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Anticipating and addressing the impending shortage of skilled disability support workers

Research and Data Working Group (RDWG)

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Executive Summary

The project is based on the premise that the anticipated rapid increase in demand for disability support services due to the full roll out of the National Disability Insurance Scheme (NDIS) is likely to create a shortage of workers with the right skills and qualifications.

The main objectives of the project are to identify and quantify potential skills shortages and to explore their composition and potential implications for the impending full roll out of the NDIS. To do so the project takes both the long view by looking at relevant evidence as far back as 2007 and the short view by looking in detail at recent evidence from 2015 and 2016 as well as in-depth interviews conducted with various stakeholder groups in 2017.

The project uses two complementary types of evidence, large nationally representative secondary survey data sets and in depth qualitative interviews conducted by the research team. The research combines these evidence sources and their analyses in order to present their integration and policy conclusions.

Recognising that occupational and qualification categories often mix different types of care work and training together, the project uses detailed course descriptions in order to define those care qualifications that are disability-specific. The rest of the qualifications were divided between two categories, 'other care qualifications' and 'all other (non-care) qualifications'.

Key Quantitative Findings

The volume of disability-specific training increased substantially by 22 per cent between the years 2015 and 2016, against a backdrop of a national decline in the numbers of all other types of training by 14 per cent, including training for other types of care by 10 per cent. The change recorded for disability specific training was due to considerably higher numbers of Certificate III and Diplomas, and moderately lower numbers of Certificate IV and Advance Diplomas.

Looking at the longer-term trend in training, we see that for disability training, earlier data shows a modest increase in training numbers between 2007 and 2013, and a stronger increase between 2013 and 2016. In contrast, for other care training, the stronger increase happened between 2007 and 2013, with a weaker increase continuing between 2013 and 2016, possibly following reform in these sectors. Overall, the increase in student numbers in the care sector is not matched with the numbers participating in training for all other (non-care) qualifications.

The demographics of those undertaking disability related training are also changing. In 2016, we find more students in the youngest age group (18 to 24) and fewer among the oldest age group (over 50) than we did in 2007. We also find more males and more non-English speaking country of origin students. There are more from major cities, and fewer from regional with too small numbers to estimate change in remote and very remote areas. We find more Indigenous students, but the numbers are still very small and we find that the proportion of students with disability has decreased. We note that the broadening of the student demographic profile observed among disability training participants is unique to this group and is not observed among other care training or the residual category of all other types of training.

We examine where workers who train for the sector are coming from and while we find that a large majority were previously employed, we also find that an increasing minority come from the unemployment stock. A large majority of those previously employed came from the health care and social assistance industry and they were previously employed as community and personal service

workers.

There are two broad reasons for undertaking training. First, to progress within an existing sector/work environment for those already in the care sector, and second to progress with either a new job or a new career for those from another sector or without a recent previous job. Notably, after the introduction of the NDIS in 2013, the proportion of newcomers to the sector through formal training has increased, which suggests that training is fulfilling its role in supporting the growing disability sector.

Regarding their disability training experience, about 90 per cent of graduates are satisfied with the quality of their training and about 80 per cent report that they have wholly achieved the main reason for undertaking disability training. Over 90 per cent state that they would recommend the training to others as well as the institution that provided the training. We note that these percentages have remained largely unchanged between 2007 and 2016 and that they indicate remarkably high achievement rates on behalf of the disability training providers. This is further evidence that formal training is supporting the growing sector.

The most important aspect of training is the degree to which it facilitates improved post-training labour market outcomes. Disability training clearly enhances the employability of its graduates and it does this considerably more strongly than 'other care' and 'all other' training do. It increases the graduates' attachment with the care sector and the chances to be working as a community and personal service worker, again more so than what is achieved through 'other care' training.

Overall, formal training in Australia has been associated with assisting people to transition from part time and possibly marginal or precarious work to full time paid employment. This is not the case with disability care and other care training: employment before and after training is more likely to be part time than full time (approx. 60 per cent of disability related training students move to part time employment after training, compared to approx. 30 per cent for non-care training graduates). This could be because of the high demand for part time employment in the care sectors. All these relativities have not changed between 2007 and 2016.

The majority of training graduates report that they find their training relevant to their current job (approx. 70 per cent highly relevant and approx. 20 per cent somewhat relevant). Furthermore, approx. 70 per cent report that their training has improved their employment circumstances, but we note that this is an underestimate as the remaining 30 per cent also includes the high percentage of people who trained because their current job required them to do so, and who are likely to have remained in the same job after training.

Key Qualitative Findings

Regarding disability training provision, most interviewees were of the opinion that little change had occurred in the number of students undertaking disability training since the start of the NDIS. This was noted to be the case despite the opinion that an expansion in student numbers would be necessary in order to provide adequate numbers of skilled disability support workers to meet the anticipated growing demand for services created by the NDIS.

Interviews identified the Certificate III as being a key entry-level qualification for the disability sector, thus accounting for its relative popularity. However, most respondent groups did not consider it necessary for disability support workers to have formal certificate level qualifications in order to be able to deliver quality care. Indeed many expressed the view that the sector recruited principally on a person's interests and traits, rather than specific technical and communication skills and competencies, which, it was often felt, could be built upon whilst employed.

Changes to the VET system in 2016 included the introduction of the Certificate III in Individual Support, which superseded the existing courses in Aged Care, Home and Community Care, and Disability Care. Accordingly, in the qualitative interviews training providers reported that the most common disability training courses they currently offered were the Certificate III Individual Support (Disability) and Certificate IV in Disability. While some training providers additionally offered diploma level qualifications, recent changes in the VET system meant that there were no longer any current disability specific diploma qualifications. Concerns were raised about the impact these changes would have on the adequacy of the skills and competencies of workers entering the sector following their VET training.

Training providers described disability training students as a very heterogeneous group, attracting people across diverse age groups and cultural backgrounds, as well as both men and women. Training organisations believed that the NDIS would continue to have further impacts on the characteristics of the students undertaking disability training and encourage increased diversity.

Interviewees identified a number of common pathways into disability training. These included disability workers who had not previously undertaken any formal qualifications, those returning to work after caring for children or relatives, young people taking their first post-school qualification and individuals undertaking midlife career changes.

Satisfaction with the quality of training is an accurate and important indicator of its overall success. Qualitative interviews revealed mixed opinions as to the quality of disability training provision. While some respondents were confident that disability support workers receive the training necessary to perform their duties well, others identified gaps in current training provision. These gaps included disability specific skill gaps as well as the need for additional training in technical skills, communication skills, soft skills, and specifically "on the NDIS". Moreover, many disability support workers reported being dissatisfied with the quality of the VET training they had received, feeling that this training had not adequately equipped them for their subsequent work. Limitations identified included course content not reflecting the 'real world' of disability care work and not providing enough focus on disability. We note that these opinions were not in agreement with the majority of students who in their responses to the Student Outcomes Surveys reported high levels of satisfaction with their training, including high relevance to their subsequent jobs and their wish to recommend their courses to others. The qualitative interviews are useful for identifying where problems may lie for the minority who reported lower satisfaction levels.

We note that the disability support workers interviewed for this study had undertaken their training prior to the introduction of the new Certificate III in Individual Support. It will therefore be important in the future to evaluate satisfaction levels of those undertaking the new Certificate III qualifications across both disability and aged care in order to judge the effectiveness of these new forms of training, especially their ability to address the specific gaps identified in that training.

Employment outcomes are probably the most important indicator of successful training. The qualitative interviews suggested that opportunities for employment in the sector were considered positive for students undertaking disability training. Many training organisations noted that students often secured employment at the disability provider organisation where they had taken their vocational placement. Training organisations also reported that disability training was sometimes used as an indirect pathway into higher level training and qualifications, in different but related industries such as health.

A question that concerns policy is the impacts of the NDIS on the skills and competencies of workers who train and enter the sector. The incorporation of a qualitative methodology in this research has allowed us to explore directly the perceptions of the impacts of the NDIS on disability workforce skills and related training. This information will inform the development of further and future training to

suit the new needs generated by the full NDIS roll out.

While technical competencies, communication and 'soft' skills are still required by disability workers, the need for additional skills and competencies is emerging in response to the new demands presented by the person-centred nature of the NDIS. These new demands include added emphasis on person-centred care, customer service, management skills and behaviour support. It was widely felt that under the NDIS system, staff need to be more responsive, they need to take on more personal responsibility for the relationship they have with their clients, and they need to be able and flexible to tailor their support to the clients' needs and preferences.

Because of the changes in the skills and competencies being required by disability support workers, training organisations reported that additional skills and competencies were being increasingly incorporated into the training they delivered. These new skills and competencies included management and frontline skills, customer service, person-centred practices, behaviour support, and professional relationships training. Training organisations acknowledged that further changes would need to be made as the national roll out of the NDIS occurs. There was uncertainty, however, about what these changes would be as they would be dependent in part upon the types of services and supports that people with disability would want to access within the NDIS in the future. Disability support workers also confirmed that the training they were undertaking had changed because of the NDIS and included more of a focus on individualised person-centred care.

Training organisations and disability support providers were of the opinion that NDIS pricing did not sufficiently allow for the provision of training to the disability sector workforce. Consequently, the NDIS was seen as negatively affecting the availability of training (and particularly on-the-job training) within the sector. In response, some training providers were developing online modes of training to provide more affordable training options. However, this type of training was broadly perceived to be of poorer quality than face-to-face training.

1. Introduction

In 2011, a Productivity Commission inquiry into the state of disability care and support services found that Australia's system of disability supports was inequitable, underfunded, fragmented, inefficient, and gave people with disability little choice and no certainty of access to appropriate supports (Productivity Commission 2011). The Commission recommended the introduction of a new national scheme that provided insurance cover to all Australians in the event of significant and permanent disability.

Developed from the recommendations of the Productivity Commission, the National Disability Insurance Scheme (NDIS) is a new scheme designed to change the way that support and care is provided to people with significant and permanent disability. The scheme is currently being rolled out across Australia and in 2017 had about 122,636 scheme participants (COAG Disability Reform Council 2017). When fully implemented, the NDIS is expected to cover 460,000 people with disability at an estimated cost of $22 billion per year (National Disability Insurance Agency 2016).

The NDIS has been heralded as one of the most significant social policy reforms in Australia of recent times. It is dramatically changing the provision of supports to people with disability in Australia. The scheme is distinguished from previous approaches in a number of ways:

- It adopts a person-centred model of care and support
- It applies insurance principles to costs
- Funding is determined by an assessment of individual needs (rather than a fixed budget)
- It is a national scheme.

However, the roll out of the NDIS has ignited concerns about the capacity of the disability sector to provide sufficient numbers of well-trained, skilled, and experienced disability support workers.

In 2010 the disability workforce was estimated to consist of 68,700 people, 62 per cent of whom were direct support or care workers (Martin and Healy 2010). A more recent estimate (Productivity Commission 2017) suggests the disability workforce was around 73,600 full-time equivalent workers in 2014-2015.

With the roll out of the NDIS, the sector is expected to face an unprecedented increase in demand for workers. The former Chairman of the NDIA board stated last year that *'It is expected that the NDIS will generate between 60,000 and 70,000 new jobs on a full-time equivalent basis over the next three years. This represents about 20 per cent of the total number of new jobs forecast to be created in Australia over this period'* (Bonyhady 2016, p. 5*).* More recently the Productivity Commission has estimated that the workforce would need to more than double in size; from 73,600 full time equivalent workers in 2014-15 to 162,000 in 2019-20 (Productivity Commission 2017).

There is some evidence that providers are already experiencing difficulties in recruiting staff for disability care and support roles:

- 26 per cent of firms specialising in disability support surveyed by the Department of Employment in 2014 stated that they would often employ staff considered not to be qualified or experienced in disability work (Department of Employment 2014)
- This is similar to that found by Martin and Healy in 2010 where 22 per cent of disability service

providers surveyed said that their most recent professional appointee did not have optimal skills (Martin and Healy, 2010)

- Nearly half of the firms surveyed by National Disability Services (NDS) in 2015-16 stated that it was extremely or moderately difficult to attract disability support workers in general (National Disability Services 2016)

- Findings from the independent evaluation of the roll out of the NDIS noted challenges with staff recruitment in the sector. Shortages of workers were particularly noted amongst support workers, therapists and support coordinators. A lack of sufficient numbers of trained staff within the disability workforce meant that providers were concerned about meeting the demand for services (Mavromaras, Moskos and Mahuteau 2016; Mavromaras et al 2018).

Furthermore, the core values of the NDIS emphasise individualised funding and consumer choice and control. The preferences of people with disability and their families have therefore become central to determining how, where, when and what services are delivered. Consequently, the nature of the skills required by the disability workforce is also likely to change.

Drawing on findings arising from the independent evaluation of the NDIS (Mavromaras et al 2018) we see that:

- The NDIS has led to an increased demand for disability services

- More than one-third of all provider organisations reported that they plan to expand their range of supports

- Types of services that are reported to be experiencing growth include one-on-one support services, support coordination and financial management, therapy, respite and accommodation services

- There is also evidence of improved flexibility in the timing of supports (accommodating requests for services outside Monday to Friday business hours), the location of support (offering home visits), and the provision of support (being able to use different services/providers)

- While service flexibility was reported to have increased, providers are still reported as being reluctant to provide services on a casual “as needed basis”.

All these changes are intensifying pressures on training providers, disability service providers, and disability workers alike, to ensure that the right skills are available to meet the sector’s rapidly expanding and changing service requirements.

There are many ways in which current training provisions may fall short of meeting the sector’s overall skill requirements. Some of the issues are well known, but others are poorly understood. They include:

- Whether the training content provided meets the current (and projected) skill needs of disability support providers and the changing support needs and preferences of people with disability and their families

- Concerns regarding the quality and consistency of accredited training, leaving disability support providers with the responsibility for ensuring that their workers are job-ready

- A presumed lack of disability-specific training courses, or difficulties in accessing those that

are available

- The risk that people with disability-relevant training may not end up working within the disability sector, or will do so only for a short time

- A perception among people with disability that the quality of supports available is below expectations or otherwise unsuited to their preferences.

Our study carefully examines each of the above issues of skills production and utilisation for the disability sector to provide an assessment of the adequacy of current modes of skills acquisition for disability support workers. The study provides a detailed, national assessment of existing and emerging skills imbalances in the disability sector, looking at both workforce size/location and types of skills available/required. The national evidence generated will inform policymakers about areas of skills under-supply and bottlenecks in the skills production chain that may lead to future skill shortages. This understanding will enable more timely policy responses to changing skill demands that avoid costly service gaps and/or service price increases. The study will enhance the disability sector's capacity to anticipate and address potential skills imbalances, a core concern as the NDIS makes progress with its planned full scheme roll out, estimated to be completed by the end of 2019.

1.1 Methodologies

The research had two main components. The first involved an analysis of nationally representative data on training, training outcomes and disability sector employment. The second involved in-depth, qualitative interviews with key stakeholders. Each of these components is detailed below.

1.1.1 Stage 1 – Quantitative component

The first stage of the research used a number of nationally representative datasets to study the connections between disability training and disability sector employment and the labour market imbalance for care workers. The quantitative analyses used data relating to:

- Vocational education and training (VET) students and courses, also known as 'Total VET activity (TVA)', from the National VET Provider Collection, National Centre for Vocational Education Research (NCVER).

- VET students' characteristics and post-study outcomes, from the confidentialised unit record files (CURFs) of the National Student Outcomes Survey (SOS) NCVER.

- State of the labour market for care workers, from the Australian Bureau of Statistics (ABS) Labour Force Survey and Characteristics of Employment Survey.

- Job vacancy situation for care workers from the Internet Vacancy Index, Department of Jobs and Small Business.

These analyses allowed us to understand how disability training is linked to disability sector employment in new ways. First, using the administrative records from state training authorities and other relevant bodies contained within the TVA, we examined recent disability program completions in Australia (for 2015 and 2016). This included program completions from TAFE and other government providers, community education providers and other registered training providers. Second, using data from three waves of the SOS (2007, 2013 and 2016), we explored the characteristics of students who undertook disability training and their perceptions of the education they received. Third, using the same SOS data, we analysed the post-training employment outcomes of graduates who undertook

disability-related training. Finally, we also calculate and present a number of indicators in order to assess potential imbalances in the labour market for care workers.[1] The indicators we use include the number of employees; total hours worked; vacancy rates; mean hourly wages; and the proportion of workforce aged 55 years and over. We explore the development of these indicators over the investigation period and we compare how our findings compare between disability care, other care and the whole of the labour market. The Australian market has been under skill shortages pressure for a long time, with unemployment levels characteristically lower than those of our international comparators. For this reason, we use skill shortage indicators to judge if the specific section of the labour market we are interested in (in this instance disability services and supports) is under more or less skill shortages pressure than, either the overall care labour market, or the full Australian labour market.

Recognising that occupation and qualification categories often mix different types of care work and training together, we used detailed course descriptions and developed our own categorisation of disability care courses. This allowed us to overcome some of the imprecisions of standard VET statistics. To select the disability related training courses used in our analyses, we undertook a systematic desk based review of current and past training available to be undertaken through the VET system for our years of interest (2007 to 2016). The focus was on formal qualifications undertaken at a certificate or diploma level rather than on short accredited and non-accredited courses. The units of competency for each of these qualifications were examined to ensure that only courses with a focus on working with people with disability were selected. This was cross-classified with the skill-based training courses included in the SOS and the TVA data to develop an extensive list of possible training courses undertaken by those seeking employment within the disability sector. Our final selection of disability-related training courses included certificate and diploma courses in *disability*, *mental health*, *home and community care*, and *individual support*. In the remainder of this report, these courses are referred to collectively as '*disability training*'.

Several caveats should be made regarding the data and our subsequent analyses. First, the TVA program completion data for 2016 is based on preliminary data received by the NCVER and may therefore be subject to change.[2] Second, our analyses on student characteristics and outcomes focused on government funded students as this was the only cohort sampled in the 2007 and 2013 SOS. In 2016, the SOS included a sample of students from all funding sources (government and non-government). In order to compare characteristics and outcomes across all three waves, the 2016 sample used in our analyses was restricted to government funded students only to allow us to compare like with like. In contrast, the analyses on total VET students and courses (using the TVA dataset) included those who received government funding as well as domestic and international fee-for-service students. Third, our analyses of the SOS data include students who had completed either their full qualification or individual subject modules: this report refers to these students collectively as 'disability graduates'.

The findings from the quantitative component of the project are presented in Chapter 2. These provide a comprehensive mapping of the links between disability training within the VET system and employment in the disability sector.

1.1.2 Stage 2 – Qualitative component

There are limitations as to what can be learned from the analysis of quantitative data alone. Specific

[1] We follow the methodology developed by some of the authors of this report for the Australian Workforce and Productivity Agency of the Australian Commonwealth government in 2013 in order to monitor possible skill shortages and surpluses in critical occupations. (Mavromaras et al. 2013 for more details).

[2] This would be a very rare occurrence for a major national data collection and it would be of no practical consequence for the purposes of this report.

to this study, is that the data contains no information as to whether there may be types of training and skills that would be useful for disability support workers to have, but which are not currently available within the formal training system. Similarly, the data contains no information about crucial skills that are learned informally 'on the job' rather than through training. To enrich our understanding, and to help translate our findings into concrete and practical policy conclusions, we conducted a series of targeted in-depth interviews with key stakeholder groups in Stage 2 of the project.

These interviews allowed us to understand more fully:

- Current and anticipated skill needs within the sector
- The types of training, qualifications and experiences required by disability support workers, and
- The potential impact that the NDIS may have on the skills and competencies required by disability support workers.

Stakeholder groups included:

- Disability support providers – to record their actual and anticipated skill requirements, and assess the range of training provisions available to them
- Disability support workers – to record their skill profiles and skill needs, learning activities, and assessment of skills acquired in formal and on-the-job training
- People with disability – to obtain their perceptions of current and/or essential support skills
- Training providers – to understand how disability training courses have been developed and which skills/competencies these seek to instil in students.

In total, 76 interviews were conducted with a purposively selected sample of 96 respondents from our key stakeholder groups. The interviews were conducted with respondents from across the country including metro and regional areas. The specific needs and requirements of disability clients from Aboriginal and/or Torres Strait Islander (ATSI) or culturally and linguistically diverse (CALD) backgrounds were also captured in the interviews. The sample characteristics of each of our key stakeholder groups and the methodology deployed to undertake the interviews are described below.

1.1.2.1 Interviews with training providers and key stakeholder groups

Seventeen interviews were undertaken with 21 representatives from disability training providers and key stakeholder groups. Interviews were conducted over the phone and generally lasted between 30 and 45 minutes. A total of nine training providers and seven stakeholder organisations participated in the research. Training providers included public and private providers, located across Australia. Stakeholder groups included disability workforce peak bodies, skills training councils, unions and professional membership bodies. The majority of the stakeholder groups were national in reach. Throughout this report the term 'training organisations' is used to refer to respondents from both training providers and key training stakeholder groups.

1.1.2.2 Interviews with disability support providers

Twenty interviews were conducted with 29 respondents from disability service provider organisations. Interviews were conducted over the phone and generally lasted between 45 and 60 minutes each. Almost two-thirds of the disability service providers were not-for-profit (NFP) with the remainder

being for-profit organisations. Service providers were located across several states and territories (VIC, QLD, SA, NSW, TAS, NT and ACT) and in both metropolitan and regional areas. All of the service providers were NDIS registered providers; however, a third of the organisations were waiting for the NDIS roll out to occur in their area. Therefore, not all disability service provider were actively providing services to current NDIS participants. The types of supports offered by the organisations varied and included respite care; in-home support (personal care and domestic assistance); supported accommodation; supported employment; youth residential rehabilitation; psychiatric subacute facilities; foster care; social/community engagement; day options; work transition programs and educational services.

The research project originally proposed to include two particular subgroups of disability service providers. The first were new providers who had recently entered the disability sector. The second subgroup were labour hire firms. It was hypothesised that both these types of providers would have distinct views about the types of skills that are required in the sector and the adequacy of the current workforce in relation to these. However, very limited evidence was found of new providers entering the market at the time of recruitment and interviews (December 2016 to June 2017). This was also substantiated by the Evaluation of the NDIS which likewise found limited evidence of new providers entering the sector in the trial years, with most new entrants being small or solo allied health practices (Mavromaras et al 2016; 2018). As the focus of this study was on the disability support workforce, new providers were therefore not included in the research. The original sample frame for the research did include labour hire firms but unfortunately despite multiple and repeated attempts, no labour hire firms were willing or able to participate in the research.

1.1.2.3 Interviews with disability support workers

Interviews were undertaken with 20 disability support workers located in South Australia and New South Wales. Interviews were conducted over the phone and generally lasted between 45 and 60 minutes each. Variation in respondents were sought on qualifications, length of time in the sector, location, worker roles, gender, and CALD backgrounds. Eight disability support workers lived and worked in regional locations (predominantly the Hunter region) and eleven in metropolitan locations; one further worker was employed in both regional and metropolitan settings. While the NDIS roll out had begun in the locations that they worked, not all had worked with NDIS clients.

Respondents included five male and fifteen female support workers. Three respondents were from CALD backgrounds and two identified as people with disability themselves. Respondents experience in disability care and time in their current disability support worker role ranged from six months to more than 20 years. Respondents held a range of formal qualifications, including disability specific and other certificate and tertiary level qualifications. Respondents worked across a number of disability care services, with nearly half (n=8) working in more than one service type concurrently. The most common service type was supported group accommodation, with half of respondents working in these services. Other service types included individual in-home support, community access, coordinating individualised programs, day programs, respite, personal care and supervision in Australian Disability Enterprises (ADEs), aqua therapy, supported holidays, transport, and a work transition program. Respondents worked with clients ranging in age, disability type and disability severity.

1.1.2.4 Interviews with people with disability and or their family members and carers

Nineteen in-depth interviews were conducted with 26 respondents including people with disability, family members and carers. Interviews were between 30 and 75 minutes in duration. Five of the interviews were undertaken one-to-one with a person with disability, six interviews were conducted one-on-one with a family member and one interview was conducted with both parents of a person with disability. Five interviews were joint interviews with a person with disability and a member of their family and one interview was conducted with a person with disability and their paid carer. The

remaining interviews were conducted with a family member who also had a disability themselves, and a person with a disability who also was interviewed in their capacity as a paid disability support worker. Sixteen respondents resided in South Australia including ten living in regional locations and six in the Adelaide metropolitan area. Three interviews were conducted with respondents living in New South Wales including two living in regional locations and one living in metropolitan Sydney. Eleven interviews were conducted over the phone and eight in person.

Nine interviews concerned a person with an intellectual disability including people with Down syndrome, other learning difficulties, and the effects of a stroke and one interview concerned a person with autism. Three interviews concerned people with physical disability encompassing multiple sclerosis, spina bifida, and muscular dystrophy. The remaining six interviews concerned people with both intellectual and physical disability. Eleven interviews concerned women with disability and nine were men. The age of people with disability ranged from 23 to 58 years. One person with disability identified as Aboriginal.

There was a range of disability services that the people with disability accessed. The most common were day programs, one-on-one in-home supports and community access. Less common supports included group supported accommodation, respite, transport to day programs and medical appointments, and assistance from support workers while working for an ADE.

1.1.2.5 Analysis

With the consent of participants, each interview was recorded using a digital recorder and transcribed verbatim by a professional transcription service. The transcribed data was entered into NVivo 11 in order to assist with the management and analysis of the data. The analysis of all interview data was conducted according to the framework approach (Ritchie and Spencer 1994) which is particularly suited to applied social research. Following familiarisation with the data through the reading of the transcripts, a thematic framework was developed and agreed upon by the qualitative research team. This thematic framework was based around the core topics outlined in the interview schedule and included the main sub-themes which had emerged during the interviews in relation to these topics. The interview transcripts were then coded according to this thematic framework. Key themes were developed and refined throughout the data analysis to enable further emergent categories to be identified.

The findings from the qualitative component of the research are presented in Chapter 3.

2. Stage 1 results: Findings arising from analysis of quantitative data

This chapter presents the findings of the quantitative analyses conducted with data drawn from the Total VET activity (TVA), the National Student Outcomes Survey (SOS), the ABS and the Department of Jobs and Small Business datasets. We present first an overview of VET program completions from 2015-16. We then present the findings relating to the characteristics of students undertaking disability training and their experiences of this training, using data drawn from the SOS. We continue by outlining the results of analyses examining the post-educational outcomes of disability training graduates. Finally, we derive and present several labour market imbalance indicators which allow us to examine the macroeconomic conditions surrounding skills shortages or skill surpluses in the disability care sector, enabling us to compare the care sector with the rest of the labour market, as well as over time.

2.1 Overview of VET program completions 2015 and 2016

The number of VET disability care completions increased by 22 per cent between 2015 and 2016. The magnitude of this increase is even more pronounced when it is considered in the context of decreasing national numbers in overall VET completions in that same time period. There are large differences by State and Territories, which are in part explained by the differences in the timing of, and the locations and age groups involved in the NDIS trial roll out. The early changes brought about by the NDIS can be seen as a core market signal of the impending changes that will occur when the Scheme is at full national roll out.

This section reports on completions of VET programs delivered by Australian training providers in 2015 and 2016. We report on all program completions, and we pay special attention to disability training completions and other community services and health ('other care training') completions.

Using data from the TVA, Table 1 reports on total VET completions for 2015 and 2016. Although disability training is only a small part of the national VET completions, it showed a large increase between 2015 and 2016. Other care training was far less attractive to students, while non-care training completions experienced a sharp reduction in numbers between 2015 and 2016. Table 1 presents the numbers and the percentages of completions for each category of training, and the percentage change in both.

Overall VET completions reduced substantially between 2015 and 2016 from 888,901 to 773,516. It is in this context of national VET completions decline that disability VET completions increased substantially in number from 19,397 to 23,642, which amounts to a 22 per cent rise. We note that at the same time other care VET completions reduced in absolute number from 119,309 to 107,908, a 10 percent drop, which presumably reflects the reforms in the aged care and the health care sectors. These changes happened against the backdrop of a national decrease in the number of total completions of all non-care types of training by 14 per cent from 750,195 to 641,966 between 2015 and 2016.

