

30 November 2006

STRATEGIC DEVELOPMENT

Survey of Staff of Disability Support Providers

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EXECUTIVE SUMMARY

Although the sample was large (n=466), the response rate was low (7.14%) and so the findings should be interpreted with caution.

The typical respondent was a 40 – 45 year old female, holding post-school qualifications, employed as either a manager or direct care worker in an urban disability support provider assisting disabled clients in a home setting.

Formal training in disability work was low with (30.5%) reporting none, followed by Certificate in Community Services (Disability Work) level IV (27.9%). Some respondents had sought formal training and been discouraged by employers. Respondents were critical of the generally low levels of formal training.

Almost all (88.0%) said training was important or very important, although most (95.8%) believed that they had the skills they needed. While most had received an induction, they were comparatively critical of these, though the reasons are unclear.

Recent learning and development activities were usually conferences or formal off the job training for people with higher educational qualifications and Certificate III or IV courses for people with school level only qualifications. People in management roles were most likely to have had their training fully paid by the organisation and direct care workers to have paid their own way. Almost everyone (80.2%) rated the training highly, usually because it had been relevant to their jobs.

Respondents were generally unsure that people who needed training got it, but they also believed that the general public needed learning and development opportunities in disability, not just the workforce. The two main barriers to the workforce obtaining training were cited as cost and high proportion of casuals (18.6% and 16.1% of responses).

Major skill areas identified in the open-ended questions were communications and managing difficult behaviour. Key priorities were attitude change in the community toward the disabled, career paths, better pay and more funding for the area.

1.0 INTRODUCTION

In September, 2006 DISTSS conducted a survey of the formal qualifications, skills and perceived learning and development needs of staff, managers and Boards of providers of disability services. The aim of collecting these data is to get a solid body of evidence based research to inform strategic planning in the sector in general and for DISTSS Inc specifically in regard to learning and development.

There were two major groups involved in the survey;

- Subscribers to the DISTSS InfoCast which sends email listings of opportunities for learning and development three to four times a week, and
- People on the DISTSS mailing list which primarily contains a mix of people working for non governmental agencies concerned with disability and other key stakeholders.

There are approximately 5,500 people who subscribe to the DISTSS Infocast and 1,046 people on the mailing list.

2.0 SURVEY METHODOLOGY

Respondents were advised that their responses would be treated confidentially and given a choice of completing a paper and pencil questionnaire or responding to a survey placed on the internet which was managed by a third party. Similarly the written questionnaires were mailed to RADAC P/L for entry to maintain confidentiality.

Once the written questionnaires had been manually entered, the two data sets were merged and a total of 466 responses was ready for analysis.

3.0 ANALYSIS

The statistical analysis was conducted using SPSSx 14.0. This is a computer program containing a large number of statistical methods. It has been in use for about 30 years and would be regarded as the premier statistical package in the social services.

Simple frequencies tables were developed for the closed ended questions. Many of these have been presented as pie charts or bar graphs.

Other questions allowed respondents to tick as many alternatives as were relevant to them and Multiple Response tables were generated for these so that a total number of responses could be provided. As there is more often more than one response per person in this situation, the answers have been shown as percentages of responses, not of people.

There were two open ended questions at the end of the questionnaire which asked respectively "What skills do you see as important to develop in the disability workforce?" and "What do you see as the key priorities to improve the disability workforce?" Some of the answers to these questions have been integrated with the other areas of the questionnaire, since respondents often commented on the available training or barriers to it.

The answers to the questions were analysed according to the role in the organisation, education level and gender of the participants in order to determine whether the different viewpoints that people with these differing backgrounds usually have influenced their answers to the questions. Where possible a test of association (chi-square test) has been calculated. Results are reported as significant or not and the groups differing most strongly from the overall sample are briefly described.

Tests of association cannot be calculated for the multiple response questions, since these tests assume that the responses are all independent. This cannot be the case in a multiple response question, since each person may give several responses, all of which would be dependent on the kind of person answering. These questions have been broken down in terms of role in the organisation, education level and gender of the participants but any apparent differences in the patterns of responses have simply been described.

3.1 Data Cleaning

The merged data set was checked for missing or incomplete responses and these were set to blank.

No cases had to be deleted due to insufficient data.

The 30 languages other than English spoken were given numerical codes.

Another question “What is your highest level of education?” posed problems as a small number of people entered several qualifications instead of only the *highest* one. The answers to this question were reviewed and combined into a single question.

One question “How many years have you worked in a disability related area?” posed difficulties in coding, as a small number of respondents replied that they had only held a formal job in the area for a few years, but had cared for someone or volunteered in the area for many more years than that. When this situation arose, the respondent was always credited with the full number of years worked.

In order to conduct statistical analyses, the answers to some questions had to be combined to form reasonably large groups. For the variable ‘highest level of education’, three groups were formed;

- School qualifications: Year 12 or earlier
- Post school certificate, diploma or advanced diploma and
- University qualifications: Degree or postgraduate degree

For the variable ‘role in the organisation’, four groups were formed;

- Direct Care Worker
- Management (CEO, Board member and manager/supervisor)
- Trainer and Allied Health Professional and
- Other.

If the variables had not been recombined in this way, the outcome would have been very large tables with many cells containing few people. These are hard to interpret and describe. People making comments are identified by age, gender and broad role in the organisation where these data are available.

4.0 RESULTS

As the population consists of approximately 6,546 people, the response rate was 7.12%.

This is a low response rate; percentages above 50% are considered desirable, so that it is possible that the responses of this sample may not generalise well to the population. Much of the population has also been selected for having sufficient interest in learning and organisation to subscribe to a website supplying them with opportunities to obtain further education and/or different jobs. It is important to keep these points in mind when considering the replies.

