

Health Services Union

SUBMISSION

Royal Commission into Violence, Abuse, Neglect
and Exploitation of People with Disability
(Submission on Workforce)

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About the HSU

The Health Services Union (HSU) is one of Australia's fastest growing unions with over 95,000 members working in the health and community services sectors across the country. Our members work in aged care, disability services, community health, mental health, alcohol and other drugs services, private practices and hospitals. Members are health professionals, paramedics, scientists, disability support workers, aged care workers, nurses, technicians, doctors, medical librarians, clerical and administrative staff, managers, and other support staff.

HSU Disability Coverage

The HSU is the primary disability services union in Victoria and Tasmania, representing support workers at the frontline of service delivery. The HSU also represents allied health professionals in every jurisdiction, including those engaged in provision of services to NDIS participants.

Additionally, we represent disability support workers in New South Wales, Western Australia, South Australia and the Australian Capital Territory; however, the HSU is not the primary union for direct disability support workers in those jurisdictions.

Our broad disability membership across a range of professions gives us a unique insight into the rollout of the National Disability Insurance Scheme (NDIS), how the scheme is interfacing with other mainstream services, and the market and workforce issues critical to the scheme's success.

Overview

The Health Services Union (HSU) welcomes the opportunity to provide a submission to the Royal Commission into Violence, Abuse, Neglect, and Exploitation of People with Disability (**the Royal Commission**), specifically regarding the workforce. Our submission draws on the responses to a recent survey conducted with our disability membership in Victoria, Tasmania, and New South Wales. Our members' insights highlight the inextricable link between decent wages and conditions (qualifications, skills and training, career development, registration, and adequate staffing), and the quality and safety of support for people with a disability. This submission is structured into the key issues and policy priorities of our members. Using a summary of responses and case studies from a recently conducted union member survey, we highlight the issues and solutions under each. We acknowledge that no policy response can occur in isolation; the issues and solutions are interconnected. All member names have been changed, denoted by an asterisk.

Workforce Perspectives

In November 2022, the HSU surveyed its disability members on what they observe as the main factors contributing to violence, abuse, neglect, and exploitation of people with a disability, and what they think needs to change from a workforce perspective. The survey was open for approximately three weeks and produced a sample size of 621 participants. Almost all respondents worked in VIC (73%), then TAS (23%), with a small number of respondents from NSW (4%). This reflects the HSU disability coverage and membership distribution by state.

While the number of respondents is low comparative to total HSU disability membership and the total disability workforce, we believe the responses and recurring themes therein are indicative of issues widely experienced by the workforce which have been captured contemporaneously through a variety of other surveys and research conducted by the union and others.

Demographics

Approximately two thirds of respondents identified as female (66.97%) and were older – with just over half (50.34%) aged 55+ and a further 27.64% aged 45-54. Only 1 in 10 respondents were 34 years of age or younger. 4.55% of respondents were a person with a disability. 9.55% reported speaking a language other than English at home. Nearly all respondents held qualifications relevant to their work in the disability sector, with 93.93% of respondents reporting their highest level of relevant education being a Certificate III or above. The most common qualification was a Certificate IV (36.18%) followed by a Diploma (31.91%). It is important to note here that the high levels of qualifications are likely due to the majority of survey respondents being Victorian, reflecting HSU coverage. In Victoria, mandatory qualifications existed for the majority of the sector employed by the Victorian Public Sector, prior to the State Government contracting out services to private providers.

Work setting

Respondents predominantly worked in a residential setting (83.91%), such as Supported Independent Living, group home, or respite facility. The next biggest cohort reported working in community access/participation (23.33%), followed by those working in a home-based setting (14.29%), and day programs (10.49%). The remaining respondents (less than 10% total) reported working in either

management, Local Area Coordination, specialist mental health, or allied health. Very few respondents worked across different settings.

Employment

Nearly half of respondents (46.52%) have worked in the disability sector for between 5 and 19 years. Just over a third of respondents (35.96%) reported working in the sector for 20 years or more. The remaining 17.53% have worked in the disability sector for less than 5 years.

A majority of respondents (81.19%) were employed on a permanent ongoing basis with access to paid entitlements, while 12.2% reported being employed on a casual basis with no access to paid entitlements. The remainder of respondents (6.69%) reported their employment arrangements as being self-employed or an independent contractor, where they are individually responsible for payment of any entitlements and financial liabilities such as superannuation and workers' compensation insurance. 1 in 10 respondents reported working for multiple organisations, while the majority worked for a single organisation.

The average number of hours per week of paid work across all respondents was 33.29 hours, however 89% of respondents reported carrying out an average of 17 hours per week of additional unpaid work.

Client/participant support

95.48% of respondents work directly with disability service users or NDIS participants. 93.1% of these respondents report working with people with an intellectual/cognitive disability. Just over half (52.3%) report also working with people with a physical/sensory disability, and 46.93% report also working with people with a psychosocial/mental health disability. Nearly 2 in 3 respondents (64.25%) report typically working with people with high support needs, followed by nearly 1 in 3 (31.23%) typically working with people with moderate support needs. The small remainder (4.52%) report typically working with people with low support needs.

