Response to questions on notice

- **Part of your submission focuses on evidence that demonstrates that service culture is associated with abuse. Have you collected data or done any modelling on this relationship?**

The underlying proposition of this assertion is - that where there is high quality practice by front line direct staff in services, there are better quality of life outcomes for the people with disabilities supported in the service. The converse of this is that poor practice is associated with poor outcomes and abuse. Attention to the quality of staff practice and services is a fundamental way of preventing abuse, that reduces the need for other more reactive safeguarding mechanisms. Quality of life outcomes include engagement in meaningful activity and social relationships as well as social inclusion, all of which are preventative factors in socio-ecological models of abuse (DeGue et al., 2014)

My research has demonstrated the differences in the culture of group homes where people with intellectual disabilities have poor outcomes compared to those where people have better outcomes (Bigby et al. 2012; 2015, 2016). The diagram below illustrates these differences on five dimensions of culture.

Likely to be found in underperforming homes		Likely to be found in better homes
	Dimensions of Culture	

Overarching characteristics →

Cohesive
Respectful
Enabling
Motivating

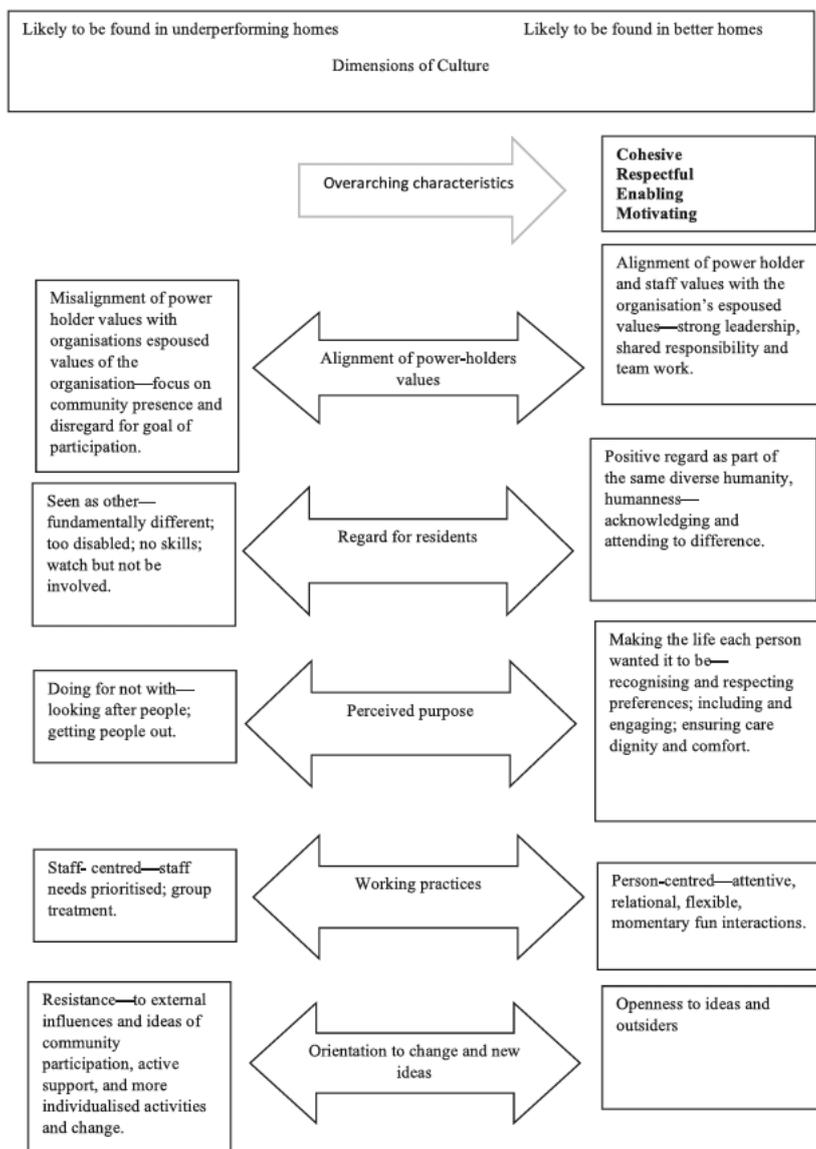| Misalignment of power holder values with organisations espoused values of the organisation—focus on community presence and disregard for goal of participation. | ◁ Alignment of power-holders values ▷ | Alignment of power holder and staff values with the organisation's espoused values—strong leadership, shared responsibility and team work. |
Seen as other—fundamentally different; too disabled; no skills; watch but not be involved.	◁ Regard for residents ▷	Positive regard as part of the same diverse humanity, humanness—acknowledging and attending to difference.
Doing for not with—looking after people; getting people out.	◁ Perceived purpose ▷	Making the life each person wanted it to be—recognising and respecting preferences; including and engaging; ensuring care dignity and comfort.
Staff- centred—staff needs prioritised; group treatment.	◁ Working practices ▷	Person-centred—attentive, relational, flexible, momentary fun interactions.
Resistance—to external influences and ideas of community participation, active support, and more individualised activities and change.	◁ Orientation to change and new ideas ▷	Openness to ideas and outsiders