The results of the frequency tables are shown below. Where appropriate the findings of the demographic analysis and some illustrative comments have been integrated into the quantitative analysis. Invalid responses have been ignored in the figures presented in the report, which are based on valid cases only. Therefore the total numbers of respondents will vary slightly from figure to figure.

4.1 Who replied to the questionnaire?

Respondents were primarily female (75.8%). Their mean age was 42.58 years, ranging from 21 to 65 years. They had spent a mean of 12.15 years working in a disability related area, ranging from 0 to 36 years. This is a middle-aged workforce with a median (exact midpoint) age of 43 years.

About one in 6 (16.5%) spoke a language other than English, but up to four languages per person were collected, so that a total of 76 responses was tallied. The main spoken languages were:

- Italian (18.4% of responses)
- Greek (10.5% of responses), and
- German (9.2% of responses).

In addition to the spoken languages, there were 9 people fluent in AUSLAN (11.8% of responses). The proportion of AUSLAN competent respondents may be an underestimate because several of the people giving this response made a comment to the effect that 'you don't really speak it but', suggesting that it might be worthwhile asking directly about AUSLAN in future surveys of this group. People holding a university degree were slightly more likely than the others to speak a language other than English.

This was a highly educated group with 28.1% of respondents indicating that their highest qualification was university degree and another 19.1% holding postgraduate qualifications. Just over one in seven (13.1%) held a diploma. Qualification level did not differ according to gender which is unusual in the Australian population where slightly more females hold tertiary qualifications than males.

As is usual, the oldest quartile (51 years and over) were likely to have the lowest level of educational qualifications (nearly two-thirds of those with only school level education). The youngest quartile (21-34) were most likely to have university level qualifications (over half of those with degrees or postgraduate degrees).

It was understood that some respondents would work with more than one disability organisation, so they were asked to give their role in their main organisation. The roles of the 456 people who answered this question are shown in figure 1 below.

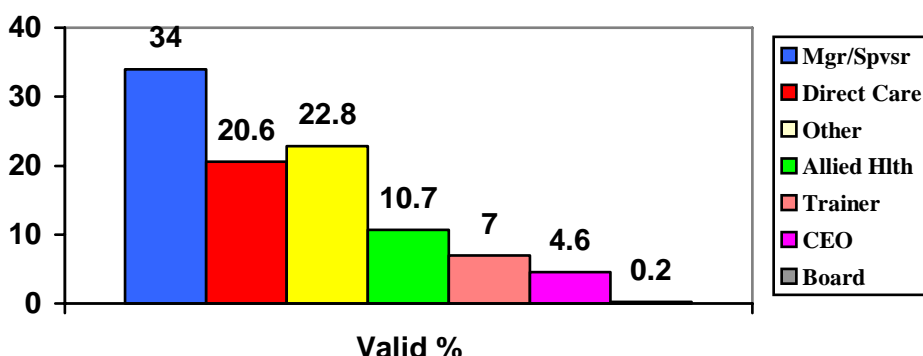


Figure 1: Roles with the main disability work organisation

Over one-third (34.0%) of respondents said that they were managers or supervisors, while 22.8% said that they had an ‘other’ role and 20.6% were direct care workers. Only one Board member responded. The high proportion of managers or supervisors may be due to the fact that the hard copy questionnaires were sent directly to the managers with a request for them to distribute it to their staff.

Education level and role in the organisation were strongly linked with direct care workers making up 41.3% of those with only school level qualifications, whereas as people in the ‘management’ group made up 43.3% of those with degree level qualifications.

People were asked what sort of organisation their main employer was, but were allowed to mark more than one box. Nearly half of the responses (42.3%) indicated a 'disability support provider', 21.5% were 'community based organisation' and 12.5% of the responses given were 'Victorian government'. These three organisation types accounted for over 76.3% of the responses.

Respondents were asked their work location. The locations of the 453 people who answered this question are shown in Figure 2 below.

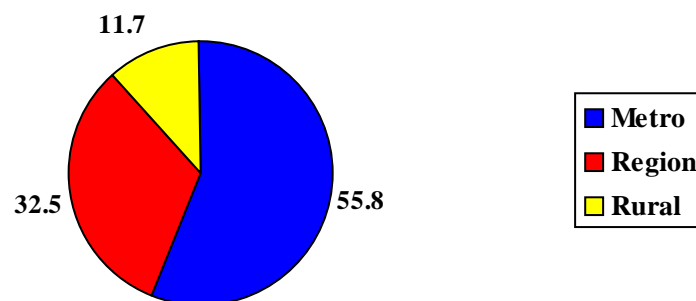


Figure 2: Locations

The respondents were a predominantly urban group. Over half of the respondents (55.8%) worked in Metropolitan Melbourne, with another 32.5% working in a regional town. Just over one in ten worked in a rural town (11.7%). Given the general distribution of opportunities in Victoria, it is likely that this is reasonably representative of the workforce.

People in rural locations were more likely to have school level qualifications than those in town

The regions where the respondents worked are shown in Figure 3 below. There were 443 responses which included 13 people who said that they did not know.