Table 1: Program completions by type of training, by year

	2015		2016		% Change in	
	Number	Per cent	Number	Per cent	Number	Percentage
Disability training	19,397	2.2	23,642	3.1	+22%	+41%
Other care training	119,309	13.4	107,908	14.0	-10%	+5%
All other training	750,195	84.4	641,966	83.0	-14%	-2%
Total program completions	**888,901**	**100**	**773,516**	**100**		

Note: Source TVA data. Due to rounding, the total percentages may not sum up exactly to 100.

VET completions specialising in a specific sector do not necessarily translate into increased employment in this sector. They only reflect the interaction between the education market and the prevailing student expectations about the labour market. VET completions are therefore a useful indicator of the capacity of the education sector and the degree to which a specialty is considered to be a worthwhile destination by prospective students. To get a full picture we will also need to look at what happens when VET graduates try to join the labour market. Hence, in order to obtain a full picture of the labour market, we need to explore indicators such as whether graduates secure employment quickly and find their recently obtained qualification relevant to their new job. Further discussion as to the role VET completions play as an indicator of a changing labour market is presented below in Box 1 below.

We expect that the decision-making of prospective VET students considering disability care between 2015 and 2016 would have been influenced by the roll out of the NDIS, which had already started to make itself felt across the nation. Commencing in July 2013, the trial stage of the NDIS occurred in several different formats across Australia. The NDIS trials in New South Wales, Victoria and the Northern Territory were restricted to specific geographical areas - the Hunter Valley (NSW), the Geelong region (VIC), and the Barkly region (NT). The NDIS trial roll out in the rest of the country was limited in different ways. In South Australia and Tasmania, the NDIS trial covered particular age groups of people with disability. In South Australia, the initial focus of the NDIS was on children and it was the youngest cohort of all eligible children who were the first NDIS participants. The NDIS roll out in Tasmania covered young people with disability aged between 18 and 24 years. Although the trial was designed to encompass the whole age spectrum in the ACT, the actual roll out was delayed, so that in the time the data used here was generated (the years 2015 and 2016) the impact of the NDIS trial would not have been as clearly felt as elsewhere in the country. Finally, in Queensland, there was no trial at all and in WA, there were state-specific arrangements regarding supports and services for people with disability, which differed from the national picture of the NDIS. The NDIS trial period ended in July 2016, and it was at that time that the full Scheme began rolling out nationally across Australia.

Table 1a below shows completions by type of VET and by State/Territory in 2015 and 2016. The uneven design of the NDIS trial roll out described here (by location, timing, and by the age group of eligible NDIS participants) could be responsible, at least in part, for the differences in graduation rates by state and territory.

Table 1a also shows that New South Wales, Victoria and Queensland are the three largest states in population, which largely explains why they also report the largest number of VET completions in all of the disability training, other care training and all other training in both 2015 and 2016. In contrast, Tasmania, Australian Capital Territory and Northern Territory are the three regions with the smallest number of VET completions.

Box 1: VET completions as an indicator of a changing labour market (Interpreting Table 1)

Prospective VET students are always searching for those courses that will help them get a job or get a better job. The choice of qualifications is very wide and the information about future job prospects is often confusing. Hence, students engage in intensive search and their choices contain valuable information about the current state of the labour market. Unlike with university degrees where the choice of a qualification must be made several years before entering the labour market as a graduate, a student commencing a disability care related qualification at Certificate III or IV level is only half to one year away from actually entering the graduate labour market. Hence, the choices relating to VET training themselves, the way they change over time, and the information they convey have a much stronger immediacy than in the corresponding university education case.

If we are interested in the degree to which market signals about the demand for workers with a particular specialty are reaching students, then the numbers we would need to look at are the proportion of graduates of that specialty over all VET graduates and how this changes over time. The proportion of all students who graduated in 2015 with a disability care qualification was 2.2 per cent and increased to 3.1 per cent in 2016 (a 41% increase in the percentage). This large increase suggests that between 2015 and 2016 there was a strong message of qualifications/skills shortages in the labour market for disability care graduates, as contrasted with the national skills shortages picture. A similar calculation could be made contrasting the proportion of disability care graduates against all care graduates where 19,397/138,706 = 14% for 2015 and 23,642/131,550 = 18% for 2016, a 29% increase in the percentage which suggests that students considering training and employment in the care professions are increasingly choosing disability care over other care sectors.

Another angle that matters is the rise in the skilled and qualified resources available to the sector. To judge this we must look at the additional training capacity utilised within the VET sector as the labour market demands more skilled workers and at the subsequent additional resources that were made available to employers between 2015 and 2016. This is best represented by the rise in the actual numbers of graduates from 19,397 to 23,642 between the two years (a 22% increase in the number of graduates). This percentage is the most accurate reflection of the potential increase in output for the whole sector due to changes in training.

Clearly, we have to be careful as to what statistic we use as we try to measure the development of the sector during the NDIS roll out.

Disability training accounts for a small proportion of the total VET completion numbers in all the states (Table 1a). The state with largest proportion of disability training is Tasmania in 2015 (6 per cent) and South Australia (7 per cent) in 2016. Northern Territory is the region with the smallest proportion of disability training (1 per cent) in both 2015 and 2016.

All states and territories experienced a decrease in the number of total completions between 2015 and 2016, the sharpest being Victoria, South Australia, the ACT and Western Australia, and the lower ones where VET was more resilient being New South Wales, Queensland, Tasmania, and the Northern Territory.

Table 1a: Program completions by type of training, by year, by State and Territory

	2015		2016		Change
	Number	Per cent	Number	Per cent	
New South Wales					
Disability training	5,071	2.2	7,383	3.4	+46%
Other care training	33,204	14.6	31,116	14.5	-6%
All other training	189,909	83.2	176,593	82.1	-7%
Total	**228,184**	**100**	**215,092**	**100**	**-6%**
Victoria					
Disability training	6,971	2.7	6,685	3.4	-4%
Other care training	40,293	15.8	33,606	16.9	-17%
All other training	207,822	81.5	158,866	79.8	-24%
Total	**255,086**	**100**	**199,157**	**100**	**-22%**
Queensland					
Disability training	3,654	1.6	4,549	2.1	+24%
Other care training	23,910	10.4	23,007	10.7	-4%
All other training	203,026	88.0	187,605	87.2	-8%
Total	**230,590**	**100**	**215,161**	**100**	**-7%**
South Australia					
Disability training	1,435	3.6	2,136	7.1	+49%
Other care training	6,501	16.2	6,412	21.2	-1%
All other training	32,208	80.2	21,692	71.7	-33%
Total	**40,144**	**100**	**30,240**	**100**	**-25%**
Western Australia					
Disability training	1,128	1.2	1,788	2.2	+59%
Other care training	10,928	11.2	10,039	12.3	-8%
All other training	85,580	87.7	69,899	85.5	-18%
Total	**97,636**	**100**	**81,726**	**100**	**-16%**
Tasmania					
Disability training	714	6.3	666	6.4	-7%
Other care training	1,815	16.1	1,482	14.2	-18%
All other training	8,759	77.6	8,289	79.4	-5%
Total	**11,288**	**100**	**10,437**	**100**	**-8%**
Northern Territory					
Disability training	40	0.7	58	1.0	+45%
Other care training	488	8.1	535	9.5	+10%
All other training	5,504	91.2	5067	89.5	-8%
Total	**6,032**	**100**	**5,660**	**100**	**-6%**
Australian Capital Territory					
Disability training	380	2.1	355	2.5	-7%
Other care training	2,016	11.1	1,530	11.0	-24%
All other training	15,829	86.9	12,084	86.5	-24%
Total	**18,225**	**100**	**13,969**	**100**	**-23%**

Note: Source TVA data. Due to rounding, the total percentages may not sum up exactly to 100.

Finally, Table 1a suggests that looking at each state and territory as a whole, NSW experienced a modest overall VET decline with a sharp increase in disability care VET. Victoria experienced a sharp overall VET decline with a modest decline in disability care graduations. Whilst South Australia almost matched Victoria in its overall VET decline, it experienced one of the steepest rises in disability care VET completions in the country, possibly in response to the underestimation in that state of the number of NDIS eligible children. Queensland experienced a modest overall drop in VET completions and a strong rise in numbers of disability care VET completions, albeit from a low starting point. Western Australia showed the steepest rise in disability care VET completions in the context of a strong decline in overall VET completions. Both Tasmania and the ACT experienced a modest decline in disability care, the former in the context of a modest overall VET decline, the latter in the context of a sharp overall decline in VET completions. The disability care VET completion numbers for the Northern Territory are too small to be interpreted in this context.[3]

Table 2 below shows the specific qualification level at which change in disability training actually occurred between 2015 and 2016. There was a large increase in Certificate III disability qualifications (from 60 to 72 per cent) and a modest reduction in Certificate IV ones (from 35 to 26 per cent). As Certificate IIIs have become the minimum entry requirement for the sector, such a shift could be the manifestation of cost compression by providers of disability care. The numbers of new Diploma and Advanced Diploma graduations are very small in comparison to Certificates and they are also following the pattern of Certificate IV showing a modest reduction between 2015 and 2016 (Diploma from 552 to 417 and Advanced Diploma from 205 to 154 cases). There is an overall clear pattern regarding new qualifications in the disability sector, in that the number of qualifications increases, but their level decreases. To the degree that quality of provision depends on the level of qualification of new workers, the message is that quality is not getting better. However, if what we see is that the sector is resorting to more in-house training and thus prefers its new hires to be trained to the level of Certificate III, we cannot make any judgement about the resulting quality of provision from this data.

Table 2: Level of disability care VET graduations by year

	2015		2016	
	Number	**Per cent**	**Number**	**Per cent**
Certificate III	11,806	60	16,935	72
Certificate IV	6,834	35	6,136	26
Diploma	552	2	417	2
Advanced Diploma	205	1	154	1
Total	**19,397**	**100**	**23,642**	**100**

Note: Due to rounding, the total percentages may not sum up exactly to 100.

Table 2a below presents the change in the level of new VET qualifications by State and Territory. Certificates III and IV account for the vast majority of the disability training completions in all the states and territories and for both 2015 and 2016. They comprise well over 90 per cent of all disability care VET completions in almost every location. In accordance with the aggregate national trend shown in Table 2 above, most states and territories shifted away from Certificate IV and towards Certificate III qualified VET graduates between 2015 and 2016. This shift was more pronounced in NSW, SA and WA. The one exception was Tasmania which appears to have shifted in the opposite direction, with a reduction in Certificate III graduates and an increase in Certificate IV ones. The reason for this difference is not clear and would require further examination.

[3] The number of other care training and all other training completions declined in all the states between 2015 and 2016 with the exception of the Northern Territory, which experienced an increase in other care VET by 10 per cent.

Table 2a: Level of disability care VET graduations by year by State and Territory

		2015		2016	
		Number	Per cent	Number	Per cent
NSW	**Certificate III**	3,082	61	5,722	78
	Certificate IV	1,738	34	1,460	20
	Diploma	251	5	201	3
	Advanced Diploma	0	0	0	0
	Total	**5,071**	**100**	**7,383**	**100**
VIC	**Certificate III**	3,878	56	3,965	59
	Certificate IV	2,942	42	2,652	40
	Diploma	151	2	68	1
	Advanced Diploma	0	0	0	0
	Total	**6,971**	**100**	**6,685**	**100**
QLD	**Certificate III**	2,627	72	3,554	78
	Certificate IV	951	26	921	20
	Diploma	76	2	74	2
	Advanced Diploma	0	0	0	0
	Total	**3,654**	**100**	**4,549**	**100**
SA	**Certificate III**	654	46	1,398	65
	Certificate IV	549	38	558	26
	Diploma	27	2	26	1
	Advanced Diploma	205	14	154	7
	Total	**1,435**	**100**	**2,136**	**100**
WA	**Certificate III**	764	68	1,546	86
	Certificate IV	358	32	233	13
	Diploma	6	1	9	1
	Advanced Diploma	0	0	0	0
	Total	**1,128**	**100**	**1,788**	**100**
TAS	**Certificate III**	552	77	440	66
	Certificate IV	140	20	192	29
	Diploma	22	3	34	5
	Advanced Diploma	0	0	0	0
	Total	**714**	**100**	**666**	**100**
NT	**Certificate III**	36	90	42	72
	Certificate IV	4	10	16	28
	Diploma	0	0	0	0
	Advanced Diploma	0	0	0	0
	Total	**40**	**100**	**58**	**100**
ACT	**Certificate III**	209	55	254	72
	Certificate IV	148	39	94	26
	Diploma	23	6	7	2
	Advanced Diploma	0	0	0	0
	Total	**380**	**100**	**355**	**100**

Note: Source TVA data. Due to rounding, the total percentages may not sum up exactly to 100.

Table 2a also shows that there are big differences in the provision of Diplomas and Advanced Diplomas by State and Territory. It is unclear at this stage whether the data on Diplomas and Advanced Diplomas could be relied for statistical analysis and we recommend that it should not.

2.2 Overview of disability training and graduate characteristics

The evolution of the demographics of VET graduates in disability care shows us the direction of change in the whole sector's workforce. The sector has been predominantly old(er), female and of Australian ethnic origin. Diversity is increasing, as we find that the proportion of younger people, men and CALD workers has increased among the new disability care VET graduates. However, we find that the proportion of new graduates from rural and remote areas is decreasing over time. Finally, we find that the number of Indigenous workers or people with disability working in the sector remains extremely small.

The following section provides an overview of disability training and the characteristics of graduates undertaking these courses. The data used in this analysis were derived from three full waves of the Student Outcomes Survey (SOS, 2007, 2013 and 2016). Before we discuss these data sets it is important to note that the three samples are of a different size as the NCVER generates a larger sample every other year. In the context of Table 3 the years 2007 and 2016 were among the smaller sample years and 2013 was one of the larger sample years. It follows that in order to make meaningful comparisons between the three samples/years, we need to be looking at the percentages rather than the absolute numbers presented in Table 3 and in subsequent similar tables in the report.

Table 3 presents and compares completions of certificate and diploma level qualifications courses and subjects within the whole VET sector. Disability training is a small proportion of overall VET, but it has increased by approx. 50 per cent between 2007 and 2016. Most of this increase took place between 2013 and 2016, which were the NDIS start years. Other care training also increased steadily, however, much of the increase took place between 2007 and 2013. Although reform and changes have also been occurring since 2013 in other care sectors, notably the aged care sector, only a relatively modest increase in student graduates was seen from 2013 to 2016. The non-care training residual category decreased steadily from 83 per cent in 2007 to 75.8 per cent in 2013 and 70.8 per cent in 2016.

Table 3: Number of graduates by type of training, by year

	2007		2013		2016	
	Number	Per cent	Number	Per cent	Number	Per cent
Disability training	889	2.5	1,478	2.7	847	3.7
Other care training	5,177	14.5	12,019	21.6	5,776	25.5
All other training	29,635	83.0	42,271	75.8	16,056	70.8
Total graduates	**35,701**	**100**	**55,768**	**100**	**22,679**	**100**

Note: Due to rounding, the total percentages may not sum up exactly to 100.

Table 4 below, shows that the profile of students completing disability training has broadened somewhat between the years 2007, 2013 and 2016, especially since the introduction of the NDIS.

Across all three years, over half of all students completing disability training were of prime working age (25-49 years), with around a third of graduates being older (50-64 years). Disability training has become more popular for those in the youngest age group (15-24 years) and less popular for those in the oldest age group (50 years or older).

The proportion of men completing disability training has increased steadily over time; males now

account for a quarter of all graduates. Similarly, disability training is becoming more popular amongst migrants from non-English speaking countries; the proportion of disability graduates from a non-English speaking background increased from 11 per cent in 2007 to 24 per cent in 2016.

A substantial majority of disability care VET graduates (83 per cent) identified that they were located in major cities or inner regional areas in 2016. The proportion of disability graduates living in outer regional or remote locations has reduced since 2013 and now accounts for only 16 per cent of all graduates. Indigenous students are a very small proportion of disability care graduates. Although the proportion increased from 1 per cent in 2007 to 4 per cent in both 2013 and 2016, we note that the numbers are still very small for any statistical interpretation.

Finally, the proportion of graduates identifying as having a disability themselves has decreased from 15 per cent in 2013 to 11 per cent in 2016.

Table 4: Characteristics of disability training graduates, by year (per cent)

	2007	2013	2016
Age group (years)	**(n= 889)**	**(n= 1,478)**	**(n=847)**
15-24	7	7	12
25-49	56	51	55
50-64	36	40	30
65+*	1	2	2
Sex	**(n= 889)**	**(n= 1,478)**	**(n=847)**
Male	17	20	25
Female	83	80	75
Country of birth	**(n=882)**	**(n=1,297)**	**(n=837)**
Australia	77	74	66
Other main English speaking	12	11	10
Other non-English speaking	11	15	24
Location	**(n=873)**	**(n=1,472)**	**(n=844)**
Major cities	44	41	57
Inner regional	32	35	26
Outer regional	22	21	15
Remote*	2	3	1
Very remote*	1	1	1
Indigenous status*	**(n=880)**	**(n=1,412)**	**(n=831)**
Indigenous	1	4	4
Non-Indigenous	99	96	96
Disability status	**(n=885)**	**(n=1,416)**	**(n=808)**
Yes	13	15	11
No	87	85	89

Note: Due to rounding, total percentages may not sum up exactly to 100. * For this category cells are too small for statistical interpretation.

The broadening out of the profile of disability training graduates described in Table 4 is not occurring for 'other care' and 'all other' training courses. Appendix Tables 4a and 4b indicate that, with the exception of students from non-English speaking countries, the two student cohorts undertaking 'other care' and 'all other' (i.e. non-care) training have remained fairly stable over time. We note that an increase in students from non-English speaking countries is also observed for 'other care' training,

but is less pronounced for 'all other' training.

The broader picture we see is that the sector is reaching out for more employees and in doing so it is opening up to new sources of people, hence its demographic profile is altering towards more men, more young people and more CALD people. However, the sector does not seem to be attracting more Indigenous employees or more people with disability as employees themselves.

2.3 Graduate experiences before, during and after VET training

Training is one of the most important workforce development policy tools. This sub-section explores the experiences of VET graduates prior to training, during their training and after their training. In order to understand the dynamics of workforce development we need to know more about the reasons why people decided to train for a specific job and what job they were doing prior to their training. As satisfaction of students with training is always a very important and practical indicator of its future success potential, it is also very useful to know how well recently graduated students thought their training went. Finally, the litmus test for whether training has been a successful investment comes from examining the employment outcomes after training. This sub-section explores these experiences in detail using the Student Outcomes Survey data sets from three years, 2007, 2013 and 2016.

2.3.1 Prior to VET training

A large majority of the new VET graduates were employed prior to undertaking their VET course and this proportion has been declining with time. More than half of those in employment prior to their VET course were working less than full time, with two thirds previously employed in the Health Care and Social Assistance industry and as Community and Personal Service Workers. The main reasons for undertaking training centred on keeping and improving their current job (the proportion of this reason is declining with time) and getting a new job or a new career (the proportion of this reason is increasing with time). The increase in VET graduates who engage in this training as a means of entering the disability sector is noteworthy.

For any form of workforce planning it is useful to know where workers are coming from, especially the workers who decide to either join a sector from elsewhere or to make progress within their present sector through formal training. This section presents findings relating to graduate experiences prior to undertaking their disability training. In particular, it examines the employment histories of disability care VET graduates and the reasons why they undertook their VET course.

Table 5 outlines the employment status of disability training graduates prior to training commencement, comparing this with students who completed 'other care' and 'all other' training. For all types of training, the majority of students who upskill through VET were in employment prior to their training. The proportion of students who did not have a job before their disability training increased from 17 per cent in 2007 to 28 per cent in 2016. A similar increase was observed for other care training (from 28 per cent to 37 per cent) and for all other types of training (from 22 to 27 per cent). In the context of an Australian labour market that is continuing to grow and experience labour and skill shortages, the data in Table 5 suggests that the disability care sector is drawing new workers increasingly from the pool of people who do not have a job and decide to train in order to get one.

Table 5: Whether had a paying job before training by type of training, by year (per cent)

	2007	2013	2016
Disability training	**(n=878)**	**(n=1,426)**	**(n=810)**
Had a job	83	79	72
Did not have a job	17	21	28
Other care training	**(n=5,125)**	**(n=11,640)**	**(n=5,528)**
Had a job	72	73	63
Did not have a job	28	27	37
All other training	**(n=29,253)**	**(n=40,845)**	**(n=15,479)**
Had a job	78	79	73
Did not have a job	22	21	27

Over half of those working prior to undertaking their disability training reported that they were employed on a part-time basis (Table 6). We observe a small rise in the proportion of disability training graduates who were in full time employment, from 38 per cent in 2007 to 43 per cent in 2016.

A similar picture emerges among graduates undertaking 'all other' training, however we note a reverse trend for those having graduated from 'other care' training, with a smaller proportion of graduates reporting full time employment prior to training (Appendix Tables 6a and 6b).

Table 6: Hours worked per week before training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=722)	**(n=1,122)**	**(n=596)**
35 hours or more per week	38	39	43
1-34 hours per week	62	61	57

Table 7 shows that the industry sector where disability training graduates worked prior to their training was predominantly Health Care and Social Assistance (67 per cent of students in 2016). This suggests that disability training is primarily being undertaken by people who are already working in the broader care sector and who are seeking formal qualifications to upskill and specialise further. Around a third of disability graduates with a previous employment history had jobs in industries outside the health care and social assistance field. These industries included retail trade, accommodation and food services, administrative and support services, and education and training.

Table 7: Industry of main job before training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=706)	**(n=1,017)**	**(n=590)**
Health care and social assistance	71	71	67
Retail trade	3	3	6
Accommodation and food services	2	4	4
Administrative and support services	4	4	4
Education and training	7	6	7
Other	12	11	12

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

The industry sectors from which graduates of 'other care training' originated are more diverse (see Table 7a), with only about half of new graduates coming into their training from a broader health care

and social assistance background (56 per cent in 2007, 53 in 2013 and 49 in 2016).

Table 7a: Industry of main job before training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=3,558)	(n=8,172)	(n=3,519)
Health care and social assistance	56	53	49
Retail trade	12	9	10
Accommodation and food services	10	6	10
Education and training	5	13	12
Administrative and support services	3	4	4
Other	15	14	15

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

One implication of comparing Tables 7 and 7a is that they show the appeal of disability support work to prospective new workers is not spread as widely as the appeal of other care work. This would suggest that there is further scope for more broadly targeted hiring campaigns for disability care jobs.

Tables 8 and 8a present the occupations of those graduates who were employed during the six months before they began their training. They show that across all three years, about 70 per cent of disability care graduates and about 50 per cent of other care graduates had previously been employed as community and personal service workers. These proportions do not appear to have changed in a substantial way between 2007 and 2016. The interesting message from these two tables is that disability care finds its students principally from the current stock of community and personal service workers (approx. 70 per cent), while other care training cast their net more widely. The implication is that excess demand for skilled workers in the disability sector has a smaller pool of potential recruits and can be thus expected to find it harder to adapt to skills shortages than the other care sectors.

Table 8: Occupation of main job before training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=710)	(n=1,019)	(n=592)
Community and personal service worker	72	70	68
Manager	2	3	5
Professional	7	8	6
Clerical and administrative worker	5	6	6
Sales worker	4	4	5
Technicians and trades worker	1	2	2
Machinery operators and driver	2	1	2
Labourer	6	6	6

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Table 8a: Occupation of main job before training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=3,592)	(n=8,189)	(n=3,532)
Community and personal service worker	53	55	55
Manager	4	4	4
Professional	7	11	7
Clerical and administrative worker	8	9	10
Sales worker	14	10	11
Technicians and trades worker	3	4	4
Machinery operators and driver	1	1	2
Labourer	10	7	9

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

The main reasons that graduates identified for undertaking their disability training are shown in Table 9. Across all three cohorts, the most frequently reported reason for undertaking a disability training course was to gain 'extra skills for my job'. The second most frequent reason was that 'it was a requirement of my job'. Both these two categories refer to workers who are upskilling in their existing jobs. Jointly, these two reasons appear to be losing importance over time, especially since 2013 when the NDIS first appeared in the horizon (from 57 per cent in 2007, to 55 per cent in 2013, to 44 per cent in 2016).

Table 9: Main reason for undertaking training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=795)	(n=1,425)	(n=832)
To get a job	13	17	23
To try for a different career	11	11	16
To get a better job or promotion	8	6	6
It was a requirement of my job	28	20	16
I wanted extra skills for my job	29	35	28
To get into another training or study	2	2	2
To improve my general education skills	5	5	6
To get skills for community/voluntary work	2	3	3
To increase my confidence/self-esteem	1	2	1
Other reasons	1	1	0

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

The next two most frequently reported reasons for training in Table 9 are 'to get a job' and 'to try for a different career'. In contrast, to the previous two categories, here we have workers who upskill in order to follow a new direction and do something different: these are the new workers for the sector. In further contrast, these two categories (to get a job and to try for a different career) appear to be gaining in importance over time, especially since 2013 when the NDIS first came in the horizon (in total from 24 per cent in 2007, to 28 per cent in 2013, to 39 per cent in 2016). Although disability training has traditionally been predominantly undertaken by those already working in the sector who are seeking to achieve formal qualifications, the evidence indicates that there has been an increase in those who engage in this training as a means of entering the disability sector. This finding provides clear evidence that occupation-specific formal training is playing a substantial role in providing new skilled workers and thus alleviating skill shortages in the disability care sector.

The importance of this message is confirmed by the findings (i) that the remaining reasons ("to get a better job or promotion", plus the bottom 5 reasons in Table 9) jointly amount for less than 20 per cent of all cases; (ii) that this number remains unchanged over time; and (iii) that the 'other reasons' category is very sparsely populated, which provides a strong indication that the reasons asked by the survey offered a sufficient and comprehensive list of all pertinent reasons. Appendix Tables 9a and 9b offer a comparison between the reasons reported by graduates of disability related training, with the reasons reported for undertaking training by graduates of 'other care' training and 'all other' training.

2.3.2 Graduate experiences during disability care training

Reporting by students on training satisfaction and their general perception of the quality of the training they received are good indicators of its future success. We do not try to disentangle the underlying causal relationships (i.e. is it that good students end up being satisfied and also successful afterwards, or is it that those students who by chance end up better off after their VET are also more likely to report *ex post* a higher satisfaction with the course?). This section reports only how these perceptions have been developing over time. A strong endorsement of the training sector comes from the almost unanimous view of disability training graduates that their training courses and training institutions were both worth recommending to other potential students.

The following section examines perceptions of the quality of disability training courses and compares them where appropriate to the perceptions of the quality of 'other care' and 'all other' training. Graduates were asked to rate their overall level of satisfaction with the quality of the training they had received. Responses demonstrated that an overwhelming majority of graduates were satisfied with the quality of disability care training courses (Table 10). Approximately 90 per cent of those who had completed their disability care training 'strongly agreed' or 'agreed' that they were satisfied with the overall quality of this training; this persisted across the three time-points. Since 2007, the proportion of graduates who were highly satisfied with the quality of their training (i.e. 'strongly agreed') has increased (from 44 per cent in 2007 to 52 per cent in 2013 and 50 per cent in 2016). Approximately 6 per cent of graduates reported dissatisfaction with the overall quality of training, and this low proportion remained constant across the three time points.

Table 10: Overall satisfaction with the quality of disability training, by year (per cent)

	2007	2013	2016
	(n=872)	(n=1,445)	(n=842)
Strongly agree	44	52	50
Agree	45	37	39
Neither agree nor disagree	6	4	6
Disagree	3	4	3
Strongly disagree	2	3	2

The proportion of disability care training graduates who 'strongly agreed' or 'agreed' that they were satisfied with the overall quality of the training was only modestly higher than the proportion of 'other care' and 'all other' training graduates (Appendix Tables 10a and 10b).

