Disability Safeguards Consultation

Prepared by Cerebral Palsy Alliance

For the Department of Health, Disability and Aging
via Australian Healthcare Associates -
disabilitysafeguards@ahaconsulting.com.au

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Contact:

Kristina Grossetti
Senior Quality Manager
Cerebral Palsy Alliance

✉ kristina.grossetti@cerebralpalsy.org.au ☎ 1300 888 378
cerebralpalsy.org.au

CPA Feedback on Disability Safeguards Consultation – Full Integrated Q&A Submission

About Cerebral Palsy Alliance (CPA)

Cerebral Palsy Alliance (CPA) has evolved to become a global leader in cerebral palsy (CP), bringing together leading services, research, advocacy and technology to improve the lives of people with CP and their families at every stage of life. CPA's dedicated research institute is instrumental in privately funding research into CP leading to reduced rates and severity of the condition in Australia.

Founded in 1945, CPA delivers life-changing services to thousands of children and adults across New South Wales and the Australian Capital Territory, employing more than 225 allied health professionals in a staff cohort of over 2500.

CPA's service model integrates clinical expertise with research translation through the Cerebral Palsy Alliance Research Institute, a global leader in neurorehabilitation and early intervention research. CPA's affiliation with research institutions such as the University of Sydney enables real-world implementation of best practice in exercise, motor learning, and functional outcomes for people with disability.

Cerebral Palsy Alliance (CPA) welcomes the opportunity to provide feedback on the review of the Disability Support Quality and Safeguarding Framework. We strongly support the intent to strengthen safeguards while promoting genuine choice and control. Our response draws on CPA's commitment to human rights, quality service delivery, and continuous improvement, as outlined in our Quality and Safeguarding Policy and Model of Care.

1. When you hear the words 'safeguards' and 'quality' in this context, what does it mean to you?

Safeguards and quality mean supporting people with disability to live with safety, autonomy, and dignity. Effective safeguards must reflect the lived experience of people with disability—not just provider responsibilities—and explicitly recognise "dignity of risk" as central to human rights.

Safeguards should enable choice and control wherever possible. Over-protective systems can unintentionally restrict autonomy, independence and personal growth.

2. What do you like or dislike about the definition of safeguards?

The definition would be strengthened by explicitly embedding dignity of risk, ensuring safeguards do not unintentionally restrict autonomy or participation. The wording should be more participant-centered, simpler and informed by the lived experiences and expectations of people with disability, not just provider expectations.

3. What do you like or dislike about the definition of quality?

The definition of quality should be simpler and more person-centred, focused on supporting people to live the lives they choose. It also lacks practical indicators. Clear, measurable, outcome-focused benchmarks are essential so participants can meaningfully compare providers and understand the quality of services offered.

Quality should be assessed not only through compliance, but through improvements in individual outcomes, workforce capability, and lived experience feedback.

4. Do you have anything to add?

Quality must be measurable, transparent, and comparable across providers. Without common benchmarks and outcomes data, neither participants nor regulators can confidently assess safety or service performance.

5–6. N/A (as a service provider).

7. What makes it difficult for people to access, understand and use information?

People who cannot communicate independently face significant barriers to expressing concerns or understanding their options. They may rely on support workers or family—who may themselves be the cause of concern. Some have limited or no informal supports, leaving them especially vulnerable.

Other barriers include:

- inaccessible formats
- complex language
- culturally inappropriate materials
- limited access to advocacy
- systems that fail to recognise diverse communication needs
- absence of supported decision-making pathways

8. Do you have anything to add?

Communication is a foundational safeguard**.** Without access to AAC, digital communication tools, assistive technology, or supported decision-making, people cannot report abuse, participate in decisions, or exercise their rights.

Recent changes to the NDIS Supports Rule (s10) have inadvertently restricted access to essential communication technologies by classifying mainstream smart devices as “standard items,” delaying or preventing access to AAC and other communication supports.

