

Advocates on Quality and Safeguarding – April 2021

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Background

On 28 April 2021 the NDIS Quality and Safeguards Commission (NDIS Commission) held a virtual Disability Advocacy Forum. A week prior to the forum, a Pre-forum Advocacy Group discussion and “networking session” was also held (an edited transcript of this discussion is included below from page 22 onwards). In the lead up to the forum DANA collated the perspectives and insights of disability advocates from existing input about quality and safeguarding issues gathered for the Disability Royal Commission (see pages 2-16). DANA also collected further input through a specific survey about the functions and operation of the NDIS Commission, so that DANA’s CEO could report back through a short presentation at the Forum itself. The responses from this survey are presented at pages 16-21.

Advocates' feedback about the NDIS Quality and Safeguards Commission

The following comments were gathered from disability advocates during online surveys and workshops held by DANA in relation to the Disability Royal Commission in late 2020 and early 2021.

Complaints

Recurrent themes and frustrations emerged in advocates' commentary about pursuing complaints with the NDIS Commission. Recurrent experiences and concerns included:

- Complaints go nowhere
- Lack of outcomes for participants
- Lack of enforcement or consequences for providers
- Reputation as “toothless”
- Bureaucratic and technical
- Risk of power imbalance
- Overly trusting of service providers who can “control the narrative”

“Complaints to the Quality and Safeguards Commission, you know, has gone nowhere and in one case we've even had to complain about the Commission because there are no outcomes and no tangible sort of investigations, you know. Even on our advice sort of saying this is what you need to look at and this is what we want, you know, to be looked at, it's just like a chat. It's pretty toothless. I don't know if it's because they haven't got the resources or what it is, it might be.”

VIC Advocate, February 2021 Zoom workshop with DRC

“I've known some people that I'm supporting and their families just choose not at all to even submit a complaint to the [Quality and Safeguards] Commission because they have heard about their reputation of not having teeth.”

VIC Advocate, February 2021 Zoom workshop with DRC

“...you have to train the staff, but the other real problem is that service providers know that they're not accountable. The NDIS Quality and Safeguards Commission does not have powers to act against service providers in individual complaints and the New South Wales Ageing and Disability Commission, who is now getting a function to what they call oversee restrictive practices, also does not have powers to make any penalties or findings against service providers in individual cases. So we now have two regulatory authorities that

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appear to be regulating but, in actual fact, do not have any powers against service providers in individual cases to stop things. I am not talking about the obvious things like assaults and sexual assaults and things like that. I am talking about the day-to-day things, like restricting diets, closing doors, not letting them go out into the community. What we really need is tribunals that you can go to that will listen to the complaints and deal with them in a very short period of time, and we haven't got it."

NSW Advocate, March 2021 Zoom workshop with DRC

"...with regards to gaps, I'm drawing on one case here so it might not be true generally but with regards to the Quality and Safeguards Commission, my impression is that most of the dialogue... if there's a complaint or reportable incident that it is between the service provider and the agency. So the service provider has the opportunity to control the narrative, so to speak, and it seems as if there isn't ... a proper investigation, at least according to this one case. Not reaching out to the family and doing site visits to speak with the participant, the client, whoever made a complaint.

That is really a lack of proper information gathering to understand what is going on, and they're taking too many cues from the service providers. 'We've heard there is this complaint, can you develop an action plan?', and then the service provider can come back and say that 'yep, we developed this action plan, we're going to do this training module'. But in the circumstances I'm thinking about, there was abuse occurring behind the scenes, it went unnoticed. I knew about it because there was video evidence that wasn't submitted to the Commission so nobody from the Safeguards Commission really ... They showed their impotence because they didn't do site visits, they didn't really speak to anyone else except the service provider. I think that's a danger. They really need to exercise the powers that they do have.

And they place the onus on the service provider to communicate to the rest of the care team and family members and they are not necessarily doing that if they have something to hide."

VIC Advocate¹

"What is really evident with the Safeguards Commission is the power imbalance. The preferred outcome for the Safeguards Commission is a negotiated agreement. They mediate or they come up with some kind of agreed resolution between the person who has made the complaint and the service provider and all of this kind of stuff.

The power imbalance in that... in that so-called agreement is just not addressed. So the person who is most vulnerable, can be almost forced into agreeing to whatever the service

¹ VIC Advocate, "Advocates Zoom In On... Safeguarding rights and wellbeing", December 2020 Zoom discussion

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provider puts forward as their preferred resolution. I think that is, again, one of the biggest failings for the Safeguards Commission. That power imbalance is not even acknowledged, let alone actively... There is no active work done to try to rebalance that between the client and the service provider. I think that is what happens... People get forced into making agreements that don't necessarily address what is happening for them."

VIC Advocate²

"One of the barriers to making complaints is the incredible inaccessibility of the NDIS Quality and Safeguards Commission. How would a person with intellectual disability actually go about making a complaint? In most cases they can not do it independently as they may not have the phone number, may not be able to use a phone and may not have safe and private access to a phone. In that case they rely on paid service providers to make complaints with them. What we have seen in advocacy though is that service providers are incredibly reluctant to support clients to make complaints and instead view it as an advocacy issue. We frequently respond to service providers to tell them that they have a duty of care to their clients and also play an important safeguarding role in supporting clients to make complaints.

...This client ...chose not to make a complaint to the QSC because he was not able to understand who they were and what the point would be in doing it. He also felt very angry with NDIA at that time and could not understand the QSC were a separate entity (and really, how reasonable is it to expect people to understand that when they look exactly like the NDIA?).

The other significant barrier I have found in making complaints to the QSC is the lack of knowledge and skill of staff at the QSC. It is difficult to explain the problem to a staff member at the QSC if they are not familiar with RPs and how they intersect with state legislation. If they do not understand local legislation (such as the Disability Act in Victoria) they are not able to comprehend how a RP can go outside any framework or legislation but is not questioned because there is no one to question it. In one instance where I contacted the QSC I stated that the client was not able to understand the complexity of the complaint about his service provider. The person from the QSC wanted to get his consent to go further but when she spoke to him he wasn't able to understand who she was or why she was calling. He eventually said he didn't want to make a complaint.

[Quote continues on next page]

² VIC Advocate, "Advocates Zoom In On... Safeguarding rights and wellbeing", December 2020 Zoom discussion

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...In one case that an advocate has been working on for more than 2 years, the client's lawyer made a complaint to the QSC which was ignored. The only way she was able to get a better response was to make a complaint about how the complaint process was handled. I have heard several advocates say that the only way to get an adequate response from the QSC is to make a further complaint about the process. This means that effectively people with intellectual disability will be locked out of the process, as they are unlikely to understand how to make a complaint about a complaint, even if they have got as far as making a complaint in the first place."

VIC Advocate³

"My experience with them is that you have to actually hound [the Quality and Safeguarding Commission] and repeatedly to get them to do anything. They don't seem to feel any obligation whatsoever to get back to the complainant and tell them anything. The complaint goes in and then all of the activity after that is behind the scenes, presumably some service provider, but you don't get told anything that happens after that unless you chase and chase and chase, make complaints, escalate, make more complaints, but even then, the latest that I'm getting ...is 'it's gone to our compliance team'. Okay, well, it's been there since September. What does that mean? What are they doing? What's happening? What is that? Nobody from the compliance team will talk to us. I don't even know who the compliance team is. Nobody will tell us that's effectively the end of it.

It's gone to a complaint to the Commonwealth Ombudsman. They're not getting any answers. It's just a big black hole. And I just have to question what's the purpose of a process that does that? The person making the complaint has had no outcome whatsoever, no communication back. Why bother?"