When asked whether they had achieved their main reason for undertaking disability training, approximately 90 per cent of graduates across all three time points reported that they had either wholly or partly achieved this (Table 11). This compares to around 87 per cent of graduates from 'other care' training and 84 per cent of graduates from 'all other' training (Appendix Tables 11a and 11b). Only 6 per cent of disability graduates in 2016 reported that their reasons for undertaking their training had not been realised.

Table 11: Whether achieved main reason for undertaking disability training, by year (per cent)

	2007	2013	2016
	(n=883)	(n=1,456)	(n=846)
Yes, wholly achieved	80	79	76
Yes, partly achieved	12	10	13
No	4	5	6
Don't know yet	4	5	5

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Graduates were also asked whether they would recommend the training course they completed (Table 12). Almost all of those graduating from disability training courses in 2016, agreed that they would recommend the training (94 per cent); this remained constant from previous years. A slightly smaller proportion of graduates from 'other care' (approx. 92 per cent) and 'all other' (approx. 89 per cent) would recommend the training (see Appendix Tables 12a and 12b).

Table 12: Whether recommend training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=871)	(n=1,332)	(n=844)
Recommend training	94	95	94
Not recommend training	6	5	6

Similarly, a high proportion of disability training graduates in 2016 reported that they would recommend their training institution (Table 13). Again, these rates of satisfaction were slightly higher than the proportion of 'other care' and 'all other' training graduates who said that they would recommend their training institution (see Appendix Tables 14a and 14b).

Combined with evidence from Table 12:s 10 to 12, these data demonstrate that disability training graduates are highly satisfied with the quality of the training they receive and that disability graduates are also more satisfied with the quality of the training they receive compared to graduates of 'other care' and 'all other' training.

Table 13: Whether recommend institution (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=870)	(n=1,330)	(n=840)
Recommend institution	94	93	90
Not recommend institution	6	7	10

2.3.2 Graduate experiences after undertaking disability care training

The litmus test for whether training has been a successful investment comes from examining the employment outcomes after training. This section presents evidence on the types of jobs that disability care VET graduates get after their graduation. It finds that the employment that follows is in accordance with the qualification's assumed objectives and is focussed on the targeted sector and occupation. Disability care qualifications were highly relevant and improved employment circumstances and the training was beneficial for a very large majority. However, only a small proportion reported that they moved to a higher skill level after their training and that most remained in a part time job.

This section presents findings relating to the experiences of VET graduates following their disability

training courses. In particular, we examine the employment outcomes of disability graduates as well as the benefits they report receiving from their training.[4] Where appropriate we compare these experiences with 'other care' and 'all other' training graduates.

Disability training graduates described the basis upon which they were employed after undertaking their training (Table 14). In 2016, almost all graduates reported that their employment after completing their disability training was as a 'wage or salary earner' (98 per cent). This is slightly higher than the proportion of 'other care' and 'all other' training graduates. The remaining 2 per cent of disability training graduates were conducting their own business or were working as a helper and not receiving wages. The proportion of those who are not wage of salary earners is a bit higher among 'other care' and 'all other' training graduates (5 per cent and 11 per cent respectively – see Appendix Tables 14a and 14b). Earlier data for 2007 and 2013 shows the same picture.

Table 14: Basis of employment after undertaking training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=796)	(n=1,255)	(n=712)
Wage or salary earner	99	98	98
Conducting own business	1	1	1
Helper not receiving wages	0	1	1

Table 15 presents the employment outcomes of graduates approx. six months after completing their disability training, comparing these outcomes with students who completed 'other care' and 'all other' training courses. Most disability students successfully obtained employment after training. However, the proportion of students who were employed after the completion of their training has decreased very slightly over time (falling from 91 per cent in 2007 to 85 per cent in 2016). The proportion of disability training graduates who were unemployed (and consequently looking for a job and available to start work) after completing training has increased (from 4 per cent in 2007 to 9 per cent in 2016), while the proportion of graduates not in the labour force across time has remained fairly constant (at around 6 per cent).

Similar trends were found across time for graduates completing 'other care' and 'all other' training. However, rates of post-study employment were higher for graduates completing disability training compared than for graduates in other fields of study. In 2016, 85 per cent of disability graduates were in employment after training compared to 77 per cent of 'other care' graduates and 78 per cent of 'all other training' graduates. Similarly, the unemployment rates are lower for the disability training graduates than those for the rest. It is interesting to note that disability training graduates are the least likely to end up in the "not in the labour force" category. The implication of these last findings is that there is evidence that either the students who chose disability training were more determined to pursue an employment career, thus showing a stronger labour force attachment, or the job opportunities were better for them, or both. To the degree that we can argue that students who aim at a disability care and other care qualifications are likely to be similar in their labour force attachment, we could speculate that the determining factor for the differences we observe is that there are more jobs in the disability sector than in the other care sector.

[4] The SOS asked graduates about their work situation on a specific date following the completion of their training. For example the employment questions contained in the 2016 SOS asked about employment outcomes as at 27th May 2016.

Table 15: Labour force status after undertaking training, by year (per cent)

	2007	2013	2016
Disability training	**(n=879)**	**(n=1,445)**	**(n=838)**
Employed	91	87	85
Unemployed	4	7	9
Not in the labour force	5	6	6
Other care training	**(n=5,108)**	**(n=11,735)**	**(n=5,692)**
Employed	84	82	77
Unemployed	7	10	14
Not in the labour force	9	8	9
All other training	**(n=29,189)**	**(n=41,363)**	**(n=15,856)**
Employed	85	82	78
Unemployed	7	10	14
Not in the labour force	8	8	9

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Data on the industry in which graduates were employed after completing their disability training are presented in Table 16 below. Across all three years, the positions that graduates held post-training were chiefly in the health care and social assistance sector. A less substantial proportion of graduates reported that they were employed in education and training or in other industries. Only a small proportion of graduates found work in retail trade, accommodation and food services and administrative and support services. Again, very little change was observed in these proportions from the previous years.

These findings provide welcome evidence that there is a good skills match for graduates completing disability training. Indeed, comparison of Tables 7 and 16, illustrates an increase in the proportion of disability graduates working in the health care and social assistance industry from pre- to post-training. In 2016, 67 per cent of graduates worked in this industry prior to training (Table 7) compared to 79 per cent of graduates after the completion of their training. It should be noted, however, that the data does not allow us to identify whether these students are moving into the disability field or into any other care sectors, e.g. aged care or community care.

Table 16: Industry of main job after training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=786)	**(n=1,136)**	**(n=708)**
Health care and social assistance	81	80	79
Retail trade	1	2	3
Accommodation and food services	1	2	2
Administrative and support services	2	2	2
Education and training	7	7	8
Other	8	6	5

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Table 16a below presents the same type of evidence about the destination industry, but for those who graduated in 'other care training'. While the majority of positions held by 'other care' graduates are also chiefly in the health care and social assistance sector, a higher proportion seems to get a job in education and training, retail trade and other industries. There seems to be less of a skills match for those undertaking 'other care' training as compared to disability care training.

Table 16a: Industry of main job after training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=4,176)	(n=9,137)	(n=4,327)
Health care and social assistance	76	66	68
Retail trade	5	4	4
Education and training	4	16	15
Accommodation and food services	4	2	4
Public administration and safety	2	-	2
Administrative and support services	-	3	-
Other	8	10	7

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

The broader occupational profile of disability training graduates is presented in Table 17. In 2016, 81 per cent of graduates were working as community and personal service workers after they completed their training, with minimal change over time. A further 14 per cent of graduates reported that they were working in white collar jobs as managers, professionals, clerical and administrative workers, and sales workers. A smaller proportion (5 per cent) had found employment in blue collar occupations, as technicians and trades workers, machinery operators and drivers, and labourers. Again, very little change was observed in these occupations over time.

Comparing Tables 8 and 17 demonstrates that the proportion of disability training graduates working as community and personal service workers increased after training. In 2016, 68 per cent of graduates were employed in this role prior to their training, and this increased to 81 per cent of graduates post-training. This provides further evidence of a good skills match for graduates completing disability training.

Table 17: Occupation of main job after training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=792)	(n=1,132)	(n=709)
Community and personal service worker	83	80	81
Manager	2	2	3
Professional	6	7	4
Clerical and administrative worker	3	4	5
Sales worker	2	2	2
Technicians and trades worker	1	1	1
Machinery operators and driver	1	1	1
Labourer	3	2	3

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Table 17a shows the occupational profile of 'other care' training graduates. We see that 'other care training' graduates have a more diverse occupational profile that disability training graduates, with a lower proportion employed as community and personal service workers (73 per cent in 2016).

Table 17a: Occupation of main job after training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=4,183)	(n=9,131)	(n=4,341)
Community and personal service worker	71	69	73
Manager	3	3	2
Professional	7	11	6
Clerical and administrative worker	7	6	6
Sales worker	5	4	4
Technicians and trades worker	2	3	3
Machinery operators and driver	1	1	1
Labourer	4	3	4

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Table 18 below presents the proportion of disability training graduates employed in full-time and part-time work after training. In 2016, a majority (60 per cent) of graduates reported that they were employed on a part-time basis after completing training. However, the proportion of graduates employed in full-time work had increased slightly over time (from 37 per cent in 2007 to 40 per cent in 2016).

A comparison of hours worked pre- and post-training showed very little change (Tables 6 and 18). In 2016, 57 per cent of graduates worked part time prior to their training (Table 6), compared to 60 per cent following the completion of disability training (Table 18).

Table 18: Hours worked per week after training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=787)	(n=1,242)	(n=713)
35 hours or more per week	37	36	40
1-34 hours per week	63	64	60

Comparison of hours worked post-training between other training groups (Table 18a and 18b) indicates that graduates from 'other care' training report similar hours of employment to disability training graduate after completing training. However, both stand in stark contrast to the hours of employment reported by graduates of 'all other' training, where in 2016 68 per cent report being employed full time after completing their training. The care sector predominantly employs part time workers.

Table 18a: Hours worked per week after training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=4,245)	(n=9,520)	(n=4,370)
35 hours or more per week	42	40	37
1-34 hours per week	58	60	63

Table 18b: Hours worked per week after training (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=24,491)	(n=33,541)	(n=12,296)
35 hours or more per week	68	70	68
1-34 hours per week	32	30	32

Disability graduates were asked to rate the relevance of their training to their current job on a four-point scale from 'highly relevant' to 'not at all relevant'. As shown in Table 19, across all three years most graduates rated their disability training as being of relevance to their current job. Only around six per cent of graduates, presumably those working in fields outside of the health care and social assistance sector, reported that their training had not been at all relevant. A higher proportion of graduates of disability related training rated their training as relevant compared to students who completed 'all other' training courses (Appendix Tables 19a and 19b).

Table 19: Whether training is relevant to current job (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=795)	(n=1,238)	(n=690)
Highly relevant	66	74	67
Some relevance	25	18	21
Very little relevance	3	5	6
Not at all relevant	6	4	6

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Table 20 asks graduates if they thought that after their training their employment circumstances improved. Between 61 and 69 percent reported that they improved, but the proportion gradually decreased from 69 percent in 2007 to 61 per cent in 2016.

Table 20: Whether employment circumstances improved after completing training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=877)	(n=1,431)	(n=817)
Employment circumstances improved	69	67	61
Employment circumstances not improved	31	33	39

Appendix Tables 20a and 20b compare the same outcome with students who completed 'other care' and 'all other' training courses. Graduates who undertake 'other care' training responded with a near identical assessment about their training impact while graduates of 'all other' training courses reported less favourable employment impacts of their training.

Table 21 below presents data about the impact of disability training on the skill levels of graduates. In 2016 most disability training graduates (82 per cent) felt that the training they had undertaken had no impact on their skill level; this was also the case in previous years. Only 11 per cent of graduates across all time points felt that the training had improved their skills, while around 7 per cent felt that their skills had actually decreased because of their training.

Table 21: Change in skill level (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=682)	(n=962)	(n=546)
Movement to higher skill level	11	11	11
Movement to lower skill level	6	6	7
No change in skill level	83	83	82

A much higher proportion of students who had undertaken 'other care' training indicated that training had improved their skills levels (Appendix Tables 21a and 21b).

Training can be the source of many different types of benefits, apart from the oft expected increase in employability and earning capacity, both reflections of a perceived or actual productivity improvement potential. Disability training graduates were asked about the benefits (both personal and job-related) which they had experienced because of their training (Table 22). Personal benefits included 'got into further study', 'advanced my skills generally', 'gained confidence', 'satisfaction of achievement', 'improved communication skills', 'made new friends' and 'seen as a role model for others in the community'. Job-related benefits included 'got a job', 'got a new job/changed my job', 'was able to setup/expand my own business', 'a promotion (or increased status at work)' and 'an increase in earning'.

Two-thirds of disability training graduates in 2016 identified that they had received both job-related and personal benefits from the training (a decrease of 8 per cent from previous years). Most of the remaining 2016 graduates (27 per cent) felt that they received personal benefits from their disability training; this proportion had increased by 4 per cent from previous years. Only a very small proportion of graduates (2 per cent in 2016) reported receiving job-related benefits only as a consequence of their training. Meanwhile the proportion of disability training graduates who felt that they had received no benefits at all from their training was remarkably small (at 2 per cent in both 2007 and 2013 and 4 per cent in 2016).

Table 22: Whether received benefits from doing the training (disability training graduates), by year (per cent)

	2007	2013	2016
	(n=788)	(n=1,227)	(n=690)
No benefits	2	2	4
Job-related benefits only	1	1	2
Personal benefits only	22	23	27
Both job-related and personal benefits	75	74	67

Comparing the above outcomes with the benefits received from undertaking 'other care' and 'all other' training (Appendix Tables 22a and 22b) we see that a higher proportion of those undertaking 'other care' training (74 per cent in 2016) and a lower proportion of those undertaking 'all other training' (60 per cent in 2016) report having received both job-related and personal benefits from undertaking the training.

2.4 Skill shortages: present and future

The NDIS has been expected to increase the supply of disability care supports and services in a substantial way. In most cases this has been planned to happen via a market system, which will be

regulated by the NDIA where necessary. The NDIS needs additional human resources in order to see the additional supports and services delivered. The expectation is that skill shortages will emerge, especially if and where caps may be imposed directly or indirectly on pay rises. This section addresses two main questions. First, do we see any early indications of emerging skill shortages? Second, will the observed rate of increase in training be sufficient for providing the necessary workforce increase for the full NDIS roll out planned to complete by the year 2020?

2.4.1 Present skill shortages

Skill shortages can be traced in disability care using a wide range of indicators, but we do not find evidence of a major skill shortage. Although the sector is growing 4 to 5 times as fast as Australian employment in general, it has done this without major signs of skills imbalances building up.

Skill shortages usually manifest themselves in the context of an occupation or a sector where the demand for specific types of workers and skills may exceed the existing supply. However, they do not happen in a vacuum and their presence and impacts are greatly influenced by the broader labour market in which they arise. For example, if a skill shortage arises in a specific part of the labour market, but within a national labour market with considerable spare capacity, it may not be felt as strongly because there will be sufficient underutilised labour to take over either straight away or after the necessary retraining. Further, if a skill shortage arises in a vocational education and training environment that can respond swiftly and efficiently by (up)skilling existing spare capacity to fill the gaps that have emerged, it may not be felt as strongly because the new skills will be developed swiftly and utilised by employers with vacancies. Therefore, it makes sense whenever we need to examine skill shortages in any specific occupation or sector, that we examine the broader labour market context for appropriate indicators that manifest the presence and possibly measure the impact of skill shortages.

There can be a large number of appropriate indicators of present or emerging skill shortages, but we do not need many of them in order to form a view on the state of the overall labour market and compare it with the state of the specific occupation/sector we are interested in (see Mavromaras et al. 2013). Here we examine a selection of such indicators and we compare their sizes and their change over time between the *disability care workforce*, and (i) the (much larger) *other care workforces*, and (ii) with *the whole Australian workforce*. The specific source of such indicators does not matter, as the various indicators do not need to be equivalised in any way. All we need to ensure is that the indicators we use are measured from reliable data sources.

After consideration of what data is available at the granularity of the disability care *versus* other care level, we examine the following indicators:

- Employment status after VET completion
- Average wage
- The degree to which training is relevant to the current job

Labour market indicators (total employment; total hours worked in a given week; the ratio of vacancies over total employment; the mean hourly wage; and the proportion of employees aged 55 or older).

The proportion of students who were in employment six months after completing their VET course was presented in Table 15 above. Two main messages emerged from that table. First, that there was a higher proportion of post-training employment for disability graduates than for all other training.

This indicated that recent disability care graduates found a job faster than other graduates, which implies that there is a higher chance of encountering skill shortages in the disability sector than elsewhere. The second message is that any such skill pressures have been gradually decreasing over time for all graduates alike, including the disability ones. When graduates start to find it harder to get a job, then we know that skill shortage pressures are becoming weaker.

Table 23 below presents a refinement in this thinking by looking at the proportion of *previously not employed* graduates who have found a job approximately six months after graduation. Pulling previously out of work people into employment is an indication that the sector is sufficiently flexible and that the training system is delivering the relevant skills, but ultimately, it also indicates that the sector has a stronger need for workers and consequently accepts people with a weaker more-recent work experience record. Table 23 shows that the disability care VET graduates *who were previously unemployed* were absorbed into employment slightly faster than other care VET graduates (who were also previously unemployed) and much faster than all other VET graduates (who were also previously unemployed). The combined evidence in Tables 15 and 23 suggests that compared to the whole labour market skill shortage pressures are more likely to emerge in the disability care sector.

Table 23: Labour force status after undertaking training (those who were not employed before the training), by year (per cent)

	2007	2013	2016
Disability training	**(n=133)**	**(n=281)**	**(n=213)**
Employed	65	56	63
Unemployed	19	27	26
Not in the labour force	17	17	11
Other care training	**(n=1,330)**	**(n=2,970)**	**(n=1,959)**
Employed	63	54	54
Unemployed	17	25	27
Not in the labour force	20	21	18
All other training	**(n=6,104)**	**(n=8,161)**	**(n=4,064)**
Employed	53	42	42
Unemployed	21	32	35
Not in the labour force	26	26	22

Note: Due to rounding, the total percentages may not sum up exactly to 100. Source: Student Outcomes Survey.

The evidence emerging from Tables 15 and 23 can be corroborated by examining the way wages develop. The thinking here is that if skill shortages or skill shortages are building (as Tables 15 and 23 indicate might be the case), then we would expect the entry wages to have increased. We continue building the broader market picture by looking at the levels of wages and how they changed in the three points of observation and for the three types of training. The labour market segment with the faster rising wages over time would be the one with the highest indication of skill shortage pressures.

The average wage of VET graduates who were employed six months after graduation is presented in Table 24 (split by their VET training) and in Table 25 (split by their occupation prior to VET training).

Starting with Table 24, higher wages after training are an indication of higher chances of skill shortages, especially if they increase for later cohorts of graduates. Higher wages prior to training indicate the expectation of even better wages after training which would be associated with higher incidence of skill shortages as well.

Table 24: Mean annual earnings after VET graduation (those in full-time employment), by year (per cent)

	2007	2013	2016
Disability training	**(n=277)**	**(n=411)**	**(n=286)**
	$40,302	$50,495	$50,432
Other care training	**(n=1,713)**	**(n=3,512)**	**(n=1,634)**
	$36,851	$50,435	$46,365
All other training	**(n=16,055)**	**(n=22,069)**	**(n=8,313)**
	$45,276	$63,346	$60,284

Source: Student Outcomes Survey.

Wages in Table 24 tell a story which hinges upon the comparison between the two types of care VET graduates (disability and other care) and the whole of Australian VET graduates, and is suggestive of more skill shortage pressures in the disability care sector than elsewhere. First note the uninterrupted growth in the Australian economy between 2007 and 2013 has resulted in the starting wages of all new VET graduates increasing considerably in the six years between 2007 and 2013. Then note that the wages of the other care VET graduates and all other VET graduates dropped in the three years between 2013 and 2016. In contrast, the wages of the disability care VET graduates stood their ground and remained unchanged. This is an indication that *relative to all other new VET graduates*, disability care new VET graduates were more desirable as new hires and were not forced to take a pay cut upon entry in the labour market. This is one more indication of a relative higher demand for the disability care skills. While we would not go as far as interpreting this finding looked at in isolation as a conclusive indication of skill shortages (as the wages did not actually rise), it offers some further corroborating evidence. This is done by combining the finding that wages dropped between 2013 and 2016 for all other types of new VET graduates with the finding that employment rates and the speed of obtaining employment were better for disability care VET graduates (Tables 15 and 23). It is in this way that we are starting to build the case that skill shortages are more likely for new disability care VET graduates than for all other new VET graduates. We continue by looking at more indicators.

Table 25 below suggests that if there has been a pressure in the skills market, it was concentrated on those who started as community and personal service workers before training and continued in the same role after their training. We note that wages are rising throughout all observation points in time, but we also note that the changes are not large and that the sample sizes are clearly too small in some instances, suggesting the need for a cautious interpretation of the contents of Table 25. Although this table cannot be used as evidence that there are skill shortages, it is worth noting that it very clearly cannot be used as evidence to the contrary, that is that there are no skill shortages.

Table 25: Mean annual earnings after undertaking disability training (those in full-time employment), by year (per cent)

	2007	2013	2016
	Remained as community and personal service worker after training		
Community and personal service worker before training	**(n=168)**	**(n=247)**	**(n=155)**
	$39,337	$50,701	$51,963
In other occupation before training	(n=25)	**(n=32)**	**(n=23)**
	$41,808	$48,051	$43,046
Not employed before training*	**(n=15)**	**(n=17)**	**(n=33)**
	$37,613	$41,064	$40,293
	Moved into other occupation after training		
Community and personal service worker before training*	**(n=16)**	**(n=10)**	**(n=6)**
	$39,000	$51,870	$43,268
In other occupation before training	**(n=43)**	**(n=88)**	**(n=55)**
	$44,381	$53,279	$57,306
Not employed before training*	**(n=2)**	**(n=7)**	**(n=4)**
	$49,400	$42,900	$46,529

Source: Student Outcomes Survey. * The reader should avoid interpreting those wage estimates based on the smaller sample sizes (in brackets above each estimate) in this table as they lack in precision.

The degree to which training is relevant to the current job of a new VET graduate (i.e. when a good match follows graduation) is presented in Table 26 split by the occupation for which the training was provided. We note that while the interpretation of the proportion itself is not straightforward, the interpretation of how it is changing over time is more revealing. It could be that a good match may be present because there is a shortage in the skills (i.e. skill shortages causing good matches) but it could also be that a shortage may be present because of the absence of the ability to generate good matches (i.e. bad matching causes skill shortages). Of course, it could be both and what we observe is the net outcome. However, we note that the interpretation of the change in the proportion of good matches is more informative, in that increasing the number of well-matched graduates (which may be happening for several reasons) is always an indication of a market reducing its skill shortage pressures.

Table 26 shows that training has been producing relatively larger numbers of well-matched graduate jobs for the care sectors than for the rest of the labour market. 'Other care' seems to be the best matched sector (at 60 per cent matched in 2016), 'disability care' follows (at 48 per cent matched in 2016) and 'all other' types of training are well below these two (at 36 per cent matched in 2016). All care training (both disability and other care) seems therefore to be producing better matches in 2016 than they did in 2013. We do not see any indication that skill shortages have been emerging from the evidence presented in Table 26.

Table 26: Whether training is relevant to current job (objective measure: 2 digit occupation), by year (per cent)

	2007	2013	2016
Disability training	**(n=792)**	**(n=1,127)**	**(n=709)**
Yes	50	41	48
No	50	59	52
Other care training	**(n=4,183)**	**(n=9,089)**	**(n=4,341)**
Yes	56	52	60
No	44	48	40
All other training	**(n=20,230)**	**(n=20,269)**	**(n=11,930)**
Yes	36	36	36
No	64	64	64

Note: Due to rounding, the total percentages may not sum up exactly to 100. Source: Student Outcomes Survey.

We conclude this part of the evidence building on skill shortages by presenting several other labour market indicators for the aged care and disability care sectors combined in Table 27 and for the whole of the labour market in Table 28. These are derived by using nationally representative ABS and Department of Jobs and Small Business data for the same years used for the Student Outcomes Survey data. We note the main difference between what we have been presenting to now using training data and the contents of Table 28 and 29 is that the latter tables refer to the whole workforce and not only to those entrants after training completion. Here we look at indicators on (i) *total employment*; (ii) *total hours worked in a given week*; (iii) the *ratio of vacancies over total employment*; (iv) the *mean hourly wage*; and (v) the *proportion of employees aged 55 or older*. We note that ABS data does not make the distinction between people who work in aged care and disability care, a limitation that given the importance of these occupations should have been corrected a long time ago, but has not. Given this limitation, below we compare these indicators for the care professions as a whole (Table 27) with the whole economy (Table 28).

Table 27: Several labour market indicators (Aged Care and Disability Care combined)

	2007	2013	2016
Number of Employed ('000s)	94	129	155
Total weekly number of hours worked ('000s)	2,418	3,360	4,074
Vacancy rate (Vacancy/employment)	1.3%	0.9%	1.0%
Mean hourly wage*	21	26	29
Proportion of workforce aged 55 or over**	16	19	20

Source: ABS Labour Force Survey; Internet Vacancy Index, Department of Jobs and Small Business.

Notes: (*) These estimates are for the ANZSCO major group (1-digit), 'community and personal service workers', which includes 'aged and disabled carers'; (**) these estimates are for the ANZSCO sub-major group (2-digit), 'carers and aides', which includes 'aged and disabled carers'. Unlike with the NCVER data, the data sets used in this table do not present aged and disability carers as one category.

Table 28: Indicators of labour market balance (Australia Total)

	2007	2013	2016
Number of Employed ('000s)	10,697	11,443	11,996
Total weekly number of hours worked ('000s)	368,032	387,522	400,011
Vacancy rate (Vacancy/employment)	2.5%	1.3%	1.4%
Mean hourly wage	26	32	36
Proportion of workforce aged 55 or over	15	18	18

Source: ABS Labour Force Survey; Internet Vacancy Index, Department of Jobs and Small Business.

Employment is rising much faster for the care occupations than for the whole of Australia. In numbers, employment has increased by 37% and by 20% between 2007 and 2013 and 2013 and 2016 respectively, compared with 7% and 5% nationally. A very similar picture emerges when we look at hours worked. It is worth noting that vacancies are not very different in the care sector and that they are dropping over time, perhaps a bit slower for the care sector – the differences are very small – thus offering no indication of present or emerging skill shortages. Similarly, we see that the national trend away from part time and towards full time employment in Table 28 is mirrored by the care figures in Table 27, albeit starting from a higher proportion of part time work in the care sector in 2007 and remaining so in 2016.

Box 2: Comparing national and sector indicators of skills mismatch (evidence on skill shortages?)

What do changes in wages and hours worked say about skill shortages?

The finding that the proportion of part time employment in the care occupations is higher than the national average is critical for our understanding of whether skill shortages are present or likely to emerge in the care sector. The skill shortages literature suggests that employers respond to skill shortages first and foremost by utilising more intensely their current employees. In the short run this can be achieved by increasing paid or unpaid overtime and in the longer run by converting part time into full time employment. Tables 27 and 28 show that the care sector grew considerably, and as it grew, it also utilised its staff more intensely (by reducing the proportion of part time employees). Was the response sufficient? The modest wage pressures presented in this section suggest that the response was sufficient and that wages did not increase by a rate above the national rate in the time period we examined. If there were any skill shortages, these have been accommodated by reducing the proportion of part time employment. Thus, the vigorous growth that happened between 2007 and 2016 did not create any major skills imbalances and was achieved in an environment where wages increased only marginally more in the care sector than in the overall economy. We note here that the relevant indicator is not the level of wages, (which remained lower in the care workforces than for the rest of Australian workforces), but the rate of change of wages over time within the sector, which is a core and highly reliable indicator of imbalance.