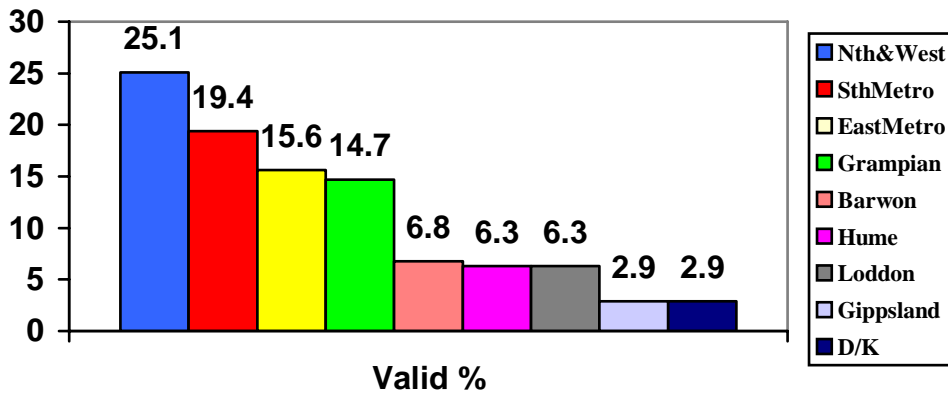


Figure 3: Regions

The major concentration of the workforce was within metropolitan Melbourne, as already indicated in the locations question above, with the three metropolitan regions acting as the main sources of respondents. Together these three regions made up 60.1% of the valid responses. Only one country region (Grampians) had more than 10% of the respondents.

Slightly more respondents said that they worked in metropolitan Melbourne than nominated a metropolitan region for reasons which are not clear.

4.2: What was their work?

All respondents were asked whether they worked with adults alone, children and families or all three. The 436 valid responses are shown in figure 4 below.

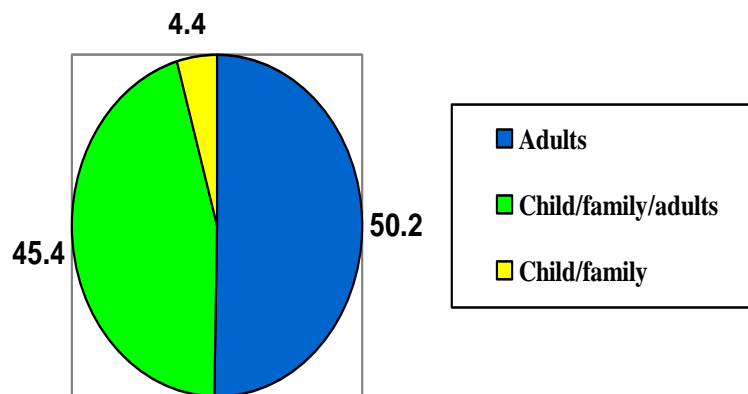


Figure 4: Who did they work with?

Very few respondents (less than 5%) worked with children and families. The largest single percentage (50.2%) worked with adults alone, followed by adults, children and families (45.4%).

Those respondents who provided support for people with disabilities were then asked whether the support was provided in a variety of different settings including home, health, workplace, recreation, education, leisure and 'other'. Respondents typically provided support in 1.23 settings each, reflecting the tendency of this workforce to work for more than one employer.

The main settings for providing support for people with disabilities were:

- home (36.1% of responses)
- workplace (24.1% of responses)
- recreation (18.8% of responses)

Health (7.1% of responses) and 'other' (13.9% of responses) were the two minority response groups, with no respondent indicating that he or she supported people with disabilities in an educational setting. The absence of this setting may be an artefact of a small and unrepresentative sample.

4.2: What formal training in disability had they had?

Almost one-third of the respondents (30.5%) indicated that they had never had any formal training in disability so that only 311 people answered this question. They gave 416 responses or 1.3 different forms of formal training per person. The main forms of formal training in disability were:

- Certificate in Community Services (Disability Work) IV (27.9% of responses)
- University degree (16.3% of responses)
- Diploma (10.8% of responses)
- Postgraduate qualification (10.6% of responses)
- Advanced Diploma (10.3% of responses), and
- Nursing (9.9% of responses).

The remaining responses were Certificate in Community Services (Disability Work) III (5.0%) and Other certificate (9.1%). Given that the low response rate (7.14%) suggests

that this is a highly self selected group with considerable interest in training, the proportion of people without formal training in disability is likely to be even higher in the population. The high proportion of the disability workforce lacking formal training in disability was a point of comment, with one respondent suggesting that the key priority to improve the disability workforce was:

*“Strong methodology in recruitment and stop accepting anybody who walks through the door with two arms and two legs”.*277: 46 year old female, manager.

Nevertheless some respondents without formal training related that they were interested in obtaining training and had even requested it and offered to pay for it, only to be refused by their employers e.g.,

“More quality training for people that are willing to learn. I have enquired about doing a couple of training sessions that are offered for free. I have even offered to pay for them out of my own pocket but have been told that they are only for people with permanent jobs.” 140: 38 year old male, direct care.

This comment illustrates the negative role played by casualisation of the disability workforce, a point which is considered further in the discussion of barriers to training.

Another respondent had been given another reason for not receiving training, e.g.,

“As a worker on the regional disability services team, I have never been offered formal training in the disability sector. I am told that to maintain employment I have to have a degree relevant to the field. The alternative is to remain a lowly paid worker.” 175: 40 year old, female, other.

Clearly more people want training, and are serious enough to offer to pay for it, than the field is prepared to train.

Many respondents wanted the entry level of training raised as they made a clear link between the amount of value placed on the work of caring for the disabled and the level of qualifications required, e.g.,

“Value the work performed and upgrade the learning and qualifications needed.” 33: 61 year old male.

A number of other respondents believed that Certificate Level IV should be an entry level qualification for the field e.g.,

“Having Certificate IV as a mandatory qualification PRIOR to gaining employment, then a period of 6-12 months in a supernumerary capacity, other a variety of locations to gain experience in many areas particularly high needs and challenging behaviours.” 121: 37 year old female manager

and

"That all staff are required to complete Certificate IV in Disability Work with HACC and Aged Care Cert III." 197: 31 year old female direct care worker.

Nevertheless, there were some reservations about the content and suitability of Certificate IV. Two respondents thought that its delivery could be improved e.g.,

"Involving services with RTOs that deliver certificate III and IV in disability in the development of the curriculum and student placement so learning is more effective for the student." 10: 28 year old female, direct care.

