in SDA properties is not easy for participants to find and there is a lack of information about properties under development. Exercising choice is therefore difficult.

Relying on consumer choice to shape the quality of SDA ignores the challenges many participants face to be well-informed and be able to operate within the market. Many are not able to exercise the choice and control this requires. It is important to note that research suggests that market-based models risk further entrenching disadvantage as the skills required to navigate them are often more present in those who are middle-class, English-speaking, and without mental illness or cognitive disability [Malbon, E., Carey, G. & Meltzer, A. Personalisation schemes in social care: are they growing social and health inequalities? BMC Public Health 19,805 (2019), viewed at https://doi.org/10.1186/s12889-019-7168-4]. Monitoring

* **Interaction between SDA and SIL**

Support and bricks and mortar interact in often subtle ways.

In some cases, the SDA framework has the potential to encourage poor practice. Properties categorised as ‘robust’ are generally used as homes for people with challenging behaviour (also referred to as behaviours of concern). Disappointingly, new robust build properties can be built to accommodate up to five people. As the property owner will be interested in maximising the return on their investment, they are likely to want all residents to attract the robust build SDA funding level. This is contrary to research which indicates that outcomes are better when people with behaviours of concern are not coresidents with one another. [Raynes, 1980, cited in Mansell & Beadle-Brown (2004), can be viewed on the [online library](https://onlinelibrary.wiley.com/doi/pdf/10.1111/jar.12291)]

This hints at another problem which will emerge. Because the SDA framework has been designed around tenancy, the ultimate decision about which residents can/will live together ultimately sits with the SDA provider. Increasingly, we can expect a property owner to have very limited knowledge of people with disability. While there is an expectation that participants can choose with whom they live and that a SIL provider is consulted, there is nothing to mandate that this is to occur.

Incompatibility of residents of group homes is a significant factor in the violence that occurs between residents (see Public Advocate, [Violence by co-residents in Group Homes](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. The framework around this needs urgent attention.

The SDA market is structured around tenancy rights and agreements. This may give some residents less security rather than more. It is possible that a tenant with a history of causing property damage may be moved from property to property as their lease agreements expire. Safeguarding secure accommodation for someone with challenging behaviour has not been given the attention it requires.

Finally, design of a property influences behaviour. SDA properties are being built by developers possessing limited knowledge of how, for instance, the floor plan can help safeguard residents and the staff who support them. For example, a person who exhibits challenging behaviour may move into a robust build which has features which exacerbate their behaviours and undermine the positive behaviour support plan they are likely to have in place.

## Other matters

* **Is there a place for group homes?**

We acknowledge there are people who advocate for the closure of all group homes. Research does not provide the evidence that this would lead to better lives for the people who live in them but it does inform us on what makes some group homes better than others. While research doesn’t tell us the optimal size of a group home, it does point to smaller dwellings being better than larger ones. More important to the quality of life for residents in a group home are factors such as: organisational culture; the quality of staff; use of techniques such as Active Support; and provision of good supervision through methods such as practice leadership.

Group homes must be funded at levels that enable an organisation to focus on the things that improve the quality of support provided by staff.

An extensive literature review was undertaken by Bigby and Beadle-Brown to identify the factors that help improve the outcomes for people living in group homes. [Bigby, C., and J. Beadle-Brown, Improving quality of life outcomes in supported accommodation for people with intellectual disability: What makes a difference? 2016, Journal of Applied Research in Intellectual Disabilities; Available from [online library](http://onlinelibrary.wiley.com/doi/10.1111/jar.12291/full)]. Positive factors included:

* staff practice reflecting Active Support
* frontline management using all aspects of practice leadership
* service culture that is coherent, enabling, motivating and respectful
* processes to assist staff to focus their practice on engagement of service users
* settings that are small (one-to-six people), dispersed and homelike

Conversely, ‘underperforming’ group homes often display the following:

* misalignment of power-holders’ values with organisation’s espoused values
* regarding of residents as “other”
* doing for, rather than doing with
* staff-centred, rather than client-centred practices
* resistance to change and new ideas [Bigby, C., Knox, M., Beadle-Brown J., Clement, T. and Mansell, J. (2012). Uncovering Dimensions of Culture in Underperforming Group Homes for People with Severe Intellectual Disability, Intellectual and developmental disabilities, 50, pp. 452–67]