What does the number of vacancies say about skill shortages?

Where growth is strong, one expects to see more vacancies as the sector is building its new workforce. However, vacancies in the care sector appear to be both lower in numbers and more stable over time than for the rest of the economy, a finding that suggests there were fewer skill shortages in the care sector than in the whole economy between 2007 and 2016. However, we must be cautious with this interpretation as it is also possible that the care sector uses more informal search avenues than the economy as a whole, and therefore jobs are more likely to not be captured by the data as they are advertised and filled informally. What we can say is that vacancies data do not suggest that skill shortages have been a problem in the care sector.

Are there any major demographics at play regarding skill shortages?
A similar picture of stable growth is given by the proportion of the workforce over the age of 55. The higher this proportion, the higher the need will be for new workers in the near future. Although this proportion increased by about 20 per cent between 2007 and 2013 for both the care sector and the whole economy, the 2013 to 2016 period saw a strong slowdown in this trend (it increased only by 5 per cent more for the care sector and remained stable for the whole economy). Given the tendency of the care sector to attract older workers, this development does not suggest that skill shortages will intensify due to the ageing of the Australian workforce.

By all accounts the care sector does not exhibit a substantially different picture than the whole of the Australian labour market, with the sole and remarkable exception that it is growing by about 4 to 5 times faster in both headcount of workers and total hours worked. Despite this extremely fast growth however, we do not see any definitive signals of an overheating skills market where skills are in shortage with potentially deleterious impacts for the expected further growth due to the full NDIS roll out. The comparison between what happened between 2007 and 2013 and between 2013 and 2016 is important in the context of the growth experienced in the aged care and the mainstream health care workforces and the anticipated very fast growth in the disability care workforce. The observation that growth continued unabated between 2007 and 2016 without overheating in the skills market is a very important message. Of equal importance are the signals that skills pressures appear to have increased between 2013 and 2016, but we note that these signals have not been strong enough to justify raising the skill shortages alarm. Next, we develop a forward-looking scenario about skill shortages in the care sector in the years to the full rollout of the NDIS.

2.4.2 Anticipating future skill shortages

The finding that skill shortages were not traced in the historical data we have examined does not imply that skill shortages may not be emerging following the increased demand for supports and services following the full roll out of the NDIS between 2016 and 2020. The rise in the demand for workers is very hard to forecast as it depends on many different co-existing and inter-dependent factors. This section conducts a scenario analysis, based on a hypothesised rise in the demand for labour by 60,000 to 70,000 new VET graduates (Bonyhady 2016). The scenario asks if the VET system is responding by training more graduates in disability care and whether the present rate at which the education sector is producing new disability care VET graduates and the present rate at which these are utilised by the disability care sector will lead to serious skill shortages all the way to 2020 and possibly beyond.

We now turn to the expectation that demand for disability supports and services will increase sharply between 2016 and 2020 due to the NDIS full roll out. Although the recent history of the care sector is shown here to have been remarkably resilient and able to adapt to the needs that arose from the fast growth of the last ten or so years, it is difficult to foretell how the sector will respond as the NDIS continues towards full national roll-out and the number of NDIS participants builds towards the anticipated 450,000 number. As we cannot know the exact number of additional disability care workers that will be needed in the future we will assume a scenario of needing approximately 60,000 to 70,000 additional workers in the years to 2020 and see how much of this need will be covered if we assume that the training sector continues to produce new entrants in the occupation at the rate observed in 2015 and 2016.

Using the TVA data for 2015 we observed 19,397 new disability care VET graduates. Using the SOS data we estimated that approx. 72 per cent (13,966) of those new graduates had a job before starting their VET study and that of those 13,966, approx. 68 per cent (9,497) were already employed as a "community and personal service worker" before starting their study. Thus of the total 19,397 new disability care VET graduates, only 11,575 were new to the sector. We also know that of the 19,397

new disability care VET graduates, only 85 percent (16,487) had got a job six months after graduation, and that of those 16,487, approx. 81 percent (13,555) found a job as a "community and personal service worker". The difference between the number of those employed as "community and personal service worker" before and after their VET graduation (13,355 – 9,497 = 3,858) was the net addition to the sector through training in 2015. The same calculation for the year 2016 returns a net addition of (16,278 – 11,575 =) 4,703 new VET graduates with a disability care qualification employed as a "community and personal service worker".

We use these calculations to build two scenarios about what it would take for the VET system to qualify enough disability care students and providers to employ enough of these VET graduates in order to avoid skill shortages if the 70,000 estimate of future needs is accurate. The first scenario assumes that no adjustment takes place subsequently from what happened in 2015 and 2016, which we call the "Same response as in 2015/16" scenario. The second assumes that the increase observed between 2015 and 2016 will continue at the same rate for the years 2017 to 2020.

Table 29: Scenarios for future employment in the disability care sector

Scenario/Year	2015	2016	2017	2018	2019	2020	Total new entrants between 2016-2020 (shortfall to 70,000)
Scenario 1: Same response in numbers as in 2015/16	4280	4280	4280	4280	4280	4280	25,680 (44,320)
Scenario 2: Steady increase in proportions as in 2015/16	3858	4703	5738	7000	8540	10419	40,258 (29,742)
Scenario 3: Meeting the 70,000 mark	3858	4703	7280	10919	16379	24568	67,707 (2,293)

Although we do not have sufficient information to forecast which of these two scenarios may be the most likely to prevail, they can be used to indicate the magnitude of qualified employment growth that would be needed to reach the mark of 70,000 additional workers to cover the additional demand when 450,000 people with disability, all acting as full NDIS participants, become a reality.

As with all forecasting, we need to be explicit that we do not claim that we know whether the number of 70,000 additional workers by 2020 is an accurate one (for example, it may be reduced with the help of rapidly advancing technology), or whether the estimated number of 450,000 NDIS participants is precise, or if it is precise, if all eligible participants will have fully active plans by the end of 2020. These are future possibilities that are extremely hard to predict with any accuracy for many reasons. Further, we do not attempt to forecast whether the sector may gain new workers already in possession of similar qualifications: in such a case the two proposed scenarios would be overstating any expected skill shortages. Aged care would be one such likely source, but existing evidence from the 2016 National Aged Care Census and Survey (Mavromaras et al 2017) suggests that this type of leakage of workers from aged care into disability care was rare among aged care workers. With all these caveats in mind we proceed to compare the two scenarios.

Scenario 1 assumes that the education and labour market will be rather unresponsive and suggests that by 2020 there will have been a total of 25,680 new disability care VET graduates working as a "community and personal service worker". If this scenario prevails, at the end of 2020 there will be a shortfall of (70,000 – 25,680 =) 44,320 workers in disability care.

Scenario 2 assumes that the education market will be increasingly responsive in numbers, at the constant rate of change of 22 percent (the one observed between 2015 and 2016). Thus numbers will continue to accumulate all the way to 2020, generating 40,258 new VET graduates working as a "community and personal service worker". The shortfall by 2020 if Scenario 2 prevails will be considerably lower at (70,000 – 40,258 =) 29,742 workers in disability care.

A rough calculation along the lines that Table 29 was populated suggests that the rate of change that would be needed starting from the net gain of 4,703 at the end of 2016, would need to exceed a cumulative increase of 50 percent every year starting from 2016 in order to get close to the desired number of 70,000 new disability care VET graduates employed as a "community and personal service worker". Although we cannot have any certainty in advance, the magnitude of the task facing the VET sector in qualifying this number of people at such a rapid rate is clearly daunting, as is the task of employing this number of additional people in terms of allocating efficiently such a large number of workers in an employment context of intense change.

Having built a picture of the task at hand facing the education and disability care provision sectors, we now move to asking core stakeholders about their views of the changes the NDIS is bringing within the disability sector and, in particular, to the training and skilling of its workforce. While the information provided by large data sets can help us quantify the policy picture, it leaves much of the important depth and nuance in the information untouched and does not allow the necessary policy intuition to be developed. The next stage of the research builds on the theme of anticipating skills shortages by conducting in depth semi-structured interviews with a large number and a wide variety of knowledgeable and critical stakeholders. As we show, the two types of information are highly complementary, each one of them helps us understand the other better and when examined together they shed new light on the whole process of how skill shortages are manifested and how they may be combatted.

3. Stage 2 results: Findings arising from in-depth interviews with key stakeholder groups

In this section of the report we detail the findings arising from the in-depth interviews undertaken with key stakeholder groups. Stakeholder groups included:

- Disability support providers (DSP)
- Disability support workers (DSW)
- People with disability (PWD)
- Training providers and key stakeholder groups (TP)

The interviews with each of these informant groups covered several areas including:

- Information about the organisation (their location, reach, main activities, training provided) or the person with disability (their living arrangements, how they spend their day)
- Information about disability supports (types provided or accessed, why and how providers and workers are chosen)
- Information about disability training (types provided/undertaken, qualification level, length, mode of delivery, funding model, course content, characteristics of those undertaking the course)
- General perceptions of disability support workers (including what contributes to someone being a good or bad worker, the types of people who are more suited to disability support work)
- Views about the skills and competencies of disability support workers (areas of satisfaction and dissatisfaction, whether workers have appropriate skills and training to provide quality care)
- Views about the capacity of the current VET system to deliver those skills and competencies
- The current and future impact of the NDIS for the skills and competencies required by disability support workers

This qualitative findings presented in this report focus on respondents' perceptions of the skills required by disability support workers, the capacity of the current VET system to deliver those skills and also on the impact that the NDIS is having on skills and competencies within the sector. We start by examining the characteristics and career pathways of students undertaking disability training.

3.1 Student characteristics and employment pathways

3.1.1 Student characteristics

Training organisations were asked about the characteristics of the students undertaking disability training. In brief students were a very heterogeneous group. For example, the age of students was

diverse ranging from those exiting school to mature aged people. Contrary to popular thinking, the sexes were quite evenly represented.

> *I think in terms of age range - quite diverse, and we have starting from VET and school programs from aged around 16 through to anyone, really. We have had students who have been in their 70s, at different times. I wouldn't say there's one age group that is more dominant than another but we do often get people who are returning to study after a period of time away from study or work, so it might be that they have broken that pattern. (01TP)*

> *I mean, it's probably slightly higher female wise. It's probably around 60 40, female male, but it's a good blend. (09TP)*

Some training organisations did report a high proportion of students coming from non-English speaking backgrounds, but others noted that the proportions were not all that different to those found in the general population.

> *So we have a range of students, there's no particular - we're a very multicultural and diverse country and our training groups are pretty much the same as well. (15TP)*

Some providers noted less variation in the characteristics of their students than others. This was partly due to localised geographical differences.

> *That depends by region…upper Northern Rivers of New South Wales, they tend to be local, with a reasonable language literacy skills. In Sydney it's always hard to get staff, and therefore that can be quite difficult, across the board. But there's no common trend across the whole organisation, because it depends where it is and what's going on. (08TP)*

Interestingly, all training organisations noted that a number of their students had a lived experience of disability with either the student themselves or their family member having a disability.

> *There are always I think a couple of people in the course who have a family member who has a disability, whether that is a parent, cousin, brother, sister, and probably siblings more than anything. Then, we have got - always probably got one or two people in each of our courses who identifies that they have a disability themselves and want to work in that area to improve the sector. (01TP)*

3.1.2 Employment pathways

The previous qualifications and work experiences of students also varied markedly; respondents reported that disability training was being undertaken by people returning to work after caring for children or relatives, young people entering the vocational education and training sector for the first time after leaving school or a 'gap' year, individuals undertaking midlife career changes, people entering the disability sector from completely different industries and people who had been in the sector previously but who had not yet undertaken the formal qualifications.

Further pathways into disability training were also discussed by training organisations. It was noted that many students came to them via related courses in mental health or individual support, most notably Certificate III in Individual Support (Ageing, Home & Community) and Certificate III in Individual Support (Aged Care). Indeed, many training providers indicated that disability training wasn't a "popular" course - aged care and community care have larger intakes. This was perceived to be in part because of available funding and in part because of a stereotypical view that disability support workers were older women.

Quite often what happens is someone does their aged care training and decide oh my goodness, this isn't for me, it's end-of-life care which it is, someone who is ageing. They say what else can I do? I say would you like to, so quite often they come through and do the next set of electives and they either pick home and community care or disability. Home and community care gives you a range of clients, so could be people who are ageing, people who have an acquired disability or people with a disability. That's primarily how we pick up, it's very, very rare that we get someone that comes in and says I just want to do Cert III Individual Support Disability. (15TP)

We've recently reignited our mental health qualifications and we've got people completing those who want to work within a community services basis. So, whilst it might not be disability specific, they want to work with people that have more of a dual diagnosis. (09TP)

Others reported that disability training was also used as a pathway into higher level training and qualification in different but related industries such as health.

Looking at a pathway into nursing rather than going into a three year Diploma of Nursing. They're looking at completing their Cert III, getting some experience…completing their Cert IV. Three units out of the Cert IV takes them into their enrolled nursing and then they only have 18 months to complete their RN. That's a different pathway into a higher qualification. (15TP)

The younger ones coming in that are finishing high school are usually going on to study at university in the allied health sector, so they're looking for something that's going to – it's like a stepping stone, a pathway into the work they're doing and a potential form of income that's going to assist them while they're studying as an alternative to bar work, hospitality or retail or whatever. (20TP)

Completion rates for those undertaking disability training were variable. Some training providers identified that they had very high completion rates, but acknowledged that this may be a perverse outcome of their funding arrangements; with funding being dependent on course completion. Others were more sanguine, noting completion rates in the 90th percentile but linked this to full fee paying provision. A further group of respondents listed very low rates of completion among the students undertaking disability training.

I mean, we don't get paid unless somebody completes. If you are a Work Ready funded student, the organisation, the training organisation, doesn't get paid unless that student completes so the completion rates are fairly high because of that reason. (01TP)

Fee-for-service is generally a slightly higher completion – government funded courses. Fee-for-service will generally get around 95 per cent completions. (09TP)

The enrolments are looking good but the completions aren't so happy. We haven't got 2016 figures yet, but 2014/15 there were just under 3000 enrolled, and during that period only about 800 completed. (07TP)

Outcomes for students undertaking disability training were considered to be largely positive in terms of future employment prospects. Many training organisations noted that their students would often secure employment at the disability organisation where they undertook their vocational placement.

We do have quite successful outcomes for our learners. It's very rare that they do not get employment. (15TP)

A lot of our students, you know, are well matched to their placements and are usually well

supported in those placements and usually get employment outcomes from it. (01TP)

3.2 Essential skills and competencies of disability support workers

All respondent groups identified a number of skills, behaviours, competencies and characteristics that are required to perform the role of a disability support worker successfully. The most common skills and competencies included 'soft skills' such as the values, behaviour and attitude of the worker; others included communication skills (particularly active listening) and specific disability support and health care skills.

3.2.1 Soft skills

Soft skills are interpersonal qualities, also known as 'people skills', and personal attributes that one possesses (Robles M 2012). Respondents from all informant groups most commonly identified 'soft skills' - behaviour, attributes and values of a person - was key for providing quality workers for the disability sector. Caring, patience, honesty, integrity, empathy, compassion, social justice, equity and a passion for the work were all attributes that were considered essential for high quality disability support workers.

> *We're talking about honesty, integrity, having an ethical standpoint, being kind of a good moral compass. Having a passion for wanting to work with people with a disability and not necessarily seeing it as a job with dollars attached. (09TP)*

> *I think people that have empathy. People that understand what respect means and how to engage with people who are wanting to make their own decisions and be able to make life choices, and that understand that they're supporting a person to do this, not doing it for them. I think also the quality of patience is high on the agenda, to allow people to move through life at their own pace. (07DSP)*

> *You've got to have a passion for it. It is a good wage, but seriously, some of the things that you have to deal with you have to have a strong stomach and the passion for it, because if the passion's not there then it's not worth it. And that's what I said, I didn't realise I had that passion until I started working in that field. (03DSW)*

> *I think somebody who is non-judgemental, who looks for all the facts before making a decision, is definitely important, as well as someone who is caring and genuinely interested in people and their lives. (13PWD)*

> *Definitely they have to have a nurturing nature. You have to be able to think of that person before yourself, as such, that this is not a job. This is more than just looking after their practical needs. They have to have a holistic approach. (16PWD)*

Interestingly, many respondent groups, including training providers, acknowledged that these attributes and traits were inherent in a person and could not be acquired by undertaking the formal training that they delivered. For many of the respondents, formal qualifications were simply not able to provide workers with 'soft' skills such as resilience, emotional intelligence and the ability to relate to a range of different people.

> *I think the consistency across providers does vary and we…I would see it as it is a ticket to the game. But we don't take it as just because you've got that piece of paper or qualification means that you're now going to meet our [clients'] needs (14DSP).*

It's more around those interests and attributes, so the training requirement in terms of the technical skills so for example administering medication is independent almost of those interests and attributes. (19TP)

Examples were also provided by people with disability and their family members and carers of disability support workers who were clearly unsuited for employment in the disability sector. These workers were seen as lacking those essential 'soft skills', using disability support work as a temporary measure while seeking alternative employment, and inappropriately bringing their personal issues to work.

We shifted from [disability support provider] because we had people - one woman was an alcoholic and then she didn't come in on time and wouldn't turn up and how they have all these personal issues in their life with their boyfriends and stuff. And I said, "We don't really care." (08PWD)

I found some people are only doing the jobs for a stop/fill gap…I won't take anyone who's not interested in their job so a lot of the support workers are studying at uni, I've requested that you don't send me anyone who's studying at uni because they're not interested in the job and they're not going to stay in the job for very long. (03PWD)

I can tell when there's someone that's just in it because it's a job for money. They don't really have a care factor for the people. Those people probably shouldn't do it. No bedside manner. (15PWD)

[Some workers are] sitting on their phone or out the back having a cigarette. No one works autonomously anymore, you know, they're not looking for work they're just doing what they have to do. They don't really care, they only do what they have to do. It's a job and it's not a career as such. It's a job. They're not really interested in helping these people to achieve a better form of life or to make their life more comfortable. It's just "If we have to do all the toileting, yeah we'll do it." but it's done and that's it. (17PWD)

3.2.2 Communication skills

Also prominent among all informant groups was the perception that an essential skill for disability support workers was the ability to establish rapport and have good communication skills both with clients, clients' family members and with other staff. Many of the people with disability that were interviewed particularly appreciated when their workers actively listened to them and involved them in decision-making. Family members reiterated these points, highlighting the need for workers who could engage with their clients and promote positive personal interactions.

I love [my worker]…She actually talks to me like a human being, like nothing's wrong with me. (11PWD)

I really like [my worker]…She treats me like a brother. Like she respects my - my being friendship. That's what it is. I feel really safe with her. (16PWD)

[My husband] tends to like to joke around and have fun and some are not as serious - they are serious, but will joke around and have a little bit more fun as well…Well, I suppose that's with any place. You go to work or whatever you do, there's always going to be someone that you're going to get on better with than others, and that's the same with some of the carers. (04PWD)

There was one guy, he was just so jovial in himself and that's what [my son] needed. [He] can

aspirate which causes pneumonia, ends up in hospital. This guy would go into the hospital each day and be telling jokes to and he would have [him] laughing. Laughter was helping clear his lungs. (17PWD)

Some disability support workers were perceived to be lacking good communication skills. This was evidenced through examples of staff not adequately listening to the person with disability; or staff not trying hard enough to understand what the person with disability wanted.

The one thing I am being shitty about, staff members don't listen to clients…some forget to ask me how I feel sometimes. (10PWD)

Recently she had some [workers] that didn't really take much care in noticing what [my daughter] wanted to do, or what she was trying to tell them. They would fob her off and say, "Oh that will be right" and leave it at that and not follow it through and find out what she was actually talking about…And then she gets frustrated and she'll lash out. (09PWD)

There's one support worker who's training at [university] that I find a bit kind of bossy…Just her whole demeanour and attitude is a bit - I think she kind of looks down a bit. Yeah. Yeah. I think, to be honest, the disability sector draws people who really are amazing and really care or people who are bullies. There doesn't seem to be much middle ground. (18PWD)

Several respondents also described issues relating to the written and verbal communication skills of staff with English as their second language.

She really struggles sometimes with the cultural barrier, actually being able to understand what the support worker is saying. Because they obviously all have to speak English and know how to speak fluent English, but I think that Mum really struggles with that side of things. (07PWD)

People with an intellectual disability or hearing problems sometimes have problems with strong accents [of overseas-born staff]. So these people can't understand them and they can't understand the people that are caring for them. So there are issues there. (19PWD)

When [my son] first went over there they were all Australian or English. Now you go over there and they're Filipino or Sudanese or Indian…I don't know if they can read properly. I don't know how they get through doing the certificate because we go over there and they know nothing. They can't talk English very well so how are they going to read what the client needs or what has to be done…It's just so frustrating. If we, for example my husband and I, go over and we can't understand what they're saying how the heck can the clients but then it's almost as if it doesn't matter, the clients don't really understand anything anyway and I just think it's pretty poor…I was told at one stage they were going to try and get people who understood more English or weren't pushed through just to get a job but it still happens. (17PWD)

3.2.3 Technical competencies

A similar proportion of respondents considered technical and practical competencies such as maintaining professional relationships, behaviour support management, understanding legal and ethical standards, and providing personal care, hygiene and manual handling as essential skills for disability support workers to have.

Understanding triggers I think is a really key part of any worker, so you understand what are the things that could raise additional behaviour support needs and requirements. (05PWD)

There are always ongoing issues. That's the nature of the beast, but they deal well with them…They try to help them cope with each other because there's lots of personalities and there's lots of clashes and stuff. So, generally, they're pretty much on the ball. There's been a few absconding, you know, where they just run off, and they've been able to, kind of, haul that in and sort that out but they do it with great kindness. You know, they don't feel they have to be, kind of, shouting and screaming at them or imposing their will on them to get them to conform. (16PWD)

The importance of support workers having appropriate skills and competencies to assist people with disability with tasks relating to their care needs was highlighted in the interviews. Particular frustration was therefore expressed by people with disability and their family members when support workers were unable and unwilling to undertake specific personal care or healthcare tasks and domestic chores.

With his medical needs they need extra training so you can't just have anybody going over there because he has a specific procedure that needs to be done, they need to know how to do it. I've got an issue at the moment; he produces a lot of saliva and if he starts coughing he needs suctioning. He actually bought his own suction machine, it's there to be used so the staff are trained. A few weeks ago there was a guy on overnight and he hadn't had any training…Now if something had gone wrong what he had been told was "If there's any issues ring for an ambulance." I understand that but in the meantime if he's aspirating he could end up with pneumonia. (17PWD)

She told me all her problems in her life. 90 per cent of the time she was here, she sat at the table just telling me her problems. She didn't really do much. And things that she was supposed to do - I think she was down to help me with the cleaning and at times that she'd come, my brother might have been visiting, and she would say well, I don't have to do that, he's here, he can do it. Things like that. She wasn't very great…She was supposed to help me shower, help with cleaning, and doing washing. (15PWD)

The family members interviewed were also vocal about instances where inadequate care had been provided to their disabled child by a support worker. This included perceptions by several respondents that some disability support providers focused on staffing supported accommodation programs to the detriment of people with disability living in their own homes.

I find that (a) they provide support workers for their own houses where the clients live-in with a disability. Now, first and foremost they provide staff for them, second most they provide them for day options and support work in the home is always a third rate service, that's why I'm having trouble getting support workers. (03PWD)

The particular agency in themselves – it, kind of, didn't give priority to their booking. So, their priority was those that were in residential homes that obviously needed 24/7 care, so they would lift – If somebody wasn't available in there, they would lift possibly the support worker that had been put down to work with [my son] and [his friend], out of there and put them in the – and just say, "Well, there's nobody available." (16PWD)

The way that the organisation looks after a person is very, very obvious, with how a disabled person comes home from their day. You can tell from their body language and the way they communicate, whether they can communicate effectively or not, you can tell whether it's been a good day or a bad day. We made the mistake of switching him to an alternate provider about six years ago, and it was obvious that it wasn't working, by what he was saying and what was happening. And we put him back to the original, and he's been back there, and been happy

ever since. (14PWD)

However for people with disability and their family, a skilled support worker was one who promoted an appropriate balance between doing things for their clients when necessary while enabling them to become as independent as possible.

[My worker] actually comes in and does jobs with me, not for me. (11PWD)

If they're having potatoes, they make her peel the potatoes and peel the carrots and all that sort of stuff…She loves it. She likes being in charge, doing things. Whereas before, in the accommodation, she wasn't able to do that, because there were other people with higher dependency and they couldn't all go in the kitchen. She was just sort of out of it. (09PWD)

I think there's a temptation to say, 'We'll do this for you,' you know, we're in a fast-paced environment...So if you're talking about a structure where we need carers who can quickly make the meals and then off they go situation, or are you talking about a structure which is far more developmental, where the individual builds their own skills. Then again, that's the structure I would prefer and so having those skills, developmental skills, I think is worthwhile. (05PWD)

3.2.4 Value of formal qualifications

Given the centrality of 'soft skills' to the provision of quality care in the disability sector it was unsurprising to find that most respondent groups did not consider it necessary for disability support workers to have formal certificate level qualifications to be able to deliver quality care. Indeed many considered that the sector recruited based on a person's interests and traits; specific technical and communication skills and competencies could then be obtained whilst employed.

It's not a skill but I'd say having the right attitude is the biggest thing. If somebody's coming into the sector and they've got the right attitude then you can teach them the individual skill sets that they actually need. You'll find a common catchphrase among employers, certainly all the ones that I speak to from general managers to CEOs to senior support workers is they've got to have the right attitude and that willingness to be hands on and the right values, the right beliefs around social justice and equity and such like. If that's in place then we can teach them everything else they need to have. (20TP)

And this is quite similar to aged care, too, in that they don't need formal qualifications. They just need to be nice people who can work with people with a disability. You've got to have the right attitude and aptitude. You don't necessarily need formal training. (03TP)

To be honest I don't see a great difference in when we recruit someone with a Cert III than someone who comes on with the right values. We go right values over the Cert III any time. (13DSP)

The more qualifications the better. In some ways because it all enhances their lives, but you can get somebody come in with no qualifications but just their heart is in the right place and they're just brilliant at their job. You know what I mean? Regardless of how you lift a person or whatever, they just know how to engage with a person who is challenged. I mean, that's the bottom line. (16PWD)

[My son needs] someone who can just keep them on track and keep it real, basically. That's the main thing. So it wouldn't have to be degree…or a certificate. It could be someone with just

the life skills who - you know, someone who's cared for their own partner or children or someone who - they'd have to demonstrate that they had the character and the knowledge…I mean, people who might go through certificate will know less than someone who's actually had a lived experience. So I wouldn't exclude lived experience. But I guess it would be comforting to know that there is some level of training there. (18PWD)

Several disability service providers had developed competency frameworks and selection processes to assess soft skills in potential support staff.

(Have developed a competency framework) we look at people's competencies, not necessarily their qualifications…it's team playing, the ability to learn is very key, the ability to listen. Again it doesn't matter too much about whether English is their second language or third language even. If they've got all the right values, as you say, and right emotional intelligent traits, we'll employ you and we'll address whatever has to be addressed… we don't really care about their hard skills, because they are completely untrained, uncertificated, who cares, we will train you up. But we want you to be the right person first and foremost. (16DSP)

Two further factors impacted perceptions as to why minimum certificate level qualifications were not considered necessary. The first related to the shift toward matching disability support workers with clients and the second related to the variability in the quality of the disability training that is being provided in the industry. Both of these are discussed at length in section 3.4.