Figure 1. Culture in underperforming and better group homes.

Other research supports this findings in that abuse is more likely to occur where people with disabilities are dehumanised and regarded as 'other' rather than as human beings of equal value, which is associated with the culture in what we call underperforming group homes.

The body of qualitative research on culture in group homes cited above formed the basis of a PhD study that developed and tested the psychometric properties of a measure of culture in group homes – the Group Home Culture Scale (Humphreys, 2018; Humphreys, Bigby, Iacono & Bould, 2020). One of the papers from this study demonstrates a statistically significant relationship between a culture where a sense of 'supporting well-being' is shared

by staff and involvement of the people supported in community activities. Other elements of culture, such as effective team leadership and alignment of staff with organisational values were also shown to be statistically associated with engagement of the people with disabilities supported in the service (Humphreys, Bigby & Iacono, 2020).

Together these studies of culture reflect findings of a larger scale study of the quality of practice and its impact on quality of life outcomes, which point to the significance front line practice leadership as key determinant of good staff practice (Bigby et al, 2019)

- **Your submission notes that the level of regulation to introduce uniform national benchmarks and accreditation of disability workers is already open to the NDIS Quality and Safeguard Commission to impose. In your view, what are the barriers to the Safeguards Commission introducing uniform standards or, why aren't they already in place?**

There are many potential barriers and reasons why uniform standards are not in place. First I would like to remind the Committee that my submission argued that the skills and knowledge required by disability workers depends on the level and type of impairments of the people they work with and the context of their work, i.e. the nature of the service they are delivering. Being a personal assistant with daily personal care tasks for a person with physical disability is fundamentally different from providing support to a person with severe intellectual disability to be engaged in everyday activities and social interactions as well as support with their personal care. Thus I do not think one uniform standard for all workers should be aim, rather consideration of a series of uniform standards that are group or impairment and context specific. In my view one of the reasons that uniform standards have not been developed is the lack of any real depth of knowledge about disability practice within the management structures and among senior staff in either the NDIA or the NDIS Quality and Safeguards Commission, and the failure to acknowledge or understand the research evidence available that should inform practice and thus the types of training and standards required. There is for example some expertise among staff in the Commission about behaviour support and it is clear this has driven work on worker competency and standards in this realm of practice but this has not been replicated in other areas of practice which are of equal importance. Thus the failure to develop standards has been due to a lack systematic attention by regulatory and funding bodies and the absence of champions to promote the significance of specific areas of practice.

One might also argue that status and cost of disability work is a compounding issue, if this work were increased in status through more uniform and minimum standards of training then the cost of providing support would increase which may have implications for the NDIS

budget and capacity to meet demands for disability support. Minimum standards have implications for provision of training infrastructure and raises questions about who bears the cost of training as well as levels of pay to reflect skills. In the long run if scandals, abuse and poor practice are to be avoided then the status, skill and pay of disability support work will have to be raised.

- **How important is portability when it comes to accreditation? What is the impact of the current lack of portability?**

I would not rate portability as high as having minimum standards, but it is important for the mobility of the workforce across services and state borders. There are national accreditation bodies for higher education and VET providers vis a vis education and training, and in the professions for many disciplines, so national standards are something where there are well established structures. The impact of the current lack of standards and portability is increased costs for disability service providers who have no reliable way of judging the quality of training that a workers bring to their position from elsewhere.

- **What can be done to recognise and encourage post-graduate levels of training in the disability workforce?**

Universities are self-accrediting institutions, thus can offer postgraduate qualifications that meet the various levels spelt out in the Higher Education Standards i.e. graduate certificate, masters etc. It would be very open to the NDIA or the Commission to recognise post graduate level qualifications offered by Universities and append additional rates of payment for delivery of services by staff who hold such post graduate qualifications . For example La Trobe offers a graduate certificate in Disability Practice which is an interdisciplinary course – this could be recognised by the NDIA in its pricing guide for services such as complex support coordination, behaviour support and so on.