Nearly 3 in 4 respondents (72.22%) reported always working with the same clients each week, with 23.95% of respondents saying they mostly work with the same clients each week. The remaining 4.02% reported only sometimes or never working with the same clients each week.

Over one third of respondents (37.93%) reported always or mostly working with clients on their own i.e. not in the presence of another worker. More than half of respondents (56.13%) reported working with clients on their own sometimes. Only 5.94% of respondents reported never working on their own with clients.

Key issues

Respondents were asked to comment on the challenges they face in their work and the inhibitors to providing safe and respectful care that supports the human rights of clients/participants.

Overwhelmingly, when asked what they thought the main contributing factor to violence, abuse, neglect and exploitation was:

- Almost half of respondents (46.4%) reported a lack of training and supervision.

- Approximately 1 in 3 respondents (37%) said a lack of formal qualifications and poor quality of training and qualifications.
- Nearly one quarter of respondents (24.2%) cited inadequate staffing levels, staff turnover, and lack of staffing continuity.
- Approximately 1 in 10 respondents (10.6%) reported inappropriate placement and housing of clients/participants.
- 5.9% of respondents cited lack of adequate NDIS funding and flawed pricing mechanisms.
- Nearly all respondents made comments that these issues are interrelated.

It is important to make abundantly clear that the HSU and its members condone all acts of violence, abuse, neglect and exploitation and are committed to ensuring that the lives of people with a disability are free from all forms of discrimination and lived with full achievement of their human rights. Our members acknowledge that these acts arise through the deliberate actions of individuals, and because the system does not support the delivery of consistently, high-quality and person-centred care. This was evident in all responses to the member survey and this submission is therefore centred on the relationship between workforce factors and support outcomes.

Training, supervision, and formal qualifications

Many workers report a lack of access to training and diminishing levels of supervision. Significant workforce pressures arise from poor quality training, absence of continued training opportunities and formal qualifications, and a lack of structural support. There is extensive scope to improve access to training – both prior to and during employment in the disability sector. The HSU is of the strong view that addressing training and supervision inadequacies will have a substantial positive impact on improving support environments and outcomes.

“Staff at group homes get no training or support to advocate for the residents within the NDIS system. Serious issues are dealt with slowly, if at all. We’re completely disempowered... residents miss out on essential services and supports and we have no way to help.”

Disability Support Worker, In-home Support, Student of Masters in Disability and Inclusion, Victoria

Training

Disability workers report inconsistency in the training they receive prior to entering the sector, with private Registered Training Organisations (as opposed to TAFE) offering courses that are variable in length, content, and delivery. Individuals report feeling ill-equipped to apply learned knowledge and skills to new and complex environments. There must be improved oversight and regulation of pre-employment training. At a minimum, new employees in the sector must receive the compulsory induction module on the NDIS Code of Conduct developed by the Quality and Safeguards Commission; workplace, health and safety inductions; and adequate shadowing and mentoring to familiarise them with participants unknown to them.

“Prior to the National Disability Insurance Scheme, I received lots of training working with people with complex communication and behaviours of concern. Now, because of the way the NDIS money works, I receive less training.”

Disability Support Worker, Group Home and Day Programs, Victoria

Disability workers report that ongoing training, particularly specialised training, is not readily available and where it is available is often unaffordable or impractical for them to access, primarily due to short staffing. Currently, there is no uniform approach or standard for employers to comply with, so place-based training varies widely from employer to employer and state to state. Minimum standards of on-the-job training and supervision must be harmonised across jurisdictions, and employers must be required to demonstrate that they are meeting this responsibility. All workers must have access to ongoing professional development and accredited training relating to specific disabilities, such as individual participant behaviour support plans, medications management, and complex health needs including PEG feeding, tracheostomy care, and epilepsy management.

“Organisations taking on clients with multiple complexities need to offer specialist training. For example, children with trauma, people with acquired brain injuries, and mental health comorbidities need adequately and appropriately trained staff. One box ticked for a disability does not mean staff have the right training or know how to follow best practices.”

Disability Support Worker, Supported Independent Living, Tasmania

Ensuring workers receive adequate and ongoing training is essential to ensuring a proper and holistic understanding of human rights, dignity and respect. It supports the application of best practice standards as and when these change, including all necessary behavioural de-escalation and intervention that ensures no harm is done (see Case Study One). Training assists workers in building a stronger awareness of the signs of abuse and the necessity of reporting. It improves the quality and safety of support and assists in empowering workers to prevent, identify and act against violence, abuse, neglect and exploitation. Coupled with good job security that enables workers to build long relationships with clients/participants, a supportive organisational culture can aid in the removal of a fear of reporting (discussed further below).

Case Study One: Thomas*

Thomas* works with NDIS participants in home and community-based settings in northern Tasmania. He is a team leader as well as a support worker. Thomas has noticed a sharp decline in the training of new starters in his team. He says that most new employees have only done short courses and since COVID-19 hit, some new workers have only ever undertaken online training. Thomas says there is a clear difference in job readiness between people who have done a longer course with a work placement and assessment element versus those who have completed coursework training only. When new employees tell him they have only done an online course, Thomas says he is immediately concerned that the worker and client will be ‘unsafe.’