VIC Advocate, February 2021 Zoom workshop with DRC

Provider Registration

Advocates expressed dissatisfaction with the role currently played by the NDIS Commission in ensuring compliance with relevant service standards of quality and participant safety.

Recurrent experiences and concerns included:

- Inadequate oversight and monitoring
- Lack of action on systemic issues identified by advocates
- Lack of measurement of participants' rights and wellbeing
- Disconnect between glossy organizational brochures and policies and reality "on the ground" within group homes

³ DANA's 2020 *Restrictive Practices* survey, Response from VIC Advocate

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“The particular service that had a mass lot of evictions, I managed to get the same Quality and Safeguards operator investigating the complaints across the board. The trouble is, their jurisdiction is incredibly limited and you have to have made a complaint, the service has to have failed to adequately resolve the complaints. And because it's all tied to market-based registration, you've got to find an issue where you can escalate to a complaint.

If they are just being obtuse, that is not complaint-worthy. In one situation the only reason we managed to get it to a substantiated complaint, was because they were refusing the person responsible restrictive practices data when she was the appointed guardian for restrictive practices. But if they are just ignoring you, it's a lot harder to get that to a formal complaint that they haven't responded in the timeframe, and then moving it on. It is very bureaucratic.

So you're looking... and you shouldn't have to look for your technical way in. It should be just, "This is not right, we need to do something about it."

NSW Advocate⁴

“I believe what's missing is there's nobody measuring this stuff. So if you look at the values that the NDIS or NDIA talk about, if we look at just basic human rights, nobody is measuring this for people in CRUs and I think that if that was literally measured and quantified, people would be horrified at what the data would tell us. So if there's nobody picking up that work, I just think we just keep talking in circles and no real significant change could happen. It's a very complex issue. There's complexity for the providers, there's complexity for the actual support workers, but nobody is actually measuring the outcomes for these individuals.”

VIC Advocate, February 2021 Zoom workshop with DRC

“...from our experience, we're finding that [Quality and Safeguarding Commission is] in the favour of the service provider rather than the participant. It's educating and hand holding and they forget that there needs to be compliance and there's nobody coming and actually checking from the Safeguards Commission to actually visit the person and actually spend some time actually getting to know what the issues are and what's going on in the houses.”

VIC Advocate, February 2021 Zoom workshop with DRC

“...One of the biggest problems I find, when I look at a group home situation a couple of years ago, the client could articulate some aspects of abuse by staff, but couldn't necessarily pull the whole picture together. So we had fragmented pieces of information but there was a basis to that. Within the service, we were investigating, but we were also detecting an undercurrent of bullying from the perpetrator to other staff.

⁴ NSW Advocate, "Advocates Zoom In On... Advocacy & Abuse Prevention", December 2020 Zoom discussion

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The issues don't go anywhere, and in the meantime, whilst that staff member who had accusations made against them, while investigations were against them... the investigation [might be] shut down by bullying from the alleged perpetrator to other staff – it [might be] shut down due to communication difficulties with the person with the disability.

But that the service itself is doing the initial investigation. And then, if you do get to the Quality and Safeguard Commission, sometimes you hear language like 'Well, it depends what the others view has taken place.' You are not always finding that they are using the power that they have and the authority that they have to actually do something about this. In the end, people don't complain, because they won't be believed or other residents in the house see what happens when one person spoke up.

I am just feeling that I don't think the service themselves should be investigating this, it would remove some of that component of bullying, removes the ability for staff to do some of that. We saw what happened with Yooralla - other staff members were silenced, victims were silenced. It is still happening. There has to be a better way. For some have systems and safeguards in place, but I don't necessarily believe that they are working effectively. And when they start work it is when untold horror has unfolded against multiple people.

I would have thought that after the Yooralla issues in Victoria, that this would be addressed and people would pay attention. But, two years later, this is still happening... So what they do is they've moved the person with disability away from the house, away from the family, from one side of Melbourne to the other side of Melbourne, because they said his behaviour was unacceptable. His behaviour is unacceptable because he is in a house where he feels unsafe. And the cause of that feeling is still there.

[Quote continues on next page]

That house, anyone associated with that house or that service, must not do the initial investigation. I think that is a good starting point. I don't know what other things. I think we need some answers to this, and if we see good practices, it would be great to hear about them."

VIC Advocate⁵

"...there're some models out there that have a very big gap between the boots on the ground to the management. So the manager might manage five houses, but there's no one actually on the ground, actually working with the staff, actually giving that sort of mentoring or that sort of leadership to make sure that things are happening

⁵ VIC Advocate, "Advocates Zoom In On... Safeguarding rights and wellbeing", December 2020 Zoom discussion

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...There's not a lot of consultation, I don't believe, with the staff and with their management. Management have it all perfectly written out. They have it all detailed, everything looks wonderful on reports, but the staff on the ground have no idea these things are in place and there's no communication down below.

So it all looks wonderful up the top and when you make a complaint to the Quality and Safeguards Commission, it all looks wonderful to them because everything is ticked off and it looks like a neat little package. However, realistically, and in reality, it's not happening. Why would people make a complaint if things were okay? If it's not investigated, then there's no point.

... there is no reason, there is no purpose for the Quality and Safeguards Commission. We thought, as organisations and people with disabilities that I've spoken to thought, that this was a really good win and it was great. They were going to have some teeth, they were going to actually be on the side of the person with the disability and they were actually going to dig up things and actually get things right and fixed. But it's actually not happening. It's completely the opposite. It's, "Oh, I'll need to send off to the organisation or the service provider and find out what they're doing about that" and then they send back all in their nice little neat package, "Yes, we're doing all these things," but on the ground it's not happening at all, and the staff often don't even know what is even... what they're supposed to be doing either.

That's a big gap to me. ...I'm sorry, but there's a lot of dishonest people working in these fields [where] there is no accountability at all. It's disgraceful.

VIC Advocate, February 2021 Zoom workshop with DRC

"It's all very well to say people should be educated, but we have said the same thing for donkey's years and it doesn't happen. People -I think it's probably a pessimistic view of human nature - many of them don't do things unless they're forced to do it. I would say, by the way, that I do think there are very many service providers out there that are very good service providers and do a really good job. So the complaints we hear are with the troublesome ones, and that's where you need effective regulation.

....There's no point in saying we've got courts and we've got tribunals, when our clients who don't have legal capacity and don't have funds can't access them. There's no point in having regulators like the NDIS Quality and Safeguards Commission or, in New South Wales with restrictive practices, now this Ageing and Disability Commission, if they're not actually given powers to hold regulators to account in individual cases. For 30 years we have had a complaints system that just says, "Give the complaint to the service provider; if they don't resolve it, maybe you can go to an Ombudsman". An Ombudsman has no power. They write a letter and say, "Well, this is what you should do," but you can't enforce it.

So unless you're going to actually give our clients legal rights, and I mean in a practical sense, where they can access a regulator who can hear the matters that are submitted for them perhaps on behalf of them by their parents or carers or their advocates, and hear the

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case and make a decision in a very short time which holds the regulator to account - you're never going to get change in this industry. It was set up to be privatised to make profits and, unless you're going to put in the legal machinery to make them accountable, it's never going to change. It's going to get worse.

...[Our organisation], we always try to settle things. I would like to settle things with service providers. What I am saying is when it gets nowhere as a last resort, our clients have got to have somewhere where they can go and get a remedy, and they can't do that. That's what I am talking about. They can't get a remedy in the courts or the Tribunals or from the Commission, so we actually need for them, at the end of the day, as a last resort, to have a legal remedy where someone can say, "Yes, service provider, you were wrong there, you denied our client Community Access 10 times in a row because you wouldn't fix your bus, and that's not acceptable, so you've now got to give him back his 10 Community Access visits." Things like that that can be fixed up. Or "you've let him," these are all cases I've got, "You haven't fixed his toilet in his room for six weeks." Now, a tenant could get an urgent repay and pay for it himself and go to the Tribunal and get compensation back. In a group home, you can't. So you should have a regulator that can say: "Mr Group home, you're at fault. He's gone and fixed up his own toilet or he hasn't had his toilet for so long, bang, you pay him a fine or compensation of \$2,000." As a last resort, that's what you need.