There is a lot more individual matching of workers and participants, there is a lot more involvement of participants in selection processes. There's also a common practice of participants bringing workers to a service and saying, "This is the person I want to support me, can you employ them or can you engage them?" (10TP)

She has made it her job to interview every single person that comes into that group as a worker…They all have to have a little bit of a background in the arts because she wants them to be able to relate to what's going on in the group…She will not have anyone that she thinks would not be suitable to work or engage with these guys, with the result that she has this really great workforce. I mean, a really exceptional workforce that really relate well and treat them with dignity and respect and there's a great – I mean, you can see it. There's great camaraderie. (16PWD)

I think one of the issues is that the standard and quality of training is very variable so providers can't necessary see good evidence that having that qualifications means a certain standard or set of skills that people bring. So they can't see the evidence link between a qualification and behaviour. So for that reason the idea of mandatory qualifications has never been probably in our sector as compelling ... So I don't think that either for practical reasons or for policy reasons that we would say ever that we would support some sort of across the board standard because as I said the quality is too variable and the link with behaviours is too weak, and different jobs require different things. (10TP)

3.3 Appropriateness of skills and training

Interview respondents were asked about the types of disability courses that were provided to, or undertaken by workers; the skills and competencies these courses aimed to cover, and the gaps in skills and competencies engendered by the content of training.

3.3.1 Types of disability training

3.3.1.1 Certificate level qualifications

The most common disability training offered by the training providers participating in the research was the Certificate III Individual Support (Disability) and Certificate IV (Disability). Some providers additionally offered diploma level qualifications, but the changes that had occurred to the VET system in 2016 resulted in there no longer being any current disability specific diploma qualification.

> *We no longer have the Diploma of Disability so that was removed under the upgrade of the package last year and we kind of reinstated the Diploma of Community Services Case Management. Case management is in mental health, it is in disability, it is in home and community care and it is in aged care…so they've kind of changed the individual industry diplomas to one and listed it under case management. (15TP)*

A Certificate III level qualification was identified as the key entry level qualification for the disability sector.

> *We offer, it's called the Certificate III Individual Support and Disability qualification. That's the entry level qualification that organisations are telling us that they need any new staff person coming in to have. What we're finding now is companies won't employ someone unless they have a minimum of a Certificate III qualification in disability, the individual support. (20TP)*

The majority of the disability service providers interviewed noted they required this qualification among their prospective employees or for them to be in the process of working towards a Certificate III qualification. Indeed for some organisations, this requirement was mandatory and the basis on which workers could be recruited.

> *If we're recruiting for disability support workers, we will be asking for Certificate III in disability or individual support as part of your criteria. (07DSP)*

> *For a contract with [our organisation], is all staff have to have the Cert III Disability as it was, or be into new individualised support. They have to have that or working towards this. When we're looking at our initial short listing, we are looking for those kinds to have the Cert III Disability or Aged Care or Community. (04DSP)*

However, for other service providers, particularly in regional areas where recruitment was more difficult, formal qualifications were not always required. In cases where they were presented with a "good candidate", the service providers instead stipulated that the worker must have some relevant life experience, the "right values" and be prepared to undertake Certificate III training within a set period of time. Challenges with regional recruitment, including competition for good workers with other provider organisations meant some providers were prepared to pay to train support workers if necessary.

> *[Potential employees] need to hold at least Certificate III or IV in Community Services, or Disability Services. If they don't, if we really think this applicant is suitable we will support this applicant to study and to get a certificate in the first half of the year. (11DSP)*

> *So ads are clear these days that we're looking for people that have actually got a Certificate III or IV in either disability or aged care or independent living as it's known now… . However, what we also do is, especially in regional locations where we don't get volumes of applications, we employ another strategy of, it's not mandatory but if you have it great. If you don't that's okay, but if you're willing to study, then we will assist you in getting you through that education.*

(08DSP)

We don't have a specific policy or a commitment to the level of funding (for training), but that will have to be driven by the need and local risk… Then on occasions where we can't find support workers and we struggle, one of the areas… There's heaps of providers up there and we're always competing against other providers for quality candidates... that could be a location where you may have to end up paying 100 per cent of the cost and study plus, plus, plus, to be able to attract the people. (08DSP)

A few service providers reported having no requirements for formal qualifications among their disability support workers. They preferred to rely on organisational 'culture,' in house training and recruiting workers with relevant 'soft skills' as a way of ensuring their staff have appropriate skills to support client needs and provide good quality care.

The biggest predictor of success in any work place is emotional intelligence and that's what we recruit for. (16DSP)

My understanding is that we're never required the certificate. I think we do a better job now of trying to match it with our values than we did before. So yeah, I think we always said that we recruited on our values. (10DSP)

Among the disability support workers we interviewed, around half held certificate level disability specific qualifications but all had obtained these after securing employment within the sector. The remainder of this respondent group were either undertaking certificate level disability specific qualifications or held qualifications in other (but related care fields) prior to commencing work in the disability sector.

Certificate level qualifications were offered on both a full-time and part-time basis. Full-time courses were aimed primarily at new entrants with no previous experience in the sector, typically ran for six months and were comprised of face to face teaching as well as an industry placement. Part-time training was targeted at people who were already employed within the sector and were balancing their current work with formal study.

Okay, now this is quite diverse. If you're a new entrant, so someone who doesn't work in industry they will do their Cert III Individual Support Disability and it's full time for six months and they must have 120 hours vocational placement…. Now if you were already working in industry, and may I say that qualification, we set that up because we deliver that face-to-face. It roughly works out that it's a year. (15TP)

If we're doing what we call existing worker programs, they will still take similar timeframes - six to twelve months for the Cert III, 12 to 18 months for the Cert IV, however the face to face time they have with us is reduced somewhat because we will set tasks for them to do in the workplace and they usually have somebody in the workplace who mentors them or supports them to achieve those goals. (01TP)

Just as the duration of training varied, so did the mode. All training comprised a face to face and industry placement component; most also incorporated online learning components. However, face to face training was perceived to be of higher quality than online training. The industry placement component of the training was considered essential to ensure students obtain the appropriate skills and competencies to work in the sector.

There are a number of online courses that people access. They have either zero or very limited contact with their training organisation face to face, and they have to go and find their own

practicums and things like that. We kind of question the quality of that. (06TP)

Now nobody should be avoiding that [the work placement]... There are some excesses and there are some concerns but generally whatever the length of the course, whether it's flexibly delivered online there still should be an assessed workplace component. (18TP)

I guess in this industry a lot of the skills you can't really learn unless you do them… I find a lot of the time, when it's stuff that's written down on paper, when you're actually doing it in practice, it's so different to how it's been taught to you. (18DSW)

I think you learn more hands-on than you do by doing the course in your lounge room with no interaction with anybody. (07DSW)

Several people with disability also discussed in their interviews the importance of staff receiving both formal training and on-the-job learning.

People skills is an amazing thing. A good care worker listens…To be treated as an individual and a person with worth, is most important. (09PWD)

In today's world you have to be qualified whereas I'm from the older school. At my job, I trained and learnt as I went along so I'd have to say I'm sitting on the fence and you need a bit of both. (12PWD)

I think everybody who does it needs to have some sort of training, like the Cert III, manual handling, first aid. Yeah, definitely need to have it. (01PWD)

3.3.1.2 Funding of certificate level training

Interviewees reflected on the funding available for certificate level disability courses. Most training providers noted the lack of funding for disability training, particularly when compared to aged care and community services training.

Funding that we have, that is purely for aged and home and community care... So what happens to the people in the community with the disability, who's making sure that we've got people trained looking after those people? I don't know what the solution is and it's probably more money and a really decent program but I don't know how that would be funded. (12TP)

Generally, there isn't necessarily a disability funding stream to address those workforce development needs. Perhaps in other areas like aged care, children's services, those types of things, there has been funding streams available when there has been significant change in the sector, to actually upskill people to respond more effectively to those changes. Our experience is that with the disability sector, that currently isn't happening, and really hasn't ever happened I don't think, from my understanding. 01TP)

Most of the training providers interviewed noted that students would themselves pay to undertake the training. While a few mentioned that disability service providers may cover the costs of training for some of their workers, it was unclear whether these providers were subsidised by government or peak bodies to do so. Others highlighted the various government funding schemes that students could access. It was noted however that understanding of, and access to, this funding was complicated because it varied across state and territory governments. It was also pointed out that while traineeships were available for disability training, they were not in high demand as a worker had to be on a permanent contract to be eligible and most workers in the sector were casual.

We're a not for profit organisation. So it's about trying to fund training. So the joy of each state - so we operate in Queensland, New South Wales, and ACT currently - and we've just started in Tasmania. Each state has a different mode of funding or delivery. (08TP)

There's also traineeships, the reason why User Choice and Higher Skills is more widely used here is because of casual workers in industry. It's very rare up here - it's mostly casual based workers that are employees of the services. (15TP)

Training providers' perceptions of who bore the cost of undertaking Certificate level qualifications (as outlined above) were at odds with the experiences of the disability support workers interviewed. The majority of workers who had completed a Certificate III or IV or were currently studying for this qualification had had their course fees paid by their employer. Only one worker reported having paid course fees themselves and another had accessed the course while on Centrelink payments under provisions that allowed one free course per year. However, it should be noted that the majority of the disability support workers interviewed had gained their Certificate level qualifications while working for disability service providers who were also registered training organisations (RTO). This factor may account for the discrepancy noted in sources of funding for training between the respondent groups.

Some of the disability service providers who reported requiring their workers to obtain Certificate III or IV qualifications once employed by the organisation, indicated that they offered support to their workers to acquire these qualifications. This support included arranging shifts to accommodate the training, providing study leave and, in some cases, contributing to the cost of the certificate. Providers who were more likely to contribute to the cost of training were typically also RTOs. However, and as will be discussed below, the NDIS is perceived to have negatively impacted on the ability of these organisations to continue to support workers to undertake Certificate level training.

And because we're a registered training organisation we offer free Certificate IV courses, and not only are they free, but they get paid to do them. So it's a very big saving to that cohort. (16DSP)

3.3.1.3 Work related training

In addition to the certificate-level courses discussed above, training providers also reported that they offered training that was specific to the requirements of disability service providers. For example, many training providers delivered accredited and non-accredited courses in core skills such as medication management, manual handling and peg feeding.

It was fee-for-service so we delivered it over a three month period and with the costs for that and they were happy for that. An RTO can design any form of training at all, non-accredited and accredited so we do some of that quite often. (15TP)

All the disability service providers interviewed accessed this form of training for their workers. This training was considered to be important in providing their workforce with more specialised skills to support individual clients' needs; such as assisting with various medical issues (diabetes, wound management, infection control, gastroenteritis and peg feeding) and behaviour support. Training around broader skill sets was also provided in-house by most of the service providers, for example in manual handling, medication, resilience, person-centred support, reflexive practice, fire safety, cultural competence, and child and vulnerable people awareness training.

If people deem that they want anything more specific, then we actually organise that, like within disability services, and do that ourselves because clearly that's kind of where our expertise is. (10DSP)

We've got a big program of training that we do in-house. We do things like infection control, food safety, rapes and abuse, child safety standard, manual handling, all of the credential work, the lower level nursing work…We do mental health training. We do dementia, palliative care. We run a program on hoarding and squalor. We are looking at things like, which we'll deliver in the future, around cultural and, of course, the CALD strategy. (08DSP)

[When] a client has behavioural issues, the client resources team will go out and work with the team that supports that client. (04DSP)

According to a majority of service providers, organisational induction was the most important in-house training received by their workers. This training was described as a comprehensive process mandated for all new staff, which educates the workers on the organisations' broad policies and procedures and covers 'on-the-job' context such as health and safety, working in clients' homes away from an organisational base, dealing with problem behaviours and also the overall context in which they will be working with clients. Peer/buddy shifts or supervised shifts were also noted as an important part of this induction process. Induction, peer/buddy shifts and ongoing supervision were also seen by respondents as providing an opportunity to assess the worker's application of their qualifications and identifying potential training needs. Spot checks and feedback from clients was another way that some of the service providers tailored their training.

We have essential trainings before a support worker complete their shift, they're required to sit through an induction, do our medication, infection control, expectations of the role and manual handling training. So they get a buddy-shift before they're let out on their own. (13DSP)

We have our induction first and then we give our staff two buddy shifts, so they work alongside […] they go for three hours each, or actually we do four hours each […] and so we then put them in our high needs home so that then they can learn about things like peg feeding, on the job peg feeding, behaviours of those participants, etcetera. (12DSP)

Now there's no service manager…there's no one there to see what goes on…It's one thing going to a session and being taught how to do the suctioning, it's then doing it. They might have the qualifications like "Yes, we are now accredited to do suctioning. Yes, we are now accredited to do the peg feeds." but, and once again it's hearsay. I have heard from once again it was a parent, was at the house, [my son] was ready to have his feed connected so the person put on their gloves, terrific, then went and saw to the other clients who were doing whatever and then went back over to [him] with the same gloves. (17PWD)

All the disability support workers interviewed had undertaken work-related training since commencing employment within the sector. For some this included buddy shifts or shadowing when they first started in the role or moved to a new work setting with different clients. Common work-related training undertaken by respondents included medication management, manual handling and first aid. Other training included mental health first aid, meal care assistance, hygiene, responding to abuse and sexual assault, incontinence and bowel care. A few workers had also received training specific to the needs of their clients such as epilepsy training. All respondents indicated that this work-related training was paid for by their employer and was mostly undertaken during paid work hours. Some workers, however, identified that they had had to undertake this training outside of rostered work hours and were not paid for their attendance.

We're supposed to do work, those things during the work time, but during the work it's very hard to keep up with it, all up to date with the training…So sometimes I personally did out of hours…I don't get paid for it and all that, yeah. (16DSW)

3.3.2 Skills and competencies aimed to cover in training

Training providers described the content of the disability training they provided, noting that there were core units that all students were required to undertake and numerous electives that were largely driven by industry demand.

> *Because we're operating out of a national training package, it's very prescriptive about what we have to deliver. So the core units, everybody has to do. And then the electives based on what industry say that they feel is needed. (11TP)*

Training covered technical competencies (such as manual handling, medication training, leadership skills and behaviour support); communications skills; skills specific to working in particular areas of the disability sector (such as group activities, supported accommodation) and skills specific to working with particular client groups (such as older people with disability). One provider summarised the key course units which they considered necessary for the development of disability support worker skills and competencies:

> *So provide individualised support; I think that's really important. Support independence and wellbeing...Communicate and work in health or community services. Work with diverse people. Work legally and ethically. Recognise healthy body systems. Follow safe work practices for direct client care. Contribute to ongoing skills development using a strengths based approach. Follow established person centred behaviour support; really important. Support community participation and social inclusion. Facilitate the empowerment of people with a disability. Meet personal support needs and support relationships with carers and family. (05TP)*

Communication skills were seen to be of central importance to disability training. These skills were considered to be fundamental to the role of the disability support worker ensuring that students/workers were able to advocate for a person with disability, to interact with them in an effectual manner, and provide appropriate person centred care and support.

> *It's the social support and interaction and I guess the way that occurs is really important if we're going to be truly empowering and educative, really, in that role, in helping every individual become as independent as possible in their own lives. I think it is really important to talk - it's a key part of it is really understanding what does person-centred practise looks like? (01TP)*

> *If we can communicate with every person then we can work on all their issues, whether it be them choosing what they want to do. Whether it be working out why they're so frustrated, whether it be letting them know in advance of changes to routine which can be difficult, I just think communicating is a linchpin connecting all the aspects of your work. And I don't think it's good enough training to send people out there who can only speak, as many of the people they work with will use non-verbal communication methods. (11TP)*

The person centred approach was also viewed as underpinning all the disability specific training provided.

> *Dignity of risk is a massive focus for us. It's that old saying, and we hear it in so many different areas; this is my body, this is my life, this is my choice, so I get to choose what happens to me and how it happens to me. You have that right, I have that right, your friends, your family have that right, and we can express that really, really clearly. It's important that when support workers are going in, whatever training we're delivering whether it be communication, Child Safe Environment, manual handling stuff whatever it is, that it's person before disability and*

that person has the right to choose what happens to them and how it happens to them. So that self-determination, that dignity of risk, that person centred approach is the underlying current to everything that we do. (20TP)

3.3.2.1 Satisfaction with content of training

While gaps in skills and training were acknowledged, overall all respondent groups were confident that disability support workers receive the training necessary to perform their duties well.

I believe that the support workers I've had undergo quite rigorous training…they'll have training sessions and meetings, so I know that they're always regularly looking to improve the way that they support clients and families…Personally, I've always had confidence in my support workers and they are well qualified and they know what they're doing. (07PWD)

They're doing a really good job, like the staff and that are really, really helpful. I've got no complaints…They always help me out, they do. (06PWD)

The ones we've got at the moment are fantastic. But we've been able to recruit very well. We've been able to insist on minimum standards and we've put them through all of our usual suite of training and so forth. (06DSP)

I've been quite lucky. I've picked up some really great people…they go in with a really good induction, they've got really good policies and procedures, they've got a great code of conduct. And that is now all - we've got a performance management process which is all embedded in that as well. We've ramped all of that up and put it together. So, I'm quite happy with the current skills, with the skill levels [of workers]. (09DSP)

Indeed, disability support workers themselves generally regarded the training that they had undertaken to be valuable.

I think it just reminds you or reinforces that you are doing the correct way…I think any training's beneficial and I'm the type that you chuck a training at me and I'll go along and I'll attend. I might not realise at the time that it's beneficial but then I might get a client or I might find myself in a situation and then I can actually recall back onto that. (07DSW)

The only training I've done has helped me out in my job. It's all given me enough to know why I'm doing it and what is it for. (08DSW)

I don't think you can ever learn enough about the industry. I don't want to stop. Every course that's been offered, I have put my hand up for because it's such a complex industry. (14DSW)

3.3.3 Skills and competencies not covered in training

While general satisfaction regarding training was high, all respondent groups identified gaps in the skills and competencies incorporated in current disability training. Disability specific skill gaps were identified, as was the need for additional training for disability support workers in technical skills, communication skills, soft skills and the NDIS.

3.3.3.1 Lack of disability specialisation

Many respondents thought that current VET disability training was too broad and did not allow students to develop specific skills and competencies around working with people with particular types of disability (e.g. blindness and deafness) or in particular areas within the sector (such as employment

support).

> *If you're working with disability, I think you should research a lot of different types. Like every single OT I've had in the last 10 years, since I turned 18, has not had any idea what MD is. And I've had to explain it. My last electric wheelchair, which I'm hoping NDIS I can get a new wheelchair - my OT that did the script for it, she ended up making the wheelchair twice the size of me…And now I've got back issues and everything, only because she was an OT that just did not know anything about my disability. (15PWD)*

> *Like I said, if you haven't had any experience before - so, particularly where there is particular disability requirements, so if you were working with somebody who was deaf, somebody who was visually impaired or blind. It doesn't drill down always to those levels. There is not a lot of opportunity to take those sorts of things as electives so there is probably a gap there and so if we think about the new system that we're going into with the NDIS, there is probably big gaps for some people around that because a lot of it would have focused on personal care and support for the broader disability community, not so much the specifics. (01TP)*

Formal qualifications were perceived to have limited scope for preparing workers for 'on the job' contexts or working in uncontrolled environments such as clients' homes and public spaces. These issues were particularly pertinent for students with no previous experience with disability work.

> *Certificate III in individual support is not about children. So if you then go to an organisation that cares for adults with complex needs, you are confronted with some quite challenging situations. And that's the feedback…and that's why I say I think that when we're talking about the training, it probably needs to have some component of whether or not we're working with adults or whether we're working with children. (07DSP)*

> *It's much broader than just having a qualification I guess…it can't prepare you for the reality of what you're going to be dealing with on a daily basis. (02DSP)*

> *I didn't find the disability significant, and the reason why is already working in the industry, I was like, yes, okay, but seeing other who had done that course not working in disability, they couldn't wrap their heads around it. And it was because the majority of the time that module, I know that it has now changed as of this year, but it's not focused enough on disability. (03DSW)*

Several of the respondents interviewed felt that it would be useful for students to receive more training about the lived experience of disability which was conducted directly by people with disability or their family members.

> *I mean, it's just pie in the sky, but when they're doing their course, they could get parents of people with disability, in, just to have a chat and just say, "Well, you know, hey, beyond all these looking after their physical needs, there's also they are a human being. They are a person"…I would love to have some role modelling maybe, or for somebody to say to them, "Look, what you have to do is, initially, put yourself in that person's shoes and think how would I like to be treated in this situation?" And, once you kind of get your head around that, you look at it in a very different light, so there's more respect. They're given the dignity they deserve and they're treated like, rather than like five year olds, they're treated like adults. (16PWD)*

> *I think there should be disabled people that gives them training. Like someone that's been with carers for years, can just help train someone. That should be a job in the industry, that disabled people can help train these people. And how to treat them. Because then they know*

first hand. (15PWD)

3.3.3.2 Technical skills and competencies

Respondents - particularly disability service providers, workers and people with disability - identified specific gaps in the technical skills and training of workers that needed to be rectified in order to improve the quality of disability support provision particularly for people with complex care needs. The key skills perceived to be lacking were around medication administration, behaviour support, safe manual handling techniques and mental health/dual diagnosis.

> *Where we struggle is when staff who are engaged in participants with complex behaviours with personal care, with other complex type of [behaviour issues]. (19DSP)*

> *Dealing with behaviours, I think, would be good just for everybody. Like how to diffuse them would be good. (07DSW)*

> *I don't like to say 'self-defence' - but it's definitely something that would come in handy with working with participants with behaviours. I'd really like to do that. That's not something that I've been able to do so far, but that's definitely something I'd like to do in the future…(keeping self safe) and keeping other participants safe, and the violent participants, themselves. (14DSW)*

> *Some of their needs are high needs. And so, you need people who are very, very happy to be working with that. And they may not really understand and know what they're walking into. It would be really nice to see some courses available for these people, so that they did have a bit of nursing skills…and I can see this in the future, that the TAFEs will pick up on this and provide a course. I think it's really quite urgent, that they start doing it soon. (14PWD)*

> *[Our daughter] has a very serious problem with epilepsy. Her epilepsy isn't controlled that well and her seizures are quite scary. So you sometimes think someone with a little bit of medical knowledge would be fine, would help. It's not necessary but it would be helpful. (09PWD)*

> *The training needs to be changed a bit more; definitely on medications and - I mean, [my son] can put his eye drops in better than what they can…If he can do it, you'd think they could work it out. (19PWD)*

3.3.3.3 Communication

The need for development of strong communication skills was a further training gap commonly identified by respondents. This included developing and utilising active listening skills and, more specifically, learning strategies for interacting with people with communication difficulties. Some disability support workers noted that training in social skills and how to interact with clients and co-workers would be useful. Workers raising this training need included staff from CALD backgrounds and a disability support worker with Autism wishing to develop their own social interaction skills.

> *Being able to communicate and enjoy the company of a person who's disabled, and not afraid to be able to speak nicely to them, and respect them, in a healthy way, where they can make time to listen to them, and speak slowly for them, and wait for answers – and just be respected. (14PWD)*

> *Because a lot of our clients actually are deaf…there is a one day course that we can do that gives us a bit of basic sign language and what have you, which I'm really desperate to do because I find it really frustrating when I can't communicate. (12DSW)*

I think the staff would need to have more social skills…like, if people are from different backgrounds, some staff they find it hard to - like, to communicate with you…And also, how to respond to the clients, especially when they are agitated or when they're upset…So, I think this training would be very, very important for staff to know that we are like role models for the clients. And the way we talk to other staff affects the clients, and how we talk to other clients affects other clients. (05DSW – worker from CALD background)

Probably behaviour training would be the only place that I'd be looking at doing a bit more…there are behaviour challenges, and with staff I think it's more just, how do you make a team work? How do you take different people from different cultures and mix them together? (09DSW)

I'm actually looking at doing a course that's designed to help - it's like a series of seminars that are designed to help people who struggle with social interaction. So hopefully that will assist me a bit…Well part of the biggest thing I struggle with in having high-function autism, is reading social cues and sometimes it's hard to interact socially. (17DSW – worker with Autism)

Given that many respondent groups considered communication skills to be essential for quality disability support, it was unsurprising to hear dissatisfaction regarding the recent shift to have the communication component on the new Certificate III in Individual Support become an elective rather than a core component. Others also thought the course could place more emphasis on written communication skills such as documentation and communicating policy and procedures.

Look the AAC, the communication is an elective that was taken out of the core units and made an elective in the latest update last year. I think that's a very dangerous move. (11TP)

So, I think just having an understanding of the policy and procedures and understanding what they mean, what effect it has on you as a support worker – I felt that there was a lack in that. (06TP)

3.3.3.4 Soft skills

The soft skills possessed by disability support workers was a further area which was found to be in need of development. Particular soft skills which were valued by respondents included having patience when assisting people with disability to develop their independent living skills, using initiative to suggest activities, and having good common sense in order to appropriately respond to care needs and behaviours. The challenges of providing training to develop these skills, however, was acknowledged by respondents.

They need to learn to be patient, because some people actually can't do certain things and they need to be shown. So they need to be patient, they need to be understanding about what's happening at that time, and they need to be able to do jobs with the person, or for the person. (11PWD)

We'd like them to have a bit of their own initiative. Do things, like if there's something on in the town, at the town hall, take [my daughter] to it. Don't not go anywhere. Sometimes they say to her…"Do you want to go surfing?" and she'll say, "No." But she doesn't know what surfing is. So con her into saying, "Let's go down the beach and we'll have a look" well she might have a go. They've got to talk her into things…Just to be attentive, but I don't know how you train people to do that. I just think they've got to be aware. (09PWD)

My friend's daughter came home with a four-litre bladder. Now, you're meant to have 500 mils in your bladder, and you're busting…And they hadn't picked it up, and she hadn't been

checked for two days…Now, anybody can make a simple mistake, but if a child is distressed as acutely as she was, there's something very badly wrong…How do you build that into training? That's very difficult…You have to have good common sense, and you have to know that person's normal behaviour. Perhaps it helps to be with that person quite a lot, so you understand what's normal for them and what's not. (14PWD)

This is more than just looking after their practical needs. They have to have a holistic approach. It's very simple, and the training has to be – that has to be clear in the training and I don't think it is. I think it's a certificate thing. It's all theory, practice as in how to lift a person who is disabled from A to B, but as far as engaging with a person with an intellectual disability who wants to go out and be part of the community, I don't know how many of them actually really get that. (16PWD)

3.3.3.5 NDIS and broader policy changes

Many training organisations believed that the roll out of the NDIS has heralded massive changes to the disability sector, its workforce and the skills and capabilities required of the workforce. However, respondents reported that the current VET courses did not adequately address policy changes associated with the roll out of the NDIS. Consequently many disability support workers were seen as being unaware of how the NDIS works and, more generally, of the huge historic shift that had entailed in the provision of supports to people with disability in Australia. It was therefore considered to be important that understanding of the NDIS be incorporated into disability training courses.

I think what isn't covered and needs to be is an understanding of the NDIS, obviously it's changing a lot at the moment, but there's no information on the bigger picture of funding or how it impacts. I think particularly now there's students going out now, are going to be working under NDIS situations, they need to have a bit of a grasp of how that works. (11TP)

3.3.4 Concerns about disability training

Respondents identified other areas that were of concern in terms of the provision of disability training. These were mostly due to the quality of the disability training and the costs associated with undertaking the training.

3.3.4.1 Quality of training

Many respondent groups raised significant concerns about the quality of the disability training that was currently being provided and the extent to which it adequately skilled students for their future employment. Several family carers raised concerns about current approaches to encourage unemployed people to pursue disability support training and the stringency of completion requirements for this training.

You have to do training or some training of some kind if you're on the dole. So they pick Disability III, people that I know from around town for years, this town and the other, that I know as the town drunks and very loud mouthed people and what not that have then got their Disability III and been sent to me…They get told on the very first day of their Disability III Certificate that no-one is going to fail this course, so everyone passes even if they don't have computer skills, even if they can't read. (03PWD)

I think there's a big push by the government to push a lot of people into courses for disability workers because they're on the dole. They may not necessarily have any interest in that work. It may spark an interest for some, but others, I think, are being pushed into it. And I think that's very dangerous. (18PWD)

The quality of disability training was questioned by most informant groups both in terms of the variability of standards across RTOs and the extent to which the courses were able to teach crucial skills.