Working in home-based care, it is rare that Thomas works directly alongside his team. He says that for many new employees it can take weeks, and even months, before he is able to spend time with them. He observes a general lack of understanding of reporting systems and basic work, health, and safety policy and practice. Understaffing and physical distance from his team means there is insufficient shadowing and mentoring.

Thomas describes a recent day where he buddied up with a new employee who had started working in the sector approximately three weeks earlier. The new employee had not yet completed their certificate qualification. It was the first chance for a shadowing shift. The client was being taken for fish and chips. The worker had taken the client out previously but told Thomas they had only gone to the local shops where the client knew everyone and the environment was familiar.

The shops and shoreline were very busy. Thomas noticed that the client was becoming agitated. He mentioned this to the worker and the worker said they did not really notice any difference. Thomas tried to enquire further and asked if the worker had received any notes or handover on possible sensory stimulation triggers prior to working with this client. They replied that they had not, but they were not worried. A baby at the table behind them began to cry. The client became increasingly agitated, before turning to try and grab the baby's pram. Thomas immediately intervened to create physical space between all parties and deescalate the situation. The worker attempted to restrain the client, causing bruising on the client's upper arm and chest.

When debriefing after, it became apparent that the worker had received no training in de-escalation and was not aware of supports that would assist the client in new environments. Additionally, the worker was unaware of their incident reporting obligations and the requisite procedures. Thomas said this incident was very distressing for everyone involved, and if the worker had received additional and place-based training they would have been much better equipped to support the client prior to and during the outing.

Supervision

Experienced workers report a lack of confidence in the capacity of new workers, and a need to divert resources and attention to them with additional on-the-job supervision. In short-staffed environments, and compounded by the proliferation of insecure work, this increases the risk of 'missed care'¹ and erodes both the confidence of new employees and their likelihood of staying in the sector. Training and supervision must be delivered to accommodate the frequently non-static nature of disability workers and workplaces, i.e. in the community and people's homes. Nearly 1 in 4 (24%) respondents to our member survey, when given an opportunity to provide free form text, referenced 'poor supervision', 'lack of supervision', 'invisible management', 'too many people to supervise' or similar terminology.

"I worry about the staff coming in who are inadequately trained. They don't understand the principle of choice and control and what this should look like in support delivery. The managers do not have any time to supervise these new workers."

Disability Support Worker, Community Participation and Day Programs, Victoria

Formal supervision should include regular meetings, on paid time, between workers and supervisors, to enable support workers to; discuss individual participant needs and connect to a broader team of support worker experience, engage in reflective exercises to consider best-practice for supporting participants with complex behavioural needs, and access opportunities to monitor and reallocate workloads, solve problems, and promote workers' development.² The aim of formal supervision practice is to ensure workers are empowered and appropriately skilled to undertake their work, including when client needs change. Formal training and supervisory structures are also an important element of a transparent and accountable sector, as they provide assurance to clients/participants and the wider community.

¹ Meagher, G, Cortis, N, Charlesworth, S & Taylor, W 2019, *Meeting the social and emotional support needs of older people using aged care services*, Macquarie University, University of New South Wales and RMIT University, p. 15.

² Definition from the [Scottish Social Services Council Code of Practice for Employers](#)

“When you combine staff who do not receive any training with managers that do not have time to offer support because they are busy doing paperwork and rosters, then things are bound to go wrong. If we had more support, we’d be able to offer our clients better support.”

Disability Support Worker, Supported Independent Living, New South Wales

Lack of formal qualifications

Closely linked with the issues of minimal training and supervision identified above, is the lack of formal qualification requirements and insufficient access to undertaking formal qualifications. The absence of a mandated minimum qualification and a culture of placing the onus of responsibility on individual workers to attain qualifications intersect to compromise the quality of care and jobs. Disability support workers are low-paid and the cost of undertaking study – both in real cost and in time – is often too individually burdensome. Studying and professional development are not built into providers’ rostering practices or Government pricing mechanisms. For example, employers are not required or funded to have a backfill policy in place for when workers are absent while studying. Throughout survey responses HSU workers identify this as a serious systemic inhibitor to providing consistently safe and high-quality care and support.

“I get asked what career progression I want, but I wouldn’t pick up a higher position. You don’t get enough time to do the study or work. I am already doing behaviour support planning, keyworker duties and shift reports with only two hours of administration covered per month - where would I even fit in going to TAFE? I was recently trying to get my administration work done, which I was directed to do, and a resident wheeled himself onto the road twice within the space of 5-10 minutes. A co-worker had encouraged the resident to come back inside because he’d seen him out there while he was coming onto shift. If we’re this stretched already and these risks are happening, it’s impossible to take on study responsibilities.”

Disability Support Worker, Group Home, Victoria

There is a correlation between relevant qualifications and years of experience of working in disability. In general, those with more years of working experience were also more likely than others to have relevant qualifications at or above the Certificate IV level. For new entrants working in the sector, this exacerbates the issues outlined earlier regarding training and supervision. With an older demographic of workers and increasing workforce supply pressures, the disability sector is facing a skills and qualifications shortage crisis.