The other method of recognising postgraduate levels of training is in relation to the professions, for example the Social Work professional (AASW) accredits mental health social workers who attract Medicare rebates and is currently considering instituting a new accreditation scheme for social workers who specialise in disability – generally this type of professional accreditation requires higher levels of study or continuing professional development in the area of specialisation. Other professions recognise and sometimes accredit postgraduate qualifications in specialist area of practice offered by Universities, particularly in nursing and psychology for example.

Disability has, for a long time, been a fairly devalued field of practice for many professions and there has been no incentive to undertake either undergraduate or graduate qualifications, as payment structures do not recognise or give any greater reward for qualifications.

Incentives to undertake higher level study need to build into award structures in disability as they are for many professions, particularly in the health sector.

- **Governments have a key role to play in developing a national training framework. If a government was going to start this process tomorrow, what would the first steps be?**

From my perspective the first step would be to scope the different types of work (see comments above re who you are working with and in what context) and propose a segmentation of the workforce based on the best available evidence from experienced researchers in the field who can back up opinion with evidence. Once this is agreed the task becomes more manageable to develop working groups around each type of work to scope the skills and knowledge required to undertake the work at beginner, competent and advanced levels and having done this, again using existing expertise scope existing training programs and curricula and or develop new curricula. These may be micro credentialled training in the form of 2 or 3 day training programs that can be stacked together to meet requirements for different areas of practice.

In short I would propose formation of an expert working group to do this work and to consult more broadly but which is comprised, not of vested interests, but of those who can draw on national and international evidence to inform their work. Clearly too there is a role to gather the perspectives of different groups of people with disabilities and their families about their perceptions of the skills and knowledge required that can be blended together with research based knowledge. I take it for granted there is a core set of values and attitudes required for disability work but consider these are already articulated in codes of conduct and practice standards, the gap is the skills and knowledge required to put these values into action.

I would not rely on the existing fairly heavy bureaucratic and slow moving processes or institutions that already exist but would form an innovative new body with a clear mandate to undertake this urgent work. Over the last few years much has been invested in short term project based work often tendered to consultants which had had little impact and has tended to be neglected and ignored by incoming officers.

References

Bigby, C., Knox, M., Beadle-Brown, J., Clement, T., Mansell., J (2012). Uncovering dimensions of informal culture in underperforming group homes for people with severe intellectual disabilities. *Intellectual and Developmental Disabilities* 50, 6, 452–467

Bigby, C., & Beadle-Brown, J., (2016) Culture in better group homes for people with severe and profound intellectual disability. *Intellectual and Developmental Disabilities, 54, 316 331*

http://www.aaiddjournals.org/doi/pdf/10.1352/1934-9556-54.5.316

Bigby, C., Knox, M., Beadle-Brown, J. and Clement, T. (2015), 'We Just Call Them People': Positive Regard as a Dimension of Culture in Group Homes for People with Severe Intellectual Disability. *J Appl Res Intellect Disabil,* 28: 283–295. doi:10.1111/jar.1212

Bigby, C., Bould, E., Iacono, I., & Beadle-Brown, J. (2019). Predicting good Active Support for people with intellectual disabilities in supported accommodation services: Key messages for providers, consumers and regulators**.** *Journal of Intellectual and Developmental Disability* doi.org/10.3109/13668250.2019.1685479

DeGue, S., Valle, L. A., Holt, M. K., Massetti, G. M., Matjasko, J. L., & Tharp, A. T. (2014). A systematic review of primary prevention strategies for sexual violence perpetration. Aggression and Violent Behaviour, 19(4), 346–362.
https://doi.org/10.1016/j.avb.2014.05.004
Department of Social Services. (2017). NDIS quality and safeguarding framework.

Humphries, L., Bigby, C., Iacono, T. (2020) Dimensions of group home culture as predictors of quality of life outcomes. *Journal of Applied Research in Intellectual Disabilities* https://doi.org/10.1111/jar.12748

Humphreys, L., Bigby, C., Iacono, T, & Bould, E. (2019). Development and psychometric evaluation of the Group Home Culture Scale. *Journal of Applied Research in Intellectual and Developmental Disabilities https://onlinelibrary.wiley.com/doi/full/10.1111/jar.12693*