NSW Advocate, March 2021 Zoom workshop with DRC

Behaviour Support

An over-reliance on restrictive practices was described by many advocates across jurisdictions. Although complex causes, including deficiencies in staff training, resourcing and inadequate cultural change, were discussed, specific issues were raised in relation to the NDIS Commission's processes and capacity to effectively oversee the provision of behaviour support. Recurrent experiences and concerns included:

- Lack of understanding among providers and family members
- Delays in funding approvals
- Understaffing and lack of capacity to monitor plans
- Risk of funding reductions

"...in relation to restrictive practices, if we happen to - either in an SRF [Supported Residential Facility] or segregated setting - if we do happen to observe that and we're concerned about it, you can take it up with the organisation, and often that's really tricky because they will always have a reason as to what you might have observed or heard from your client or the person that you're dealing with. We can report those things to the Quality and Safeguards Commission. Again, from my observations of what they do, they take it up with the organisation and then they will accept an explanation as to what's occurred. We

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can feel really limited, and I'm not sure how other advocacy agencies deal with that in terms of getting some action in relation to those restrictive practices that we do observe.”

SA Advocate, December 2020 Zoom workshop with DRC

“The NDIS QSC [Quality and Safeguards Commission] is drastically understaffed and does not have the resources to monitor behaviour support providers/practitioners and the adequacy of behaviour support plans.

The biggest barrier is insufficient funding of NDIS QSC and OPG [Office of the Public Guardian]. NDIS QSC needs to have sufficient funds for ALL PBSPs [Positive Behaviour Support Plans] to be properly vetted, and for the work of ALL behaviour support practitioners to be properly monitored. This includes monitoring of whether statutory timeframes for completion of IBSPs [individual behaviour support plans] and CBSPs [comprehensive behaviour support plans] are met and of whether the BSPs meet the criteria in the NDIS Behaviour Support Rules.”

QLD Advocate⁶

“...since the introduction of the NDIS and the quality safeguards, on a couple of occasions, services don't actually understand what a behaviour of concern is and they're seeking positive behaviour support plans to try to get, I guess, better training on how to do a particular issue, and in order to get that, they're using language that's quite harmful to a person's reputation. They're bringing out past behaviours, and they are also describing things in a way that makes it sound like a behaviour of concern but, when you put it in context, it isn't.

So a couple of examples of that is someone I advocate for potentially has a tic and this person has done this particular involuntary movement for a long time and they're describing this tic as a behaviour of concern because it's becoming more apparent. And when I tried to challenge that it wasn't actually a behaviour of concern, it was just something the person did to communicate or was an involuntary movement, the NDIS still provided a positive behaviour support plan and lots of the issues they raised in the interim support were ... the person was communicating when they had no other way of doing so.

And so another example was the person was trying to get out of a car at stopped traffic lights, but this person didn't understand ... because of their disability, they didn't understand they hadn't arrived at their destination but were stopped at a traffic light.

Those were the sorts of things when you put it in context, it's not a behaviour of concern, but that's what they got the positive behaviour support plan for. So while there's extra measures in place, the services are still inappropriately describing and referring people for

⁶ DANA's 2020 Restrictive Practices survey, Response from QLD Advocate

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those plans when actually what they want is perhaps more training to deal with particular issues.”

SA Advocate, December 2020 Zoom workshop with DRC

“There are issues with maintaining funding. I have worked with a couple of clients who had the amazing behavioural plans and 2:1 funding to ensure support. After 12 months there have been no behavioural concerns, due to them being well supported. No incidents reported means the NDIS funding will be cut and then they are no longer able to be supported well enough.”

VIC Advocate, February 2021 Zoom workshop with DRC

“A recent experience that I had for a young man who I am [an] advocate for., he's now an adult but very recently turned 18 and has very significant behaviour support needs. He recently had his NDIS plan reviewed and, as part of that review process, during his 12-month plan, the family was requested to develop a behaviour support plan through a registered [behaviour support] clinician, and they undertook that process. Restrictive practices were, I guess, highlighted as being undertaken with him by the clinician. The mother was outraged that the things that she does just to keep her son physically safe and alive were being labelled as a restrictive practice, so there was work around, I guess, explaining that situation to her.

Now, this young man, his NDIS plan review meeting took place and we explained clearly to the planner that within 48 hours he was going to be completely without any level of funding. He was left for 15 days with zero dollars in his plan, so no ability to provide any supports, because they said that they had to take time to have the restrictive practices lodged and approved. Now, this is despite the fact that the mother had willingly taken part in having a really comprehensive [behaviour support] plan drawn up, had done everything right through every part of the process and had that done a month prior to the plan review meeting, and this young man was left with, as I said, no funding for 15 days, and the NDIS were very aware of that. In the end, I had to raise the issue repeatedly with the state manager and they finally approved the plan 10 minutes past 5 on a Friday night after the mother had called me and said that she couldn't face going through the weekend without any overnight supports or support for her son.”

NSW Advocate, March 2021 Zoom workshop with DRC

“I have [had dealings with NDIS Quality and Safeguards Commission], only in the instance of just trying to obtain information and to also speed up the delays involving funding approval for a behavioural support specialist to put together a behaviour support plan, and so the extensive time it takes for that plan to happen and the number of hours that the behavioural support specialist might need to put in until the restrictive practice is approved. It takes so much time... and I have tried to reach out to many different avenues to make

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that happen... And the response I receive is: 'It's been escalated to the relevant team', and that's it. 'We don't have any further information we can provide you, apart from we're looking at it. We're looking into it.'"

NSW Advocate, March 2021 Zoom workshop with DRC

"We have had request for advocacy support from a support coordinator. The participant is in shared accommodation. They don't have any family members or appointed guardians. There is a behavioural support intervention which is funded through NDIS and they need to have restrictive practices signed off. Who is going to do that? That's what the question is, and we've been asked for support on that. So that's something else to throw in the mix about restrictive practices and those practicalities about getting them signed off in the first instance."

NSW Advocate, March 2021 Zoom workshop with DRC

"I have just found that with a lot of behavioural specialists, registered ones, they're not always across restrictive practices. So I have found that those who are great with preparing a behavioural support plan, they will then have to do their own research or speak to their managers or their team leaders in putting together the actual restrictive practice side of things. Often enough, part of the procedure, I believe, is they do need that two-person kind of check because it's part of the requirements. But I have just found I just haven't really come across anyone who really understands the space really well, and that's a huge issue because there's hundreds and thousands of people, individuals, who might need it. But, if there are only a small handful of specialists out there who actually understand, it falls back on advocates. I [have] found myself in a situation where I am trying to pore over the legislation on restrictive practices. I am going through websites trying to work out who does this and who does that and who do I talk [with to] get this set up for this family, and when I finally find that person - for example, a behavioural specialist or I'm speaking to the receptionist - they kind of go, "Oh, we don't do that." So what do we do now? That's the biggest obstacle I have come across."

NSW Advocate, March 2021 Zoom workshop with DRC

I have had quite a few examples where a client will have a BSP, a good behaviour support plan, and they have got quite complex needs and there's a lot of restrictive practices including in the BSP, and even though it is stated how they will be eliminated or reduced, there's absolutely no funding at all for implementation or training in the budget, in the NDIS budget, which is just ridiculous. And that does come up time and time again, and then restrictive practices are just used, and that plan is then essentially rendered useless.