“We need more appropriately trained and qualified staff. There needs to be more done to acknowledge staff with years of experience in the disability field that cannot afford to pay out-of-pocket for a Certificate IV in Disability. Everyone should be able to get this certificate, but we can’t when we don’t have the time and money.”

Disability Support Worker, Supported Independent Living, Victoria

“If you’re lucky, you do a two-day drug course. Then you’re expected to hand out some of the most powerful drugs. If you’re going to work with high and complex needs, you need more training.”

Disability Support Worker, Group Home, New South Wales

Under the NDIS, training and professional development is not properly priced and is therefore treated as an unnecessary or unavailable cost by providers. HSU members advise that for workers undertaking work placements as part of a qualification, supervision is inadequate or not offered. As a result, job-

readiness and completion rates for qualifications are diminished. Traditionally, traineeships that enable attainment of a formal qualification require wages to be paid for both the trainee and trainer. This is hard to reconcile under the fee-for-service NDIS model. NDIS providers have said that “supply for traineeships and student placements is low” as they “lack resources to provide supervision, cover costs of administration relating to placements, and guarantee work hours”, indicating that the NDIS pricing model precludes the option for widespread uptake.³

Case Study Two: Jane*

Jane* is 54 years old and has worked in the disability sector for 10 years, following a long career in aged care. She works in a residential setting, caring for four men. The clients are housed in two units, side by side. One client in each unit has high care and support needs and the other has lower needs. The service is in northern Tasmania. Jane has a Certificate III in Disability and Aged Care. She completed her formal qualifications some time ago but has since completed additional skill sets in First Aid, PEG feeding, dementia, and Huntington’s disease.

Her biggest concern is the lack of training and qualifications in the sector. She describes it as becoming ‘non-existent and impersonal’ with inductions done online. New staff come in with minimal knowledge, no pathway to getting their Certificate qualification, and no understanding of individual participants’ needs. She says that disability support is the only industry where anyone can ‘come out of nowhere’ with no training and get a job. This worries her immensely as her clients need and deserve highly skilled staff.

Jane describes a situation where she and another employee, who had been employed for about 6 months but held no formal qualification, were working with two clients with degenerative diseases – Parkinson’s and Huntington’s. There was an age gap between the clients, being 50 and 65 years of age respectively. Jane said it was very important the men were kept apart as their personalities clashed and the situation could become ‘a bit hairy’ for everyone involved. It was the first shift the new, younger worker had done with Jane and the two men.

Jane says that she had to take a quick bathroom break. She estimates being away from the room for less than 5 minutes. The new worker decided to bring the two clients together into the living space, even though Jane had already stated they were best to stay apart. One of the clients became violent with the other and it was not until Jane ‘raced back’ from the bathroom that they were able to be separated and deescalated. Jane says that afterwards the younger worker asked, “As his disease progresses, will he become more violent?” and Jane had to explain, “No, it’s not Huntington’s that is causing the violence, it is other health issues and stimulation.” Jane says that when you do not undertake a Certificate and/or have very good on-the-job training these are the basic things you do not get taught and are therefore not prepared for escalations.

Jane would like qualifications and training to focus on mental health and wellbeing. She says that well-researched degenerative illnesses, such as Parkinson’s and Huntington’s, are easier to understand and care for, but when there is also an acquired brain injury or drug and alcohol abuse (for example) it leaves people – especially new workers – feeling out of their depth. Jane always tries to offer hands-on training like she herself received in aged care and when she first started in disability support but said that it’s rarely possible with time and money constraints. She says young people are coming into the workforce only to be left without assistance, and many leave soon after.

³ Department of Social Services NDIS National Workforce Plan, consultation paper, 2020.

Strong supervision enables the early identification of qualification, training and skills gaps for workers. It assists providers in identifying behaviours and attitudes that are contrary to supporting and enabling people’s human rights and participation in society. Collegial supervision can also play a central role in empowering workers to speak up and engage in formal reporting. At present, the NDIS and wider disability sector does not effectively utilise formal supervision (and training) structures to prevent, identify and address skills gaps. HSU members report a culture of fear when it comes to incident reporting and engagement with management.

“The person with a disability is often unable to or has limited means to communicate for themselves. We [the workers] lack confidence in the reporting systems, even though we should be the ones doing this for our clients. It’s a vulnerability of employees to their employer - they’re constantly changing our work hours and contracts and shifts; the managers have a high turnover and we never see them anyway – which prevents transparent reporting. We feel our concerns will be silenced or we’ll get sacked.”

Disability Support Worker, Respite, Metropolitan Victoria

The HSU recommends there be a re-appropriation of State and Commonwealth training funds to be focused exclusively on NDIS, with wrap-around supports ensuring learners complete qualifications and develop new skills. Additionally, a new pricing mechanism that facilitates traineeships and funds the costs involved in supervising a quality placement is urgently needed. Qualification and training opportunities must be linked to clear career development and pathways. A direct link between these professionalisation measures and capacity-building will make disability support a more attractive career to enter and remain in while also elevating the quality of care and support delivery.