And

"A lot of training providers, especially those who offer 16 week courses, for Certificate IV in Disability Services are not able to give enough knowledge for workers to work in the field." 120: 34 year old male.

Another respondent believed that on-the-job Certificate IV training was not effective:

"Get rid of on-the-job Certificate IV training. Go back to training Certificate IV at TAFE level only." 73: 35 year old female, manager.

Still others believed that Certificate IV was not a sufficiently high level of qualification and that people with higher qualifications needed more recognition:

"Higher qualification requirement. Ongoing formal training." 9: 29 year old male.

"Provision of high quality, tailored, funded training. Accreditation." 101: 47 year old male, direct care.

"Reward people with degrees and postgraduate qualifications. Certificate IV should be a base only qualification." 7: 50 year old female, manager.

"A recognised qualification that contains more relevant training. Many people working in disabilities have no underpinning knowledge of the needs of people with disabilities. Their training is too light." 233: 48 year old female, other.

The respondents were then asked how important learning and development was to them and their answers are shown in Figure 5 below.

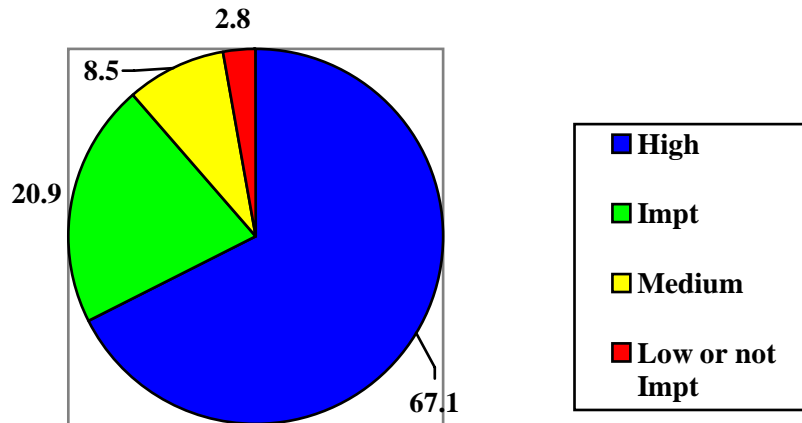


Figure 5: How important is learning and development?

Over two-thirds (67.1%) of respondents thought that learning and development were highly important with another 20.9% saying that it was important, so that this was clearly a group who put a high level of emphasis on learning and development as might be expected given the sources of the sample.

They were then asked whether they thought that they had the skills and knowledge they needed to do their work satisfactorily and their answers are shown in figure 6 below.

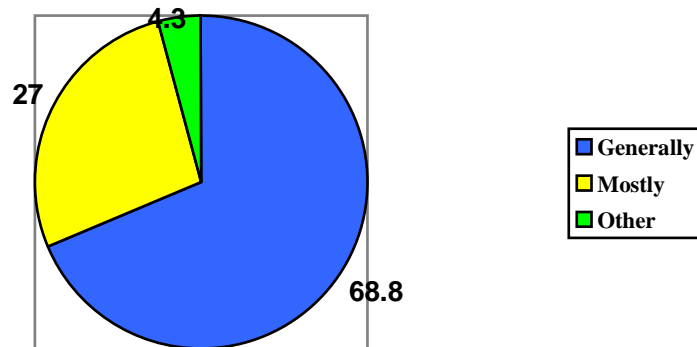


Figure 6: Self rated skills and knowledge

Over two thirds of the group (68.8%) believed that they generally did have the skills and knowledge that they needed and another 27.0% thought that they mostly had the necessary knowledge base. These responses indicate that they are confident in their existing skills despite their interest in further learning and development opportunities.

Employers seemed keen to foster skills, as when the respondents were asked about induction, only 14 people responded that they had received no induction.

The sort of induction received by the others is shown below:

- Formal induction, regularly conducted (39.7% of responses)
- On the job induction (47.6% of responses)
- Formal induction conducted occasionally (12.7% of responses)

The respondents were about equally divided between receiving formal and on the job induction.

Respondents were then asked to rate the usefulness of the induction and their answers are shown in figure 7 below.

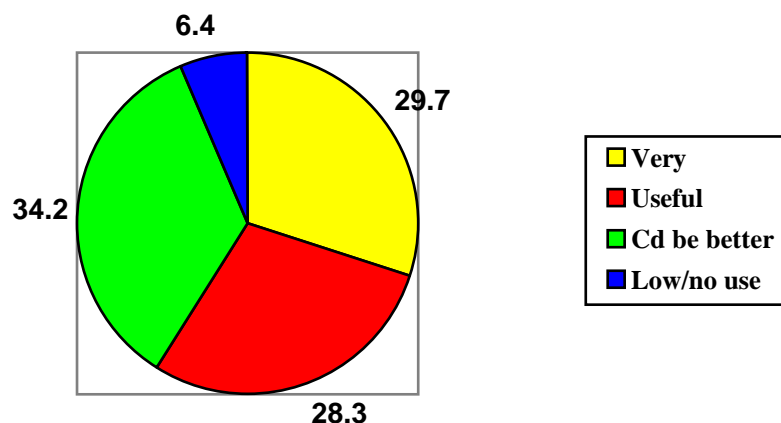


Figure 7: Usefulness of the induction

Given the positive attitude of this group to learning and development, their critical response to induction was surprising. The largest single group (34.2%) thought that the induction 'could be better', though large percentages rated it as 'useful' (28.3%) or 'very

useful' (29.7%). Unfortunately only two respondents commented on the induction process, e.g.,
"Inductions need to be longer and cover more areas. Management and front line staff need to be involved in these inductions, either by input or presence at inductions." 117:
 45 year old female, manager.