NSW Advocate, March 2021 Zoom workshop with DRC

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“Policies within organisations need to change. Restrictive practices should be kept to an absolute minimum (one or two occurrences per year at most). Effective behavioral management plans should minimize the frequency of emotional outbursts as well as the need for restrictive practices.”

QLD Advocate⁷

“...in group homes, with untrained staff, and people who would know this, I am not aware that there's any signs about basic ...what restrictive practices are. I think it would be a good idea if it was mandatory for there to be signs about a few principles about restrictive practices, especially that they should be used as a last resort, even if they are authorised by [the] restrictive practice panel. Also, to educate workers that small things - like not letting residents go out into the community because they misbehaved in the morning - [are] restrictive practice. So- I think we should work in that direction as well.”

NSW Advocate, March 2021 Zoom workshop with DRC

“So I just wanted to support ... comments around how not just training but how staff are valued, paid, trained, all of these things to do these jobs. I'm also interested in what funding there is for research in this area and if that's something that the DRC is looking into in terms of understanding behaviours from the perspective of things like these behaviours being adaptive behaviours, survival. I have had clients who later on, it has been six months, and they have found out they have actually had infections and that's why they were behaving in certain ways, and the brother has lobbied to get that person seen by a doctor and then that's been the root cause of that. So I am just curious about the funding and research that might be happening or could be proposed around this as well.”

NSW Advocate, March 2021 Zoom workshop with DRC

“If funding bodies attached funding to the reduction of restrictive practice, or the increasing of positive practice, maybe useful”

VIC Advocate, February 2021 Zoom workshop with DRC

“There needs to be mandatory stakeholder meetings held to correlate information for behaviour management strategies to be put in place – ie. seeking a behaviour management plan.”

QLD Advocate⁸

⁷ DANA's 2020 *Restrictive Practices* survey, Response from QLD Advocate

⁸ DANA's 2020 *Segregated settings* survey, Response from QLD Advocate

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"I think even going back to before the review in 2014, first of all take out the immunity provisions. That makes it all too easy for service providers. Take the short-term approvals back to what they were, which is half the duration they are now. And I think the big thing is, which happened to a couple of people just as NDIS was rolling out here, people who live with restrictive practices should be able to self-manage and hire their own workers, not have to have them registered as providers as long as they do the same things that they did under Your Life Your Choice, which is the data collection and the reporting. So, the number type frequency and the situations around the use of restrictive practices.

That should be monitored by, well, it used to be the Centre of Excellence, but I can't say that we could rely on the Quality and Safeguards Commission because they're hopeless. I think that there should be a separate independent mechanism that does collect that data, and that they do monitor it, and that they then step in when they see that either the use is not coming down, or it's even escalated, and look at why - whether it's mandatory retraining of staff or even then a forced change of provider."

QLD Advocate, December 2020 Zoom workshop with DRC

"...the regime in Queensland should apply to people who are under 18 as well as people who are over 18 because it's when people are under 18 that they get set in this pattern of chemical restraint and restrictive practices that they end up in for the rest of their life. That's one thing that I think really needs to change.

A second thing would be this skills deficit exemption, which is just an absolute, or has in the past been an absolute, rort for providers: "Oh, this person doesn't understand how to cross the road, therefore we need to lock everything," but there's never really been any plan in place to say well, how about we teach this person about road safety and then we won't need to lock them in because they will be able to cross the road. So I think there's too many loopholes in the Queensland legislation.

...I'm concerned about the fact that in respite, if a person in Queensland was only receiving respite, then you can give them fixed-dose chemical restraint with only the permission of their guardian and with no further investigation of whether this restraint was appropriate or not.

So I suppose too many loopholes in Queensland and too many exemptions that I would like to see removed. The NDIS partially gets there, but ... they're hopeless in terms of their supervision of restrictive practices, so we can't just rely on them looking after the under 18s because I don't think they've got the resources to do it."

QLD Advocate, December 2020 Zoom workshop with DRC

"There should be a means for the person and their advocate/informal supporter to reject any PBSP [positive behaviour support plan] that they do not feel is adequate."

QLD Advocate, December 2020 Zoom workshop with DRC

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In terms of people alternatives to restrictive practices, obviously that entails a whole lot of researching, right down from the on the ground stuff in terms of ascertaining people's will and preferences and being able to support those choices through to the high level support that people need, in many cases across their lifespan. And that's one of the issues we're not talking about today, that the disability sector is not properly resourced and so many of the things - the concept of last resort, for example - is often first cab and only cab off the rank because nothing else is available. So if government was going to be genuine about this, they would actually make sure that the supports are there, not just decision making supports but the actual support services. And I could give a long story about what we are hearing in New South Wales, when the NSW Government exited the sector, particularly around that sort of clinical support that used to exist within ADHC, and there's all sorts of problems that ensued from that. So I would say resourcing... would be a really critical issue to address.

NSW Advocate, March 2021 Zoom workshop with DRC

“Better education about what a restrictive practice is.

Streamline the process of applying for a restrictive practice and make it simpler to understand, for all users. Currently it's unclear when and how to apply for a restrictive practice and to what regulatory body. The current process is confusing for users who are usually making decisions about implementing practices in a time of unexpected crisis.

Make disability services accountable when they breach the restrictive practices laws.

Make regulations about minimum standards of care for services employed to care for people with disability. On the ground all disability workers should have to have a minimum level of training so they understand that the same laws apply to the people they work for as themselves. There are widespread (in my estimation) misconceptions about what is and is not a restrictive practice, or perhaps more simply, what is and is not illegal when it comes to working with people with disability.”

NSW Advocate⁹

⁹ DANA's 2020 *Restrictive Practices* survey, Response from NSW Advocate

Pre-forum survey responses

What is working well in quality and safeguarding?

“not really sure at present other than I’ve heard the commission are now fully operational in group homes locally now”

“Some clients report that the actual staff members handling complaints in Tasmania have been patient, listened well, and were careful to make sure the client understood what was being communicated.”

“The experiences that myself and my clients have had with the commission is : nothing”

“I have no experience of it working well in relation to the 2 clients that I am working with.”

“Increased oversight and accountability for service providers. Increased accessibility for stakeholders eg., LAC's and NDIS Delegates to raise concerns and seek guidance. Increased protection of rights for NDIS Participants.”

“not much from our perspective. staff we engage with are nice but complaints do nowhere”

“- that there's a place for complaints

-once engaged there is communication from the QSC”

Do you have any examples you would like to share of interaction with the NDIS Commission?

“I have phoned the commission in regards to an issue presented to me by group home support worker re: the service implementing male workers for personal care for a home of which women were only supported by female support workers for 40 years for personal care, the service was not engaging with the home or people living there to discuss these changes, I made contact with commission after trying to discuss with the service's regional manager and having no luck, the commission made contact with the regional manager and stopped the process of male support workers doing personal care occurring without appropriate consideration of appropriateness of this decision.”

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“NDIS Commission lacks ‘teeth’ and needs the ability to be more than just a tokenistic mediator. The person already has an advocate- they need more powers and than just that.”

"1. Client's partner reported for not providing necessary care for husband in wheelchair in Nov 2020. Husband finally interviewed just before Christmas, where he denied any concerns for his own care. Registered nurses have been providing wound care for the last 3 months and client now has to return to hospital due to issue with the wound not healing. This was part of the complaint made against the carer last year and yet the same issue arising with attendance of registered nurses?

Carer has not yet received a list of the complaints made against her or yet been interviewed by the commission. it is now [April] 2021

Disability advocate has not been kept informed of the process . Communication has been poor and still have not received notes from client's meeting with [Person]'s meeting with him prior to Christmas.