Staffing and continuity of care

“Staff are burning out, especially the longer-term staff. There will come a point in time where I will have to walk away because I cannot bear the lack of continuity and support that the people we support need. We need a plan for the future, because things are not working now.”

House Supervisor, Supported Independent Living, Regional Victoria

Short staffing and high turnover in the disability sector is indicative of a system that is under-resourced and failing to address systemic attraction and retention drivers such as training, wages, and working conditions. For workers and people with a disability, short staffing translates to insufficient time with clients and participants. When workers are not able to consistently work with clients to build relationships and become familiar with individual support plans and needs, there is a higher likelihood of systemic neglect and mistreatment of clients as well as aggression and abuse toward workers. Inadequate staffing leading to workers feeling rushed, stressed, and forced to compromise care standards was frequently raised by members when asked to expand on the issues they identified as the main contributing factor to violence, abuse, neglect, and exploitation in their work.

“They [the provider/employer] are always trying to cut back on staff. The rosters don’t match the client’s needs and we end up having more staff for the hours we least need them, like bedtime. We have one resident who does not verbally communicate, so they grab and pinch you to indicate they need to use the toilet.”

Disability Support Worker, Supported Independent Living, Victoria

“There are staff shortages everywhere. It means staff work overtime hours, normally without any pay but just because it’s what they have to do to finish everything. Staff are unable to take leave and they burn out. Most have accumulated hundreds of hours leave. We feel bad if we take it because the clients go without.”

Disability Support Worker, Day Programs, New South Wales

“A resident with schizophrenia had no mental health plan in place and no psychological support. The house was understaffed due to a lack of funding that had not been resolved, despite us [workers] at the house trying to get the support coordinator to review. The support coordinator kept changing. We were concerned the resident was disengaged and depressed, but before we could get him the supports he needed, he seriously assaulted a staff member.”

Disability Support Worker, Supported Independent Living, Regional Victoria

Scope of practice

Workers report having to practice outside of the scope they are trained and employed to work within, placing them at risk of disciplinary action, in a position of ethical dilemma, and – most significantly for them – stressed by the ‘missed care’ of care recipients. Increases in scope of practice are arising from structural pressures outside the individuals’ control such as a sustained reduction in staffing levels or pricing for services set at inadequate levels, driving down quality of care.

Additional scope of practice without requisite supports and training leads to high rates of stress, burnout, injury to workers and/or care recipients, and a decline in overall quality of care. HSU members describe being in a vicious cycle where time and pricing pressures contribute to burnout, burnout then drives high staff turnover, and high staff turnover diminishes continuity and capacity for high-quality care.

“Where I work there are 8 residents housed across 5 units, with a staffing profile of 5. This site has had 60% turnover of staff since it opened around 3 years ago. On occasion, there has been only 2 staff on site resulting in neglect of residents and a great risk of harm to everyone. A resident who requires support to safely access the community was found crossing the road unsupervised - twice - as a result of understaffing.”

Disability Support Worker, Supported Independent Living, Victoria

“We urgently need better assessment of client needs and appropriate placement of workers, related to these needs. I have seen clients moved based on expediency for the organisation rather the best outcome for the client. Staff need to be selected and trained for the needs of the clients. Staffing ratios should reflect client needs and NDIS funding should meet these.”

Disability Support Worker, Residential Setting, New South Wales

Casualisation

Further diminishing the capacity for continuity of care and meeting client needs is a highly-casualised workforce, with an increasing prevalence of precarious work arrangements. Underpinning the rise of precarious work is the restrictive pricing, low wages, and poor working conditions of employment in

the disability sector (see also below ‘Pricing pressures and employment standards’). When there is no stability of work, there is significantly diminished capacity for stability of care. High staff turnover drives employers to fill shifts with workers that do not have the requisite skills and training to care for people with disability. Additionally, workers from gig platforms and other precarious models are less likely to be captured by regulation, such as the NDIS Code of Conduct, and this directly erodes the safety of both client and worker.

“They [the provider] have to fill our rosters with casual and agency staff. They hardly have any training and they don’t really want to work in disability. You and the client only see them once, then they’re gone again.”

Disability Support Worker, Home-based and Community Services, New South Wales

“The provider mostly wants to hire casuals because they’re easier to find and cheaper. It currently takes several months to onboard and get to the orientation stage. Many cannot wait and find other employment, so after everything we only end up with a few extra people on our casuals list. It really makes no difference to staff levels because by the time you onboard one new casual, someone else has burnt out and left.”

Disability Support Worker, Home-based and Community Services, Tasmania

Funding must be available to allow workers to access qualifications, training and continued professional development at no time or financial cost to themselves. Removing barriers to career and skills development will retain staff and in turn allow for continuity of care. Service providers must ensure that rostering supports continuity of care and that staffing levels allow workers time to complete all requisite work, including paperwork and other administrative duties. This requires pricing and funding reform to ensure that workers are not encouraged to carry out non-direct work on their own time or divert direct care time away from clients/participants in order to meet other responsibilities, such as paperwork.