NDS commissioned La Trobe University to develop ‘A Guide to Good Group Homes’ (2017), informed by the above research (the guides can be found on the [CADR website](file:///C%3A%5CUsers%5Calisa.maxted%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5C6ODMWTVS%5Cwebsite%20https%3A%5Cwww.cadr.org.au%5Cresearch-to-action-guides%5Cgood-group-homes)). The guide considers practice, culture, design and resources, policy and procedures, and external factors (such as regulation and community attitudes). In translating the research evidence, the guide represents a practical tool service providers can use to gauge their service provision against when considering its quality. [Ibid., see Figure 1 in the Practice Guide Checklist] This material is supported by a guide to assist people with disability and their families make decisions about supported living arrangements.

NDS has promoted the use of this material by disability service providers.

For people with significant disability, living alone may place them at increased risk of abuse from a staff member or other person, and it may isolate them to the point that the main contact they have is with a paid staff member. Loneliness and isolation can result. They may also have limited income, making living alone unaffordable (particularly if they are not eligible for SDA funding).

These factors make decisions about the optimal number of people living together in a shared support arrangement more difficult.

## Matters from the Issues Paper not addressed above

* **Quality of life in a group home and the alternatives**

Fundamental to people exercising their rights is that they have choice over where and with whom they live. As noted above, research suggests that the group homes model is not negative or positive per se, but that a number of organisational factors are required to deliver good outcomes. [ Bigby, C., and J. Beadle-Brown, Improving quality of life outcomes in supported accommodation for people with intellectual disability: What makes a difference? 2016, Journal of Applied Research in Intellectual Disabilities; Available from the [online library](http://onlinelibrary.wiley.com/doi/10.1111/jar.12291/full)]. Living alone is not the preferred option of many Australians. Group homes should be one option available to a person with disability but not the only option. To support this, we should be seeking ways to give people with disability greater ability to determine whom they live with.

Recent research involving people living in group homes and those living in supported living suggested limited difference in quality of life experienced between the two groups ([Comparing costs and outcomes of supported living with group homes in Australia (2018)](https://www.tandfonline.com/doi/pdf/10.3109/13668250.2017.1299117?needAccess=true)). Nonetheless, it noted significant room for improvement in both models and concluded that “a sizeable minority” living in group homes could be living independently. It was suggested that this may not only benefit the person, but would also be a more efficient use of resources. The researchers suggest more initiatives are required to allow these people to trial alternative models to test whether it appeals to them.

The NDIA is investigating the availability of Individual Living Options (see NDIS [Individual Living Options](file:///C%3A%5CUsers%5Calisa.maxted%5CAppData%5CLocal%5CMicrosoft%5CWindows%5CINetCache%5CContent.Outlook%5C6ODMWTVS%5C%29%20https%3A%5Cwww.ndis.gov.au%5Cproviders%5Chousing-and-living-supports-and-services%5Chousing%5Cindividual-living-options)) as alternatives to group homes. These have merit but come with their own safeguarding challenges. It is also hard to see some of the options scaling to become available to many participants (such as a host family model).

Assistive technology is likely to increase the range of housing options for people with disability. We need to fast-track the evaluation of housing options, including the benefits of emerging assistive technology, and make the information readily available. Providing this information to participants, families and carers is essential to help them make housing decisions.

* **When violence, abuse, neglect and exploitation occurs in group homes, what do you think are the causes? What can be done to prevent violence, abuse, neglect and exploitation in group homes?**

The report by the Victorian Office of the Public Advocate previously referenced discusses causes of resident-on-resident violence and makes suggestions about how this should be reduced.

Earlier in this submission, we have noted concerns about the lack of accountability on parties to consider the compatibility of participants living together in a group home. SIL providers are, however, tasked with preventing violence from occurring but may not have the ability to move participants to another location to prevent it from occurring.

There is an urgent need to review how vacancies are being filled under the NDIS and to assess whether what we have is fit-for-purpose, particularly for participants with challenging behaviours for whom this market approach may not deliver good outcomes.

The staff culture within a group home has a significant impact on the quality of supports delivered to those who live there. A culture based upon upholding the human rights of all people is fundamental to reducing violence, abuse, neglect and exploitation.