> *Look, I think the curriculum, or the assessment guidelines, the whole training package, if it's followed properly and it's delivered by good trainers and good assessors, I think it's pretty good. The problem is that the range of quality is so enormous that you can't guarantee just because that curriculum does cover everything that the end product, someone who has been signed off as competent, is necessarily good. (07TP)*

Changes to Certificate III qualifications

The decision to replace the Certificate III in Disability with a common qualification across aged care and disability was predominantly viewed in a negative light by many training organisations. A training package review conducted by the Community Services and Health Industry Skills Council (CSHISC) led to a recent change in the entry level qualifications for disability support. At the Certificate III level, a new general qualification, the Certificate III in Individual Support, replaced the former Certificate IIIs in Aged Care, Home and Community Care, and Disability. Under the new qualification, a student completes core subjects, and can then choose to specialise in up to two areas: ageing, home and community or disability.

The qualifications were brought together under the understanding that common skill sets exist between the aged care and disability sectors and to enable greater flexibility for workers to move between the two sectors. However, this rationale was disputed in the interviews with training organisations. Little workforce movement was felt to be occurring between the two sectors and the majority of disability providers themselves were perceived to consider the two workforces to be quite separate.

Specific concerns were raised that the combination of the qualifications did not adequately address the difference between the sectors in terms of where the care was largely being undertaken (in the community versus a residential setting). It was also noted that the ethos and training models of the disability and aged care sectors were different; with the disability sector having a greater focus on developing independence and having an employment and vocational orientation.

> *I don't think the merging of the two workforces is happening if that's part of the question, I don't think that is happening much. Most organisations appear to keep their workforces quite separate and they see them as separate. That's not to say individuals don't get work in different sectors, so I think individuals are probably working across, but I don't think organisations are doing as much cross functional work as you would expect. (10TP)*

> *There is a lot of resentment towards this idea that the work is the same and that the skills and competencies are the same, they are not. People choose to go on to work into the disability sector for very different reasons for those who go and work in the aged care sector and the needs of those people are quite different. And, in fact, people with disabilities in particular have quite a strong reaction against this idea of being clumped in with aged people in terms of their needs when historically…we've often had young people with disabilities in aged care homes or locked away in aged care facilities and not had appropriate support for their development and independence and participation in society so there's a real concern there. (04TP)*

> *Unfortunately in the study of disabilities it's returning to a medical model, because it's being swallowed up by aged care individualised support type things. There's a number of units that go across both courses and the assessments that we buy are very much focused on elderly people, they're very much focused on aged care setting. There's very little about community*

settings, there's very little about working alone, often the answer to the question is, you know, immediately inform your manager, where you're down at the swimming pool with somebody there is no manager. There's not a reasonable answer, I've been quite disappointed to see disabilities slipping what I consider back towards medical model as it gets absorbed by the greater numbers of people going into aged care. (11TP)

In contrast some respondents were more positive about the new Certificate III qualifications. In particular, they felt that the generic Individual Support qualification could encourage greater workforce flexibility and enable workers in the disability field to attain their preferred working hours.

And again there's the other problem that is – the pressure of the last few years has been relatively increasing pressure towards multi-skilling based on the things I was talking about before, about how departments have got every sort of service within them. So having workers who can be a disabled worker for some of the time and an aged care worker for some other of the time and a home care worker for some other time, that's become more attractive to employers 'cause they're providing a range of those services. And it might become more attractive to the workers because they can fill up their working weeks that way. Whereas they can't – they have to get contract after contract to do 35 hours disability or 37 hours disability. (18TP)

For the small minority of providers delivering both aged and disability services the changes to VET were viewed positively as they utilised their support workers across both client groups. These providers did not believe there were significant differences in basic skills required and disability specific training could be delivered if required.

Because our business is spread across both aged care and disability, we don't separate our employees into just purely disability workers, or aged care workers, because they do work across both segments…We do provide specialist training for our employees around disability as much as aged care. We do have one or two, obviously the facilities that we manage, that are all disability. We classify very few of our employees as purely disability in those facilities. (08DSP)

I found that the competencies are totally identical, whether it's aged care or disability support practitioner. (16DSP)

Essentially we don't split them. There is no formal splitting process. So they work across - they have to - there is an expectation they can work across aged or disability in any particular moment in time. It is something we are looking at but at this stage that is the model. There is no idea of changing that at this stage. (14DSP)

(Operate) under two streams I guess. One under the CHSP which is for over sixty-five and the other is through the NDIS on people under sixty-five…It's a little difficult for me to isolate how many (support workers are) involved in disability…It's more about where the client's located more than anything else in which care worker goes to them. (20DSP)

Factors influencing quality of disability training

Feedback from disability support workers indicated that many were dissatisfied with the quality of certificate level qualifications believing, that the training did not adequately equip them to work in the disability sector. Limitations identified included course content not reflecting the 'real world' of disability care work and not providing enough focus on disability. It is important to note though that the disability support workers interviewed for this study had undertaken their training prior to the introduction of the new Certificate III in Individual Support. It will therefore be important in the future

to evaluate satisfaction levels of those undertaking the new Certificate III qualifications across both disability and aged care in order to identify specific gaps in that training.

> *Truthfully I don't think half the stuff that we did in the course really benefited what we do day to day. (01DSW)*

> *It really isn't – a lot of the stuff that I did you know as I was doing the module I thought – and this is you know really not - this is not the real world… the theory is nothing like the reality. (02DSW)*

Variability in the quality of disability courses was perceived to be largely attributable to poor training provision by private RTO's, with many training organisations narrating accounts of rogue RTO's and the student loan scandals.

> *Where you had large RTOs signing up hundreds and hundreds to do Diplomas that the students weren't equipped to be able to finish and making a fortune in the meantime and leaving the students with a loan to repay even though they haven't got the qualification. (18TP)*

Poor quality training provision was said to be resulting in an increasing proportion of disability service providers opting to employ unqualified workers and provide internal training to their workforce themselves.

> *And what we're seeing, that is a result of this, too, is that more and more – because of this poor training quality, providers, more and more, are saying, "We don't need people with qualifications. They don't need to have qualifications. We can train them on the job, and we can get them doing what we want them to do, the way our organisation works." And my response to that is, well, that's a result of poor-quality training provision, and you don't solve that by people not having formal qualifications. You solve that by improving the quality of the training. (03TP)*

Indeed instances of unqualified workers with inadequate skillsets working with clients were reported by some respondents.

> *Q: Do you know if they [the disability support provider] require their workers to have a Certificate III in Disability, or any kind of qualification?*

> *A: Disability, no I don't think so. I don't think that was a requirement. I think it was voluntary if you wanted to get your certificates in disability. (09PWD)*

> *These days you don't even have to have a Disability III or Aged Care Certificate to do 99 per cent of the jobs. So apparently even showering you don't need it for now, it's only if you give them medicine, apart from that they can send unqualified people to you these days…I won't take newbies anymore. You take a newbie it takes 100 hours to show them what to do with [my daughter], they do four weeks then you get another one and spend 100 hours showing them what to do. (03PWD)*

Quality was also associated with the mode and duration of the training. Many training providers noted the financial need to offer some components of their courses online, in order to reduce costs and increase access for those in regional and remote locations. However, it was acknowledged that some training providers offered more components online than face to face, negatively impacting on the quality of training. Quality was also associated with the duration of the course being offered. Certificate level qualifications that were of a short duration were viewed as being of poor quality. Training organisations also reported that employers in the disability sector held similar views and

given the choice of candidates, would not hire those who had undertaken an online, short course.

> *There are a number of online courses that people access. They have either zero or very limited contact with their training organisation face to face, and they have to go and find their own practicums and things like that. We kind of question the quality of that. (07TP)*

> *We've run into a number of training providers who can do the Certificate III in Individual Support in four weeks. I don't believe that….It's ridiculous, you can't learn it. That includes work experience they reckon. So I just go, no…HR will call me and say such and such has found this person. I go, where did they do it, and how long did it take? Oh it's only a couple of weeks. Oh, really? Well you tell me - you tell me why you shouldn't employ them? Because they don't have the skills. It's just risky. I'm not prepared to put people's lives at risk for a shonky deal. You don't have to read too much to see who's out there…you know, a job network provider...They want a cheap, shonky job done. Because they've only got so much money to spend themselves. (08TP)*

Another aspect of training quality related to the skills and industry experience of the trainers. Trainers/teachers with current or recent industry experience were considered important in ensuring the currency of the skills and competencies they aimed to deliver to their students. Having trainers with current industry experience and skills has particular implications for the roll out of the NDIS which will be discussed below.

> *They have to come from industry … every trainer must have currency. That means they've had to have industry experience and they need to maintain that. (15TP)*

> *One of the biggest issues in the disability sector at the moment is trying to find adequate trainers with the relevant industry experience and skills combined with the Cert 4 training skills is really difficult. If we're having such a huge influx of new workers that need this training, where do the disability trainers come from?…So having trainers with access to enhance their skills as support workers is critical. (20TP)*

3.3.4.2 Training costs

The cost of undertaking disability training was a further area of concern for respondents. This particularly included paying for trainers/courses and also the cost of covering shifts for staff that were undergoing training. A number of disability support providers also spoke about 'competing priorities' in trying to manage the need to keep staff well-trained alongside maintaining service or business continuity. In this respect, upskilling workers quickly in order to respond to a particular client need (e.g. peg feeding) could be difficult.

> *It has definitely been a challenge because the service delivery has always taken precedence over somebody attending training…We've made a very conscious effort over the last 2½ years about the importance of training and attendance and participation and being fully there, rather than showing up and saying, "Oh my supervisor said I could rock up anytime I like. And, by the way, I've got to leave at one because I accepted a client and if you've got a problem you can take it up with my supervisor." So it's the fine balance, I guess. (08DSP)*

The financial cost of training courses was indicated to have increased dramatically over recent years. There were additional concerns that the NDIS would increase training costs in the future.

> *My big beef at the moment is with the cost of training. I guess it's the same as Australia wide, but the cost of doing the Certificate III. About three or four years ago was about $600 to enrol in a Certificate III and now it's over $2000 and rising. Every year the fees go up. In the past,*

employers could maybe say, "Well, yeah, I'll invest $600 to put someone through a Certificate III." Well, they invest much more, because they've got backfill that person. But now some employers say, "We just can't afford that kind of money unless we're getting some sort of training incentive." And that's getting harder. (07TP)

Further, many of the full-time disability support workers were considered too time poor to successfully undertake the training they needed. Respondents also noted that team leaders and supervisors often did not have the time to follow up and evaluate whether workers were putting their training into practice. Lastly, service providers in regional areas were presented with geographical barriers to upskilling their staff, such as requiring trainers to travel long distances at great expense to deliver training.

I mean there's always a training module that you think that's going to be fabulous and then when you do it, it crashes. We've just done a five units on behaviour with about seven staff and that's been challenging for some, again because people come from a whole range of backgrounds. Whilst they might have had a Cert 3 some of these units were actually diploma level units. And some people's education made that difficult for them. (20DSP)

I think time is probably the difficulty for many of the workers. Because there's a 24/7 support service, some workers do work their full 38 hours in a challenging environment, and they're exhausted at the end of that, to actually then go online and have a look and see what there is. (07DSP)

The affordability of training was perceived to be negatively impacting the quality of the training provided, as disability providers were said to be scaling back on the training they offered to their workers as a way to decrease training costs.

You go to organisations and they go, "Well I can't afford that. I need that training but I can't afford it. Instead of doing a full day's training session can you do a two hour training session?" Two hours is an information session, it's not training it's just somebody standing there talking, and they go, "Okay, well there's your positively managing behaviours training done", two hours, they can tick it off. But that doesn't teach somebody how to do something. So people are taking shortcuts in my opinion because the money's not there to do it. (20TP)

Concerns about the complexity and adequacy of state and federal funding for disability training also remained a concern for training providers.

But the availability of public funding was the key. You could encourage training delivery to Cert III level because there was access to State and National funding through traineeships and normal State delivery. But that's gone. Not completely, I mean there's still incentives there for traineeships but it's not as much as it used to be. (18TP)

3.4 Impact of NDIS

A major topic of discussion with each of the informant groups was on the impacts of the NDIS; both current and future impacts were discussed. These included impacts for the skills and competencies of workers; changes to disability training as a result of the NDIS; impact on student numbers and student characteristics; and impacts on funding for disability training. We discuss each of these impacts below.

3.4.1 Impacts on the skills and competencies of workers

Some respondents did not consider the NDIS to have impacted on the skills and competencies required of disability support workers.

> *To a disability support worker their role is probably pretty much unchanged under the NDIS, there's still going and visiting clients and doing what they need to do. (12TP)*

> *But I think the support given to the person with the disability would have to be the same, the same concepts of respect, the same concepts of empowerment, the same knowledge of alternative formats for information. Those sorts of things will be the same with or without NDIS. (11TP)*

> *At this stage I'd probably say no, there hasn't been too much of a change, but again, the NDIS itself is quite new. (13PWD)*

The majority of respondents, however, made clear that the introduction of the NDIS had already, or would in the future, change the nature of the disability sector, its workforce and the skills and competencies required by disability support workers. For example, the shift to an individualised funding model was identified to have increased competitiveness within the sector. Indeed one respondent reported that not-for-profit disability service providers within her area were struggling to retain skilled staff who were increasingly being employed directly by NDIS participants using self-managed funding arrangements.

> *The organisations are bleeding, because these workers are going out and getting money from NDIS clients who are offering one-on-one at much greater rates. So, there's a lot of high turnover happening, at the moment, in this interim process. They can't depend on their workers being there long-term, to get to know their clients, because they're coming in, they're seeing the gold. They're talking to the parents and being hand-picked and plucked, and asked to stay at home, and take them out to the movies, or go shopping, and do nothing, for a lot of money per hour, one-on-one…They can pay them three times as much as what they can earn in the NGOs. So, the NGOs are bleeding, at the moment, all these good, skilled workers. (14PWD)*

3.4.1.1 Types of skills and competencies

Respondents considered that the roll out of the NDIS had required disability support workers to become more business savvy and develop an understanding of market principles.

> *An example I'll give you that has come directly from our sector is support workers with great intent, great values, great knowledge, have a great relationship with the person they're supporting and they're meant to finish supporting the person at two o'clock, but the person says, "Look, my washing's not quite dry and I can't bring it in from the line myself. Do you mind hanging around and maybe you can help me with such and such until the washing's dry?" "Yeah, for sure." But the support worker these days now needs to understand that that half hour that they hang around isn't bringing in funding because the organisation has only been contracted by government to provide a set number of hours. Hence that organisation's going to have to find that extra half hour to pay the support worker somewhere. Now, if that happens occasionally it's no big deal, but as you can imagine, as the NDIS is fully phased in, support workers need to understand that won't be able to happen across the board, and they need also to be able to respond in a way that's respectful, and to say no in a way that's respectful, or to problem solve with the person around alternatives. (07TP)*

And, also, it's much more of a business approach. So, if you're supporting somebody out in the community and you're there to deliver two hours' work, that's what you've been funded for, and they're certainly asking you to stay on for another 40 minutes. It's how they manage that sort of difficult conversation. (09TP)

The other thing that we see as becoming more and more evident - and again, it's covered in training, but needs to be a real focus - is the frontline management. Because what the support worker does and what they say directly will impact on whether that person with disability, who now will be a customer, stays with that organisation or not. So the frontline staff's behaviours directly impacts on the bottom line of the organisation. (06TP)

Our frontline staff are very capable but we have to hedge them to be confident and use their initiative and just go through pretty basic problem solving processes because that's what people and NDIS are going to expect, closely aligned with really good customer service. (02DSP)

They will be more accountable to deliver really quality services. (09DSP)

Many respondents also believed that business management skills would become progressively more important for disability support workers as they increasingly worked independently with clients. Decision making activities were projected to transfer from large organisations to individual workers. Disability support workers would therefore need to develop skills to make appropriate decisions to support the choices of clients while managing risk. Ethical practices were also considered to be important.

Traditionally, I guess, we would have been training for people to go to big organisations that had certain structures or were funded in particular ways, whereas it's a much broader picture than that now, and a lot of students actually probably at that Cert IV level will need to understand a lot more about being a self-employee and perhaps addressing their own microbusiness type of model. (01TP)

Like you might be the sole person providing services to somebody and so how do people maintain their legal, ethical and best practise models. That is going to be a key consideration into the future, I think….You know, if I work completely on my own, how do I manage that and maintain a good - How would I know I'm maintaining good practise standards? (01TP)

It depends on what the client wants. Like, they might want somebody who can sit down with them and work out how they can go on a holiday, or work out their budget so they can go out every Friday night. You know what I mean? At the moment, you can't do that because we're part of an organisation and we're restricted, but when it's NDIS and you're working private - you're working closely with somebody and it's their choice what you do on that shift, I think there will be many different things that will come up…(support workers) would need some training around dignity, and risk, and ability to make decisions, and decision making - what's it called? Being capable of giving consent and things. Yeah, so the staff would have to be aware of that, which at the moment they don't really have to, because the manager or somebody else would do that. (09DSW)

The shift towards individualised funding and person centred delivery of services was perceived by respondents to necessitate a shift away from task oriented training and competencies to more client focused, goal orientated skills and competencies. Greater specialisation was believed to be required as a result of disability support workers increasingly working one on one with clients rather than in group based settings. However, at the same time, it was also thought that there was a need to have increased multidisciplinary skill sets to be able to work across disability types. Workers were therefore

seen as needing to exhibit flexibility and resilience in the provision of client-centred support; and the development of skills in supporting people with complex and multiple needs.

> *So orientation to the client, how empathetic, how compassionate, willing to undertake problem solving behaviour with the client, encouraging of participant self-direction. (02TP)*

> *So we see two types of change I guess, there's a specialisation for individual needs and the multidisciplinary skillset for specialisation across multiple clients. And I guess the third area is, as I said, person centred service delivery and that is around relational skills. (04TP)*

> *It would be the sort of skills that you would develop if you have a client that's got a particular goal or aspiration then probably you would develop that on the job. (06DSW)*

> *With the introduction of the NDIS support workers have had to change how they work; they have had to become more flexible in their approach, and become more customer focused. This means workers now must look at what a customer wants to do and be responsive to their wishes rather than working from a service directed plan. (15DSP)*

> *Flexibility is one of the big qualities we're looking, because they're preparing for NDIS, now we could have clients changing the requirements, the needs, so we need staff who can be responsive, flexible and able to deal with change. (04DSP)*

3.4.1.2 Addressing the needs and preferences of people with disability

A key topic of the in-depth interviews with people with disability and their family and carers was the impact of the NDIS on the disability support workforce. It was anticipated that workers would have a greater understanding of disability in general and receive specific training in care tasks. A more individualised approach to disability support under the NDIS was also anticipated by some respondents; workers would therefore require additional skills and training in order to understand and address the specific needs, preferences and goals of their clients.

> *There's not that big choice of agencies to go to. Now I think with the NDIS, there probably will be more choices in our area…The care workers would be trained in disabilities more, so it would be more disability trained workers than aged care. (04PWD)*

> *Because now that we're moving away from a State-based system, I think definitely it will be absolutely vital for support workers in the future - and I guess this is something that's important for providers as well; is that they're always changing and improving the way that they provide their support so that it keeps up with the needs of clients and families…I also think the challenge will be…just making sure that they're up to speed with the needs and the concerns of clients and families, and providing supports that meet those needs clearly and effectively, and also helping the client to achieve what they want to achieve in life. (07PWD)*

Indeed with this anticipated shift to greater person centred care under the NDIS, all respondent groups perceived that workers would require higher levels of customer service and an ability to market themselves in order to secure and maintain customers. This was expected to become more pertinent in the future as the NDIS roll out widens and the individualised funding model beds in.

> *There is a whole lot about marketing to people directly who have disabilities. How do I actually find clients? (01TP)*

> *A big thing now a lot of people are looking at is customer service because as the NDIS has come in it's switched from being that community services model to now people are going, "Well hold*

on we're a business and this is about customer service, the customers have choice and can go anywhere." So customer service is a big thing. (20TP)

Certainly I think in terms of discussing issues with clients, it effects everybody because we have to be quite a lot more careful about how we do discipline, for example, and things like that. We can't come on too strong, because if one of the clients doesn't like how we've done that they can quite easily move. When I think that is certainly- especially in pre-employment workplace behaviour is obviously a very strong component of that. So within that, if you've got people who aren't acting appropriately you need to be able to tell them so without fearing that you're going to lose them. (13DSW – works in employment transition program)

It's basically you know client's if they're not satisfied, whilst they're not moving that readily at the moment, as the NDIS settles down and people understanding, you know what if I'm not happy I can go and look elsewhere. That you know service to the client is going to be very important for meeting client's needs. Now again if you've been a disability support practitioner where you really haven't been held that accountable, and then all of a sudden the spotlights on a bit more in how you work and all that, that's been unsettling for a few people and they have moved on. (16DSP)

I think that the skills are going to become more complex and more specialised, particularly as more people have their packages individualised and want to take some control and ownership of who it is that comes into their homes and provides them with that support along the way. I think that as that happens there's likely to be less of a requirement or reliance on a qualification. You're also going to be looking at matching values, attitudes, people, personalities and so forth across the board. (09TP)

Aligned to these issues, the matching of disability support workers to client interests and preferences was also identified as being a new development under the NDIS. This required workers to promote their values and abilities to the client – not necessarily just their qualifications.

You've got the people with disability now who are recruiting their own support workers by advertising online or in the paper, and, whilst it may be a bonus that someone's got a qualification, that is not the key thing that they're looking for, they're looking for the right match to suit them. (07TP)

It's often other interests and hobbies and skills and things that people are looking for, they might be looking for someone much younger, they might be looking for someone who likes collecting stamps or who likes surfing or who likes playing the guitar, things that align with their own interest. (10TP)

A greater match of skills/knowledge and really, age is part of it, I've got to say, in terms of where we're up to and what we want to do. Do you want to be a 25 year old, always being followed around by a 50 year old? Why? And at the same time, what are some of those interests and skills that you have that you want to share? Really it's about appeal, you can link very closely with skilled people who are students for two and three years at a time, but not viewing them as 'the carer' of this poor person with a disability, but rather as, you know, 'We have a mentor, we go out together, we enjoy the things we have.' (05PWD)

[With the NDIS] you might be able to choose somebody you think that would fit in better and have the same interests as that person…so hopefully we'll get better care with better choices. (19PWD)

Overall, the future impact of the NDIS on staff skills and competencies was seen by respondents as largely revolving around the need for staff to be more responsive, take on more personal responsibility for the relationship they have with their clients and being able to tailor their support to the clients' needs and preferences. This was viewed as requiring significant upskilling among the current workforce.

> *I think from a commercial perspective, they do need to broaden their skills. I think it's going to require a lot more relationship type skills, influencing skills, and ability to understand what their role that they play in creating independence at home, and they need to work toward goals, which they currently are not expected to. I think that will challenge the existing people in the sector because that's a huge shift for them, from where they are currently, to being assessed on whether their clients are reaching goals and how are they assisting them to help them to do that. And that's going to require quite a big uplift in competencies. (08DSP)*

The independent evaluation of the NDIS reported similar findings. The evaluation highlighted that increased consumer demand had led provider organisations in the NDIS trial sites to experience expansion and consequently hire more staff. However, providers were reported to be offering contract or casual positions at lower rates of pay and skill levels. Some increased casualisation in the workforce was perceived to be leading to higher levels of turnover and churn in the sector and reducing the quality of services for people with disability (Mavromaras, Moskos and Mahuteau 2016, p. 48).

A de-professionalisation of the disability workforce was also commonly reported in the NDIS evaluation, with increasing numbers of allied health assistants in the sector. Concerns were raised about the ability and skills of these workers to provide more complex supports and the impact this could have on the quality of care and outcomes for participants (Mavromaras, Moskos and Mahuteau 2016, p. 49).

3.4.2 Impact of NDIS on disability training

3.4.2.1 Current impacts on disability training

As the skills and competencies required of disability support workers were considered to be changing as a result of the NDIS, so too was the training that was being provided. Training organisations identified that in response to the NDIS, additional skills and competencies were being increasingly incorporated into the training that was delivered. These new skills and competencies included management and frontline skills, customer service, person-centred practices, behaviour support, and professional relationships training.

> *It's definitely less about the task focus, and if you look at some of the training it's been very task focused and now it's very goal focused. (02TP)*

> *For example the change is more marketing for the frontlines because the NDIS coming in is now market driven. So the disability support workers are essentially the face of the organisation, so they have to have more customer service training and frontline training as far as how to deliver their supports in the most customer serviced orientated fashion. (02TP)*

> *A lot of the calls and the questions I've been getting from employers lately has been around that sort of stuff; communication, customer service, positive behaviour support and professional relationships within the worksite, so how do you manage yourself, because the nature of the work that the support worker does almost implies that there's friendship between the support worker and the customer, but yet it needs to be a professional friendship not a true*

friendship that you would have because at the end of the day they're a paid employee. So a fair bit of work around that type of stuff has been pretty important. (20TP)

I think I'll be emphasising more the sort of skills needed in individualised support. I won't be letting students assume they'll be working in a day service, because I think [that service] will become less and less available. (11TP)

Well we have through our current staff, are currently running training in three main areas. One is in customer service, because they're so used to saying this is what we're doing today, and their customers are saying no this is what we'd like to do today.… The second thing is the fact that writing skills needed to be improved. So we're currently running some writing skills programs… helping not for profits, disability organisations, write policies and procedures in plain English. The third area that we've found is really behaviour support. (08TP)

Other training providers were in the process of undertaking changes to their learning resources, ensuring that core NDIS principles were included and information about the scheme covered.

Resources is a big one…All of our learner resources reference NDIS, all of them. They always reference legislation, where possible accompanying resources will be resources from NDIS or the Department of Community Services or any disability organisation like the big advocacy groups etcetera. We feel that we're pretty right on with what we've got. We access all the DVD links so they can go on the NDIS and you can watch a short little DVD. (15TP)

Disability service providers were also implementing changes to their training processes, both internal and external. Some organisations that were affiliated with external training providers (such as TAFE) were reported to be negotiating changes to course curriculums based on their operational requirements. A small number of the disability support providers interviewed were also RTOs; these organisations were in the process of developing modules and courses to better support their workers' skill sets with the aim of improving quality care and support. Service providers described responding to the changing competencies required under the NDIS by recruiting workers with additional skills (such as language, surfing, music and dance). Further, as described above, staff members were increasingly being matched with clients, based on shared interests and the workers' broader skillsets.

It's more these days it's much more about aligning interests and skills, and giving the increasing choice and control. We've got staff who are qualified surf instructors that are now, through the NDIS, taking people surfing which is something that - that person's been working for us for five years and we never tapped into the fact that he was a qualified surf instructor. (17DSP)

Disability support workers confirmed that the training they were undertaking had changed as a result of the NDIS and included more of a focus on individualised person-centred care.

Well, I think it already has, you know with this personalised-centred support, I think that's part of the NDIS approaching us. And, it is, I'm finding it one of our better, more personalised, more person-centred, more individualised training that we have done. (10DSW)

3.4.2.2 Future impacts on disability training

Training organisations also considered that further changes would need to be made as the national roll out of the NDIS occurred. In many instances these changes were considered to be required as a result of the anticipated increased incidence of disability support workers working independently with clients out in the community.

I think so. I think the training package will need to change into the future. I think they are going to have to address that self-employed worker component more, definitely, and the working alone or independently aspect of the work will be critical. (01TP)

Several training providers considered the NDIS to have so fundamentally changed the disability sector that they did not yet have full knowledge of the types of services and supports that people with disability would want to access. At present, therefore, they were unable to adapt course content until the support preferences of people with disability became better known.