The second comment simply said induction needed improving, so it is not clear why such a high proportion of the sample was dissatisfied with it.

4.3: Recent learning and development activities

In discussion with DISTSS representatives, a concern was raised that people with lower formal education levels might then receive fewer training opportunities when they entered the disability workforce. An attempt was made to investigate this possibility by analysing all the information available on the training opportunities that participants reported by their formal qualification level at entry.

The learning and development activities that the respondents had undertaken over the past year was the next item and the responses to this question supported their attitude statement that learning and development was very important to them. Only 24 respondents had undertaken no activities in the past year and the 399 people who answered the question had undertaken an average of 2.1 activities each.

The main learning and development activities undertaken in the previous 12 months were:

- Attending conferences (32.6% of responses)
- Other formal off the job training (23.6% of responses)
- On the job training (21.5% of responses)
- On the job coaching (18.1% of responses)

The remaining 4.2% of responses were concerned with Certificate in Community Services (Disability Work) III or IV.

The type of learning and development opportunities varied quite a lot by pre-existing education level, with participants with only school qualifications most likely to report on the job training (52.9% of this group). People with post school qualifications and degrees were more likely to have attended conferences (67.6% and 68.8% of those groups respectively) or have undertaken other formal off the job training (52.5% and 49.5% of

those groups respectively). People with degrees were the group most likely to report receiving on the job coaching (41.6%). This observation does suggest that pre-existing education level has quite a marked influence on the kinds of subsequent training opportunities made available.

Direct care workers were most likely to have taken Certificate III or IV courses in the past year (18.2% of this group). People in management roles were most likely to have received on the job coaching, other formal off the job training and attended conferences (43.5%, 55.9% and 80.7% of this group respectively). People in an Allied Health/trainer role were also quite likely to attend conferences (62.3% of this group).

This training was typically fully paid for by the organisation (66.8% of responses) or partly paid for by the organisation (12.7% of responses). In 6.8% of responses the organisation made a part payment. Only 13.8% of responses indicated that the training had been done entirely at their own expense. The people most likely to have paid for their own learning and development were the group with post-school qualifications. People in a management role were most likely to have their training fully paid for by the organisation (83.9% of this group) while direct care workers were most likely to have paid their own way (22.1% of this group).

Three major groups of organisations provided the training. These were:

- Private registered training organisations (19.7% of responses)
- Consultants (18.1% of responses)
- Government registered training organisations (15.7% of responses)

In relation to who provided the training, people with disabilities or their registered support organisations accounted for only 2.8% and 13.2% of the responses respectively. The government itself and disability support organisations that were not registered training providers accounted for 9.0% and 4.2% respectively. Participants in management roles attended training provided by private registered training organisations (38.5% of managers) or consultants (34.6% of managers), while people in direct care roles were most likely to attend training provided by disability support organisations registered for training (26.2% of direct care workers).

People with school qualifications were most likely to have attended training provided by government registered training organisations (30.6% of this group) while people with

university educations were most likely to have had training provided by consultants (32.8% of this group).

4.4: How useful were the learning and development activities?

Respondents were asked how useful to their work these learning and development activities had been and their answers are shown in Figure 8 below.

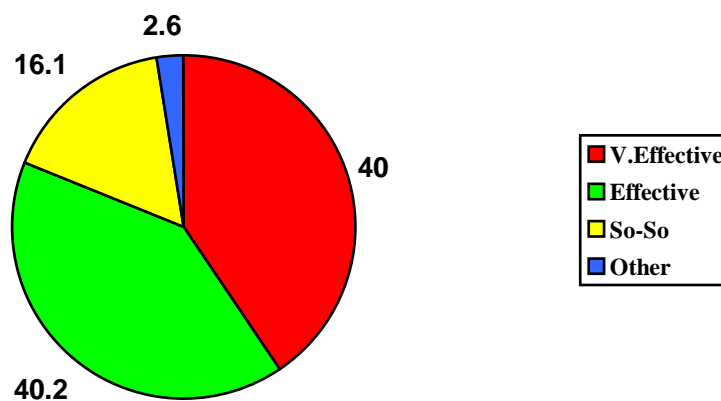


Figure 8: Usefulness of the training

Respondents were markedly more positive about the learning and development opportunities that they had received with just over 80% rating them as 'effective' or 'very effective' than they had been about the induction process. Fewer than 3.0% were disappointed in them or unsure.

Those who had found their training effective were then asked why they had thought so and 344 people gave an average of 2.1 responses each. The major responses are shown below:

- Relevant to my job (43.1% of responses)
- Quality of trainer(s) (21.3% of responses)
- Interesting training methods (13.9% of responses)
- Employer support (11.1% of responses).

Only 5.9% of responses were that training had been effective because it had involved people with a disability in the training delivery, 1.9% that it had been because a mentor was available at work and 1.4% because it had led to promotion.

People with university level educations were more likely than the other two education groups to say that the activities had been useful because they were relevant to their jobs or because of the quality of the trainers (94.8% and 52.3% of people with degrees respectively). Participants with school qualifications emphasised employer support (38.5% of this group). Although the learning and development activities had very rarely led to promotion, people with post-school qualifications were most likely to emphasise that point (4.5% of the post school qualification group).

People in management or allied health roles were more likely than those in other groups to say that the learning and development opportunities had been useful because of the quality of the trainers (52.1% and 46.2% of these groups respectively).

4.5: Other training and who needs it

Respondents were then asked whether they thought that people in the disability sector who needed training were getting it.

Their responses are shown in Figure 9 below.