Since 2013, NDS has been building a suite of resources, providing training and encouraging service providers to rethink service provision under its Zero Tolerance initiative (Zero Tolerance resources can be viewed on the [NDS Website](https://www.nds.org.au/resources/zero-tolerance)). Zero Tolerance assists disability service providers to understand, implement and improve practices which safeguard the human rights of the people they support. The initiative is human rights-based, begins with the premise that abuse and neglect are never okay, and encourages staff to continuously think about how they could be better supporting people. It addresses how to recognise, prevent and respond to abuse, how to identify risk factors, and assists in embedding this knowledge into practice.

The range of resources is tailored to different groups—from frontline workers to Boards—and is available in a range of formats. They are designed to assist organisations to develop positive cultures that align to the new expectations and to the regulatory framework. The ongoing development of the Zero Tolerance initiative is still impeded by a lack of data about the specific nature of instances of abuse, exploitation and neglect in particular service settings and for particular population groups.

NDS is committed to continuing to build this suite of resources and to drive their uptake by disability service providers.

* **Use of restrictive practices in group homes and what can be done to reduce or eliminate them**

Restrictive practices are placed on some people living in shared living arrangements for their safety and/or the safety of others. Decreasing the need for their use is influenced by a range of factors such as the use of positive behaviour support, Active Support, housing design and compatibility of coresidents.

National consistency on the reporting of the use of restrictive practices (arising from the new NDIS Commission) will improve knowledge of their use and ultimately drive improved practice for managing behaviours and a decrease in their use. This work is underpinned by the ‘National Framework for Reducing and Eliminating the Use of Restrictive Practices in the Disability Service Sector’ which can be viewed on the [DSS website](https://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). This should be a positive result of the new regulatory arrangements.

Unfortunately, there is currently a shortage of positive behaviour practitioners, delaying the development of behaviour management plans which are designed to help reduce the use of restrictive practices. There is also a lack of coordination between the reasonable and necessary funding of supports by the NDIA and the practice and reporting requirements of the NDIS Commission.

For example, if a participant begins behaving in a manner that results in the use of a restrictive practice, this must be reported to the NDIS Commission and a behaviour management plan developed. In this example, the participant is not likely to have the appropriate funding in their plan to access the services of a behaviour support practitioner to develop such a plan. A plan review will need to be requested from the NDIA, which may take many weeks to occur. Once the funding is in the plan, there may then be a long wait to have the plan developed (due to the shortage of behaviour support practitioners).

These long delays are problematic; ways to streamline this process are required.

In shared living settings, restraints—particularly environmental—intended for one resident can impact other residents. If a fridge is locked to prevent a resident from eating compulsively, or a door is locked to prevent a resident from fleeing and putting themselves in danger, other residents should be given means to bypass these restrictions (keys or swipe cards, for example). This can be difficult to implement as other residents may not have the capacity to use these options.

There is very little knowledge about this issue, including how the impact of environmental restraints on others is being reduced over time.

As noted earlier in the submission, compatibility of people living together may not have been prioritised in housing decisions. In situations where more than one person with behaviours of concern are living together, restrictive practices may be introduced as a response (for example, a locked door separating two residents on either side of a house). Better tenancy management would prevent this from becoming an issue in the first instance.

Behaviour support plans are the preferred method of reducing and eliminating the need for restrictive practices by managing their antecedents. However, a behaviour support plan is only as good as its implementation. A casualised workforce with limited training is unlikely to be able to implement a behaviour support plan with the knowledge, strategy and consistency required to do so effectively. Record keeping and data collection may support a case for reducing restrictive practices for a person with disability—however this is less likely to be done by casual or temporary staff.

Practice leadership is identified earlier as a key characteristic of good group homes. Decisions regarding how management roles intersect with practice leadership are left to service providers—in many cases the same staff fulfil both roles. Given the significant time management roles have to give to recruitment and rostering, important time for supervision and practice leadership can be squeezed. Violence, abuse, neglect and exploitation are more likely to occur where there is insufficient supervision.

Any violence against, or abuse, neglect or exploitation of a person with disability is unacceptable. This includes when it occurs due to the behaviour of another person with disability. The Victorian Office of the Public Advocate report cited earlier in this submission includes some shocking statistics regarding resident-on-resident violence. In NDS’s experience the threshold for action to be taken when a resident poses a risk to another resident is too high. The NDIA appears to have given inadequate attention to how emergency responses should be implemented and funded (for example, a resident may need to be moved immediately from a property and accommodated elsewhere with additional support staff).