2. Timely responses to complaints. Timely and effective communication to all those involved. Same lack of communication as above, occurring with another client who has made a complaint about a service."

“Day option providers failed to keep accurate and comprehensive records when staff raised concerns about potential abuse and neglect to a participant in their home environment which caused delays in addressing the safety and wellbeing of the participant.”

“complaint to the commission about a person in extremely restricted environment with service that was resistant to changing their practice to ensure better outcomes resulted in a meeting with the service who made no change and ultimately abandoned the person by withdrawing all supports including therapeutic and direct supports. there was no accountability and no consequence for the service”

"Complaint issued about abuse and neglect on behalf of participant in supported accommodation, more than 12 months later and issues are still occurring despite QSC being involved and their response has been they are educators and there is no teeth or repercussions to ensure the service provider complies just taking 'their word'" for it that it's being done. There has been no attempt to physically investigate the service on the ground level.

This particular investigation of complaint has now been going for approximately 18 months and is still continuing."

Different advocates have had interactions with a number of different clients.”

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What areas require improvement?

“The above example was an excellent example of how the Commission supported the advocate and residents without the need to obtain consent to act on this issue of which needed prompt response and this is exactly what happened”

“There is a perception that the Q&SC exists to support providers rather than people with disability. Some clients have felt like the intake/initial contact line has been resistant to accepting complaints or has been attempting to "fob off" clients to other complaints or safeguarding mechanisms.”

“As above”

"Timely communication.

Actual responses to complaints, let alone resolutions. Time frames are appalling, especially in the light of no communication from the investigators. "

“Increased information about the commission to people living with disability, information sessions in regional and remote areas through community engagement to increase awareness.”

“more attention and action in regard to complaints”

"- Physical on the ground investigation to ensure compliance

- Belief of the person making the complaint that it is real to them and they require validation

- but this can take a few weeks before they are engaged"

“Timeliness of response, adequacy of follow through/ complaint resolution processes. Advocates advised clients had generally found that the process took too long, and didn't adequately address their concerns.”

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How could complaint processes be improved?

“I think the above example is how some complaints may need to be obtained, as the residents in this home were unable to give consent and time constraints of advocacy role meant this issue could have taken quite some time to commence, yet the commission responded quickly and proactively, well done Commission.”

“Complaints processes could be improved by prioritising the voice of the person with disability themselves- not their family members or service providers. They could also be improved by reduced gatekeeping- taking an inclusive attitude and routinely referring all matters to complaints officers for investigation, then doing warm referrals to other processes if that turns out to be appropriate, rather than turning people away at initial contact because they've not been able to articulate the issue clearly enough.”

“Faster and more helpful support as above”

“Communication and action on complaints in a timely manner.”

“by making services accountable and ensuring feedback to advocacy about matters they bring to the attention of the commission”

"- Serious investigations and penalties for non-compliance

- For the QSC not to take the side of the service provider because they give politically correct answers and know the hoops and processes to adequately satisfy the commission

- random and follow up of service provision that safeguards framework is being followed and met"

“Timeliness, responsiveness, tailoring responses to individual situations, keeping the client and advocate up to date.”

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How could provider registration processes be improved?

“not to have self assessment of providers”

“Be more accountable and stringent to the safeguarding of the participants they are working with”

What do you think of the NDIS Commission's communications (including Provider alerts and new SAFEGuard eNews for participants)?

“good”

“It is helpful to assist people with self- advocacy, but unfortunately not helpful for those who are unable to access this through information technology ie. remote VIC”

“Totally irrelevant in light of the Commission's inability to communicate with people who are in the midst of the complaints process. What use is a newsletter to them?”

“Does anyone have the time to read these given the inundated issues advocates are having to manage on the ground?”

Do you have ideas for how advocates and the NDIS Commission could better work together?

“this was worked on and discussed in forums at least in Victoria that i know of many years ago”

“Regular regional meetings between staff in Commission locations and advocacy orgs for two-way feedback, updates, and flagging systemic issues.”

“No”

“Seriously? How about they actually communicate with advocates, act upon complaints and resolve the issues that are brought to them.”

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“Representatives from both attending information sharing and planning activities to discuss common barriers, recurring issues and identify solutions.”

“the commission ought to engage directly with advocacy organisations to seek their input into safeguarding for people with disability”

"When a request has been made for face to face investigations and compliance issues need to be investigated, it would be great if the commission could actually follow through with this.

Not be the ""inbetweeners"" the ""fence sitters"" - get service providers to comply as a matter of urgency and give them timeframes that aren't just ""when you get to it attitudes"".

Listen to the issues and ensure they are not just glazed over - understand that advocates are working tirelessly to try and empower and teach participants and their family members/guardians that it's ok to complain but when they do ""nothing changes or happens to show any difference"". This process is exhausting and if the QSC are not going to take advocates and complaints seriously then what's the point? There is none in having a commission!"

Anything else you would like to tell us?

“As it stands the Commission appears totally ineffectual and yet another bureaucracy that doesn't effectively service people with disability.“

“We avoid the commission as we have no confidence in their capacity or willingness to take service providers to task for bad practice”

"The safeguarding processes need more work to protect those that are vulnerable in our community as service providers are getting away with a great deal without being accountable and checked on for their overall compliance and are ensuring a duty of care is being followed.

Participants are totally reliant on those around them to complain and if those around them are the ones that are the abusers or are not listening to their complaints or concerns then how do they get help? How [are] those in supported accommodation who are non verbal meant to get the help they need if the very people assigned and employed to care for and look after them are the abusers or not caring for them properly?"

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Pre-forum Advocacy Group discussion (edited transcript)

A week prior to the NDIS Quality and Safeguards Commission (NDIS Commission) virtual 2021 Disability Advocacy Forum on 28 April, delegates were invited to an online forum for advocates only.

The purpose of this session was to provide an opportunity for advocates to:

- discuss what is working well in quality and safeguarding
- identify areas requiring improvement
- propose ways for advocates and the NDIS Commission to better work together.

The NDIS Commission organised for Live captioning to be provided by [Ai-Media](#).

MARY: Good morning, everyone. Welcome to this forum which is a pre-forum for the one next week with the NDIS Quality and Safeguards commission. I would like to start with an acknowledgement of country. I'm here in Canberra today and I would like to acknowledge the traditions and ownership of this land by the aboriginal people and acknowledge their elders, past, present and emerging, and welcome any Aboriginal people who are with us today. Today's event is being run by DANA but as a preliminary to something that the commission is doing next week. Some of you will remember because you went to a previous version of this that happened face to face, the most recent one was in Melbourne and not last year but in 2019, obviously. We did something like this. It was in the morning before the commission started in the afternoon. It was a bit trickier to do the same thing online, but we are having a go at it.

[Preamble, Zoom housekeeping and introductions from attendees... *redacted for privacy*]

MARY: Siobhan [DANA Policy Officer] has just put the agenda into the chat again and people can follow through there. I know that the introductions take a little bit of time but I think it is really important that you all realise that you are all sitting in your own spot around the country, are doing very similar and very aligned work. We are not a sector that gets together very often and perhaps we should do it more often. But it is really lovely to have people with us today from so many different parts of the country.

[More Zoom housekeeping]

MARY: So we're going to start by talking about some quality and safeguarding issues. Yes, we have had many separate conversations with lots of you over the last couple of years about some of the issues to do with complaints and Quality and Safeguard Commission. We sent out yesterday, or the day before...we sent out a document which had some feedback that we have gathered through the workshops that DANA has done through the Royal commission. We did workshops that some of you, not all of you, but some of you or

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people from your organisations will have taken part in, is some of the state and territory workshops we did for the commission. They were focused on restrictive practices in segregated settings but, obviously, the issue of complaints came up. It came up frequently in those discussions. Siobhan has put that document, in case you haven't or got it, she has put a link to it in the chat.