Placement and client/worker safety

To provide safe and high-quality support to people with a disability living in residential settings, it is essential that services appropriately place clients. Appropriate placement means that clients are living with others that are compatible to their needs and wellbeing, and that there is consideration and matching of staffing numbers and skills profiles. HSU members report that under NDIS pricing, and without comprehensive regulation, incompatible housing is a common cost-saving measure for service providers. They attest to the risks to the health and safety of both clients and workers that arise from inappropriate placements.

Case Study 3: Sarah*

Sarah* is a disability support worker in Supported Independent Living in regional Victoria. She has 20 years of experience.

Sarah reports the house where she works is an unsuitable environment for a female, non-verbal client whose behaviour becomes heightened when other clients are receiving support or there are changes to her environment. When the client’s behaviours are triggered, this causes a high level of frustration

for a male client who also has behaviours of concern. Several times he has yelled and raised his fist at the female client – Sarah reports that this has been happening for many years.

“The staff have been constantly expressing our concern that he will hit her. In response, we’re told that it is about the male client and his behaviour, but I’m advocating for him and trying to explain that he is responding to another resident’s behaviour. I fear that this customer will be moved, so I speak up for him.

We also keep advocating for her, that should be in an environment where she can shut doors or control the heating and cooling. I can’t tell you how many years in a row I’ve tried to push for her to have a holiday every year. The one time we succeeded it made a big difference. We had to send emails, bring it up at staff meetings – and we had a good coordinator. People shouldn’t have to spend all day with the same people, living and going to day placement, they deserve a holiday.

I’m so passionate about this industry and it breaks my heart to see what’s happening. No one consults with our residents. I haven’t seen a support coordinator or planner in the house regularly for so long. I’ve spoken up, but none of our clients have any involvement with any planning or placement.”

Appropriate accommodation enables people with disability to live as independently as possible. The HSU recognises that ensuring the supply of appropriate housing is costly and takes time. However, a lack of housing and inappropriate placements heightens the risk of violence, abuse, and neglect, while also creating risks to worker health and safety. Investing in housing and lifting caps on pricing that inhibits adequate and skilled staffing in residential support settings will deliver immediate positive change.

“We really need better training on safe work practices, such as policy and procedure that is practical and designed with users in mind - so paperwork is understood as being necessary, not just a meaningless check box exercise for compliance. NDIS as a scheme should have case management but doesn't, which means people fall through the cracks regularly.”

Quality Assurance Officer, Tasmania

The HSU recommends that in tandem with better professional supervision and ability for workers to debrief, employers must be funded to provide additional training on managing and responding to work health and safety risks common to shared housing. Additionally, rosters must ensure client-to-staff ratios and skills matching is undertaken regularly.

Case Study 4: David* and Elizabeth*

David* has been working in residential disability services in regional New South Wales for 23 years. He has specialty experience working with people with psychiatric and intellectual disability. He currently works with 3 clients housed in 2 units on one site. There is a 3:1 client to staffing ratio. Two clients have psychiatric disability while the other client has an intellectual disability (primary) and psychiatric disability (secondary). David is employed part time and works 32 hours per week. He is qualified with a Diploma in Community Services. He tells the story of Elizabeth*.

“Elizabeth is a 64-year-old woman living with mild intellectual disability and diagnosis of schizo-affective disorder. She lived in supported accommodation from the age of 12 to her mid-30s. She then lived in different types of community-based supported accommodation. She has challenging behaviours and is

supported with a Positive Behaviour Support Plan. Her support needs mainly stem from her intellectual disability and physical health issues.

In 2020, Elizabeth was moved from her shared accommodation house to a unit where she lives on her own. While she had expressed a desire to live alone, occupational therapy assessments indicated that she did not have the skills to live alone and that there were risks associated with her living by herself. Where Elizabeth had been living prior to January 2020 there had been active overnight staffing with two staff on duty during the day and evening to support three clients with intellectual disability. In her current accommodation there is one staff member to support three clients and a sleepover arrangement for overnight emergency support only. The skills and experience of the staff who work at this site are in mental health rather than intellectual disability.

The move to the new site has had a negative impact on Elizabeth and others, as there is not the level of support and supervision that she requires. This had led to significant safety issues for herself and others due to inadequate staffing to accompany her in the community or provide supervision when she is alone in her unit. Elizabeth frequently expresses feelings of loneliness since living by herself and often ventures into the community without support. When in the community alone she has been known to threaten people or expose herself to risk by getting into cars with strangers.

Moving Elizabeth to her current supported accommodation site appears to have been influenced by financial pressures to fill vacancies quickly to keep sites financially viable. This has meant that a unit that could have housed two people is now being occupied by one person as Elizabeth declines to share her unit with someone else. Occupational therapists and behaviour support practitioners continue to indicate that the current support level is too low for her needs and that she needs more 1:1 support for supervision and guidance.”

David describes the NDIS funding model as rigid, not allowing for vacancies in Supported Independent Living to be maintained until suitable participants are identified and assessed. This financial risk encourages inappropriate placement of individuals, or the shuffling around of existing clients to keep beds filled. In this case it resulted in Elizabeth being placed in a situation where she is at increased risk, staff safety has been negatively impacted, and there has been a detrimental effect on the quality of life for other clients at the site.