As part of the Zero Tolerance initiative, NDS has developed important training films on Recognising Restrictive Practices and Responding to Abuse. [Ibid.]

* **Improving or changing staffing in group homes to better support the choices and potential of people with disability?**

Group homes need a sufficient number of well-trained and well-supported staff and the right culture. A greater number of staff operating in a poor culture will not deliver better outcomes for the people they support.

NDS has been collecting workforce information from providers over recent years. Disturbingly, and largely a result of a rapidly growing market with difficult-to-predict demand, the use of casual staff has increased to being in the order of 40 per cent. This is a worrying development, particularly when close supervision is not available to these casual workers.

Since the NDIS began (with pilot sites) in 2013, NDS has been negotiating for higher prices for many supports. The NDIA’s Cost Model for Disability Support Workers (see link to Cost Model in the NDIS [Individual Living Options](https://www.ndis.gov.au/providers/housing-and-living-supports-and-services/housing/individual-living-options)) underpins many prices for NDIS supports. Some of the assumptions within that Model understate the costs associated with providing quality support.

In our recent submission to the NDIA, NDS stated:

Some of the assumptions within the Cost Model for Disability Support Workers will be tested against the forthcoming survey of providers charging prices that include the TTP [Temporary Transformation Payment]. To supplement this information, NDS conducted a short survey on some of the assumptions, receiving usable responses from 70 of its members. The results demonstrate that one of the most problematic assumptions in the model is that for overheads. While the model makes an allowance of 10.5%, respondents report a mean of 16.7%, a median of 16%, and a maximum of 30%.

The Agency’s allowance of 10.5% needs to be substantially increased.

The ratio of permanent to casual workers also needs significant adjustment. While the model allows for a casual usage of 20%, the industry figures are substantially higher. This survey gives a median of 38% with a median of 33.3% and a range of up to 100%. This is consistent with NDS’s regular Workforce Wizard survey (the last survey conducted in June 2019 showed 40% of workers were casual employees).

The importance of addressing the casual workforce assumption has been magnified by the recent decision by the Fair Work Commission that will mean casual employees will be paid any relevant penalty rates as well as a casual loading of 25%, taking effect from July 2020 (see [Fair Work Commission Determination](https://www.fwc.gov.au/documents/sites/awardsmodernfouryr/pr713525.pdf)).

Our survey shows the average wage is higher than the wage level used in the Cost Model. The assumption of a SCHADS Level 2.3 ($29.05) is lower than the survey mean of $30.10 and median of $29.50. Utilisation rates of 78.1% (mean) and 90% (median) compare unfavourably to the 92% used by the NDIA.

The profit margin allowance of 2.0% is inadequate; a minimum of 3.5% is sought in the current economic environment (adjusted annually).

Payments of allowances varies substantially across organisations. Our survey indicates the most common allowance paid is for first aid. ‘On call’, meals or no allowances were reported with similar frequency but were less common than paying a first aid allowance.

A growing number of states and territories are introducing portable long service leave. As an example, from January 2020, NDIS-funded activities were included as ‘community services work’ in Victoria. This applies to the ‘ordinary pay’ of both permanent and casual workers. It is currently levied at 1.65%, with a potential to increase it to a maximum of 3.0%. The ACT has a similar scheme, and Queensland is in the process of introducing one.

The cost of such a levy must be included in the Cost Model.

In addition, the Model allows for a supervision ratio of one to eleven Full Time Equivalent workers. Given the average hours worked by disability support workers is about 25 hours per week, a supervisor is often responsible for more than 20 staff. This is too high to adequately allow for the practice leadership needed to drive the provision of high quality support.

Some NDIS prices do not adequately cover the costs of the training and supervision of workers. This is exacerbated by high turnover rates. NDS’s regular survey of the workforce suggests the turnover rate for permanent workers is about 4.6 per cent per quarter (relatively stable over 11 quarters); and 8.5 per cent per quarter for casual staff (its rate has been more volatile than that of permanent staff). [NDS (2018), [Australian Disability Workforce Report](https://www.nds.org.au/news/disability-workforce-report-introduces-state-analysis): Third edition, p.9]. Ongoing training and supervision is essential for all workers in group homes but is particularly critical when the people living in the shared arrangement have complex needs. High quality support being delivered at all times is essential to assisting a person with significant disability to have a good life.