The replacement process is slow, inequitable, and disproportionate to the risk or cost, directly undermining a person's safety, autonomy, and ability to raise concerns.

Safeguarding frameworks should explicitly recognise independent communication access as a mandatory safeguard.

9. What are ways we can support people with disability to shape their own support system?

- Co-design of services and supports
- Regular, accessible feedback opportunities
- Transparent complaints pathways
- Employing and empowering people with disability in service design and evaluation
- Ensuring **reliable, funded communication supports**
- Providing tools and training for supported decision-making

People can only shape their supports when they can communicate their preferences and concerns safely and independently.

10. Do you have anything to add?

Safeguarding is strongest when people with disability have ongoing decision-making power at every stage of their service experience. Independent communication supports, cultural safety, and accessible information are central to enabling this.

11. What does person-centred support look like?

Person-centred support means enabling a person to express what matters most to them, supporting them in the way they choose, and ensuring their communication—however it occurs—is recognised and respected.

It also requires that services adapt to the person, not expect the person to adapt to systems.

12. How can services get better at putting the person first?

- Invest in workforce capability—including human rights, communication, cultural competence, trauma-informed practice, and abuse prevention
- Embed co-design and lived experience in service design
- Ensure feedback is acted upon with accountability
- Recognise that service settings are people's homes and communities, not workplaces
- Address structural barriers, such as transport or accessibility

- Reduce system fragmentation, especially between health, disability, mental health, and aged care systems

Cross-sector fragmentation is a major safeguarding risk. Clear protocols for transitions—particularly between hospitals, SIL providers, and community supports—are essential.

13. Do you have anything to add?

Mandatory training across the workforce—in rights, communication, cultural safety, and recognising signs of abuse—is essential. Workforce capability is not just a quality issue; it is a safeguard.

System-level improvements, not just provider-level actions, are necessary to enable genuinely person-centred services.

14. Do you think the services you receive are held accountable to deliver quality and safe services?

N/A (as a provider).

15. Are there other forms of accountability you think would increase quality and safety?

- Mandatory registration or accreditation for all disability providers
- Consistent national standards
- Transparent, outcomes-focused, publicly available quality information
- Stronger alignment across sectors to reduce duplication and clarify expectations

16. What could be changed to keep services accountable?

- Clearer regulatory guidance
- Stronger, trauma-informed oversight
- Accessible, responsive complaints pathways
- Nationally consistent approaches to quality measurement
- Mechanisms to monitor service environments for systemic barriers (not just individual incidents)

Accessible complaints processes are essential safeguards, particularly for people with complex communication needs.

17. Do you have anything to add?

Complaints systems must be independent, trauma-informed, accessible, and responsive. People must be able to raise concerns without fear of consequences or reliance on the person they are complaining about.

18. Do you have any examples of when services have worked well together?

CPA’s collaboration with the NSW Ageing and Disability Commission (ADC) is a strong example. When a client faced physical and financial abuse, ADC and CPA coordinated rapid safeguarding measures—over a weekend—ensuring a safe transition to Supported Independent Living and maintaining the person’s voice and preferences throughout.

19. Are there things that stop services working well together in your experience?

- Fragmented systems
- Unclear cross-agency responsibilities
- Inconsistent disability competence in other sectors
- Funding pressures
- Health discharge timelines that conflict with disability safety needs

System fragmentation is not an inconvenience—it is a safeguarding risk.

20. Do you have anything to add?

Formalised, shared protocols and cross-sector pathways (including with hospitals, education, justice, and aged care) are essential for safeguarding. Safeguards must operate across systems, not just within provider organisations.

21. How else can we make safeguarding better?

- Rapid, flexible funding reviews when needs change
- Better coordination between agencies
- Shared accountability across providers and funders
- Safeguard approaches that prioritise prevention, not just incident response
- Policy flexibility to support emerging technologies that enhance independence and reduce risk

22. What role(s) best describes you?

Provider or worker in the disability support sector.