David says there is no oversight by the NDIS or any independent body to ensure standards are met and best practice is maintained. Under previous arrangements, funding bodies scrutinised the services they were funding and there was a level of reporting against funding criteria that ensured proper use of funding.

Pricing pressures and employment standards

“A work force that is undervalued, under-trained, and underpaid will never attract the right staff or retain them.”

Disability Support Worker, Residential settings, Victoria

There is an inseparable link between decent jobs and safe, high-quality disability services. However, the approach to pricing and the Cost Model used by the National Disability Insurance Agency (NDIA) does not account for high-quality service provision and prevents disability support workers from being able to provide consistently person-centred care aligned with the client/participant’s needs. Restrictive pricing dictates low wages, precarious work (including high rates of casualisation and low-hours part-time contracts), limited career progression, and unsustainably high-workloads. Workforce turnover is

high, and the sector will struggle to find the additional 83,000 workers it is projected to need by 2025. Supply of workers is limited in large part due to competition with other industries that offer better pay and conditions. HSU members describe the erosive relationship between pricing, decent jobs, and quality supports.

“We need to recognise that the supports given to a participant rely on all staff to keep the person cared for and an organisation going [viable]

. The way things are headed, there will be no managers in any SIL homes. They are already spread thin and have no time to address the issues staff and clients have. NDIS is cutting funds left and right for participants, which is making companies have to cut staff. Staff are forced to work on their own or with client/staff ratios that are well under safe standards. This means clients are not getting quality of care.”

Disability Support Worker, Supported Independent Living, Victoria

“NDIS needs to delve deep into where the funds are going and ensure that their participants are receiving the care they are paying for. Staff are stretched and end up cutting corners out of desperation and necessity. It means there is neglect, but none of us would ever mean for that to happen.”

Disability Support Worker, Day Programs, Tasmania

Precarious employment and quality of care

In health and community services, there are proven links between job and wage security, continuity of care, and health outcomes for care recipients. Despite the evidence demonstrating this causal link, workers in the disability sector report increasing rates of precarious employment arrangements, including casualisation, insecure wages, underemployment, and the fractured “gig-economy” model, where workers are denied the rights and entitlements afforded via the traditional employment relationship. In the disability sector, 58% of the sector is part-time employed and 37% is employed on a casual basis (and rising).⁴

Despite the COVID-19 pandemic highlighting the devastating intersection of job and wage insecurity with poor public health outcomes, the rate of permanent employment in disability has significantly decreased, from 80% in 2019 to just over half of the workforce. The perverse effects of precarious employment are most pronounced in the erosion of continuity of care, quality assurance, and client and worker wellbeing (physical, emotional and financial). Precarious employment presents as a major attraction and retention barrier.

Case Study 5: Betty*

Betty* is a Disability Support Worker in regional Victoria in Supported Independent Living. She has over 20 years’ experience and has observed the changes in the sector as new approaches and pricing models have been introduced.

⁴ National Disability Services 2022, ‘State of the Disability Sector’, report, p. 35.

Betty works with a resident in a group home who had 2:1 staff to client support due to physical support needs. The client's needs meant he would stay at home during the day. After his NDIS plan was introduced, he was only provided 1:1 support, despite still needing 2 staff to assist him – including with using the toilet. Betty and other staff provided the NDIS with a letter of support from an incontinence nurse clearly stating that the client needed 2:1 support. Rather than having the funding reinstated for the second staff member, Betty and her team were advised that the resident should be wearing incontinence aids between 10am-3pm instead, because he opts to stay at home.

Betty says that prior to the NDIS, staff ordered incontinence pads from a supplier on an as-needed basis. Since the NDIS, they are required to put in a request to the Support Coordinator, who may or may not respond in a timely manner. Betty explains that lags in a response aren't the fault of the Support Coordinator; they do not have caps on how many people they provide services to and so are often overworked and running behind. Betty says that in addition to this cumbersome process, incontinence pad companies appear to have put caps on order sizes and/or require payment before disbursing orders. They never used to do this, and Betty believes the change is because of delays in payments though the NDIS.

NDIS Price Setting and Enterprise Bargaining Agreements (EBAs)

The HSU has extensive experience in negotiating enterprise agreements with service providers, and this gives us a unique insight into the impact of pricing on service delivery and job quality.

The NDIS cost methodology (CM) is a pricing strategy providing the underpinning pricing assumptions for the Scheme. The Disability Support Worker CM produces the cost for 1-hour of support delivered by a disability support worker to an NDIS participant by using the *Social, Community, Home Care and Disability Services Industry Award 2010* (SCHADS) as its basis. Specifically, Award classifications for Level 1, Level 2, and Level 3 intensity support are set as SCHADS, Schedule B, Levels 2.3, 2.4/3.1, and 3.2, respectively. The assumption ignores the reality that thousands of disability support workers are employed on enterprise agreements which set wages and conditions *above* the Modern Award.