# Appendix: NDS Submission to the Royal Commission – Quality & Safeguarding

## Introduction

The publication of the NDIS Quality and Safeguarding Framework in 2016 and its subsequent implementation in the form of the NDIS Practice Standards and NDIS Commission Rules has brought national consistency to a patchwork of regulation across the jurisdictions.

Reaching this point has followed the same broad pattern over the last two decades in every state and territory. A regulation of the sector by legislation in the first instance, accompanied by the initial measures to safeguard service users by screening workers employed in the sector (often requiring only a declaration of suitability by the applicant); an extensive revision of this legislation in the decade before the launch of the NDIS with a trend towards increasing scrutiny of provider service quality standards – often mandated by state-based standards later aligned with the National Standards for Disability Services (NSDS); the formalisation of procedures for governments to receive reports of critical incidents and to investigate these, as well as complaints from service users; and an increasing awareness of the human rights implications of the unregulated use of restrictive practices.

What follows is a brief survey of the principal arrangements in each jurisdiction prior to launch of the NDIS.

## Australian Capital Territory

Safeguards and quality assurance frameworks to protect people with disability receiving services in the Australian Capital Territory sit under the ACT *Disability Services Act 1991* and related instruments. Prior to July 2019, oversight of disability service providers under the Act was the responsibility of the ACT Human Services Registrar (HSR).

In the ACT relevant safeguards prior to the launch of the NDIS Commission included: requiring people working or volunteering with vulnerable people to register with the Office of Regulatory Services under the *Working with Vulnerable People (Background Checking) Act 2011*; the requirement for Specialist Disability Service providers to provide support within a Standards framework that included the National Disability Service Standards, Home Care Standards and National Standards for Mental Health Services; and the reporting of critical incidents. Restrictive practices were effectively unregulated until the appointment of a Senior Practitioner and the commencement of the *Senior Practitioner Act 2018.*

The Human Services Registrar maintained a team of regulatory assessors responsible for the assessment of providers directly against the relevant national standards. Targeted compliance reviews were also undertaken in response to complaints or critical incidents.

## New South Wales

In NSW prior to the 1 July 2018, disability service providers needed to comply with standards generated by the *NSW Disability Inclusion Act 2014* and *Regulation 2014* and the NSW Disability Services Standards. The *Disability Inclusion Act* replaced the *Disability Services Act 1993* under which quality assurance had primarily been obtained by the activities of a dedicated team within the Department of Ageing Disability and Home Care (ADHC) which undertook regular quality reviews of funded partners.

Among reforms which preceded the NDIS were the introduction of the NSW Disability Service Standards, the roll out of the ADHC Quality Framework and a requirement from 2012 that funded providers undertake regular third-party verification (TPV) of their compliance with the Standards.

A limited reporting of critical incidents in ADHC-funded supported accommodation services also began in December 2014 under Part 3C of the *Ombudsman Act 1974*. Providers were required to have an internal complaints handling process in order to comply with both the NSW Disability Service Standards and the *Community Services (Complaints, Reviews and Monitoring) Act 1993 (CS CRAMA)*. Beyond that, the Ombudsman’s Office also had a broad range of functions under the *CS CRAMA Act* in relation to disability services that included hosting the Community Visitors Scheme, which maintained a monitoring role of client safety in Supported Accommodation outlets.

The use of restrictive practices was regulated by the ADHC’s Behaviour Support Policy and authorised by a number of regularly convened Restrictive Practices Authorisation Panels. These have continued in a modified form into the arrangements in place since July 2018. An Aging and Disability Commissioner has been in place in NSW since July 2019, with the power of own-motion investigations.

## Northern Territory

The NT Government developed Disability Service Standards (DSS) to ensure the services provided to consumers were consistent with the principles and objectives of the *Northern Territory Disability Services Act 1993*. Service providers were required under their contractual and funding arrangements to meet the DSS and service delivery was reviewed by the NT Department of Health (DoH).

In the period after the launch of the NDIS but in advance of the NDIS Commission, the NT Government strengthened the NT Quality and Safeguarding Framework with a revised assessment process that required provider self-assessment against the Framework, independent on-site assessment by a third party auditor with registration determined on the basis of the auditor’s report.