But, the other area of course is that if people are going to have a lot more choice and control over the types of services and supports they have in their own lives, there will be, I think, a range of other services and supports that we've never thought about yet and we don't train people for. So, I always think about the problem if somebody says, "My health would be a lot better if I was going to the gym on a regular basis," you know, does the training actually support somebody to take on that kind of activity? Probably not, at this stage. That might actually need to be a different kind of training that a person gets to support someone to participate at the gym. (01TP)

3.4.3 Impact on funding for disability training

3.4.3.1 Training organisation and provider perspectives

Training organisations identified that one of the main impacts of the NDIS on disability training had been on the availability of specific funding allocated to training. Respondents indicated that NDIS pricing did not sufficiently cover the provision of training to the disability sector workforce. The NDIS base hourly rate was noted to only allow for three minutes per hour of contracted time to be non-face-to-face work, such as administration, training and development, case notes and supervision. Training organisations were therefore very dissatisfied with NDIS pricing noting that as a direct consequence many disability service providers were decreasing the amount of training they were providing to their workers.

The NDIS comes with a new pricing framework, which means there's less and less margin. There's almost zero. The new pricing framework, for example, per FTE only allows 11 days a year of non-client facing time. So that means apart from holidays, that means there's 11 days a year that a full time person cannot be actually delivering support. And those hours need to include the support worker's travel to and from their customers, or their clients. It needs to include meetings, it needs to include all their administration, and it includes training, so there's very little time in that NDIS pricing framework - it works out at about two days per year per FTE for training. That's not a lot for a full time employee, given that more than half the sector is part time it works out about a day a year that organisations can afford training in an NDIS framework. The NDIS isn't fully phased in over here, as you probably know, so when margins shrink and surplus shrinks one of the things to go is always training. So for organisations to support or subsidise their staff to do the Certificate III will become more and more difficult, unless they have some kind of traineeship arrangement. (07TP)

Certainly, we're hearing reports from members that are currently in NDIS roll out areas, that on-the-job training has all but disappeared, in a lot of instances. Because of the way the NDIS is funded...So, if the payment is for an hour, it's assumed that 90-something per cent of that hour is face-to-face time for the worker, with the client. So, providers are saying that they don't have the money anymore, because of the changed nature of the funding, to get people together and provide training. So, certainly, we're hearing that training is disappearing. Things like staff meetings are disappearing. Any other time when workers would come together, in

any other way, whether it was formal training or not, are becoming less and less common. (03TP)

But I am aware of the fact that there is no money available to train staff under the NDIS. "Why should I as a parent of a child [with disability] pay for my support worker to go to training?...I want you to spend the money on my child, not on people's support". I met a lovely lady recently who had been paying for training for the people who support her child - and she said, "and every time they get qualified after I've paid to get them skilled they leave and get a better job….now going to keep them for three months, and then if they're still there at three months she's going to start paying for some training. That to me has put my child at risk". (08TP)

One of the largest providers/NGOs in New South Wales said that they no longer provide any formal or paid training to their staff of I think over 1,000 support workers, they just send around little newsletters that advertise free training that may be available that they've found themselves for staff to do in their own time. (04TP)

As a response, training providers were developing the availability of online modes of training to offer affordable training options to organisations. We note however the aforementioned perception of online training being of poorer quality than face-to-face training methods.

We're trying to build systems to develop online training at a cheaper cost. Some of that's been - I just had a little program built in India, because it's cheap. (08TP)

Disability service providers also acknowledged that the provision of training to their staff had indeed become more difficult due to the lack of NDIS funding.

But that's where the insurance scheme actually does not acknowledge the necessity for the cost of training...What's had to happen in organisations, or certainly ours…have the same challenge is that supporting, like we used to, people going off to their training sometimes within time and also us providing a higher level of training than is possible now. That is a challenge in the last couple of years where before people would come in and we would have an expectation that if they didn't have the qualification but they had to get their Cert III or IV and disability work in the first three months. (19DSP)

Yeah so for example, we cut down our induction a lot recently in line with that. Personally I think the cuts we made are sensible and I'm comfortable with them. Perhaps we were overdoing it before, but the question is, once we start to look at how we're travelling financially, whether there will be cutbacks even further and at what point will that become - yeah. (13DSP)

With NDIS, if you look at the dollars that are provided for the support, there is no capacity to have people come in for extensive training, induction, team meeting, all those things that help people understand the culture and make them a better worker, make them better at their job. There's not that capacity within NDIS funding to do that. So we are spending some time thinking about what's the absolute minimum that we can give these staff and still believe that we are going to be able to provide a quality service. (06DSP)

Going into NDIS one of the things that we're really quite concerned about is how we're able to maintain that because in our overheads we have to cover off anything that's not non-face time. So any training has to be included in that service meeting or supervision. So we know that it's going to be really tight. It is already and so we need to make sure that the training that we provide is meaningful training that's actually going to transfer into people's work and

obviously we know that there are going to be a few difficulties with that. So we're not exactly sure how we're going to manage that going forward because it's been tricky enough in the tight environment, let alone putting it into one where we've got really, really tight financial arrangements around that. (02DSP)

[In the] NDIS, there is no funding for training. So as an organisation, we need to work out 'well how can we skill up our staff so that we have staff who are multi skilled to be able to develop a more flexible responsive workforce and there's obviously a cost attached to that. (04DSP)

3.4.3.2 Disability support worker perspectives

Disability support workers in contrast, felt that training opportunities provided by their employer had not diminished under the NDIS to date. Those employers that had provided training to staff free of cost and in paid work time prior to the NDIS were still doing so. Disability support workers based in areas where the NDIS was operational (including locations where the NDIS was just starting and those in sites where the scheme had been operating since 2013) reported that they were still able to access training.

I haven't seen much of a change, to be honest… if you want to get training, you can still go get training, of course. (04DSW)

I haven't seen it yet, but again, it is early days. I would certainly like to think that there would be more training available. But I haven't seen any change in training availability. (13DSW)

I started when it was just rolling out, so I really haven't known anything else - it's always been the NDIS. All I can see is our company definitely jumps on any training that's offered, and passes it through to us. (14DSW)

Indeed one disability support worker noted that if anything, training opportunities had grown as a result of the NDIS and the increased demand it was generating.

NDIS has opened up a whole lot of choice for people…New clients come through… I think if anything we're seeing more training because we're seeing a larger range of clients come with disabilities that I've never seen before. For example, we're getting a lot of autistic children and Down's syndrome children coming through that may present with behaviours that we may not have been as used to before. So I think yeah, definitely if anything we've probably tried to up our training a bit more to keep up with the demand. (18DSW)

However, several disability support workers noted that more training was being delivered online since the introduction of the NDIS. While this was seen as being more convenient and involving less time, this mode of training had implications for learning with less opportunity for the 'hands on' training preferred by many respondents.

So when I first started, they were face-to-face. But now three years on it's now being done online... I think that was something for them to change because of the amount of us that would be away from work, and our training is a fair bit away from where we all work…I think it's out of the convenience really, and a lot of the training they found was not worth doing face-to-face and having a full day off work. (08DSW)

Before there was like face-to-face training, and now most of the training went on line, so there's no practical part of training. (16DSW)

Disability support workers also had concerns that the shift to individualised funding and the increasing

incidences of disability support workers being directly employed by clients under the NDIS would decrease incentives among the workforce to undertake training. In addition, there was concern that clients may opt to employ less qualified staff if that meant paying less for a service, and that more qualified staff were an additional expense.

> *Then the training opportunities; yes, then you would have to do all of that yourself…Because if you've got people that are responsible for keeping up to date on their own and not with an organisation on support worker roles, I can see that people won't. Because it's not cheap to do training and that means that you're also not - you're out of work for that day while you are at training. (12DSW)*

> *It could be done differently in - yeah, I suppose it depends on what the client wants to pay for, isn't it? So, I know at the moment we train all of our staff in tube feeding, for example, but I do know that in the future they may not do that, because maybe not everybody will want to pay for a staff person that's done tube feeding…Rather than having everybody doing it because that's what we as an organisation - because the organisation is paying for it, but if the client is then able to go, well, if I'm paying $20 an hour to (worker) who has tube feeding, but only $15 for somebody else who doesn't, they might choose to take that other people. (09DSW)*

The independent evaluation of the roll out of the NDIS also reported concerns about the impact of NDIS pricing on funding for disability training. Concerns were raised that NDIS pricing did not provide funding for the training of staff and this would undermine workforce quality. Moreover, the ceasing of block funding arrangements was expected to be detrimental to the availability of training and supervision in the sector. Key workforce organisations and disability service providers reported that opportunities for training, student placements and supervision had reduced within the NDIS trial sites. Concerns were also expressed about the future impact that this could have on the skilling of the workforce and the ability to attract new workers to the sector (Mavromaras, Moskos and Mahuteau 2016, p. 49).

3.4.4 Impact on student numbers

A lack of agreement was found amongst respondents as to the impact of the NDIS on the number of students undertaking disability training. Most respondents viewed that no change had occurred in the number of students undertaking training as a result of the NDIS. In contrast other respondents indicated that there may actually have been a decrease in student numbers since the introduction of the NDIS. This was attributed to a widely-held perception that NDIS pricing did not adequately allow organisations to provide training or other professional development activities to their staff.

> *The NDIS don't pay for training; that's my understanding of it. All the NDIS money that comes to our organisations is fee for service for the work that you put into the customer, to the person with the disability. So they don't provide money directly to companies to train staff. The company needs to proportion that money they get for the services they provide towards a training budget.*
>
> *Q: Have you seen a decrease in training as a result of –*
>
> *A: Yes. (20TP)*

A further group of respondents indicated that there had been an actual increase in student numbers to date or expected this to occur in the future as providers became more aware of the expected minimum level qualification of the NDIS and jobseekers were cognisant of the labour market opportunities in the sector. Without an expansion in student numbers, respondents cautioned that

there would not be enough disability support workers to meet the demand for services created by the NDIS.

> *I think because of the NDIS roll out, because there's going to be huge demand, I think they're seeing that there possibly is going to be a shortage. So there's going to be opportunities in the carer careers area. That will mean, obviously, providers will need to provide training. (05TP)*

> *No I've seen an increase because it's outed as the largest growing workforce in Australia at the moment. So whether that's from [NAME] standing in front of the cameras and doing a little speech about it, or the Job Active providers have been doing their jobs and they've done their labour market research and understand that, or whether it's just because there's more information out there at the moment about disabilities and about the NDIS, it's in the news or you go and do a Google search and you'll find lots of stuff out there like that. And I suppose also RTOs are actively advertising funded courses for people to get jobs. So we do certainly see more of an increase. (20TP)*

> *I don't think that the industry has enough skilled workers to do what the ND - the main objective of what the NDIS is all about; giving that flexibility to people, to have that service when they want it and how they want it. I don't think we've got enough workers to do that. Not trained workers and skilled workers, I honestly don't believe we've got them…I think there's going to be the expectation that they'll at least have some sort of understanding from the beginning, and that won't be there. So, that they'll have at least some background, because - well, the expectation is going to be there but that demand won't be met. (12DSW)*

3.4.5 Impact on student characteristics

While not yet observed, training organisations considered that the NDIS would have an impact on the characteristics of the students undertaking disability training. They noted that the expected increased demand for disability support workers required within the sector would encourage non-traditional workers to enter, including men, young people and people with no prior industry experience.

> *Because we're going to clearly need to be looking for people from different backgrounds to come in, there isn't enough workers currently in the NDIS workforce. We need to be looking at attracting younger people, people from diverse backgrounds, people who might not have worked in disability before into the sector. (04TP)*

As discussed above, the shift to person-centred care and individualised funding was resulting in disability support workers increasingly being matched with the characteristics of the person with disability. This would require a diverse support worker labour pool to draw from, with workers not only having appropriate qualifications, but also appropriate values, interests, attributes and personalities.

> *I guess, that is becoming more and more evident and more obvious is as our state gradually rolls into having a full NDIS, there's a greater, greater emphasis on consumer choice, as you would know. So people with disabilities are identifying the sort of person they want supporting them. And that's not just saying gender or age of whatever, they're specifying, 'somebody who is into acid punk' or 'somebody who is in to bodybuilding, or gym or fitness' or whatever, as well as, 'it's got to be a bloke under 30' or 'similar to my age' or 'likes my sort of things. (07TP)*

Finally, the NDIS was reported to be resulting in disability support workers having to be willing to work for shorter shifts and at more diverse times and locations. Students seeking future employment in the sector were said to need to be increasingly willing to be flexible in the location and amount that they

worked.

> *What we're going to look for is staff who are flexible to work short shifts. That's going to be one thing. (04TP)*

> *Depending on how easy it is to get onto these sites already you might find workers who just do it for a bit of extra cash, like people with a nine to five job who Uber it a couple of nights a week. (11TP)*

The NDIS evaluation similarly found evidence of disability sector organisations seeking to employ from non-traditional employee pools. For example, one provider advised they now sometimes hired older men leaving earlier careers who brought considerable life experience and valuable community contacts. Another provider interviewed as part of the NDIS evaluation was trying to employ support workers from the fitness industry or with music skills to match the more diverse services being requested by their clients. In response to demand from younger NDIS participants, several providers sought younger staff to work with these clients (Mavromaras, Moskos and Mahuteau 2016, p. 49).

3.4.6 Impact on the disability workforce

Perceptions were raised by several family members that while the disability sector was expanding in response to the NDIS, inadequate discernment was being shown regarding the types of workers who were being employed. Low wages within the sector were felt to impact upon the ability of provider organisations to adequately attract and retain skilled disability support workers.

> *I think at the moment it's just a means to an end as far as employing people who can't get a job anywhere else. They're all being shuffled into this area because this is the demand – this is the area where we need people and it doesn't matter who you are or what you've done, or what you haven't done, "You go in there, you'll be fine." They're just literally – They're not even thinking of the whole picture. They're just thinking of filling these jobs and it doesn't matter how it's done…but they may not be suited. They may not be in – their heart may not be in the right place. (16PWD)*

> *If you take $15 out of every $40 and you put it in non-direct service, you will not recruit the staff on an ongoing basis…The trouble is that if you constantly have an environment where people are turning over…and some of those people who were left to come, were happy to take a low rate because they're not interested…If you don't [provide good working conditions] then what you're really trying to say to a person is, 'Oh look, this is just a fill in job. Just do it now. You won't get much. This is not important.' (05PWD)*

> *Unless people are paid well, you're never really going to attract people with the skills that you want. I think pay's probably a big issue for a lot of the workers. That's possibly why it's hard to get good people…It needs to be recognised as very worthwhile and real work and it needs to be paid better. (18PWD)*

Several of the family members interviewed expressed concerns that the anticipated expansion of the disability workforce under NDIS would lead to greater numbers of unskilled staff who would be unable to provide adequate quality of care.

> *I think we're going to have a lot more new ones [support workers] on the market with very basic skills. (03PWD)*

> *I think if people are going to be getting the type of funding that everyone seems to be applying*

for that they're going to need more carers so if they can't get enough English-speaking carers well they've got to get them from somewhere and I honestly think that it will deteriorate again…Just some of the people that we've seen goodness knows what's going to come through. (17PWD)

The NDIS evaluation also reported concerns about the attraction and retention of adequately trained and skilled disability support workers. NDIA staff reported that a lack of sufficient numbers of trained staff within the disability workforce meant that providers were struggling to meet the demand for services. Shortages of workers were particularly noted amongst support workers, therapists and support coordinators (Mavromaras, Moskos and Mahuteau 2016, p. 43).

3.5 Summary

The above findings arise from qualitative research and therefore are subject to limitation in their generalisability to broader population groups. However, the findings do point to a number of policy and practice considerations that are important for workforce planning in the disability sector. These relate to the skills and competencies of disability support workers, the appropriateness of skills and training, and the impacts of the NDIS on the disability workforce.

3.5.1 Disability support worker skills and competencies

The qualitative interviews examined the skills and competencies which are considered necessary for disability support workers.

3.5.1.1 Essential skills and competencies

The findings indicate that three key skill-sets were essential for disability support workers to provide quality care – soft skills, communication skills and technical skills. Of these the skills considered to be most important for disability support workers to have are 'soft skills' such as the values, behaviours and attitudes of the worker. Indeed, it was common for the sector to recruit based on a person's interests and traits; requiring disability support workers to obtain specific technical and communication skills once employed. Some disability service providers had developed competency frameworks and other selection processes to identify desirable soft skills in potential support staff. It was also thought that soft skills would become progressively more important in the future as the roll out of the NDIS widens and the individualised funding model beds in. Soft skills were not considered to be easily acquired through current disability education and training. The current and projected importance of 'soft skills' to the disability support worker role suggests that more could be done to unpack what these skills are, how they are acquired by a person and whether or not modules could be developed to foster such skill development in the future.

3.5.1.2 Perceptions of people with disability and their families and carers

The interviews with people with disability and their family members and carers highlighted a preference for disability support workers who have excellent soft skills including a passion for the work, a caring nature, patience and honesty. Many of the people with disability interviewed also stressed the need to workers to actively listen to them, understand their wishes and to involve them in decision-making. The ability of disability support workers to be able to provide appropriate support with personal care and healthcare tasks was also considered essential. Where support workers did not have these necessary skill-sets, respondents considered that the quality of their care was compromised and a detrimental impact on their well-being and independence was experienced. Indeed many people with disability and their family members and carers stressed the need for a more individualised approach to be taken to their care whereby their specific needs, preferences and goals

were supported. For some interviewees this approach went beyond the formal skills held by workers and necessitated a better matching of workers and clients according to age, gender and interests.

3.5.2 Appropriateness of skills and training

Three key aspects around the appropriateness of the skills and training of disability support workers were found in the study. These included perceptions of the quality of disability training, gaps in skills and competencies, and modes of skill acquisition and learning.

3.5.2.1 Quality of disability training

While some respondents expressed satisfaction with the training that disability support workers receive through the VET system, widespread concerns about the quality of disability training, particularly certificate level training, was questioned by all respondent groups. Concerns around the quality of training included poor training provision by some private RTOs, increasing reliance on online training methods, the short duration of some training courses, and a lack of 'real world' relevance in the content of training. It is important to note though that many interviewed for this study may have been reflecting upon training that was undertaken or provided prior to the introduction of the new Certificate III in Individual Support. It will therefore be important in the future to evaluate satisfaction levels of those undertaking the new Certificate III qualifications across both disability and aged care in order to identify specific gaps in that training.

3.5.2.2 Gaps in skills and competencies

All respondent groups identified gaps in the skills and competencies incorporated in current disability training. These gaps included insufficient attention to the skills found to be essential in this study for disability support workers (soft skills, communication skills and technical skills) and also understanding around the values and processes of the NDIS. A further key concern among respondent groups was the lack of disability specific training. This concern should be monitored as it has the potential to be exacerbated with the introduction of the new Certificate III in Individual Support which replaced the former Certificate IIIs in Aged Care, Home and Community Care, and Disability.

3.5.2.3 Skill acquisition and learning

A variety of formal and informal training methods were recognised as being important for the acquisition of skills and knowledge by disability support workers. Opinions were mixed as to the need for disability support workers to possess a formal disability-related qualification such as a Certificate III. While most disability service providers considered the Certificate III in Individual Support (or previously in Disability) to be a key entry level qualification for the sector, other providers (and particularly those outside metropolitan areas) preferred to recruit workers with good soft skills and subsequently to provide them with on-the-job training.

In addition to formal VET qualifications, on-the-job training was considered as being important in enhancing the technical skills of disability support workers and to provide an understanding of the specific requirements of a disability service provider organisation and its individual clients. On-the-job training came in various forms: accredited and non-accredited courses, in-house training, induction training, peer/buddy shifts and ongoing supervision. Recognition was also given in the interviews that some disability support workers come to the sector with a lived experience of disability – either personally or through a family member with a disability – and that this provided them with important informal skills and knowledge that they brought to their work.

3.5.3 Impact of the NDIS

Finally, the roll out of the NDIS was considered to have impacted on the skills and competencies of workers and also on the content and funding of disability training. As the NDIS is one of the most significant social reforms since Medicare, it is unsurprising that it is significantly changing the nature of the disability sector, its workforce and the skills and competencies required by disability support workers.

3.5.3.1 Impacts on skills and competencies

The range of skills and competencies required by disability support workers is changing as a result of the introduction of the NDIS. In particular, the NDIS is leading to disability support workers needing to further develop skills around person-centred care, decision making, risk management, business management and customer service. In addition, workers are expected to need good multidisciplinary skill-sets to work well with people with different types of disability, while at the same time have more specialised skills to work with people with particular support needs or disability types. Overall the NDIS is requiring that the disability support workforce becomes more highly skilled, flexible, responsive and able to tailor the provision of supports to the needs and preferences of the people with disability that they work with.

3.5.3.2 Impacts on disability training

Some of the impacts that the NDIS is having on disability training can be viewed positively. The qualitative evidence found that additional skills and competencies were being incorporated into the training that was delivered. The disability support workers that we interviewed confirmed that the training they received had changed under the NDIS and had more of a focus on individualised care.However, other impacts of the NDIS on the provision of disability training are more concerning. Opportunities for skill acquisition and development were considered by many respondents to have reduced since the introduction of the NDIS. Pricing models under the scheme were not felt to sufficiently cover the provision of training and this was leading to a decrease in the level of training offered to workers by their employers. In addition concerns were raised about the quality of training under the NDIS. A greater use of online modes of training were found to be being used (in part to reduce costs under the NDIS); this was considered to have negative implications for learning opportunities and skill development. These impacts certainly need more exploration and monitoring as the NDIS continues to full national roll-out.

4. Synthesis of the quantitative and qualitative findings

The objective of this project has been to assess the degree to which we should be wary of the emergence of skill shortages within the disability sector as the NDIS is being rolled out throughout Australia. Anticipating skill shortages and exploring how these may arise and with what effect, is a sensible policy position to take in the case of the NDIS roll out for two main reasons. First, the NDIS roll out will come with a rapid rise in the total expenditure on disability support: the total annual expenditure is planned to be considerably higher than its pre-NDIS annual counterpart. Second, the NDIS is introducing a drastically changed method of disability support provision through the new person-centred focus of the Scheme, which will require new and different provision of skills. In brief, not only will the NDIS fund more provision of services, which will require a larger workforce, but it will also introduce new ways for conducting this provision, which will require a differently skilled workforce.

4.1 The context of the research

It is important that we have placed these specific considerations within the broader context of the current Australian labour market and workforce development. The country as a whole has been growing uninterruptedly for a very long period, so rather unsurprisingly, skill shortages have been a permanent feature of several parts of the labour market, as have labour shortages, with unemployment staying at relatively low levels. Those sectors with workforces related to disability support and care (principally, aged care and other care within the mainstream health sector) have also been growing in the last decade and they are forecast to continue to grow, although perhaps not as rapidly as disability support will during the intense years leading to the full NDIS roll out. These related care sectors are important in the present context for two reasons. First, they can be very useful for benchmarking. For example, what happened to the workforces of the aged care sector during recent national reform and upskilling, can provide us with useful information and lessons. Second, we should always be aware of the proximity and relationship between the disability care workforce and all other care workforces. For example, in many cases employers provide both disability and other types of care, which can only mean that the workforce boundaries between care professionals may not be as fast and tight as specific occupational titles may suggest. The implication would be that an emerging shortage in one part of the care sector may be alleviated by utilising labour and skills provided by another part where there may be fewer shortages, or where the wages may be lower. We note that to date (end 2018) this type of flow of skilled labour between the different parts of the care sector has not been observed in any substantial numbers.

It is also important that we have placed all skill shortage considerations within the broader context of the capacity of education and training providers to close emerging skill gaps. The Australian VET system has been active in providing new skills for disability care through the formal upskilling of different types of VET students. First, it provides existing care employees updated knowledge on those parts of disability-specific care that need to be done differently under the NDIS. Second, it trains previously non-care employees who wish to learn about disability-specific care. Third, it provides people who were previously not in employment a new specialisation and allows them to enter a new sector. An important distinction that must be investigated further is that between the upskilling of members of the existing care workforce and the newcomers to the care workforce, as it is principally the latter who will help with the expansion necessitated by the NDIS roll out. Thus, the education and training providers are tasked to increase the number of trainees substantially, differentiating between previously experienced workers and newcomers to the sector. They are also tasked to support the

development of those new skills and competences that the disability sector requires under the NDIS. We note the overall complexity of these tasks involved in workforce upskilling and the need to rely on market forces that, however, will in some cases either not be present or will not be sufficiently well developed in the context of the NDIS.

Finally, it is important to remind the reader that the evidence we use comes from two different sources, each of them with their distinct strengths and weaknesses. The quantitative evidence allows us to examine the national picture as a whole. Its strength is that it allows for generalizable statements and its weakness is that it is poor in detail and depth and the detailed sector data extends back only to the year 2016. In contrast, the qualitative evidence reveals specific aspects of the big picture that will very often not be representative in a broader sense, but may nevertheless be very useful by providing deep information on important specific circumstances. By way of example, a quantitative result may be telling us that till the end of 2016, the problem of skill shortages was not too disruptive for the whole disability care sector. A qualitative result may, however, be telling us of strong concerns about skill shortages in specific sub-groups of the sector and/or concerns about overall anticipated skill shortage pressures in the near future as the NDIS roll out is building up. The qualitative detail and depth can then be utilised to help us understand how things are in these instances where shortages are a problem including how they have arisen, how they are perceived and addressed and how their development may be anticipated. Qualitative research can also be used to examine where the strongest weaknesses are perceived to be in the disability sector workforce and why. Will getting the right numbers of workers be the main worry, or will it be the quality of these workers? Such distinctions have important implications about the relevant policies and the two different types of evidence are highly complementary for understanding the problems and designing the most effective policies.

4.2 Provision of disability training

Our findings show that the provision of training for disability support services appears to be growing. Developing our own categorisation of disability care courses allowed us to overcome some of the imprecisions of standard VET statistics. We find that the number of students undertaking the relevant qualifications has been changing to adapt to the needs of the labour market, especially after 2013, when the NDIS was first introduced, and that the numbers of those trained is increasing. However, although the number of those who choose disability specific training has been increasing rapidly in proportional terms, it still forms a very small part of total VET training and will need to grow considerably within the next few years if it is to meet the added demand for skilled labour presented by the full roll out of the NDIS. To understand how this may work out we synthesise several aspects of training. First we examine the demographic composition of the students and then we examine what they think about their training experience and about the outcomes of their training. We combine this evidence with the granular detail provided by the qualitative evidence. We conclude with an analysis of present skill shortages and construct scenarios about future training levels and skill shortages.

4.3 Characteristics of disability students

The demographics of the students who obtain a disability-specific qualification and join the sector are gradually becoming more diverse. Stakeholders interviewed believed that the NDIS would continue to influence the characteristics of the students undertaking disability training. For example, stakeholders expected that the projected growth of the workforce would encourage greater numbers of non-traditional workers to enter the sector, such as men, young people and individuals with no prior industry experience. This increase in diversity within the workforce was also thought to be encouraged by the increasing incidence of matching disability support workers with the person with disability on

the basis of shared values and interests.

Both the qualitative and quantitative data indicated that a majority of disability training is primarily being undertaken by people who are already working in the sector and seeking formal qualifications, while other care training casts a wider net towards potential recruits to the sector. The implication is that excess demand for skilled workers in the disability sector has a smaller pool of potential future recruits and can be thus expected to find it harder to adapt to skills shortages in the short run than the other care sectors. However, this conclusion also implies that the disability sector may be able to learn from the rest of the care sectors about broader and improved recruitment practices. We would need to integrate and compare information about the way the 'other care' sector is conducting its recruitment, but at this stage we note the possibilities that are suggested by the data, suggesting that future skill shortages could be alleviated through a stronger and wider recruitment strategy by the disability care sector.

An important aspect of our findings is that such a widening of the recruitment strategy is already underway. An increasing proportion of new students come from a background that is not related to disability, either from another sector or from a non-employment status. This is an important finding regarding the sector's ability to counter future skills shortages, in that the broader the pool of potential recruits is, the lower a threat skill shortages present. We noted that this route is countercyclical for those who exit unemployment to study, in that it works more when the whole labour market is in a downturn and less in a labour market upturn. Finally, we developed scenarios indicating that the present increase in the size of the workforce is likely to be inadequate because only a small proportion of recent disability care VET graduates are new to the sector (most already work in the sector) and not all such graduates start working in the sector after completing their disability care VET qualification. The level of training must increase considerably in order to provide the numbers needed by the full roll out NDIS.