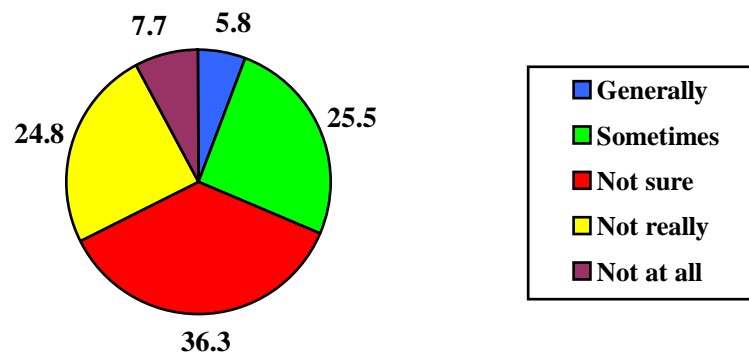


Figure 9: Do people who need training get it?

Clearly there was considerable doubt about this, with only 5.8% saying that people who needed training in the disability sector generally got it, with another quarter replying 'sometimes'. At the other extreme, 7.7% were quite definite that some people did not receive necessary training, with almost another quarter (24.8%) saying 'not really'.

They were asked to specify what groups they thought needed further training and development opportunities. This question elicited a major response, with 418 people giving an average of 5.9 responses each. The main groups are shown below:

- General public (13.7% of responses)
- Disability workforce (11.6% of responses)
- Business sector (11.4% of responses)
- Community and health sectors (10.6% of responses)
- Staff of government departments (10.6% of responses)
- Managers & Supervisors in Disability (9.4% of responses)
- Allied Health professionals in Disability (9.3% of responses)

People with disabilities (6.6%), training providers (7.9%) and Disability Sector Boards of Management (8.9%) accounted for the remaining responses.

People with school qualifications were more likely than the other education groups to suggest the general public needed learning opportunities (85.5% of respondents with school qualifications), but the general public was their main focus. People with higher educational qualifications took a broader view. Those with post school qualifications were particularly likely to name several groups as being in need of learning and development opportunities; believing that the disability workforce, staff of government departments, allied health professionals, the business sector, managers and supervisors in disability, the community health sector and the general public needed more opportunities to learn about disability (73.9%, 63.8%, 57.2%, 71.0% 57.2%, 65.9% and 83.3% respectively of this group). Those with university level qualifications also thought that the staff of government departments and allied health professionals managers and supervisors in disability and the community health sector (65.8%, 57.9%, 56.9% and 65.3% respectively of those with degrees).

Role within the organisation was less influential in views about which other groups needed training than pre-existing education levels. Direct care workers and people in management were likely to believe that the disability workforce needed more training

(74.7% and 72.0% of those groups respectively). People in the Allied Health/Trainer group were most likely to nominate allied health professionals (63.2% of this group).

The comments about the kind of learning and development that respondents believed was required by the general public and business sector suggested that they meant that an attitude change was needed more than a skills upgrade e.g.,

“Overcoming barriers and prejudice in the community and educating people without disabilities in tolerance, acceptance, inclusion and communication.” 11: 35 year old male, direct care.

And

“The disabled should get a decent wage like those without a disability. More business owners should get involved and hire disabled people. Having the set up to accommodate wheelchairs etc. There should be more disabled friendly workforces.” 304: 33 year old female, direct care.

Similarly some respondents believed that people in the disability workforce needed more training but along completely revised lines to equip them for the future rather than dealing with focussed skill areas e.g.,

“Training that supports the re-orienting of the sector, away from passive service provision and support and towards active community participation and inclusion. As the population ages, future clients will have a whole new approach to what they need that doesn't fit the current model.” 66: 52 year old female, manager.

Or just to have the same opportunities for learning as those without a disability.

“For people with a disability to be able to access suitable training without the barrier of red tape in government departments e.g., Centrelink.” 85: 57 year old female, other.

4.6: Barriers to training

Respondents were then asked if they perceived any barriers to training and what these were. Again this question elicited considerable response with 388 people nominating an average of 3.4 barriers each. The main barriers listed are shown below:

- Cost (18.6% of responses)
- High proportion of casuals (16.1% of responses)
- Too busy with day to day work (13.0% of responses)
- Not confident about studying (9.3% of responses)
- Family responsibilities (8.8% of responses)
- Disability workforce (8.7% of responses)
- No support from employer (7.8% of responses)

No encouragement to apply (6.8%), training is boring (6.0%) and 'other' (5.1%) were the remaining responses. Two examples cited earlier of comments from untrained people who had been refused training even though they had requested it should be recalled when considering barriers to training.

So far as the response 'disability workforce' is concerned, a number of respondents commented on the casualisation of the workforce, that it was desirable for disability workers to speak functional English and the common custom of people working two or even three jobs in this workforce which made them too tired to undertake training. People in management or Allied Health /trainer roles were particularly likely to emphasise the high proportion of casuals as a barrier (59.9% and 54.9% respectively of these groups). The Allied Health/trainer group were most likely to say that the employers were not supportive (31.0% of this group).

Level of education was not very strongly associated with beliefs about the barriers to training. People with university qualifications were more likely than the other two groups to mention the disability workforce itself (32.6% of this group). Both people with post-school qualifications and university qualifications were likely to cite 'too busy' (43.7% and 46.7% of these groups respectively). The lack of association between pre-existing education levels and confidence about studying is particularly interesting and may reflect either that people with school qualifications undertook very different training levels from those with higher qualifications or that this is a highly selected and motivated group.

Males cited the disability workforce and boring nature of the training (50.0% and 29.8% of men) but women nominated lack of employer support as barriers to training (29.6% of women).

One respondent believed that lack of confidence about studying was particularly likely to be found among older workers e.g.,

“Added help and support for older workers to be re-educated. A lot of workers feel they have been out of education for too long to start again. They are frightened of the unknown.” 187: 50 year old female, manager.