In relation to complaints, providers were required to maintain complaint handling processes compliant with the Territory’s quality framework. People receiving services also had a capacity to take complaints to the NT Health & Community Services Complaints Commission.

In relation to behaviour supports, providers were required to access the Positive Behaviour Support Team in the DoH which had responsibility for advising on the requirements of people with complex behaviour support needs. Legislation has recently been passed creating the office of the Senior Practitioner and authorising that officer to approve the use of restrictive practices. The unauthorised use of such practices would previously have required lodgement of a critical incident report with the Office of Disability.

## Queensland

The Human Services Quality Framework (HSQF) is the Queensland Government’s quality assurance framework for assessing and promoting improvement in the quality of all human services, including disability services. The Framework incorporates a set of quality standards, known as the Human Services Quality Standards and most specialist disability service providers have been required to demonstrate compliance with the Standards through certification under the HSQF. This recognises that an organisation has met the requirements of the Standards through a process of independent third-party audit. Certification occurs over a three-year cycle and incorporates a certification/recertification audit and a mid-term maintenance audit conducted within 18 months of the certification decision.

Matters on which the auditors and regulators focused include: the authorisation of restrictive practices by the relevant decision-making body in accordance with the *Disability Services Act 2006* or the timely reporting of unauthorised uses of such practices; the existence of an effective complaints process with evidence of providers advising and supporting service users to access external, third-party complaints handling bodies; the effective operation of policies and procedures to report critical incidents, as defined in the standard funding agreement; and the operation of a continuous quality improvement system that demonstrates the organisational learning from these activities.

The Queensland government introduced criminal history screening requirements for people who work for government-funded providers or for an NDIS registered provider. Such workers must undergo criminal history screening and be issued with a “positive notice”, which generates a Positive Notice Card (or Yellow Card). A provider is responsible for ensuring that applications for workers are submitted prior to the commencement of a person’s employment. The Queensland Police are responsible to monitor any changes to a person’s ‘positive notice’ status.

While third-party auditing has been undertaken in Queensland for some time, Queensland government had historically funded the cost. As such, the cost of audit to Queensland providers is new.

## South Australia

Disability services in SA were regulated by the *Disability Services Act 1993*. For non-government providers receiving disability funding from the SA Department of Human Services (DHS), quality requirements included: compliance with all applicable DHS polices and with funding terms that specified quality requirements; providers engaging in a formal quality improvement program that suited the size, type and complexity of their organisation; and engagement with the DHS unit monitoring service quality and collecting data about key performance indicators.

The requirement for a continuous quality improvement process was non-prescriptive meaning that providers could choose to work within an overarching quality assurance or service improvement framework configured to align with an appropriate industry standard (the National Standards for Disability Services among others). Providers could use a Standard like ISO 9001 or apply to participate in ASES (the Australian Service Excellence Standards), a quality improvement program developed by the state government.

The reporting of critical incidents was covered by Departmental policy (Safeguarding People with Disability Management of Care Concerns). Providers were required to report any incident involving a person with disability that might constitute an offence to the Police and had obligations to the Department under their funding agreements. They were also required to maintain accurate and up-to-date documentation on any allegations of deficits in care and the Department’s Investigations Unit could conduct investigations into serious care concerns. However, the system was heavily dependent on self-reporting.

All consents, authorisations and approvals for each use of a restrictive practice within an organisation was managed by a restrictive practices compliance officer; providers were also required to appoint an internal Restrictive Practice Governance Committee reporting regularly to the Chief Executive Officer and Board. The Office of the Senior Practitioner (currently vacant) was expected to visit services regularly in the context of which staff monitored the progress of each organisation towards building their internal restrictive practice reduction capacity and reducing their overall use of restrictive practices. However, service providers advise that reporting obligations out of this cycle were opaque.

## Tasmania

The *Disability Services Act 2011 (DSA)* provides the legislative basis for disability service provision in Tasmania. Quality assurance was provided by the requirements of the *Tasmanian Disability Services Regulation 2015* and the Quality and Safety Framework for Tasmania’s Department of Health and Human Services-funded Community Sector Organisations.

The Framework required providers to meet at least annually with the Department to discuss performance against the Funding Agreement, including provider activities in relation to supporting and monitoring compliance with the Framework. This included a requirement to have systems and processes in place to record and monitor improvement activities.