But we will, after today's forum, send back out to everybody, those of you who are on today and some of the others who are attending next week [not] able to take part today, we will send back out the various lengths that we have shared today. And we will be sharing the document. But, if you've had time to look at it, or when you do, you will see that the feedback that we got from you and other advocates...it is predominantly negative feedback about the Quality and Safeguards Commission. A lot of it was to do with complaints, and how the complaints function works or doesn't [work]. For lots of you, who have taken complaints to the commission, you have been very unhappy about that process. You have found it quite unsatisfactory. In this forum that the commission are doing next week, you probably will have received an agenda from them by now, I think, or if you have not looked at it, it's visible in the platform ... too. Graeme Head, the Complaints Commissioner, will be speaking, as well [as] the registrar and Jeffrey Chan. I [There] is a formal opportunity where I have a 15 minute slot on the agenda next week to present back to the commission the feedback from advocates. Now, the content of the document we all have already got, that would mean I'm giving them entirely negative feedback, or completely negative feedback. We have sent a link to a very brief survey we are doing this week. It will have gone out. I think it only has about five questions and it closes this Friday at 5 PM. It is just to gather some more feedback around the commission.

[Discussion of technical issues]

MARY: So, that link is in the chat here for anybody who wants to have a look at it. But one of the things, I suppose because we have had such overwhelmingly negative feedback about advocates interactions with the quality and safeguard commission, something I'm particularly interested in today in asking [is] whether any of you have had positive experiences with the commission? If you have, what has that been like? Put your hand up or just dive in and [unmute] yourself if you want to speak to it. If you have, for instance, taken a complaint to the commission and you feel it is handled very well, you have been kept in the loop and the whole thing worked well. Just dive in if anybody has experience.

[AUS ADVOCATE 1]: We did have one client who provided really strong positive feedback, not about the process per se, but the individual staff members who were investigating and handling their complaint. They said the staff member involved was really patient, really considerate and clear, careful to make sure everything was being understood and the client was kept in the loop the whole way through. You know, at least one positive experience with a client who felt strongly enough to provide that!

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MARY: Can I ask, was the advocate sort of working with the client as well on that complaint issue? Was the advocate kept in the loop as well? Or did it not apply because the client themselves was able to deal directly with the commission?

[AUS ADVOCATE 1]: So, that one was a mix. The client initially asked for advocacy support to get started. The advocate was involved initially. Once it became clear that the client was able to self-advocate, and felt comfortable with [the] communicating relationship, the advocate dropped out and the client continued.

MARY: Yes.

[AUS ADVOCATE 1]: We didn't get any follow-up about that issue. The client had disengaged.

MARY: Thank you. [TAS Advocate 1]? You have your hand up?

[TAS ADVOCATE 1]: In the first instance, when I've helped assist people refer to the quality safeguarding, it peters off towards the end. But at the start they have been quite proactive. But the outcome hasn't always been necessarily the best, not prepared for the complaints process in Tasmania.

MARY: Thank you, [TAS Advocate 1]. [SA Advocate 3], I can see you have put a comment that the people were nice but the complaint went nowhere. We will skip past that for a second and check if there is anybody else who wants to speak to a successful, positive interaction that they have had. [VIC Advocate 1]?

[VIC ADVOCATE 1]: This is...sorry, very similar to the last couple of people's reflections. I had one that was supported by advocacy to liaise reporting safeguards. The people were very supportive and listened to the complaint and their concerns. However, the communication subsequent to that was fairly poor. It required a great deal of prompting. And the outcome wasn't particularly helpful. But the personnel and their approach were positive.

MARY: Yeah, thanks, [VIC Advocate 1].

[NSW ADVOCATE 3]: Mary, this is [NSW Advocate 1]! Sorry, I'm using...we had a good experience with one of our consumers who had been given by the commissioner. He was the one who took the story of this young lady with an intellectual disability and he was very patient. He gave her lots of time. I think it is important that a person with an intellectual disability is given the opportunity to tell her story in her own pace of time, and also, [people] are considering her disability, and it was good for her that she was finally able to tell her story, you know, freely and without fear and without judgement. It was a good experience for her.

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MARY: Thanks, [NSW Advocate 1]. Anybody else want to dive in? Or put your hand up? I can see [VIC Advocate 3] has added a comment. You are heading into the next issue that we want to talk about, and that is changes to the process of how advocates are dealing. [VIC Advocate 8]? You have a note there about a positive experience. Do you want to speak to it or do you want a leader?

[VIC ADVOCATE 8]: Thanks, Mary, I'm happy to speak to it. It was a very simple matter that, because of our clients disability, she needed a lot of support to make a complaint. It was a huge step for her, and she was very anxious about it. And she was anxious about the commission itself. But, the person who handled it actually did it really well, and she felt really empowered about it. She was raving about him, but it was a very simple matter. We were kept in the loop at the request of our client. I guess that was a positive experience.

MARY: Yep. Thanks. Anybody else quickly want to speak to a positive experience before we move to the next stage about changes we want to see and the way that the Quality and Safeguard Commission interacts with advocates in particular?

[SA ADVOCATE 1]: Mary, [SA Advocate 2] has a story to share.

[SA ADVOCATE 2]: Can you hear me? It says we are unstable!

MARY: I can hear you fine.

[SA ADVOCATE 2]: OK, so, I was approached by the NDIS commission regarding a complaint that I didn't actually put in, but a situation that was involving at the time. One organisation was complaining against another. I was called in as the advocate. Things were sort of happening right then. And the person from the commission came back to me after and said... She had a conversation with me and she asked me to document a few things. I never heard any more, but it made life a lot easier for getting rid of recalcitrant support agency as the advocate moving on down the track. It was a tricky situation but that was a good experience and I felt that I was heard and I don't know what they did about it...whether there was recourse to anybody, but as far as being a witness goes, I thought that they gave me every opportunity to put my dealings in writings to the commission. And to speak to them.

MARY: Thanks, [SA Advocate 2]. Can I clarify, [SA Advocate 2], that was in your role as a citizen advocate for someone?

[SA ADVOCATE 2]: Yes.

MARY: Thank you, yes. Can I... [VIC Advocate 3], do you or [VIC Advocate 2] want to speak...we might move on a little bit to the issue about... because we have just asked first few positive interactions, but if we weigh that up against the last few years of stories of

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negative interactions, they are still significantly outweighing the positive. ...do you want to speak to the comment [VIC Advocate 2] has put in about how the commission managed a complaint and what has happened from it?

[VIC ADVOCATE 2]: Alright. So, we had a... We had multiple complaints lodged from one service and the response from the commission was so poor that we complained to them about their response. There were serious indicators in the complaint that we lodged and then we met with Jeff. What were the roles of the people?

[VIC ADVOCATE 3]: State director and regional director, so a person in Victoria and (inaudible).

MARY: Thanks, [VIC Advocate 2].

[VIC ADVOCATE 3]: We lodged a complaint raising our concerns with the head honcho at [the] commission and their response was to set up a meeting with those two people. We spoke about the complaint. During that time, video evidence was gathered by two parties who are making a complaint about the same agency. There was significant video evidence collected during that time. And the severity of the complaint was crystal clear. We then subsequently met with them and they reported to us about the review of how they were making complaints. So, essentially, we raised a number of things. What we were saying was that [they] were largely disinterested in the complaint. They never spoke to the person making the complaint or their family members or loved ones. They relied on the advocate to provide all of the communication. There was not a site visit. I mean, this was during the time of COVID, but there was no site visit. There was an action plan, but it had been developed and wasn't completed. We raised issues of compliance. The agency was beyond their date for the audit. And so, they didn't seem to be any...any matching up of compliance and complaints. I believe they are reconsidering that in their review. I mean,...[VIC Advocate 2] can talk to it.