One barrier to training mentioned by several respondents was the tendency of members of the disabilities workforce to hold down two or three jobs so that it was very difficult for them to attend training e.g.,

“.. pay staff members to attend sessions as most are working in several organisations and cannot afford to take time off to attend.” 54: 54 year old female, manager.

Or that the training was simply not accessible or not actively encouraged, especially by employers e.g.,

“More accessible training and education. More encouragement from employers.” 186: 45 year old female, manager.

“Training to be accessible i.e held in regional Victoria, it is not always possible to travel to Melbourne for training.” 221: female, trainer.

4.7: Responses to the open-ended questions

The first of the open-ended questions asked respondents what *skills* they thought were important amongst the disability workforce, but many respondents listed personal qualities rather than skills e.g.,

“Patience, empathy, assertiveness, awareness of cultural differences, tolerance, confidence in own abilities, being able to preserve confidentiality, honesty and being a good role model, to name a few.” 317: 51 year old female, direct care.

This respondent covered most of the personal qualities mentioned by the others, except for ‘flexibility’ and ‘commonsense’ which were also popular. Empathy was the most frequently mentioned personal quality. It was not clear how respondents believed that these personal qualities could be increased in the workforce; since no one suggested that employees should be selected for these qualities.

The skills seen as important to develop in the disability workforce were overwhelmingly ‘communication’, mentioned in 60 of the responses to question 13. Most respondents simply wrote the word, but some gave more elaborate replies. It was clear that communication skills were regarded as vital not only to assist nonverbal clients, but also to reach out to the community outside the agency e.g.,:

“Communication/public relations skills to open up more opportunities in the community.” 2: 59 year old male, direct care.

Or to work more effectively with colleagues and/or to follow departmental protocols, e.g.,:

“Better communication between providers, support staff, families and service users.” 140: 38 year old female, direct care.

“Communication/literacy. Ability to understand and follow policies/procedures.” 276, 36 year old female, trainer.

The main emphasis though was on the importance of communicating with the clients and the need to acquire special skills to do so e.g.,:

“Communication methods from Auslan to positive outcome conversation models – so staff can flow more easily from one type of support to another and be aware that they are doing this.” 4: 45 year old female, manager.

“Skills around communication with people with complex communication needs.” 466: 43 year old female.

“Communication would be the greatest skill needed to function in the disability sector, this also incorporates the ability to use a wide range of aids.” 123: 47 year old female, manager

“Communication using adaptive technologies or being able to assess for the need to use adaptive technologies, communication with people with particular disabilities e.g. people with vision impairment/blindness.” 126: 54 year old male, manager.

“Effective communication with clients, working with children with disabilities, OH&S, Auslan and Makaton, communicating with people with complex needs.” 302: 33 year old female, manager.

Though it was clear that many respondents knew that communication should be a two-way street e.g.,

“Communication, particularly listening.” 119: 40 year old male, manager.

“Listening skills – people want to be heard.” 176: 36 year old female, manager.

“Listening skills are most important, and we can refer people to counselling, but often families open up more in informal settings.” 218: 38 year old female.

Although some people believed that:

“Some skills can't be taught within this field – in terms of empathy and good communication.” 27: 35 year old female, other.

But another said that

“There is a lack of adequate training about how to communicate with and support people with disabilities to participate in everyday activities.” 264: 52 year old female.

The only other actual skill mentioned by more than a few people was ‘dealing with challenging behaviour’ (22 mentions).

The second open-ended question asked about key priorities. When they were asked what were the key priorities to improve the disability workforce, there was an overwhelming emphasis on training, attitude change and greater learning and development opportunities, which were mentioned by the great majority of those who commented. While there was a clear demand for government, business, the disability workforce and the community to learn more about the disabled e.g.,

“Education of government and funding bodies.” 41: 23 year old male, other.

“Education and acceptance by the general public of people.” 84: 42 year old male, direct care.

There was also recognition of the need to give the disabled themselves more opportunities e.g.,

“Empathy, abilities. Encouraging independence and self determinism. Skill up the workforce appropriately. Life skills.” 115: 42 year old male, trainer.

“Not putting people with disabilities in boxes and presuming that they have achieved the best they can but giving them the opportunity always to try new things.” 20: female, trainer.

“Education of business and employers to destigmatise people with disabilities, empathy, respect, congruence and better communication skills. Too often in my place of work, I see people with a disability being treated as children or as being incapable of making decisions.” 26: 50 year old female, other.

And to assist people in the workforce to improve their knowledge e.g.,

“Scholarships provided by DHS are to be commended re learning and development.” 46: 53 year old male.

“Recognising that volunteers are part of the disability workforce and including their learning needs in training.” 53: male, manager.

“Starting at the school level and attracting people genuinely interested in the field. Talking to career counsellors and letting them know about what the job is.” 100: 42 year old male, direct care.

“More training, too many young people entering into this field while doing uni studies to help them out financially and not skilled enough in this area.” 78: 47 year old female, direct care.

There was also a considerable consensus about the need to develop career paths (22 comments), obtain more funding (39 comments) and better pay (40 comments). A number of people mentioned all three as priorities or two out of the three in their comments. Some examples of this group of the comments are given here, chosen on the basis that the respondents elaborated what they thought would be the impact on the sector of the proposed change instead of simply saying ‘better pay’:

a. Pay

Respondents usually linked higher pay (for direct care workers) to attracting a better quality of applicant or recruiting in rural areas, that pay levels reflected community views of the status of the work or the possibility of demanding more skilled and dedicated work from a well paid workforce e.g.,

“Improve pay and conditions and then you’ll attract higher quality workers who feel valued and respected and this value and respect will then be passed on to the people with whom they work.” 30: 35 year old female, other.