4.4 Quality of disability training

The degree to which present and recent past students are satisfied with the quality of their training experience is a major factor for a successful recruitment drive. The statistics overwhelmingly and consistently over the 2007 to 2016 period praise the high quality of the training, with a big majority of students finding that they achieved the main reason for undertaking their training and that they would be willing to recommend very strongly to others their courses and the institutions that delivered these courses to them. This endorsement suggests that if student places were to be increased in order to alleviate or prevent skill shortages, student numbers would be more likely to rise due to the good reputation of the courses.

Finally, the litmus test for any vocationally oriented student course is the labour market outcomes after graduation. Courses that lead to the desired jobs are always considered to be good courses by both prospective students and prospective employers. We thus look at the degree to which present and recent past students are satisfied with the labour market outcomes following their training as another major factor for a potential successful recruitment drive. The message here is clear: this is a desired qualification that leads quickly to employment as a specialist in a relevant sector, where students report (i) that their training was relevant to their job, (ii) that they derived personal and job benefits from it, and (iii) that their employment circumstances were improved because of this training. This is an important endorsement by the student body, which suggests that the training sector is functioning well, in a way that is clearly recognisable by students, and suggests that training providers would be ready and able to work towards alleviating skill shortages, should they emerge strongly in the future.

However, the ringing endorsement of training provision by the student body is not fully shared by employers and training organisations who have to manage the change brought in by the NDIS both in terms of quantity, quality and prices for all provisions. While some employers felt that disability support workers received good training through the VET system, others expressed concern about the quality of disability training and the extent to which it adequately provided new entrants with the skills and competencies needed in their day-to-day work in the sector. Concerns about training quality were also shared by some of the disability support workers and people with disability we interviewed. Stakeholders also reported that while technical competencies, communication and 'soft' skills were still required by disability workers, additional skills and competencies required by disability support workers were emerging in response to the NDIS. These included a greater emphasis on person-centred care, customer service, management skills and behaviour support. For some training providers, these emerging skills and competencies had led to changes in the content of disability training courses. Training organisations acknowledged that further changes would need to be made as the national roll out of the NDIS occurred. There was uncertainty, however, about what these changes would be as they would be dependent in part upon the types of services and supports that people with disability would want to access in the future. These concerns highlight the need to be considering skills shortages not only as a quantity of labour issue, but also as a quality of labour and training issue.

4.5 Availability of disability training

Training organisations and disability support providers identified in the qualitative interviews that NDIS pricing did not allow for the provision of sufficient training to the disability sector workforce. As a consequence the NDIS was seen as negatively impacting on the availability of training (and particularly on-the-job training) within the sector. In response, some training providers were developing online modes of training to provide more affordable training options. However, online training was perceived to be of poorer quality than face-to-face training. One can see how such considerations and concerns expressed by employers and training providers would not surface as clearly from questions asked of students of disability care, but these are nonetheless matters that will impact the ability of the labour market to handle any future skill shortage pressures. Where the voices of the many students surveyed suggested that skill shortages were being handled by the labour market, the voices from the fewer employers and training providers interviewed send a very different but equally valuable message, namely, that the NDIS' focus on person-centred provision is likely to result in NDIS-specific skill shortages, even in a situation where the broader efforts of the training sector provide the necessary numbers. Thus, employers are expressing reservations about the content of the training and the possibility that it could lead to skill gaps (defined as the situation where the workers' skills are not of the desired standard, but they get hired nonetheless as the alternative of not hiring is more damaging to the employer). Furthermore, employers say that the pricing caps imposed by the NDIS, combined with the high costs of training is likely to result in certain provisions becoming uneconomical for support providers to offer to their workers.

4.6 Skills shortages and forward-looking scenarios

The last source of evidence we presented has come from the broader labour market skill shortages indicators we have calculated in order to examine the macroeconomic conditions surrounding skills shortages or surpluses in the disability care sector and the broader labour market. Due to data constraints, we could only calculate these national indicators for the combined disability and aged care workforces. Although the message is less precise, it still is relevant: the increase in demand for services and supports has been addressed by a big rise in the number of employed people and hours supplied in the care sector and has not been followed by a commensurate increase in either wages or number of vacancies which would indicate that skill shortages were at play. Thus, the overall market

picture is not one of broader skill shortages or surpluses, but rather one of managed vigorous growth. We noted that this conclusion is based on numbers that have incorporated only the start of the full NDIS roll out and that remains an open question whether the sector will continue to manage change as successfully when faced with the much larger numbers of participants that will follow in 2018, 2019 and 2020 on the way to full roll out. Indeed, the qualitative interviews highlighted a growing concern about the capacity of the sector to meet the anticipated growing demand for services created by the NDIS.

Following up with this concern, we used the quantitative analysis results to build several hypothetical scenarios about possible future skill shortages. We assumed that the full NDIS roll out would be completed by the end of 2020 and that it would require approx. 70,000 additional qualified workers. A scenario assuming no change in the number and composition of new disability care qualified VET graduates that were experienced in 2015 and 2016, suggested that there would be severe skill shortages by 2020 amounting to a deficit of approx. 46,000 disability care qualified VET graduates. Another scenario which assumed that every year would see a 22 per cent rise in the number of disability care qualified VET graduates (this was the actual rise between 2015 and 2016) concluded that there would still be major shortages of approx. 29,000 disability care qualified VET graduates at the end of 2020. The final scenario asked what would be the necessary annual percentage rise to cover the hypothesised 70,000 need for new workers by 2020, the answer being just over 50 per cent every year starting from 2017.

These are indicative and hypothetical numbers and should be treated as such. They are not designed to tell us precisely what skill shortages to expect under different circumstances, they are rather built to provide ballpark figures and percentages about potential future developments. There are many reasons why as the NDIS is being fully rolled out, things may turn out differently to what is assumed here. If the capacity of VET providers to build the specific skills needed by the NDIS is not developed according to these needs, we may end up with the planned number of additional graduates, but not with the right type of skills. In such a case of mismatch, skills pressures could still emerge and persist. If providers manage to develop in-house and on-the-job training, then the skill pressures could be alleviated, however, if the NDIS price caps continue to be as restrictive as many providers are presently arguing it to be, providers may not be able to afford their planned internal upskilling targets. If the sector becomes more successful at attracting younger and full time employees, the pressures would reduce, as they would if more of the present part time employees start working more hours. The picture is complex and contains much uncertainty. The necessity of close and regular updating on the state of the labour market to keep track of these developments is a critical conclusion of this report.

5. Policy implications and recommendations

In summary, our evidence suggests that, with the full roll out of the NDIS, the disability sector workforce will need to expand considerably. This research has examined the current presence and future possibility of skills shortages for disability care VET graduates within the disability sector. A main conclusion of this research has been that by the end of 2016 large-scale skill shortages could not be traced in the sector. However, considering the anticipated needs by the sector for the full NDIS roll out by 2020, the current level of training and the level of workforce growth are both estimated to be inadequate.

Given the speed at which the full roll out will take place and also given the change in the nature of provision due to the market-driven and person-centred care model of the NDIS, this research suggests that the sector stands high chances of encountering severe skill shortage pressures by the end of 2020.

This research identified increasing activity in the way the relevant qualifications are developed nationally. We identified a marked increase in 2016, as the NDIS trial (2014-2016) was building up to its full scale in several parts of the country. We observed differences between some States and Territories, indicating that while the NDIS trial may have increased provider awareness in some trial areas, the overall national increase in upskilling beyond the trial areas in anticipation of the post-trial roll out was modest.

This research revealed concerns that the sector is not attracting enough new workers. Most of the new disability care VET graduates were already employed in the sector prior to undertaking their disability-specific VET courses. The sector is slowly opening to a broader cohort - with more males, younger people and more workers willing to work full time hours. However, once consideration is given to the employment needs identified for the full NDIS roll out, the observed growth is clearly too modest and likely to prove inadequate.

This research revealed concerns that the sector is not attracting workers with the right skills for the full NDIS roll out. In particular, the type of training currently provided to VET students will need to become better adapted to the customer-driven new market for disability supports and services within the NDIS. The need for disability-specific training, the development of soft skills and enhanced understanding of the NDIS that will contribute to higher quality support and services, were considered to be critical by all stakeholders.

The fact that the increased training activity in 2016 amounted primarily to obtaining more of the entry level Certificate IIIs, and not to upgrading towards the more specialised Certificate IVs or Diplomas, adds to the concerns of skill shortages, indicating that we could be heading towards shortfalls in the quality of future provision of services and supports.

NDIS price caps are perceived by providers to be a hurdle in promoting high quality training and hiring adequate numbers of appropriately skilled workers in the disability sector. As a result, providers argue that quality of supports and services may suffer. It is feared that price increases may emerge as a response behaviour where subsidies and additional funding are introduced, to the detriment of the originally intended consumer benefits from such additional funding. Such situations (where a subsidy primarily results in higher prices) should be closely monitored in order to discourage rent seeking behaviour that allows providers to absorb a large proportion of the additional funding in the form of higher prices and without productivity increases. Additional funding should instead be designed in such a way as to encourage transparent behaviour where genuine upskilling efforts by providers and

students/workers alike improve the quality and/or reduce the prices of services and supports. A major policy tool for such an outcome is to provide supports for training and quality control.

Box 3 below provides details of the specific recommendations which have emerged from the research findings of this project.

Box 3: Specific recommendations which emerge from our research findings include:

The research suggests that training must become a national priority as a means of improving productivity and allowing supports and services to be provided in larger numbers and in better quality. Additional training must be delivered in sufficient numbers and be of the desired quality both in terms of its content and its mode of delivery. A set of interventions must be put in place and continue until the national targets of provision by the disability sector have been reached retaining reasonable prices and quality.

Support for training must be provided at a national level with close monitoring of the course content and delivery.

Providers must be encouraged to engage in the upskilling of their workers in-house. Providers must also engage in evaluating the provision of disability training by educational institutions to ensure that this is meeting the skill needs of the sector.

Whilst financial and in-kind support can speed the process of genuine upskilling and attraction activities, it must be provided in ways that clearly discourage rent-seeking behaviour either through price increases or through quality reductions.

Close examination of the development of the market prices of supports and services to avoid excesses in either direction must continue, measuring and monitoring where the market seems to be settling down as the NDIS reaches its full roll out capacity.

People with disability must be engaged in evaluating the effectiveness of the training provided to their disability workers and how this is translated into their supports, as they report that they need them and as they report that they wish to use them. The ultimate judge of the success of training will be when, first, the cases of price excesses have been reduced to small numbers and, second, the cases of people with disability who report the training of the workers who support them to be of the expected high quality are encountered in large numbers.

As the evidence stands now, it is an open question whether the sector will continue to manage change as successfully (as it did to the end of 2016) when faced with the much larger full roll out numbers of NDIS participants that will follow to 2020 till the full roll out is reached. The qualitative interviews highlighted growing concerns about the capacity of the sector to meet the anticipated growing demand for services created by the NDIS. The quantitative analysis highlighted the intense change that VET training provision would have to achieve in order to get to the desired number of skilled disability support workers by the end of 2020. Given present circumstances, the year 2020 is becoming increasingly unlikely to be the year of full roll out for the NDIS.

The research conducted for this report will need to be extended and updated regularly, in order to provide a continual monitoring and evaluation of how workforces develop on the way to full roll out. Preferably, it will also need to incorporate additional and new different sources of data on student training, on employment in the sector and on the provision of supports and services to people with disability.

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7. Appendix 1 - Additional tables

This Apendix includes several tables that were referred to in the main text and provide supplementary information to the tables and the arguments presented in this report. The numbering follows that of the main text table numbers.

Appendix Table 4a: Characteristics of other care training graduates, by year (per cent)

	2007	2013	2016
Age group (years)	**(n=5,177)**	**(n=12,019)**	**(n=5,766)**
15-24	27	19	21
25-49	51	56	57
50-64	21	24	21
65+	1	1	1
Sex	**(n=5,174)**	**(n=12,019)**	**(n=5,766)**
Male	9	12	13
Female	91	88	87
Country of birth	**(n=5,040)**	**(n=11,168)**	**(n=5,629)**
Australia	77	74	66
Other main English speaking	9	10	6
Other non-English speaking	14	16	27
Location	**(n=5,105)**	**(n=11,967)**	**(n=5,734)**
Major cities	49	49	58
Inner regional	27	27	26
Outer regional	18	18	14
Remote	3	4	2
Very remote	3	1	1
Indigenous status	**(n=5,111)**	**(n=11,613)**	**(n=5,573)**
Indigenous	3	5	4
Non-Indigenous	97	95	96
Disability status	**(n=5,146)**	**(n=11,626)**	**(n=5,298)**
Yes	9	9	8
No	91	91	92

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 4b: Characteristics of all other training graduates, by year (per cent)

	2007	2013	2016
Age group (years)	**(n=29,635)**	**(n=42,271)**	**(n=16,056)**
15-24	37	27	33
25-49	48	51	49
50-64	14	20	16
65+	1	2	1
Sex	**(n=29,621)**	**(n=42,271)**	**(n=16,056)**
Male	47	51	54
Female	53	49	46
Country of birth	**(n=29,334)**	**(n=39,958)**	**(n=15,604)**
Australia	79	76	75
Other main English speaking	8	9	7
Other non-English speaking	13	14	18
Location	**(n=29,068)**	**(n=41,988)**	**(n=15,922)**
Major cities	53	56	60
Inner regional	24	24	24
Outer regional	17	15	14
Remote	3	3	2
Very remote	3	2	1
Indigenous status	**(n=29,316)**	**(n=40,687)**	**(n=15,505)**
Indigenous	2	3	3
Non-Indigenous	98	97	97
Disability status	**(n=29,442)**	**(n=40,746)**	**(n=15,102)**
Yes	8	8	7
No	92	92	93

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 6a: Hours worked per week before training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=3,686)	**(n=8,533)**	**(n=3,566)**
35 hours or more per week	41	42	38
1-34 hours per week	59	58	62

Appendix Table 6b: Hours worked per week before training (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=22,663)	**(n=32,357)**	**(n=11,405)**
35 hours or more per week	62	68	64
1-34 hours per week	38	32	36

Appendix Table 9a: Main reason for undertaking training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=4,626)	(n=11,638)	(n=5,679)
To get a job	24	22	31
To try for a different career	17	16	21
To get a better job or promotion	7	7	7
It was a requirement of my job	17	17	10
I wanted extra skills for my job	16	22	16
To get into another training or study	6	5	5
To improve my general education skills	5	5	5
To get skills for community/voluntary work	3	2	2
To increase my confidence/self-esteem	2	1	1
Other reasons	3	2	3

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 9b: Main reason for undertaking training (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=27,339)	(n=41,227)	(n=15,857)
To get a job	18	16	20
To develop my existing business	2	3	7
To start my own business	4	3	-
To try for a different career	10	8	9
To get a better job or promotion	9	8	7
It was a requirement of my job	21	22	18
I wanted extra skills for my job	18	24	21
To get into another training or study	4	4	5
To improve my general education skills	10	8	9
To get skills for community/voluntary work	1	1	1
To increase my confidence/self-esteem	2	2	1
Other reasons	1	1	1

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 10a:Overall satisfaction with the quality of other care training, by year (per cent)

	2007	2013	2016
	(n=5,084)	(n=11,764)	(n=5,712)
Strongly agree	45	48	45
Agree	43	40	42
Neither agree nor disagree	6	6	7
Disagree	4	3	4
Strongly disagree	2	3	2

Appendix Table 10b: Overall satisfaction with the quality of all other training, by year (per cent)

	2007	2013	2016
	(n=29,137)	(n=41,489)	(n=15,895)
Strongly agree	35	41	39
Agree	51	45	45
Neither agree nor disagree	8	7	9
Disagree	4	4	5
Strongly disagree	2	3	2

Appendix Table 11a: Whether achieved main reason for undertaking other care training, by year (per cent)

	2007	2013	2016
	(n=5,151)	(n=11,890)	(n=5,757)
Yes, wholly achieved	76	75	73
Yes, partly achieved	11	12	13
No	6	6	7
Don't know yet	6	6	7

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 11b: Whether achieved main reason for undertaking all other training, by year (per cent)

	2007	2013	2016
	(n=29,471)	(n=41,853)	(n=16,006)
Yes, wholly achieved	69	69	65
Yes, partly achieved	15	15	17
No	7	8	9
Don't know yet	9	9	10

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 12a: Whether recommend training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=5,036)	(n=11,391)	(n=5,744)
Recommend training	94	92	92
Not recommend training	6	8	8

Appendix Table 12b: Whether recommend training (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=29,288)	(n=40,947)	(n=15,963)
Recommend training	92	91	89
Not recommend training	8	9	11

Appendix Table 13a: Whether recommend institution (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=5,026)	(n=11,395)	(n=5,729)
Recommend institution	92	90	87
Not recommend institution	8	10	13

Appendix Table 13b: Whether recommend institution (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=29,231)	(n=40,910)	(n=15,943)
Recommend institution	91	90	88
Not recommend institution	9	10	12

Appendix Table 14a: Basis of employment after undertaking training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=4,262)	(n=9,601)	(n=4,363)
Wage or salary earner	94	95	95
Conducting own business	5	5	4
Helper not receiving wages	1	1	1

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 14b: Basis of employment after undertaking training (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=24,574)	(n=33,897)	(n=12,272)
Wage or salary earner	91	90	89
Conducting own business	8	10	10
Helper not receiving wages	1	1	1

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 19a: Whether training is relevant to current job (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=4,269)	(n=9,508)	(n=4,231)
Highly relevant	64	66	65
Some relevance	18	19	19
Very little relevance	6	6	5
Not at all relevant	12	9	11

Appendix Table 19b: Whether training is relevant to current job (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=24,562)	(n=33,448)	(n=11,997)
Highly relevant	46	50	46
Some relevance	30	30	30
Very little relevance	10	8	10
Not at all relevant	15	11	14

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 20a: Whether employment circumstances improved after completing training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=5,123)	(n=11,663)	(n=5,558)
Employment circumstances improved	68	64	61
Employment circumstances not improved	32	36	39

Appendix Table 20b: Whether employment circumstances improved after completing training (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=29,232)	(n=40,932)	(n=15,559)
Employment circumstances improved	63	60	53
Employment circumstances not improved	37	40	47

Appendix Table 21a: Change in skill level (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=3,298)	(n=7,485)	(n=3,129)
Movement to higher skill level	21	17	21
Movement to lower skill level	7	6	7
No change in skill level	72	77	73

Note: Due to rounding, the total percentages in this table may not sum exactly to 100.

Appendix Table 21b: Change in skill level (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=20,798)	(n=28,713)	(n=10,166)
Movement to higher skill level	19	13	16
Movement to lower skill level	6	5	6
No change in skill level	75	82	78

Appendix Table 22a: Whether received benefits from doing the training (other care training graduates), by year (per cent)

	2007	2013	2016
	(n=4,237)	(n=9,390)	(n=4,222)
No benefits	2	3	3
Job-related benefits only	1	1	1
Personal benefits only	19	21	21
Both job-related and personal benefits	77	75	74

Appendix Table 22b: Whether received benefits from doing the training (all other training graduates), by year (per cent)

	2007	2013	2016
	(n=24,405)	(n=32,934)	(n=11,947)
No benefits	5	5	7
Job-related benefits only	2	1	2
Personal benefits only	25	26	31
Both job-related and personal benefits	68	68	60

8. Appendix 2 - Qualitative interview topic guides

People with disability/family and carers topoic guide

About the participant…

Please could tell us a little about yourself; who you live with; what you do in your usual day (education; work; community involvement); your interests or any activities you are involved with?

We would now like to ask about your disability services and supports. What services and supports do you use? Are you an NDIS participant? *Probe: personal care and everyday living, case management, participation in community/social/physical activities, support with transport, therapies and medication, respite, aids and equipment, help at work or with study*

How long have you been using this disability support provider?

How did this come about? *Probe: why choose provider; if previously received similar supports from another organisation - why change*

About disability support workers…

Thinking back about the different workers you have received supports from, do any people stand out as being particularly good disability support workers?

What was it about this worker compared to the others that stood out to you? *Probe: behaviour, gender, age, appearance, manner, skills, qualifications*

Are there any people that stand out as being particularly bad disability support workers?

What was it about this worker compared to the others that stood out to you? *Probe: behaviour, gender, age, appearance, manner, skills, qualifications*

Do you think some people are more suited to disability support work than other people?

What types are persons are more suited? Why do you think that? *Probe: behaviour, gender, age, appearance, manner, skills, qualifications*

Thinking about your support worker(s)…

Do they have the appropriate skills and training to meet your support needs and provide you with good quality care? *Probe: skill gaps; training that would be helpful that they are not currently receiving*

NDIS and the future of the disability support sector…

Has the introduction of the NDIS changed the types of skills and competencies disability support workers need? *Probe: changes to types of services; changes to support needs; skills around facilitating choice and control, independent living and active community engagement*

What do you think will be the future impact of the NDIS on the skills and competencies disability support workers will need?

Disability service providers topic guide

Introduction…

Please could we start by you telling me a little bit about your organisation? *Probe: type of organisation (not-for-profit or charitable/privately owned or for-profit/public or government), part of larger organisation, NDIS registered provider*

What types of disability support does your organisation provide?

How many staff does your organisation have? *Probe: staffing profiles/roles*

As a disability support provider…

Can you tell me a little about the last time you last advertised to fill a vacancy for a disability support worker?

Probe: when was it? How did you advertise (web/word-of-mouth/newspaper)?

In the most recent recruitment effort….

How many applicants did you get?

How long did it take to fill the vacancy?

What was your overall impression of the calibre of the applicants?

Any difficulties with recruitment? (If yes) are these difficulties unique to this recruitment or general problems?

Do you have any skills needs or vacancies that are so hard to fill that you just do not bother to advertise?

What types of people are more suited to disability support work? Why do you think that? *Probe: behaviour, gender, age, appearance, manner, skills, qualifications; examples of workers*

Are these the types of characteristics you seek in potential employees?

What type of people are just not suitable for disability support work? Why do you think that? *Probe for: behaviour, gender, age, appearance, manner, skills, qualifications; examples of workers*

Thinking about your staff…

Do the disability support workers on your staff hold any specific qualifications in disability care?

(If yes) How well do you feel this training has equipped them to work in disability care?

Are there any skills that disability support workers need that they cannot (or do not) learn through formal training?

Do your disability support workers have the appropriate skills and training to meet the support needs of clients and provide good quality care? *Probe: skill gaps; training that would be helpful that they are not currently receiving*

How do you support your staff to develop their skills and training? *Probe: training (in-house, external, on-the-job, induction), mentoring/buddying, supervision*

Is there anything that you have done that works particularly well?

Is there anything that you have tried that hasn't worked?

Are there any issues or difficulties your organisation faces in providing this support? *Probe: access to training, staff time and availability, financial costs*

NDIS and the future of the disability support sector…

Has the NDIS impacted on the prices charged for supports and services?

Has this impacted on the work arrangements for disability support workers? *Probe: wages, schedules, employment contracts*

Has the introduction of the NDIS changed the types of skills and competencies disability support workers need? *Probe: changes to types of services; changes to support needs; skills around facilitating choice and control, independent living and active community engagement*

How has your organisation responded to these changes?

What do you think will be the future impact of the NDIS on the skills and competencies of disability support workers will need?

Disability support workers topic guide

Thinking about yourself…

What is your current role in disability care? *Probe: job tasks*

How long have you worked in disability care?

Why did you choose to work in disability care?

Do you hold any specific qualifications in disability care?

(If yes) Was this training completed prior to or after you began working in disability care?

How well do you feel this training has equipped you to work in disability care? Are there any skills that you should have, but didn't, learn when you did this course?

Did you have any issues accessing this training? *Probe: availability of disability-specific training, location of training, cost*

Have you done any further work-related training?

What kinds of training have you done?

To what extent does your employer support you to do work-related training? *Probe: time release from work, financial support*

What kinds of training do you find most useful?

Have you done any training that hasn't been useful? If yes, what kinds?

Is there any training which you have not done, which you feel would be useful in your work? If yes, what kinds?

Are there any skills that you have acquired either inside or outside the workplace that you feel help you to provide better quality disability supports?

How and where did you gain these skills? How do they help you to provide better quality care?

Are there any skills that you think you need to work in disability care that you have not developed either through training or personal experience?

Do your clients have any particular needs, preferences or aspirations that require certain skills or competencies? *Probe: living in regional, rural, remote areas; ATSI or CALD background; support needs – complex and high/psychosocial*

How satisfied are you with your work arrangements and conditions? *Probe: wages, employment contract, work roster, flexibility*

Are you paid a fair wage for the work you do?

Could you be earning more in another job or sector? (If yes) what keeps you working in disability support?

What would you like to achieve in your work in the next 3-5 years?

Thinking about the disability support workforce…

What do you think makes a good disability support worker? *Probe: skills, competencies, qualifications, worker personality traits/attributes (age, gender, culture, language skills)*

Is there anything that could be done to help disability support workers to provide better support to their clients? *Probe: training, management support/supervision, workplace policies and procedures, working conditions (pay, schedules, contracts), time available with clients*

NDIS and the future of the disability support sector…

Does the organisation you work for provide supports under the NDIS? (If yes) has the NDIS impacted on your working conditions and arrangements? *Probe: wages, schedule, employment contract*

Has the introduction of the NDIS changed the types of skills and competencies disability support workers need? *Probe: changes to types of services; changes to support needs; skills around facilitating choice and control, independent living and active community engagement*

How has your employer responded to these changes?

Has the NDIS impacted on the level and type of training available to disability support workers? *Probe: overall level of training, types of training courses, employer support (financial, paid time from work)*

What do you think will be the future impact of the NDIS on the skills and competencies of disability support workers will need?

Disability service training providers topic guide

About your organisation…

Please could we start by you telling me a little bit about your organisation? *Probe: location (metro, regional, rural), types of training provided, methods of training delivery (on-site, external, online), number of students*

Thinking about your current training courses…

What disability-related training courses and/or qualifications does your organisation provide? *Probe: length of training, method of training (onsite, external, online, placements), entry requirements*

Where do you receive funding from for the provision of disability training courses?

What are the characteristics of the students undertaking disability training courses? *Probe: age, gender, country of birth, previous qualifications/work experience*

What are the outcomes for the students on your disability training courses? *Probe: completion rates, employment opportunities – disability sector/other employment*

Do you provide any non-disability-specific courses that commonly supply staff to the disability sector?

Thinking about skill needs in the disability sector…

What are the skills that you believe are necessary for providing quality workers for the disability sector?

What skills and competencies do you aim to cover in your disability training courses? *Probe: technical competencies; communication skills; skills specific to: particular types of disability (e.g. people with complex and high support needs, psychosocial disability); working in regional/rural/remote areas; working with people with disability from ATSI or CALD backgrounds*

Are there any skills or competencies that that are important for quality disability service provision that are not currently covered by disability training courses? *Probe: technical competencies, soft skills*

How do you think these should be developed? *Probe: further training (formal, on-the-job), mentoring/supervision, work experience*

Impact of the NDIS…

Has the introduction of the NDIS changed the types of skills and competencies disability support workers need? *Probe: changes to support needs/types of services; changes to skills, e.g. facilitating choice and control, independent living and active community engagement*

Has the introduction of the NDIS impacted upon:

Sources of funding for the provision of disability training courses?

The numbers of students expressing an interest in or enrolling for disability courses?

The type of people taking part in disability training courses and qualifications? (If yes) In what way? *Probe: age, gender, country of birth, previous qualifications/work experience*

Have there been, or do you plan to introduce, any changes to the courses that you provide as a result of the NDIS? *Probe: type of courses, content of training courses, method of delivery*

What do you think will be the future impact of the NDIS on the skills and competencies of disability support workers will need?