[VIC ADVOCATE 2]: Excessive reliance on communication with the service provider rather than the person. It was raised with the service provider and then an action plan was promised but they didn't get back to the family and they even had to ask us for contact details at some stage to see who they were meant to talk to in the family even though they raised the initial complaint. It was all based on communication with the service provider which was under control. It was not until they mentioned that they didn't take anything that looked like appropriate action for the escalation in actually going to the site and talking to the people involved and other people involved. Even then, it seemed like it was only because of the complaint, not what they were expecting to do. It was all paper-based, reliance on the provider, not putting people with a disability at the centre of the process, and not taking it seriously enough.

[VIC ADVOCATE 3]: I mean, you couldn't really describe the process. We were asking, what do you do if an agency... like, how do you monitor an action plan? What do you do if

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the actions are inadequate or do not comply with the action plan? What do you do? It was very difficult to get, to even understand, what the commissions process was about that. And how does compliance measure up with complaints? When is a complaint ticking over to compliance? ...There were a series of complaints justified that were taken further. At one point, things were changed from a complaint to, possibly, internet and communication stopped. The person...what do we do? Follow through, that would be nice. Between the audit function which appears to be primarily about getting service providers into the system, versus compliance, which is verifying they are doing what they [are] supposed to be doing versus complaints. They seem to be not communicating with each other at all or not enough to make this a seamless process from our point of view or the point of view of the service users.

[VIC ADVOCATE 3]: This agency, this particular agency, I think the last time they were audited was...well, they had fallen out of compliance. They were out of the cycle. That had been due in 2019. You know, in my mind, that would be a good trigger for an audit!

MARY: Thanks, [VIC Advocate 3].

[VIC ADVOCATE 3]: Before you close it off, the initial response to our complaint, and the tone of the first meeting, how can we communicate better with you and the families to make sure everyone is comfortable with what is going on? There was no sense that what was being done was inadequate. It was just about communicating better. They never understood our process at all. By the second meeting, we were clear it was and what we thought. We think that some of those changes in the process were at least in part [due] to that sort of complaint, even if not necessarily this one. Issues like this, they must communicate better.

MARY: Thanks. One of the things that is interesting, and we will see if we can get them to speak to it next week, for instance, to have the Victorian management, or managers, of the commission - they may have picked up their game, but it doesn't mean that has happened for the other states and territories. The practice is not a same -- the same around the country. [ACT Advocate 1] have had their hand up for a while.

[ACT ADVOCATE 1]: Thank you. I just wanted to raise a concern. As a participant, before participants were even contacted by quality and safeguards, her family and their participants support worker were contacted by the service provider who was the subject of the complaint. So really, that's an issue for me in my experience - effectively, interrogating the support worker. The family were trying to work out who lodged the complaint. That is obviously a major concern for me. When I raised it with the people who had carried over the matter [to] the Quality and Safeguards Commission, I mean, they were gobsmacked. But they could not provide me with enough information regarding what mechanisms are in place currently to ensure they are protected, and that families and participants and their supports don't come under that kind of fire, or if there is any kind of room for reprisal, effectively. I

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mean, that is intimidation by that provider. Yeah, I was not convinced by the response that I was provided by quality and safeguards. I'm not convinced that there is any kind of infrastructure in place to ensure that kind of thing takes place.

MARY: I think we need to push them at the forum next week, or in the lead up to it, to make sure they understand that advocates all need to clearly and completely understand how all their processes work so that you can then explain that to the people you are working with and then expect that they will follow those processes. Can I ask something and see if anybody wants to leap in and speak to it. To what extent do advocates assist people to resolve complaints, directly with service providers or wherever the complaint is, you know, that they have a complaint about, before [the complaint] gets to the commission? Generally, in the work you are doing, is that the general practice? People have their hands up. If you can, to give us your thoughts on this. I think the commission thinks something different. I am interested to know what you would say about your practice. [VIC Advocate 4], do you want to go first?

[VIC Advocate 4]: Sure. Look, we have a number of clients on our waiting list at the moment that [have] complaints with the Quality and Safeguards Commission who need our help to get something done about their complaints. We have also got...we have also had a number of clients wanting us to lodge complaints against service providers with the agency, and we have recommended to let us deal directly with the agencies, with the service providers themselves. Because I was shocked, as you were, no doubt, Mary, a few months ago when we had one of the Victorian complaints officers at a forum here. And when we asked the question, you prioritise complaints from advocates who work in the field, over and above any other type of complaints, she said no. She said that we treat all complaints as they come in as equally as important. We were all shocked about that because advocates work on the ground. If they don't prioritise and advocate submissions on behalf of the client, what hope [for] a parent or a client is there if they lodge a complaint? We, after that, we will not lodge a complaint with the commission after that comment. We find other ways are better at dealing with it. Some of them involve lodging a complaint of discrimination. If there has been fraud involved, we refer them to other agencies. Sometimes it involves, I remember a case, it involved a client who could not sign, could not write because of Cerebral Palsy. Her signature was on a service agreement because the agency had got a worker to hold her hand while she signed it! It wasn't even in English, she couldn't understand what she was signing. It was a \$200,000 service agreement. We will not deal directly with the Commission because they are just ineffective. They take too long to get an answer and we can get something done quicker. As soon as we raise these kinds of issues directly with the service provider, and asked to see a copy of the service agreement, that raises a flag and we usually get something done and go through everything with the commissioner.

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MARY: Thanks, [VIC Advocate 4]. Just put yourself back on silent. If everyone can do this, make sure they are on mute. We will just quickly go through [SA Advocate 3] then [NSW Advocate 2] then [VIC Advocate 5].

[SA ADVOCATE 3]: Yeah, I guess we resist complaint processes, really, because we find that what they do is the shutters come down and you can't really get anything moving. And so, we definitely try to work really hard at trying to get the issue that is happening for the person resolved, really at the grassroots level. Our experience with the commission is also that there is no outcome. Very nice people, and we are talking about some very serious matters in one instance, a very serious matter that we took, and here we are 3.5 years down the track and it has not been resolved. It is the day-to-day engaging. Some of you will know that we do long-term relationship-based advocacy so we stay in their life for a long-term basis. Sometimes we are in their day-to-day or week-to-week or month-to-month basis because things break down and nobody is making a difference. I note this on the commissions report that the complaints about service provider practice, you know, it is not changing service provider practice. You know? That is a very deeply ingrained bad practice and we don't see the commission doing anything about that. We're just always in their, watching. Them knowing that there is someone watching makes them behave a bit better but the wheels fall off and we have to keep going back in. But we don't find the complaint process has changed that kind of stuff because providers, you know, I forget who it was who was talking before, but they said how they are listening to the service provider narrative [and] are not really listening to what is happening for the individual person. I think [VIC Advocate 2] said that.

MARY: Thanks, [SA Advocate 3]. We will go to [NSW Advocate 2]. We have 15 minutes left in the session. ...There are some good comments there in the chat but they are available afterwards , I won't share it. Over to you[NSW Advocate 2].

[NSW ADVOCATE 2]: Hi, Mary. It has been covered, but like everybody else, trying to solve issues at the service provider level, just because of our experience with the commission with really obtaining no outcome at all and providing no feedback. The most problematic thing, I think, that I was going to raise, is just the fact that advocates are shut out from outcomes and shut out from receiving information. There needs to be a pathway where advocates are able to, especially when we are assisting a person with intellectual disabilities, to make a complaint, and, some of these complaints are very serious, to receive feedback. You know, being shut out means there is no information we can provide to the person with a disability. There is just no outcome that is received.

MARY: Thanks very much, [NSW Advocate 2]. [VIC Advocate 5]?