However, as in SA, these requirements were not highly prescriptive: providers only needed to undertake quality and safety activities against recognised standards (i.e. state, national, or international) relevant to the services funded by DHHS. And providers could choose the format that most appropriately met their needs to document continuous improvement activities.

Beyond that, providers were subject to a quality and safety review of their funded services at least once in a three-year cycle. These reviews were conducted by the Tasmanian Government’s Community Sector Quality and Safety (CSQS) Team via both desktop audits and site inspection visits. The CSQS Team advised the DHHS of the outcome of the review and worked with accredited CSOs on an individual basis to determine how their accreditation could be recognised by the Framework.

Policy of the Department of Disability and Community Services (DCS) also required funded partners to have a complaints management process and complainants were required to make use of that in the first instance. Where resolution could not achieved between the complainant and the provider, the matter could be pursued through the Tasmanian government’s Disability and Community Services’ area office to the Director of the Office.

With respect to critical (or reportable) incidents, providers were required to verbally report serious consumer related incidents (i.e. unexpected / unintended harm, injury or death of a consumer during an episode of funded service delivery etc.) to their Funding Agreement Manager within 24 hours or the next working day. Regarding allegations of abuse, service providers’ responsibilities included preservation of evidence and provision of an Allegation of Abuse Alert form to DCS within two days of being notified of an allegation.

The use of regulated restrictive practices is also authorised by the DSA, which created the statutory office of Senior Practitioner. The definition of restrictive practices was noticeably narrower in Tasmania than other jurisdictions, covering only the two domains – ‘personal’ and ‘environmental’ – and with no reference to chemical restraints. Approval for the use of restrictive practices was provided by either the Secretary of the Department or the Guardianship & Administration Board on the recommendation of the Senior Practitioner, subject to provision of a satisfactory behaviour support plan.

## Victoria

Disability service providers that applied for registration under the *Disability Act 2006* needed to demonstrate their capacity to comply with the Human Services Standards of the Department of Health and Human Services (DHHS), a process undertaken through an online self-assessment tool. Most registered organisations were further required to undertake an independent, third party review within 12 months of initial registration and to demonstrate continuing compliance with the Standards at the time of renewal of registration. The assessment cycle covered three years from the initial audit through a mid-cycle review and development of Continuous Quality Improvement Plan.

Complaints about service provision have been handled by the Office of the Disability Services Commissioner, which required providers to report annually on complaints received, had powers to investigate those complaints further or to receive complaints from people with disability and their supporters directly and in the last 18 months has been reviewing all deaths of people with disability.

In respect of worker screening, Victoria has recently required all disability service providers to conduct an additional pre-employment check prior to making an offer of employment to a potential employee (the Disability Worker Exclusion Scheme). The state government has also passed the *Disability Service Safeguards Act 2018* which provides for a voluntary Disability Worker Registration Scheme and a catch-all Victorian Disability Worker Commission which will introduce a mandatory code of conduct for workers.

Prior to July 2019, the DHHS’s Office of the Senior Practitioner (OSP) was responsible for the authorising of and receiving reports on the use of restrictive practices in Victoria. Behaviour support plans need to the lodged with the OSP with all lodgement and reporting done through an online portal.

## Western Australia

The WA Quality System for disability service providers has operated since the late 1990s. It includes both a self-assessment and triennial quality evaluation visits to assess providers against the National Standards for Disability Services (NSDS), conducted by the State Government’s Department of Communities. The Independent Assessments result in a report and findings that either recommend or require actions, the latter being tracked by the Department to ensure compliance.

The Department also requires registered service providers to have a complaints systems that conforms to the NSDS and to report annually on complaints received and how these have been handled. A third-party complaints handling agency exists in the form of the Health and Disability Services Complaints Office. Complaints must be lodged in writing “unless there is a good reason why this is not possible” and settlement of matters is confidential. According to HaDSCO, only 3% of the complaints received in 2017-2018 were related to disability services.

Serious incidents that affect people with disability must be reported by service providers to the Department of Communities within seven days.

Since 2012 Positive Behaviour Supports have been dealt with under the WA Code for the Elimination of Restrictive Practices, although participation remained voluntary for providers until 2018 when the Quality and Safeguarding Working Arrangements for transition to the NDIS in WA were released. WA has not had a state-managed authorisation process for restrictive practices. This is currently being developed for implementation from 1 July 2020.

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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 over 1050 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.