“Increase in pay if a direct care worker, especially in rural areas where getting carers is difficult.” 42: 24 year old male, other.

“Higher pay so we can poach from other professions e.g., tradesmen, nurses, etc.” 81: 57 year old female, direct care.

“Raising wages generally in order to attract a higher class of worker.” 118: 24 year old female, other.

“Better wages and conditions for disability support workers, and a greater expectation, and demand for staff to be working at acceptable standards. If this field is continually paid poor wages this will continue to be reflected in the poor staff and retention rates.” 169: 33 year old female, direct care.

“Decent pay and conditions for workers and adequate funding. Cannot recruit, train and skill up workers on flexible packages only, that are here today and gone tomorrow. Consequence is that skill development becomes low priority.” 33: 61 year old male, direct care, trainer.

Some contrasted the pay levels of direct care workers with those of management e.g.,

“Having more highly qualified people at the direct care level. Generally management attracts much higher pay with little direct responsibility to the client, whereby many direct care workers are poorly paid and often poorly skilled leaving little value.” 239: 49 year old female, other.

Others suggested that pay levels were related to turnover e.g.,
“.lower the turnover of staff by introducing better pay for those people working within the disability workforce.” 192: 26 year old female, other.

b. Funding

Many respondents commented about the lack of funding and the great need for it in a sector experiencing growing demand for services e.g.,

“Money, money, and more money. This sector (mental illness) is growing every day yet less and less really money is poured into support. If extra money is budgeted there are very tight criteria that most don’t fit.” 87: 64 year old male, direct care.

“Increased funding (S&C, Home First), more variety of respite services. HACC funded services such as in Home Respite through councils are coming to a grinding halt or families are faced with long waiting lists. Often the cost for the service is also beyond them.” 218: 38 year old female, other.

“More funding for the clients and more staff to give more quality programs.” 241: 50 year old female, manager.

One participant suggested that increased funding input should be linked to quality output e.g.,

“To ensure that quality of life achieved by PWDs as a result of the services provided for them is taken into account in the granting of financial assistance for the provision of those services.” 39: 65 year old male, direct care.

c. Career paths

Respondents were clearly aware of the high rate of turnover and casualisation of the work force and proposed that more clearly identified career paths might be a way to solve both of these problems e.g.,

“Provision of more mentoring and secondment opportunities between the Government and the Non-government sectors to show those entering the disability field for the first time that there are range of interesting career pathways.” 27: 35 year old female.

“Better career paths to be identified so knowledge and experience is not lost when people leave.” 88: 37 year old female, other.

“Improve the pay rates and career structures or else we are not going to attract new workers let alone keep the existing workers.” 213: 50 year old female, manager.

It was hoped that identifying career paths might be part of a wholistic approach to improving the standard of the workforce e.g.,

“Standards (establish). Career path. Improved wages and status. Leadership and support by government departments. Less reliance on casuals.” 16: 54 year old female, other.

The size of the employing organisation was seen as a barrier to better career paths, e.g., “Career opportunities – almost nonexistent within small organisations.” 277: 46 year old female, manager.

The most telling comment on the quality of the workforce and the need to improve it was:

“Having carers who actually give a shit.” 48: 44 year old male, direct care.

This man’s beliefs about the most important skills required to work in disability were “Compassion and patience.”

5.0 DISCUSSION

The participants can be described as a highly motivated and well educated group of urban based workers keenly interested both in learning and training opportunities and in making careers in the disability workforce, although almost one-third of them have no formal training in caring for disabled people. They enjoyed the learning and development opportunities that they had undertaken in the previous 12 months and believed that they had the skills they needed. Many of their comments about the need to change attitudes in the community show considerable idealism and commitment to the area. There are some clear hints in their comments (e.g., the remarks about the need to improve literacy and to ensure that incoming carers could speak English) that they are not representative of the workforce as a whole. It is likely that the workforce as a whole has far lower levels of formal training and pre-existing qualifications and may perceive greater barriers in the paths to attaining formal training.

Nevertheless the commitment and vision of these participants, and like minded colleagues, suggests that they might well be the basis of a culture change in the area and that they would be a useful group to have ‘on-side’ in any attempt to improve the skill level of this work force.

The systemic barriers to improving the skill levels of the disability workforce came out clearly in the comments. The picture that emerged from the comments as a whole is of a casualised, or at best part-time, workforce of poorly paid and unqualified people, receiving poor quality induction from the employers. Those with qualifications or ambition were frequently working in the area as a means of getting through university and had no plans to stay, while many of those who were going to stay were essentially 'trapped' in their jobs by poor English or low pre-existing qualifications. As one of the respondents memorably commented, it is very difficult to impart skills to a people "...who are here today and gone tomorrow..". Many respondents linked this situation to community beliefs about the low status of the disabled and consequent lack of importance of the work of carers and suggested that this needed to be changed, which would require a virtual revolution in community attitudes.

Nevertheless there were some perceived barriers, such as cost of the training, which could be addressed quite easily and quickly. The very low numbers of respondents who reported that training had been valuable because it had led to a promotion was quite surprising as was the discovery that there was no qualification level required for workforce entry – again both of these factors could be easily altered.

There was evidence of a 'two-track' system whereby people with lower level qualifications became direct care workers and received lower levels of training, often at their own expense, while people with post school and university qualifications became managers and received further learning and development opportunities at the expense of the employing agency. How typical or extensive this problem is could not be gauged from this sample.

When asked what skills were important, many people mentioned personal qualities rather than skills, but there was interest in communication skills and dealing with challenging behaviour. Communication skills were perceived as being useful far beyond the challenges of communicating with the clients.

This sample clearly would be very interested in further learning and development opportunities and may be able to inspire a similar level of interest amongst their colleagues in the disability workforce.