[VIC ADVOCATE 5]: Mine is all very similar. We definitely go to service providers first. I am working with a participant at the moment who I spent probably about four or five months trying to work with the service provider, which did not come to any outcome. Now it has been sitting there with the commission for...over 12 months. There is very little work done. It

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is very difficult to get any response from the commission to get any feedback. When I call them as an advocate, you know, they say they may have other complaints that are similar from the same service provider, they want to get together a working group to do something about it and nothing ever actually happens. Still, to this day, and I spoke to them last week, there is no further movement in the issue from 12 months ago.

MARY: Thanks, [VIC Advocate 5]. Let's see whether this forum that we have got on this week can try and put some pressure from the top down of the commission to get some of those things, some action happening. ...Take your microphone off.

[VIC ADVOCATE 5]: Sorry. The complaint we made two years ago, the outcome was very unsatisfactory. The response was along the lines of that "we are trying to build the capacity of service providers, educate them, work with them" rather than come down hard on them with compliance breaching. The whole process was very frustrating. The outcome was that they reported that they had spoken several times to the service provider. This was a serious matter, a very vulnerable young man. They certainly reported that the service provider denied or explained or, I don't know, made excuses which they were happy to receive. And there were no steps then to verify with the complainer anything that the service provider had done in response. It was a closed process. That to me is almost like they are being captured by the service providers, agreeing with what they are being told so they don't have to take further action, and what is the further action they can take? Is it to deregister them? When you read reports of complaints that have been followed up, they have heavy privacy concern if you are reading it, you don't even know the name of the person because it is talking about the service provider and not the staff, not the actual support worker, that could be at fault. So, the privacy safeguards actually worked in reverse. You do not get any information if you read those reports. I am just echoing what I'm hearing. It is a very frustrating process to deal with the commission.

MARY: Thank you. For this, my 15 minute feedback session for next week, it is sometime in the middle part of the day. We will be providing the sort of feedback from today and we have already provided other feedback to them to impress on them that they are not to spend a week session giving you bits of information or patronising you. They have a tendency to do that. All of us have to stop them doing that when they try. There are some great points people are making in here in the chat function, so I hope people have time to either follow along now and read them. But they have put in that the commission doesn't understand issues with distressed or frustrated behaviour from autistic people and is not addressing quality, safety or complaints issues. And it got to the point, like some others, that people don't bother with the commission at all now. There is a discussion going on there between [VIC Advocate 3] and maybe [VIC Advocate 7] and somebody else about whether there was mention that maybe advocates should get some sort of priority treatment, and then there has been some discussion about that and [VIC Advocate 3] is making the point that people who have no support at all to make a complaint, you know, should not be put second best after an advocate. I think one of the...all of these are issues that could do with some serious discussion. One of the...yeah, one of the issues is, one

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somebody touched on a minute ago, this sort of systemic stuff. I think maybe it was you, [VIC Advocate 5], when you said they kept saying they were going to set up a working group. This is something advocates...for each individual, who takes a complaint to the commission, they have a complaint about the situation and the circumstances. At any one time, an advocacy organisation may have multiple complaints running to the commission, all will have had [complaints] , maybe a series of complaints. You may have seen multiple complaints about the same provider. If we were able to look at conference of the all the complaints that the whole advocacy was running at the same time, there could be a provider around the country who had many, many complaints against them. Now, if the commission, that systemic capacity of our sector, [is] be able to assist, not just each individual with a disability but the whole sector, to try and force a commission to improve, or as best it can, to force improvements in practice...anyway, it's an issue we need to pay more attention to. I think [SA Advocates 1 and 2] were wanting to speak?

[SA ADVOCATES 1 & 2]: Yes, I just want to make a point that the NDIS is only part of what is involved in the advocacy arena. For many vulnerable people, the issues often lie outside the scope of this commission. I think that is often forgotten that all of us who are here today are dealing with and supporting people with issues far beyond just the NDIS stuff. You know? The daily living things, the issues that come up for people go far beyond that. [There] are some people who come to us who are not eligible for NDIS. And so, that is a whole other area. I think possibly, that is forgotten in this equation, that the advocacy area is dealing with far more and has far more experience in disability than often the NDIS people think.

MARY: Thanks. A really good point which is not lost on all of you. But the NDIS commission, of course, they have a certain scope. That is what they work with. I have had some...yet, we have some good input from some of our previous workshops about our advocates describing attempting to take a whole range of potential people who could resolve it and all of them passing it on to the next person, including the commission. So, [VIC Advocate 5], you are making the point that some of the systemic patterns of bad behaviour from providers could be usefully provided to the commission if they would meet with advocacy organisations on some regular basis in your region. That is an assumption that probably, at the very beginning, when this quality commission started, that it would be like, but it didn't. But that is one of the things we can be absolutely recommending to them.

[VIC ADVOCATE 5]: Mary, sorry, it is [VIC Advocate 5] again. I want to add because I forgot to say, my complaint that I put through, there was stuff that had been going on prior to the NDIS safeguards commission coming in to place in Victoria. There was stuff with the ombudsman and they would not take on anything that happened before they came into effect. That sort of meant that half of our issue was not put into the commission. They would not deal with it.

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MARY: That's right. I remember the line in the sand at the beginning when they came in where they would not deal with prior issues. I sort of lost sight of that, really. I presume that means there are things that nobody ever dealt with.

[VIC ADVOCATE 5]: Yeah, my one in particular, there was stuff that needed to be brought through to the commission that happened prior to them but they wouldn't take it into account.

MARY: Yeah...

[VIC ADVOCATE 5]: It made [it] challenging but, I thought I'd had it.

MARY: [VIC Advocate 6], maybe they need advisory committee made of advocates? What is interesting about that is that there is an advisory committee, consultative committee, I'm on it! So are some of the other national peaks and a few of the others which includes people from advocacy organisations. It is run on a very bureaucratic style and, for instance, at the last one, maybe a month or so ago, there were some complaints data provided but not in a format we were allowed to share any further. I have asked them to share that information with all of you next week, so that it can come out in the public arena. They are just tentative for some reason. They are not settled into their way of working, but anyway, we need to, as a sector, be putting forward to them all the ideas that all of you can see on the ground about what will make that commission work better.

Yeah, [NSW Advocate 3] making the point that the value of the feedback from this sector is incredibly important. It is not recognised, yes. It is by some but not...they are not accepting, really, some of the assistance that advocates want to provide. The commission and others are not open to it. We only have a couple more minutes in this particular part of the session. I will just see, does anybody else have any other things they want to say about dealing with the commission in any other way? Positive, negative or any recommendations on the commission? Just dive in.

[AUS ADVOCATE 2]: I would like to say, of any agency or body of power, decision-making, you know, I would think that disability advocacy sees the NDIS safeguards commission as an ally. The frustration that we have, because of their sheer disinterest, largely, and I say that to my colleagues here is astounding. You know, we're looking for an ally, Mary. We're looking for assistance. And solutions. And they are absent.

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MARY: And that is interesting. I saw a comment, they are coming in so quickly so I can't quite keep up with all of them and bring them quickly enough, but there was one where somebody was asking about...what is the reason? Is it to do with legislation all the personnel involved?

My sense is that it is partly that they see themselves as a young, new entity and that [their] sense of themselves as a regulator has something to do with this, that they feel a regulator has to be kind of removed in some way. Somehow, they have not found a way of bringing in our sector as firm, quite closely linked allies while they have to, or should be, keeping providers at a distance. They are nervous about it and have not found the solution and we have to help them try to find a solution to it and keep putting forward some process they can do [at] a national level, state-level and perhaps regional levels, where they are hearing not just the individual complaints you are supporting people to take to them, but the systemic stuff as well.