While it is true, as the CM states, that “any additional benefits offered by EBAs over the Award have been voluntarily agreed to by providers” the reality is that enterprise agreements that set pay rates above the Modern Award have been negotiated in good faith between employees and employers over long periods of time, with incremental advances to wage classification structures and conditions achieved through successive rounds of bargaining. These successive rounds of bargaining occurred well prior to the introduction of the NDIS and the NDIA's decision to unilaterally impose price caps predicated on minimum Modern Award classifications. Moreover, the Modern Award cannot be viewed as “generous” – the role of the Modern Award system under Australia's industrial relations system is to simply provide a minimum floor on wages and conditions. Instead, the NDIA – through its RCM and its successor, the CM – has reappropriated the Modern Award as a ceiling on wages and conditions across an entire sector. Wage growth and career progression is severely restricted by funding linked to low price settings.

“The NDIS guidelines and the Award conflicted on whether or not you could claim travel to and from a participant, when leaving from your home. We were able to claim this cost. There was then a reversal of rules and we cannot claim travel costs. Some workers have had no choice but to cancel support for certain participants where the support worker relied on provider travel

reimbursements to justify driving there. We are constantly fighting over scraps and it leaves our clients without support.”

Disability Support Worker, Supported Independent Living, Tasmania

Pricing caps, participant packages and wages

NDIS participants are first assigned packages and then exercise choice and control over how, and with which providers, they spend their available budgets. The NDIA argues that if the amount of the caps is increased, without increasing the amount of a participant’s package, then the worker will receive more, but at a cost to the participant. Of course, if a provider or disability support worker is under a better agreement, this impacts the proportion of a participant’s package spent on a particular service/worker and the participant may go elsewhere in search of a provider where they can access more services via lower wage costs. The HSU is not suggesting that clients should not have choice and control over expenditure of their package, but rather that the pricing mechanisms must not force clients to make choices between cost savings and workforce wages, conditions, and service quality.

“The NDIS undervalues staff by paying ridiculously low wages and putting high demands on people. The pay doesn’t match the work we do.”

Allied Health Services, New South Wales

A resident had been supplied a walking frame before transition to NDIS. After the transition, the walking frame started to fall apart and the brakes were not working at all. When staff asked about a replacement, we were informed by the support coordinator it wasn’t in the plan and would need a review with evidence from an Occupational Therapist. After more than 6 months of waiting for the NDIS review, a physiotherapist who was already funded offered to intervene and share her funded hours with an OT in her workplace to assess and supply a walking frame on the spot. NDIS and support coordinator never suggested another possible solution despite the walking frame being necessary for the resident and unsafe to use.

Disability Support Worker, In-home Support, Student of Masters in Disability and Inclusion, Victoria

Workloads

NDIS funding only covers direct care. Workers report increasingly large and unsustainable workloads for administrative tasks and non-direct care work, for example completing client notes and travel time. More experienced staff report doing the majority of administration and management tasks, meaning inexperienced staff are left with high needs clients. Workload pressures are frequently cited by workers as a main reason for leaving the sector.

“There is simply too much admin/paperwork and not enough time ‘on the floor’. I started disability support work so I could work with people, but now I basically have a desk job.”

Disability Support Worker, Home and Community Access Support, Victoria

“Staff feel bombarded with paperwork and constantly changing regulatory requirements. We get less time with clients’ or end up doing everything out of hours on our own time and money.”

Disability Support Worker, Supported Independent Living, Victoria

The HSU advocates for pricing and a price-setting mechanism that captures the true cost of service delivery. Appropriately set pricing will ensure that service providers do not have to make decisions about financial viability at a cost to client support. Workers should be able to deliver direct care, aligned with client needs and choices, without compromising quality, safety, and the completion of essential non-direct work.

“The government should take a more active role in pricing and be an employer of choice themselves, setting the standard for pay and conditions, quality and act as a safety net, especially in regional areas where private providers don't see the opportunity to turn a profit. If disability support followed a similar model to public schooling, it would be a much safer and more accountable model.”

Disability Support Worker, Group Home, Tasmania

In order to provide the highest possible standard of support and care to people with a disability, the workforce must be securely employed, with access to entitlements that afford them a balanced and fulfilling work life. This includes but is not limited to paid leave, superannuation, and workers' compensation in the event of injury. Precarious models of work must be appropriately regulated by the Commonwealth and disability safeguards framework. Pricing and funding must ensure that service providers do not shift labour costs onto workers, via precarious and casual employment.

Concluding Remarks

An incongruence exists between the discourse of person-centred care and choice of services, and how the disability sector functions in reality. The HSU concludes that neglect occurs predominantly because the systems fails to provide work conditions conducive to high-quality and safe support. The structural drivers, as outlined by our members (a non-static and precariously employed workforce without access to decent training, professional development and supervision; low and declining staffing levels with rostering arrangements that expose workers and clients to work health and safety risks; inappropriate client placements; and undervalued work reflected in poor wages) converge to create work and care environments that are out of step with what we expect from these essential services. All of these issues are underpinned and exacerbated by poorly informed pricing that does not capture the true cost of quality supports and decent jobs. Addressing any one shortcoming will not go far enough. The issues, and therefore solutions, are interlinked and policy responses must therefore be holistic.